Letters to the Editor

LEPROMATOUS LEPROSY: FOLLOW-UP RATE IN 84 PATIENTS

Sir,

Many may recall the research into nasal involvement in lepromatous leprosy at Victoria Hospital, Dichpalli, Andhra Pradesh, India initiated by the late Dr Frank Davey in the 1970s. Several other distinguished doctors took part in what was essentially a team effort, including Drs Dick Rees, Colin McDougall, Professor Graham Weddell and Drs Gordon Ellard and Lykle Hogerzeil. As a young ENT Surgeon I was privileged to be involved examining noses, interpreting clinical findings and taking biopsies and smears for further investigations. As a result of these investigations many papers were published.

Material

In April 1985 I was fortunate to revisit Victoria Hospital and took the opportunity to review, from the outpatient records, how the patients who had been studied had fared. Several hundred patients had been examined but two particular groups had been extensively investigated. Thirty-four patients, previously untreated, all with early lepromatous leprosy (‘Bergen’ Series) of whom 33 had obvious clinical involvement of the nasal mucosa¹ and a further 50 patients (‘RR’ Series) seen in 1978 all with lepromatous leprosy and having already had dapsone monotherapy for 3 months to 8 years with varying regularity.²

Results

Table 1. Bergen series.

<table>
<thead>
<tr>
<th>Period of follow-up after initial consultation</th>
<th>Number</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 years</td>
<td>12</td>
<td>(35%)</td>
</tr>
<tr>
<td>2–5 years</td>
<td>12*</td>
<td>(35%)</td>
</tr>
<tr>
<td>5–10 years</td>
<td>7</td>
<td>(21%)</td>
</tr>
<tr>
<td>10–12 years</td>
<td>3†</td>
<td>(9%)</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

*Artificially high as 6 (50%) of this group responded to a letter and financial inducement and returned in February 1978.
†All three patients regular attenders over whole period.
Discussion

At first glance the follow-up rate appears good and certainly every effort is made at Victoria Hospital to maintain a high return rate even though the need for such long-term follow-up may have been reduced now by the introduction of multidrug therapy. All the patients referred to in this article were treated, at least initially, with dapsone monotherapy. Although a 30% (Bergen series) and 38% (RR series) follow-up for 5 years or more may appear encouraging, when the records are examined with reference to regularity of treatment a different picture emerges. For example in the Bergen series only 3 (6%) had attended completely regularly—this being arbitrarily defined as having not been more than 3 months late for an appointment on more than one occasion. In the RR series 5 (10%) patients failed ever to return following evidence of a positive ‘nose blow’ on the last attendance, despite having started Lamprene or multidrug therapy and having been counselled adequately regarding further treatment. Looking through the records it is possible to read with depressing regularity statements such as, ‘Returns after four year gap’, or ‘absconded from inpatient treatment’. Only 2 (4%) of the patients in the RR series had been entirely regular through to 1985.

There are, of course, many reasons for non-attendance in rural India and it is not suggested that the figures here show an entirely accurate picture. Patients will have died from other causes, moved to other areas, obtained treatment elsewhere or have been cured despite theoretically inadequate treatment.

However, with the introduction of multidrug regimes and the possibility of vaccines in the future all hospitals and institutions treating leprosy should be looking more carefully into the importance of detection and then of ensuring adequate follow-up of patients undergoing treatment.

Acknowledgment

I wish to thank Mr Devedanam and his staff in the out-patient department for providing the patients’ records most efficiently and my son, Thomas, for his help in reviewing them. I am also grateful to Lt Col LD Ponnaiya, Officiating Director, for permission to review the records of patients at Victoria Hospital.

R P E BARTON

Leicester Royal Infirmary
Leicester LE1 5WW
A POSSIBLE ‘FLU’ SYNDROME ON ONCE-MONTHLY RIFAMPICIN

Sir,

Recently, changes have occurred in the management of leprosy with rifampicin becoming the mainstay of modern treatment, alongside the traditional dapsone.

In countries which can afford daily rifampicin, this is seen to produce few side-effects, except occasional gastrointestinal or cutaneous complaints and, in a few cases, drug-induced hepatitis, especially when given in combination with ethionamide or prothionamide (Pattijn 1983, personal communication). ²

In the WHO recommendation for leprosy control, once-monthly rifampicin is advised. From tuberculosis treatment it was known that intermittent rifamycin administration given once or twice weekly could lead to a potentially dangerous reaction called the ‘flu’ syndrome.¹ It was considered unlikely that such reaction could occur when rifampicin was given only once monthly.

We would like to report a patient who presented with features of ‘flu’ syndrome on the once-monthly rifampicin regimen.

The patient, a 55-year-old caucasian woman with subpolar lepromatous leprosy, had started multiple drug treatment (MDT) 9 months previously (rifampicin 600 mg once monthly, clofazimine 300 mg once monthly, clofazimine 50 mg daily and dapsone 100 mg daily). She took her monthly dose of rifampicin in the morning and a little over half-an-hour later she felt a sharp pain from her midthorax extending downwards into her lower limbs. She found it very difficult to stand and walk. One hour after taking the drug she felt cold, nauseous and developed a headache. After 2 h she was shivering severely, which was extremely painful due to muscle-ache. Five hours after taking the tablets, the shivering subsided but she felt pyrexic and started sweating. During the afternoon she started feeling better. The next morning the fever and pain had abated but she remained slightly nauseous and exhausted. She recovered completely later that day. There was no evidence of malaria or erythema nodosum leprosum which could have produced similar symptoms. The patient reported that on previous occasions she had experienced slight discomfort after taking rifampicin and this had gradually become worse but not severe enough to report.

Although the diagnosis of ‘flu’ syndrome was not definite (provocation was considered unethical under local circumstances) her treatment was changed to ethionamide, isoniazid, dapsone and clofazimine, in daily dosage and a similar ‘reaction’ has not occurred again.

Over 3000 patients are taking or have been taking rifampicin once-monthly within our programme and until now we have not encountered any serious side-effects. If our patient was indeed suffering from the ‘flu’ syndrome, which we think very likely, it indicates that this reaction with its unknown mechanism can also occur when rifampicin 600 mg is given once monthly.

B NAAFS & B O MATEMERA

Ministry of Health, PO Box 8204
Causeway, Harare, Zimbabwe