standard 6 digit disability index, as recommended by WHO, or as the highest single digit. In either case it is misleading and meaningless. The numbers from 0 to 3 are not, and never were intended to convey a numerical sequence. In fact in the very early days we did consider using other symbols, exactly to avoid such misunderstandings. It is obvious that no numerical average can be calculated from such 'sequence'.

Calculation of an 'average' between loss of corneal sensation, clawhand, and plantar ulceration is nonsense.

The single highest figure is a slightly better indicator of disability. Still it does not allow for the great and important difference in the actual management of patients with disabilities of eye, hand, or foot. Neither does it show a possible multiple disability. I suggest that the rational use of a disability index is to record the full 6 digit disability index. With modern computer analysis it is simple to extract much relevant information of the greatest importance both for evaluation of a project and for planning of future prevention and treatment of disabilities.

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BORDERLINE LEPROMATOUS LEPROSY MASQUERING 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 x 2.5 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 1-3 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
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 WHO9 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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*(Prefloxacin Mesylate dihydrate is marketed as ‘Tab Proflox 400mg’ by PROTEC Division of Cipla Ltd, and Manufactured by CIPLA Ltd, Virgo Nagar, Bangalore 560 049).
PENTOXIFYLLINE MAY BE USEFUL IN THE TREATMENT OF TYPE 2
LEPROSY REACTION

Sir,

Leprosy reactions (LR) are among the most significant complications during the development of leprosy.

Up to now thalidomide and cortisone are the main drugs used in the treatment of Type 1 (reversal reaction) and Type 2 (erythema nodosum leprosum) LR.

Thalidomide and cortisone are the drugs of choice in the treatment of erythema nodosum leprosum (ENL), and cortisone is the only treatment for reversal reaction. The results are quite good with these drugs, but, side-effects are significant. Mainly for this reason the World Health Organization (WHO) recommended that, 'priority should be given to finding an acceptable alternative to these drugs'.

According to present knowledge pentoxifylline (PF) could be useful in the treatment of LR because it interferes on the level of TNF-alfa and IL-1. TNF-alfa and IL-1 are probably associated with the development of leprosy reactions.

Pentoxifylline (Trental®), also known as 1-(5-oxyohexyl)-3,7 dimethylxanthine, 1-(oxyohexyl) theobromine, is a methylxantine derivative with properties similar to theobromine, caffeine, and theophylline. It has potent haemorrhheologic properties. Although doctors using a new drug are under an obligation to check the contraindications, it may be helpful if the authors included a short note that oxpentifylline is contraindicated in patients who show drug allergy to theophylline and caffeine, and that care should be exercised in patients with coronary artery disease or orthostatic hypotension, as the drug has a hypotensive effect.

Recently we observed a patient with Type 2 reaction treated with PF. The good results prompted us to treat more LR patients with PF.

From July 1994 to January 1995 we treated a further 8 patients presenting with Type 2 and Type 1 reaction with PF.

Patients and methods

Four patients with Type 2 reaction and 3 with Type 1 reaction were treated with oral pentoxifylline (400 mg three times a day). Another patient with Type 2 reaction started with the same dosage but as no response was observed the patient received IM injections of 100 mg PF, 3 times a day, for 3 days followed by oral PF, 400 mg four times a day (see Table 1).