LEPROSY SECTION
MANAGEMENT OF TROPHIC ULCERS IN LEPROSY

By

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Trophic ulcers are frequently met with in leprosy and pose a serious problem. The condition constitutes "a cripple." The incidence is more rural and agricultural than urban. Socio-economic standards, environmental hygiene and lack of personal cleanliness perpetuate the condition. Illiteracy, ignorance and a sense of fatalism, all aggravate and prolong the condition.

Trophic ulcers have variously been described as perforating, penetrating, plantar and leprotic. This concept appears to me to be incorrect. These terms at best, merely describe the depth of the ulcers and their anatomical location. They do not connote the aetiology and pathology. Ulcers in leprosy could be plantar, palmar, malleolar, digital and decubitus.

The essential underlying morbidity is that of a sensory deficit resulting in anaesthesia and analgesia of the part. Now, this can occur in other conditions too, apart from leprosy. Tabes dorsalis, Syringomyelia, Spina bifida and Diabetes mellitus offer some examples of the occurrence of the trophic ulcers.

The fact emerges that the cause is neuropathic – either central and cerebral or peripheral and partial.

Trauma, infection, ill-fitting country chappals with protruding nails are contributory factors in the causation of trophic ulcers. To these must be added continued weight-bearing, paralysis with wasting and weakness of the intrinsic muscles of the foot, resulting in frequent friction of the surface area of contact, which results in a thinning out of the skin area, opposite to bony prominences, notably those of the heads of metatarsals, the calcaneus and the digits. This is prerequisite and pre-ulcerative.

Treatment of trophic ulcers.—It has been our experience that patients with trophic ulcers seek advice with well-established perforating plantar ulcers. The fact must be emphasized that there are no substitutes for well-eatablished, fundamental surgical concepts. Rest and elevation and keeping the part clean and dry and restricted locomotion, offer the best solution for rapid recovery and wound-healing. Debridement of the hyperkeratinized, over-hanging skin with saucerization of the ulcer site, have yielded good results in our hands. As regards dressing-up the raw wound surface, various medicaments like Livoderm, Chloromycetin skin-ointment, Cicatrin, Zinc and its products, Lepsulimin ointment etc., have been tried with varying results.

Plaster of Paris casts below the knee is best but they are very costly. Three of the patients on whom they were applied, removed them during the 2nd week

with the help of a local barber. So, this practice has been discontinued in this Centre.

As the patients attending our Centre are illiterate villagers, they are treated as domiciliary, ambulatory patients. Our drug of choice is Pantothenic acid. The remedy is simple, the ointment is easy to apply, and the villager understands the instructions given. Specifically at this Centre, the Pantophyll ointment of Messrs. Anglo-French Drug Co. is being used with gratifying results. Well over seventy patients have been treated at the main centre and sub-centres with this ointment. Rapid re-epithelialization of the wound occurs in from 4 to 6 weeks' time. The dressings are done by the patient himself bi-weekly. The patients continues the ointment for a further period of two to three weeks.

During this period, bed-rest and elevation of the part are enforced. Long-acting sulphas like Orisul are administered (one tablet daily) for three weeks. Specific therapy with D. D. S. is continued. Two cases of excision of malleolar ulcer with skin-grafting were performed with good results.

SUMMARY

1. About 70 trophic ulcers in leprosy have been treated with Pantophyll ointment, containing d-Pantothenyl-alcohol.
2. The patients receive domiciliary ambulatory treatment. The dressings are done by the patients themselves.
3. Long-acting Sulphas and D. D. S. are administered.
4. No P. O. P. is appliad.
5. Rapid re-epithelialization with gratifying results have been observed.

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