Letters to the Editor

PROTECTIVE FOOTWEAR FOR LEPROSY PATIENTS WITH SOLE SENSORY LOSS OR ULCERATION OF THE FOOT

Sir,

We would like to respond to the letter on this topic published in Lepr. Rev. (1994) 65, 400–402. We agree with the need for protective footwear and ALERT has a well-equipped orthopaedic workshop employing 15 technical staff. We have supplied MCR sandals, plastazote shoes and boots as well as lower limb prostheses, as necessary, for many years.

In recent years we have found that it is impossible to supply these in sufficient quantity for all the former patients who need them. We have also noted some of the problems found in India and reported by Dr Krishnamoorthy, especially an unacceptable design causing greater stigma for people affected by leprosy. Because of infrequent use many patients have not been helped by their shoes. An additional problem has been that shoes made far from the patient’s home may not be properly fitted or reviewed and may actually cause new ulcers.

Amidst this rather depressing scenario we are attempting to do more education in self-care, to get patients to take greater responsibility for their own feet. However, we have been very encouraged by the initial results of using canvas shoes produced by a commercial company here in Addis Ababa. They were able to make a new design incorporating an MCR layer and these shoes are sold at a subsidized price to patients. We are currently discussing with the manufacturer how the upper canvas part can be strengthened as durability is a problem. Different models for men, women and children are available.

We have just started a study to compare canvas shoes with plastazote shoes for patients with damaged feet and hope to report the results within one year, including the relative costs. In the meantime we have already noted a vast difference in acceptability and a number of chronic ulcers have quickly healed with the canvas shoes. It seems likely that a more attractive shoe helps to develop a more positive attitude in patients, as well as providing some physical protection for the feet.

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DOES LOSS OF NERVE FUNCTION EQUAL PURE NEURITIC LEPROSY?

Sir,

When your patient is carried into the clinic semiconscious on a stretcher and you cannot feel his pulse, you know he is in trouble: cholera? septicaemia? a haemorrhage? . . . When your patient strides into the clinic greeting you heartily, and you cannot feel his pulse, you know you are in
trouble! Unable to feel pulses, I substituted for a while by auscultation of the heart and measuring blood pressure (one obtains much the same information with more effort). When I was unable to detect thickened nerves by palpation, I was worried. For a few days I paid close attention to my hands as I carried out daily work. I realized that everything I touched felt the same: smooth/rough, hard/soft, hot/cold, sharp/blunt. One day I spilled near-boiling water onto my own fingers and felt nothing in my burnt hand, only alarm in my mind. I had not only lost sensory discrimination but also protective sensation. This was serious, so I shared the discovery with a colleague. My attention was then drawn to the fact that my feet also had become numb.

Had I presented at an average rural clinic in this part of the world with my ‘glove and stocking anaesthesia’, and a history of many years’ occupational exposure to leprosy, it is likely that the local Leprosy Supervisor would have labelled me as ‘pure neuritic leprosy’. I would have been condemned to 24 months of MB-MDT. Being a foreigner, I went, not to the nearest clinic, but instead to the physician at our district’s general hospital. After a thorough physical examination and numerous tests (including a skin smear) he was able to reassure me that it was an isolated sensory neuropathy almost certainly attributable to a medicine I had taken for unrelated reasons.*

I was lucky that in my case the neuropathy was a reversible condition. Now that it is partly recovered, I have been forcefully reminded that different modalities of sensation can be lost and regained at different rates. Long after acquiring the ability to feel ‘light touch’, I am still unable to distinguish between heat and cold. I still do not know if something is sharp enough to cut my skin.

I was lucky: I already knew how to prevent injuries to my hands and feet. I was lucky too that I escaped from being registered as a leprosy patient. I have been spared the necessity of attending a leprosy clinic monthly for 2 years and the risk of side-effects from antileprosy drugs (which would not have helped my condition).

This letter is submitted in the hope that it will remind field workers to be very cautious about diagnosing anyone as ‘pure neuritic leprosy’ simply on the basis of loss of nerve function. It happens often in this country, probably elsewhere. The standard question for ‘drug history’ at a leprosy clinic (Did you ever take antileprosy medicine before?) is inadequate. We need to ask, ‘Did you take any medicine for any reason?’. The standard testing for sensation in a leprosy clinic is often confined to light touch (by feather or ballpen or filament). If this is normal, we need to remember that a patient may still have impairment in other modalities of sensation. This is relevant not only at the time of diagnosis but also in deciding whether a patient has ‘recovered’ from an attack of neuritis.

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CYNTHIA R. BUTLIN

RECORDING OF THE DISABILITY INDEX

Sir,

Recording of the disability index is common in follow-up studies. Usually the disability grade is recorded as a single figure. It is not clear when this is understood as a numerical average of the

* This drug was ‘Maloprim’ (made by Wellcome, UK). It contains dapsone 100 mg and pyrimethamine, 12.5 mg and is taken once weekly. I took it for one month as malaria prophylaxis in January 1995.