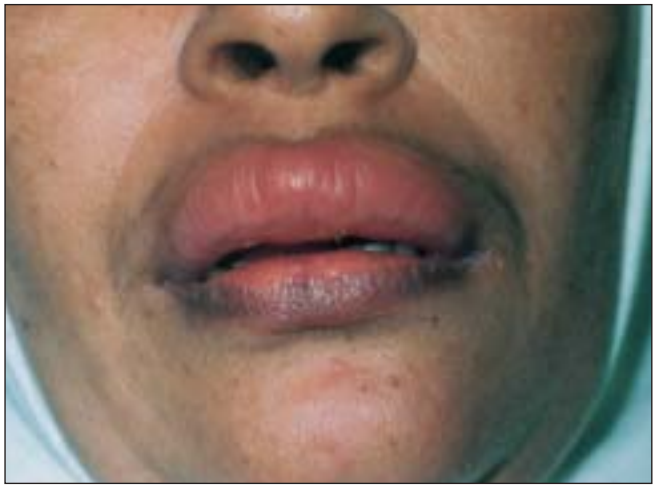

Figure 1: Bilateral upper labial edema

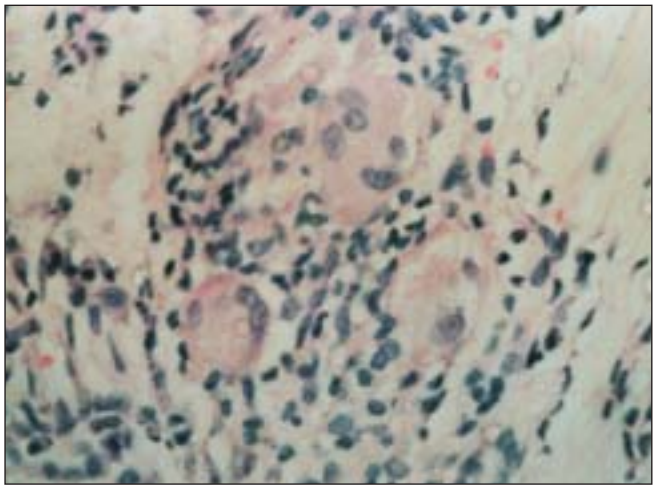

Figure 2: Histopathology - High power view-epithelioid cell granuloma with giant cells and plasma cells (400x, H/E).

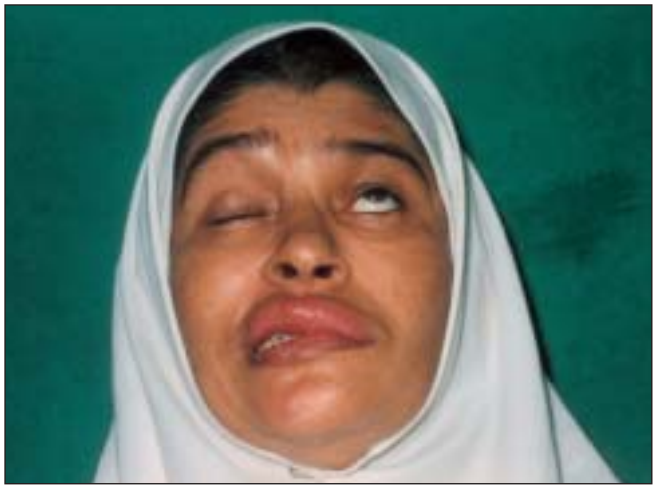

Figure 3: Labial edema subsiding, left facial palsy.

may precede the attacks of edema by months or years or may develop later and while initially intermittent, may occasionally become permanent.[1] Recurrent edema can be periorbital or vulval (vulvitis granulomatosa). In our patient, the labial edema responded partially to metronidazole and significantly to clofazimine and intralesional steroids,[3] but treatment did not prevent the occurrence of facial palsy. This case report highlights the interesting evolution of granulomatous cheilitis to full fledged MRS with bilateral facial palsy. The presence of the complete triad in a single patient is rare, being reported in only 10-20% of cases, and bilateral facial palsy in MRS is even rarer.[6]

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Disability rates in leprosy

Sir,

Leprosy causes disabilities through damage to peripheral nerves. Disabilities and deformities frequently persist even after successful treatment. The

disability rates reported from different centers vary greatly because of the type of leprosy prevalent and the criteria followed for labeling disabilities. The second report of the WHO Expert Committee on Leprosy estimated that about 25% of leprosy patients have some degree of disability.[1]

In a retrospective study (1993-2001) based on the records of an urban leprosy clinic in Jodhpur, we found disabilities in 178 (35%) of the evaluated 500 patients with leprosy. Disabilities of hands, feet, eyes and face were recorded into Grades 1-3 according to the WHO Expert Committee on Leprosy.[1] The data were analyzed using the Ridley-Jopling classification of leprosy, i.e. tuberculoid, borderline (BT, BB and BL) and lepromatous leprosy.

The disability rate was highest in the age group above 60 years (50.1%), followed by the age group 46-60 years (43.6%), and lowest in the age group of 0-15 years (8.3%). It was higher in males (38.7%) than in females (30%). Males, by virtue of their occupation, outdoor habits and smoking, are more likely to be injured. The disability rate was highest in lepromatous leprosy (53%) and lowest in tuberculoid leprosy (8.3%) as shown in Table 1. The duration of disease also affected the disability rate, being highest in the more than 2 years duration group (44.1%) and lowest in the 0-2 years duration group (26.9%). The disability rate was more in lepromatous leprosy with duration more than 5 years (32%) and lowest in tuberculoid leprosy with duration less than 2 years (2.5%). The hands were the most common site of disability in all disability grades followed by the feet and eyes (Table 2).

The reported disability rates in India vary from 16%-44%.[2] These reports have included grade 2 and grade 3 disabilities only, but we included grade 1 disabilities too. Kalla, et al in Jodhpur found the disability rate to be 43.9%,[3] but in our study, also from Jodhpur, the overall disability rate was 35%. This decreased disability rate may be due to increased patient awareness, early diagnosis and prompt treatment.

Table 2: Number of cases with disability according to the site and grade of disability

Site	Grade I	Grade II	Grade III
Hands	120	64	24
Feet	108	56	20
Eyes	32	10	9

In New Delhi Sharma, et al found peripheral anesthesia (grade 1) in only 39% and grade 2 and grade 3 deformities with or without anesthesia in 29% of patients.[4] Selvaraj, et al[5] found that the overall disability rate was 39% in Thiruvannamalai district of Tamil Nadu, while Saha and Das[6] found it to be 22% in Kolkata.

The higher disability rate in our study was mainly due to the large number of lepromatous and borderline leprosy cases, 49.4% and 29% respectively. Hence, detection of disabilities for early treatment or correction should be particularly emphasized in elderly men with lepromatous leprosy. We found the hands and feet to be most frequently involved and anesthesia of the extremities (grade 1 disability) to be the commonest disability. This is similar to the studies by Thappa, et al[7] and Saha and Das.[6]

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Table 1: Disability according to the type and duration of leprosy

Duration of disease (yrs.)	Disability according to type of leprosy			Total disability	Disability (%)
	Tuberculoid (n=108)	Borderline (n=145)	Lepromatous (n=247)		
0-2 (n=219)	2	8	49	59	26.9
2-5 (n=114)	3	12	27	52	45.6
>5 (n=177)	4	16	57	77	43.5
Total (n=500)	9	36	133	178	35.6
Total (%)	8.3	24.8	53	35.6	

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Extrusion of sebaceous gland into a blister of pemphigus vulgaris: An unusual processing artifact

Sir,

Extrusion of sebaceous glands through the follicular canal onto the skin surface is a well known phenomenon first described by Pinkus and Mehrgan.[1] Transfollicular sebaceous gland extrusion is explained as an artifact caused by damage to the fragile sebaceous gland by the effects of the physico-chemical changes that occur during tissue processing and the squeezing effect of the microtome knife as it slices through the paraffin block containing the biopsy tissue, pushing up the dislodged sebaceous gland outward through the common folliculo-sebaceous conduit.

Some authors have expressed reservations about it being an artifact, proposing instead that it be considered a natural phenomenon.[2] Sebaceous glands are found either totally extruded onto the skin surface, or may be seen in a subcorneal location.

We report an unusual location of sebaceous gland extrusion, namely, within the suprabasal blister of pemphigus vulgaris.

A 34 year old male presented to one of us (HSM), with a one year history of multiple fluid filled blisters all over the body. He had earlier received short courses of oral steroids in the dose of about 15-20 mg prednisolone per day with partial clearing of the blisters. However, on discontinuing the steroids, he had developed extensive relapse with numerous small flaccid vesicles appearing on normal looking skin. Oral lesions had been present on and off, but no oral involvement was present at the time of this presentation. A clinical diagnosis of pemphigus was considered and a biopsy that included one of the new vesicles was obtained from the right side of the upper back.

Sections from the biopsy showed a small suprabasal blister with an intact sebaceous lobule occupying the cavity of the blister. (Figure 1) This structure was identified as a sebaceous lobule as it was made up of typical mature sebocytes with central scalloped nuclei and abundant vacuolated cytoplasm. A few acantholytic cells were seen in the blister, but no inflammation or other blisters were seen in the section. Serial sections taken through the block revealed in the mid dermis a folliculo-sebaceous structure that showed suprabasal clefts with acantholysis in follicular and sebaceous epithelium, findings consistent with pemphigus vulgaris.

In sum, we report an unusual histopathological finding of extrusion of sebaceous gland into the blister cavity of pemphigus vulgaris. The acantholytic process in the

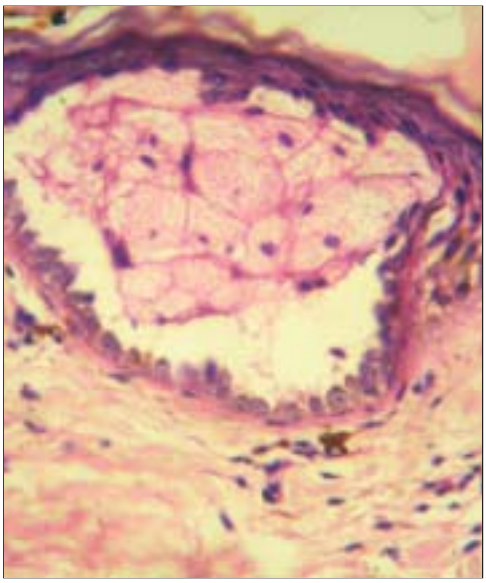

Figure 1: Part of sebaceous gland within intraepidermal blister of pemphigus