OBSERVATIONS ON GRANULOMA MULTIFORME IN UGANDA

Sir,

Granuloma multiforme (GM) is a skin disease of unknown origin that clinically resembles tuberculoid leprosy. It was first described by Leiker *et al.*[1] in 1964. The importance of its early recognition by leprosy workers, particularly in some parts of Africa, cannot be overstressed, for the following reasons:

1 If erroneously diagnosed as TT leprosy, the patient will suffer the stigma of leprosy (still a serious matter in many countries): and no amount of leprosy drugs will effect a cure. Moreover, the leprosy worker's credibility will be challenged when the patients eventually realize that their lesions are not due to leprosy.
2 As lesions of GM can coexist with genuine leprosy lesions, and may 'come and go' during treatment, failure to recognize them may result in cured leprosy patients having their chemotherapy for leprosy unnecessarily prolonged.
3 Wastage of drugs by treating this disease as leprosy (particularly important now that there are suggestions that all types of leprosy should be given MDT).

Differential diagnosis

The disease starts with itching followed by skin lesions, which may continue to be irritable for up to 3 months. The lesions, which may last for months or years, often leave some residual hypopigmentation after spontaneous healing. The clinical picture varies considerably: most commonly seen varieties are annular lesions with papular or nodular edges. However, slightly elevated plaques or markedly elevated plaques may be seen. The disease has been found only among adults; with a higher incidence among females; and not among children. The lesions show no loss of sweating, no loss of sensation, and there is no nerve involvement.

The disease has been reported from Nigeria,[1–3] Kenya,[3] Tanzania,[5] the Congo[4], Zaire and the Cameroons[5] and Leiker[5] reports a very important focus on the island of Sumba in Indonesia. It would seem, therefore, that the disease is not confined to Middle Africa, as was originally thought.

Having had experience of GM in Nigeria, I found 3 cases in Uganda not long after my arrival there to work in Bukedi District. One of the patients had lesions not only on the lower arms and legs, but also on the backs of the hands—a rare site, and one which could clearly confuse diagnosis between GM and granuloma annulare. The diagnosis of GM in all 3 cases was confirmed by biopsy (Dr D L Leiker).

Furthermore in one of my cases (a female aged 47), there was a possibility of co-existent leprosy and GM, a combination which has been established by Browne[6] in a female patient in Nigeria.

I believe this disease is overlooked for two main reasons: a, it has been comparatively recently reported in the literature; and b, paramedical workers are not aware of the possibility in differential diagnosis. Since the publications listed below, do your readers have further experience of this condition?

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