LETTERS TO THE EDITOR

WHO REGIMEN FOR PAUCIBACILLARY LEPROSY : RECOMMENDED DURATION INADEQUATE ?

Short-course chemotherapy (rifampicin 600 mg once a month and dapsone 100 mg daily for 6 months) as recommended by WHO is now widely used for the treatment of paucibacillary leprosy. Ten patients (4 cases of TT and 6 cases of BT) who received the above recommended regimen from this department were closely followed up. Before starting the treatment, histopathological confirmation of the type of disease was made in all the patients. Repeated examination of the smears from the skin lesions and ear lobes did not show any AFB. They were followed up every month till 6 months, after which histopathological study of the lesion was carried out again. It was observed that in 3 patients, even though there was reduction in the size of the lesions, the erythema and infiltration were still persisting and histopathology showed evidence of tuberculoid granuloma in the upper dermis. In 2 patients, even though the skin lesions regressed completely leaving only atrophy and analgesia, histopathology revealed a dense collection of lymphocytes and a few epithelioid cells in the upper dermis. There was no clinical or histopathological evidence of activity of the disease in the remaining patients. Thus, 30% of the patients had clinical as well as histopathological evidence of persistence of the disease, while 20% had histopathological evidence of activity in spite of good clinical recovery.

These observations indicate that either the regimen recommended by the WHO for paucibacillary leprosy is to be reconsidered or the duration of treatment recommended as 6 months is quite inadequate and needs further evaluation. Spontaneous healing of these 'resolving' granulomatous lesions in the absence of further continuation of chemotherapy is quite possible because of the adequate cell-mediated immunity in this type of patients, but it is impossible to distinguish those who will heal spontaneously from those who will not. Further, the bacilli remaining in these skin lesions are already exposed to dapsone and rifampicin during the short-course therapy, and if such lesions later progress to multibacillary forms, the treatment may become more complicated and problematic. We would like to hear from our professional colleagues about their experiences in treating paucibacillary cases with the WHO regimen.

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EPIDERMAL NAEVUS LOOKING LIKE ACANTHOSIS NIGRICANS

Epidermal naevus resembling acanthosis nigricans is a rare abnormality. When a 12-year-old male was 9-year-old, he noticed a linear hyperpigmented plaque over his left upper extremity extending over to the trunk. The lesion was slowly progressing, but growing faster during the last 6 months. None of his family members including his two siblings had a similar lesion. The lesion was a thickened and linear plaque extending from the middle of the anterior part of the chest, through the axilla to the medial aspect of the arm. On the medial aspect of left forearm and the little finger, there were interrupted linear hyperpigmented macules. The surface of the plaque in the axilla was velvety, and brown hyperpigmentation was extending beyond the margins of the plaque (Fig. 1).

Fig. 1. Epidermal nevus looking like acanthosis nigricans.

Other body folds were normal. Biopsy from the velvety plaque showed severe hyperkeratosis, marked acanthosis and papillomatosis. Non-specific, patchy lymphocytic infiltrate was seen in the dermis. The histopathological features were compatible with epidermal naevus.

Epidermal naevus is generally considered to follow Blaschko's lines[1] and may be distributed in linear, irregular and wavy patterns.[2] Usually the surface is verrucous and hyperpigmentation is limited to the verrucous lesion. In our case, the surface was velvety as in acanthosis nigricans. The hyperpigmentation extended beyond the margins of the plaque which is common in acanthosis nigricans rather than epidermal naevus. Curth[3] recorded a similar case where an epidermal naevus on the right side of the abdomen, resembled acanthosis nigricans.

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LOCALISED HEMIFACIAL ATROPHY

Recently we have come across a case of localised hemifacial atrophy with non-cicatricial alopecia in the area supplied by the maxillary division of trigeminal nerve.

A 20-year-old boy complained of a gradual depression of the right side of his face extending from the lower eyelid to the right angle of his mouth, after having had trauma of the skull 5 years back. It was associated with flattening of the right naso-labial fold, loss of eyelashes of the right lower eyelid and right side of moustaches and occasional sudden tightness (spasm) of the right side of face. These were gradually increasing in severity without any remissions. There was no history of pain, neurological deficit or epilepsy at any stage of his illness. He was having difficulty in masticating food on right side. He also had protrusion of the right eyeball without any symptoms. Personal and family history were insignificant. General examination revealed no abnormality and physical growth was normal. Examination of the face showed a general depression of the right side of face with non-cicatricial alopecia in the area supplied by the maxillary division of the trigeminal nerve, it was sharply demarcated in the mid line. (Fig. 1). Naso-labial fold was flattened, there was a slight protrusion of the right eyeball, angle of mouth was retracted towards the affected side, the cheek was sunken and the ala nasi was thinned. Skin of the affected area was not atrophic and not adherent to the deeper structures. The subcutaneous tissue was atrophic as also the buccal pad of fat and muscles of the involved area. The cranial nerves were normal. Cutaneous sensations and sweating in the affected area were normal. Teeth, nails, tongue and the jaw bone were also normal. Eye and ENT check up showed no abnormality. A depressed scar of an old injury was present over the vertex. Systemic examination was normal. X-rays of the skull and jaw were normal.

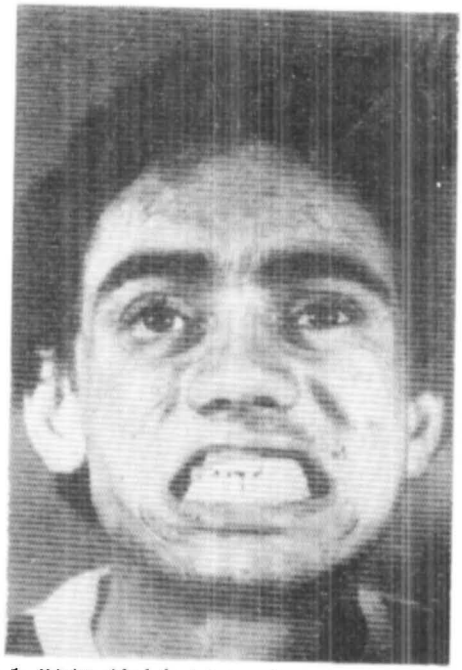

Fig. 1. Right sided facial atrophy with non-cicatricial alopecia in the area supplied by maxillary division of the trigeminal nerve.

In this case, the disease seemed to have started after trauma to the skull, supporting the theory which implicates antecedent trauma as the triggering factor, the atrophy being thought to be secondary to a localised vasospasm from sympathetic nerve injury.[1] Non-cicatricial alopecia in this case may be due to a trophic effect on the hairs in the involved area.

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INTERDIGITAL PSORIASIS

We wish to draw attention to the lesions of psoriasis occurring in interdigital areas, particularly toe-webs. Waisman[1] used the term 'white psoriasis' for chronic, recalcitrant, sodden patches between the toes of middle aged and older psoriatics. They are commonly mistaken for macerated interdigital fungus infection. Examination for fungi is consistently negative and histopathology shows concordant changes of psoriasis. He concluded that interdigital, white or hyperkeratotic psoriasis is a distinctive example of chronic intertriginous psoriasis whose peculiarities are influenced by the site. Pitting of nails and psoriasis elsewhere make the diagnosis easy. Castellani[2] described a similar condition as 'pseudotinea pedum' and emphasized the chronicity and resistance to treatment of the interdigital disease. He advocated an ointment with 3% ammoniated mercury and 6% precipitated sulphur.

Recently, we encountered two patients having psoriasis, both males, aged 25 and 40 years, with lesions in the toe spaces apart from psoriasis vulgaris in other areas. Repeated scrapings for fungi were negative. They did not respond to topical coal tar ointment and Whitfield's ointment for several weeks, though the lesions in other parts of the body showed remission. Later, they showed marked relief with topical fluocinolone in cream base in 3 weeks time. Examination for fungi was repeatedly negative. There may be many other patients with interdigital psoriasis with plantar psoriasis or with minimal psoriasis elsewhere who would be missed as tinea pedis or intertrigo. However, we do not accept the new term white psoriasis which did not rightly gain common acceptance, as it probably represents only the state of hydration and maceration in this area.

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