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.

Braineparken 85,
6100 Haderslev
Denmark

LEPROMA OF THE METAPHYSIS

Sir,

A 20-year-old Ethiopian with slit-skin smears positive for acid-fast bacilli presented with a
clinical diagnosis of polar lepromatous leprosy and an acute, hard swelling of the right elbow
region.

The radiogram was interpreted as an osteoclastoma. A drill biopsy was taken to confirm this but
unexpectedly the tumour was found to be a lepromatous granuloma, containing many acid-fast
bacilli, both intact and broken and also many globi. Under continued treatment for leprosy the
tumour regressed as did the skin manifestations.

Lepromata of cancellous bone are well-known, particularly of the fingers in relation to the
proximal interphalangeal joints. So far only one report of leproma of cortical bone has appeared\(^1\) and
it is of interest that in both cases the identical misdiagnosis was made initially.

Leproma of bone should be suspected whenever a cystic lesion is found in a bacilliferous patient.
Since the leproma can be expected to regress under medical treatment, no specific treatment is
indicated, except support of the region to avoid collapse of the bone, until satisfactory healing has
taken place.

Braineparken 85,
6100 Haderslev
Denmark

Reference