REPLY: CORTICOSTEROID-INDUCED ACTIVATION OF CHRONIC ULCERATION IN LEPROSY

Sir,

In response to the letter by Dr J G Andersen (*Lepr Rev*, 1988, **59,** 185) I would like to comment as follows: Certainly one wants to prevent ablative surgery in every instance where there is damage to an extremity but I do not think it is necessary to recommend that steroids not be used when indicated for control of reaction. This, the control of reaction, is so extremely important in order to prevent progressive nerve damage and destruction to limbs that it is essential to implement it in every instance.

For this reason any person with plantar or other ulceration should be given an antibiotic to control secondary infection when it is necessary to suppress reaction. Destructive surgery is almost never necessary and the use of antibiotic coverage is vital to attain that goal. It was my practice to use penicillin for any patient with any ulceration in which there was a possibility of a secondary infection. When that did not obviously begin to control the infection rather promptly, it was augmented by the addition of streptomycin.

In this way when a patient has plantar ulceration and also an active reactive state it is possible to treat both of these problems at the same time. This approach to the management of reactions in a patient with ulcerated extremities is entirely satisfactory—it was used repeatedly.

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R E PFALTZGRAFF

Dr Pfaltzgraff rightly underlines that we should not omit treatment of reaction with corticosteroids if they are indicated. Neither should ablative surgery be necessary. My communication was prompted by several unhappy experiences where deep, septic infection in the foot was overlooked with disastrous results. I wanted to emphasise two points: even deep purulent infection does not respond with such activation, provided there is free, open drainage from the focus. And secondly that antibiotics have little if any effect on such closed purulent infection.

I notice that Dr Pfaltzgraff recommends the use of penicillin and streptomycin. My own preference would be sulphadiazin/trimethoprim, occasionally supplemented with metronidazol.

Thus we avoid the use of questionable syringes and make the medication easier to administer in the field.

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