

CORTICOSTEROID-INDUCED ACTIVATION OF CHRONIC ULCERATION IN LEPROSY

Sir,

The immune suppressive effect of corticosteroids is well known and widely used in the management of reversal reactions in leprosy. The danger of provoking spread of tuberculosis by such medication is commonly recognized, but the potential dangers from plantar ulcers, without frank discharge of pus or other signs of active infection, are frequently ignored. That this can have disastrous results is illustrated by two cases seen at ALERT, Addis Ababa, in neither of whom was there any evidence of active, progressive infection.

Case 1. A borderline lepromatous patient in reversal reaction received corticosteroids in spite of chronic forefoot ulceration, which was considered indolent and inactive. Two weeks after the start of corticosteroid treatment the right foot became swollen and pus seeped from the previously inactive ulcer. Surgical consultation was requested. The radiogram showed bunching of the dorsal surfaces of talus and of naviculare, but no plantar displacement of the latter. There was capsular

new bone formation at the first metatarso-phalangeal joint and periosteal new bone formation of the shafts of the second, third and fourth metatarsal bones with sclerosis. These changes were interpreted as the result of chronic forefoot ulceration, probably with infective changes of the first metatarso-phalangeal joint, while the changes of the metatarsal shafts are considered to be due to toxic damage from the ulceration. In addition there was erosion and lysis of the distal and proximal phalanx and of the metatarso-phalangeal joint of the great toe. These were considered to be fresh, progressive changes, undoubtedly provoked by the administration of corticosteroids.

Case 2. A borderline tuberculoid patient in reversal reaction received corticosteroids in spite of chronic midfoot ulceration, which was considered indolent and inactive. Within 2 weeks of the introduction of corticosteroids, the foot became swollen with discharge of pus from the ulcer and several sinuses. Surgical consultation was requested. The radiogram showed two sclerotic remnants of metatarsal shafts, indicating longstanding bone changes from loss of sensation. Otherwise, the picture was one of violently spreading infection throughout the whole foot, including the ankle joint.

Eventually both patients required major, ablative surgery, midfoot amputation, respectively, below the knee amputation under heavy antibiotic cover.

Ideally no patient with any evidence of secondary infection, even the so-called chronic, inactive ulceration, should receive corticosteroids, but since plantar ulceration is such a common feature of leprosy, this is obviously an impossible demand.

However, all patients who are considered for corticosteroids should be carefully examined and watched for secondary infection. If possible, surgical consultation and intervention should be requested before corticosteroid treatment is instituted.

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