

FIELD DETECTION OF EARLY NEURITIS IN LEPROSY

Sir,

The article by Dr Fritschi (*Lepr Rev*, 1987, **58**, 173–7) on the early detection of neuritis in a field situation is very timely. We must accent the need to identify the acute problems that, if adequately treated, can be reversed, and to remember that silent neuritis is not uncommon.

He did not accent the necessity of recording the baseline evaluation on the first examination of the patient, or the need for adding a comment on each subsequent visit regarding any change, or no change, in muscle strength. Patients may not realize they have a minimal muscle weakness for some period before a paraesthesia attracts their attention. If the baseline has not been recorded it may be assumed that the paraesthesia is the first sign of a neural deficit, and everyone is disappointed when recovery does not occur with appropriate therapy, because it was ‘too late’.

For three years our unit has been taking ‘baseline’ records and keeping monthly records of changes. We have detected a number of silent neuritis and have had the satisfaction of seeing recovery in the majority of them.

In testing for neuritis we seek the first signs of deficit.

With the ulna nerve the first motor sign detectable is the inability to adduct the little finger to the ring finger (3rd palmar interosseus). Full loss of function of this muscle may occur but the patient may still be able to assume the ‘Indian Dance Position’ in which the little finger is not adducted. There may be a total loss of adduction of the little finger without atrophy of the hypothenar muscles or loss of their function.

With the radial nerve the first muscle to show weakness is frequently the extensor digiti communis. This can best be tested with the PIP joints flexed and the patient extending the MCP joints. In the ‘Indian Dance Position’ it is possible for the lumbricals to extend the PIP joints of the fingers and if the EPL is affected the median muscles of the thenar eminence may extend the thumb IP joint, so masking the early weakness of these muscles.

The easiest rapid test for common peroneal function is to ask the patient to walk on his heels—any weakness of peroneal or anterior tibial muscles is rapidly displayed by the inability to hold the forefoot up—yet he may be able to assume the positions described in the article.

Sensory variations are less easy to assess, but if we really wish to prevent the development of deformity we just start making baselines and keeping regular records of muscle power changes.

GRACE WARREN & JOLENE K TOMLAN

*The Leprosy Mission
Christian Hospital
Manorom, Chainat
Central Thailand*