FIELD DETECTION OF EARLY NEURITIS IN LEPROSY

Sir,


After our patients’ hands have been checked for muscle weakness, the examiner runs forefinger and thumb of each hand over the patient’s little fingers simultaneously comparing the stickiness of the two fingers.

This delicate test gives a reliable indication—sometimes the earliest sign—of ulnar neuritis. If positive, relative dryness will be found on one side due to early diminution of sweating. This should be recorded immediately and followed up by a full functional check-up, and of course steps taken to prevent progression of the neuritis.

A similar test could be applied to the feet. While stroking the foot in Fritschi’s last procedure, a mental note is made of the relative dryness of the two sides. In this case dryness of the sole could indicate an early tibial palsy.

Once again the dryness, when found, is recorded and appropriate action taken.

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[Our reproduction of figure 6 on page 175 of Dr Fritschi’s publication was perhaps somewhat short of optimum quality; to check the sensory area of the posterior tibial nerve, the examining finger should stroke the lateral part of the sole of the foot. The lateral border of the foot is supplied by the sural nerve. Editor.]

THALIDOMIDE IN ERYTHEMA NODOSUM LEPROSUM (ENL)

Sir,

An adult male patient from Bosé, Ikom Local Government Area, Cross River State, Nigeria, presented himself to us at Moniaya Leprosy Hospital, on 20 March 1985. He reported that the first lesion had appeared on the right cheek in 1984, about one year before. At the time of reporting he had erythematous nodules on the upper and lower limbs. Both ulnar nerves were enlarged and tender. He was classified as having borderline lepromatous (BL) leprosy.

Smears taken on 21 March 1985, were reported as follows: + I, + 4, + 2, + 1. He was started on multidrug therapy (MDT) with rifampicin, dapsone and clofazimine. On 9 May 1985, he suffered from a severe reversal reaction, and because of severe neuritis, he was given steroid therapy. On 24 May 1985 it was reported that the lesions were still active. They were on the thighs and lower limbs. On 21 June smears were repeated: – , – , + , + , + , – . (6 sites).

I saw him for the first time on 22 January 1986. He was suffering from an ENL reaction. For four days he had tender nodules on the arms and legs, and he complained of severe pain along the left elbow. On examination I found impaired function of the left ulnar nerve (3/5), the left median nerve (4/5) and the left radial nerve (4/5). I started him on another course of steroids, i.e. six months of dexamethasone, beginning with 4 mg daily and reducing the dose monthly. Because of the severe pain the left arm was splinted and he was given analgesics. Both ulnar nerves were enlarged and tender, graded 1/3 (right) and 0 (left), (normal = 3)

On 26 February he was having agonizing pain. I made a diagnosis of ulnar nerve abscess and took him to theatre for incision of the nerve sheath, eased the pain; the nerve has not been tender since.

On 6 April he suffered from another ENL reaction. He had pyrexia and ulcerating nodules on the arms and legs. He was given increased doses of lamprène, chloroquine and panadol, and the