

**A CASE OF RELAPSED BORDERLINE-LEPROMATOUS (BL) LEPROSY
FOLLOWING 27 MONTHS OF MULTIPLE DRUG THERAPY, BHUTAN**

Sir,

In July 1984 at Yebilaptsa a 30-year-old male patient was diagnosed with clinical findings typical of borderline-lepromatous (BL) leprosy. The bacteriological index (BI) of skin smears was 3, with a morphological index (MI) of 0.5. He was treated with multiple drug therapy (MDT) (dapsone, clofazimine and rifampicin) according to the WHO recommendations for multibacillary leprosy, and he completed 27 months treatment without default. He was released from treatment in October 1986, when skin smears had been negative at monthly intervals on 3 occasions. His clinical state and skin smears remained negative on annual surveillance.

In early January 1993, more than 6 years after release from treatment, he presented complaining of tingling and pain in the right arm, both legs, and the left side of his face. The right radial, both ulnar, and both popliteal nerves were mildly tender on palpation. There was no new anaesthesia or muscle weakness. No skin lesions were found on any part of the body, despite repeated examination. Skin smears from all sites were negative.

There was discussion as to whether, more than 6 years after release from treatment, he was having a very late reversal (upgrading type I) reaction, relapse without any skin involvement, or was malingering to avoid heavy labour. He was started on Prednisolone 40 mg daily for possible reaction and sent to the national referral centre at Gidakom for consultation and nerve biopsy. A skin biopsy was taken, the site being arbitrarily chosen, since no skin lesions were detectable at this time, from a previously affected site, and a nerve biopsy was taken from the terminal branch of the right radial nerve, at the wrist. Dr Sebastian Lucas (University College and Middlesex Hospital Medical School, University Street, London WC1E 6JJ) reported the skin biopsy as showing 'slight perineural inflammation (in dermal nerves), but no acid-fast bacilli' and the nerve biopsy as 'active borderline-lepromatous (BL) leprosy neuritis, with BI 4, many solid-staining forms'. The patient was therefore re-started on MDT in July 1993 and has continued treatment without any neurological complications or reaction. He does continue to have mild nerve tenderness and tingling pain, especially when doing heavy work.

Particularly (taking into account) the bacteriological findings in the nerve biopsy, we consider that our revised diagnosis of relapse is correct. The heavy involvement of nerve and the complete absence of skin lesions under these circumstances is clearly of interest. Furthermore, had this patient reported in another part of Bhutan, or in a different country, and failed to reveal his previous history, it is possible that he would have been diagnosed as having 'purely neuritic' leprosy.

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