BORDERLINE LEPROMATOUS LEPROSY MASQUERADING AS LYMPHOCUTANEOUS SPOROTRICHOSIS

Sir,

G.S. a 51-year-old office worker from Northern India, reported with asymptomatic nodular-plaque lesions of 3 months duration of the right hand. Initially he noticed a solitary pea-sized erythematous nodule over the dorsum of the right hand near the base of the ring finger. The lesion grew insidiously and changed into a nodular-plaque lesion over a period of 3 months during which he also noticed a similar lesion near the wrist joint. There was no history of trauma at the site of initial lesion. Cutaneous examination revealed two non-tender, dull red, nodular-plaque lesions $3 \times 2{\cdot}5$ cm each, with well-defined borders and shiny stretched overlying skin over dorsum of right hand and wrist (Figure 1). On examination a cord-like structure was felt between the two lesions. A differential diagnosis of lymphocutaneous sporotrichosis and atypical mycobacterial infection with organisms like *Mycobacterium marinum*, *M. kansasii* and *M. chelonei*[1–8] was entertained. A biopsy was taken from the lesion of the right hand and sent for histopathological examination, fungal and AFB culture.

A haematoxylin and eosin stained section from the lesion showed thinning of the epidermis, preserved grenz zone and a diffuse collection of foam cells and lymphocytes in the dermis. Stain for lepra bacilli was positive. Culture for fungus and AFB was negative. A slit-skin smear examination done subsequently from the lesions revealed a bacillary-index of 2+. X-ray of the right arm and forearm did not reveal any bony abnormality. Upon testing of sensations, a loss of 10–20% was detected to all modalities over the lesions while no peripheral loss of sensation was found.

Hence a diagnosis of borderline lepromatous leprosy restricted to one anatomical area with involvement of a cutaneous twig of the ulnar nerve was made based upon the histopathological findings and the patient was put on MDT MB (WHO) regimen.

Within two weeks of initiation of therapy he developed Type I reaction manifested by features of neuritis (pain in the cutaneous twig), lesional tenderness with bright red erythema and swelling of the lesions along with swelling of the dorsum of the right hand. He also developed two similar nodular-plaque lesions of the medial aspect of the forearm in a linear alignment with the previous two lesions with progressive thickening of the proximal part of the nerve (Figure 1). MDT–MB was continued and tablet prednisolone 30 mg once daily was added along with splintage of the right upper limb. Though the Type I reaction subsided, the cutaneous lesions and thickened nerve

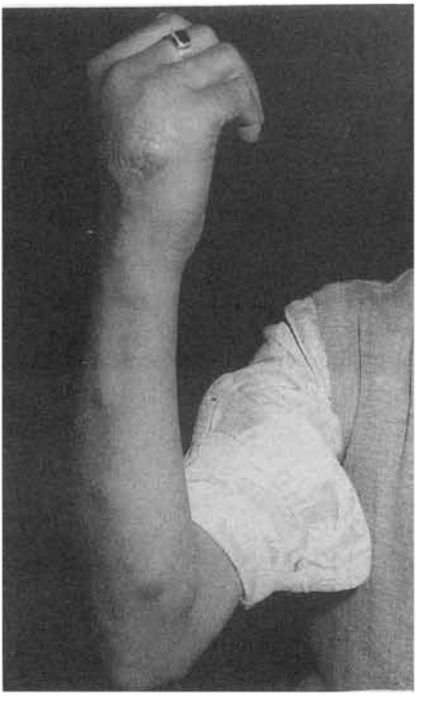

Figure 1. Nodular-plaque lesions of the hand and wrist in a linear arrangement.

remained unchanged over 6 weeks. So, tab prefloxacin 400 mg b.d.* was added and was given for 4 weeks to which the lesion responded dramatically with flattening of the nodular-plaque and significant subsidence of nerve thickening.

Nerve involvement in leprosy is one of the diagnostic criteria as proposed by WHO[9] but development of nodular-plaque lesions along a nerve, exactly mimicking lymphocutaneous variety of sporotrichosis is almost unheard of. Excellent response to prefloxacin makes this rare presentation even more interesting.

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*(Pefloxacin Mesylate dihydrate is marketed as 'Tab Proflox 400 mg' by PROTEC Division of Cipla Ltd, and Manufactured by CIPLA Ltd, Virgo Nagar, Bangalore 560 049).

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