COMMENT: ULNAR ABSCESS—4 MONTHS AFTER RELEASE FROM CONTROL WITH PAUCIBACILLARY-MULTIDRUG THERAPY

Editor,

We have read the case report: 'Ulnar abscess: 4 months after release from control with paucibacillary-multidrug therapy' published in *Leprosy Review* Vol. 68.2. 1997. The conclusion: 'Thus the use of steroids is a useful means to treat nerve abscesses and should be tried before surgical intervention' is too hasty. In the last 7 years we have examined more than 5000 nerves and operated more than 600, therefore we feel justified in making the following comments:

1 The authors say that 'the swelling reduced to the size of a 3-mm nodule' but fail to say what was the size of the swelling prior to the treatment.

2 The size of a swelling is no clinical evidence of abscess. Large oedema of the ulnar nerve up to 20 mm (as against the normal 3 mm) have been photo-documented by us.

3 There is no mention of sensory and motor deficit but no quantification is given. Therefore the assertion that following steroid 'motor power improved' has no meaning, moreover there is no record of sensory improvement, although sensory improvement may occur faster and more consistently than motor.

4 The authors use indiscriminately the words 'abscess' and 'segmental necrotizing granulomatous neuritis' (SNGN). On page 173 they write about abscess and on page 174 say '... the clinical presentation ... is more in favour of a localised nerve pathology probably a segmental necrotizing granulomatous neuritis'. These two entities are not the same. As defined by surgical textbooks an abscess is a collection of pus;[1] which implies a cavity and a collection. While in SNGN, as described by the original authors,[2] there is no cavity and no pus collection.

5 It is possible that the authors have confused a large oedema with abscess. We apologize for quoting our book. 'We have had two cases where we made a clinical diagnosis of abscess beyond doubt; yet on the operation table we were faced with oedema. Unless surgical exploration is done, the clinical diagnosis can always be questioned. The assumption that an abscess disappears by itself (*or even with drugs*) is against all principles of surgery. This wrong clinical impression is due to the fact that whenever there is an abscess there is a certain amount of oedema too. With large dosages of steroids, the oedema is brought under control and therefore it *appears* that the abscess too has reduced in size, when actually only the oedema-component of the swelling has diminished, but the physician will believe that the abscess has disappeared.[3]

6 SNGN can reduce with steroids and this could be a valid explanation. But abscesses do not disappear with steroids, and even in the unlikely hypothesis that in this case steroids reduced an abscess, a single case is not sufficient reason for changing surgical principles.

We have reported on 145 *true* nerve abscesses operated by us.[4] All those patients had been on steroids for a minimum of 6 months to 3 years; in none of these cases did the abscesses disappear and this was the reason why they were referred to us.

7 Among the conditions which masquerade as nerve abscess we have to include, in the case of ulnar nerve, abscesses of the supratroclear lymph node (see photo N.33 in our book, and page 96).

In conclusion, the authors can say that a SNGN can decrease with steroids but cannot maintain that: 'The usefulness of steroid therapy in the treatment of leprosy nerve abscess is demonstrated in this case report' because they do not have a case. Such a statement is dangerous as it may send the wrong signals down the line. For years we have been saying that cases of neuritis should be referred to surgery before it is too late. A paper which claims that steroids can cure nerve abscess is the last thing we really need. An abscess, if not excised surgically, will sooner or later break into a sinus. We have seen too many discharging sinuses, and not only from the ulnar nerve.

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References

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[4] Salafia A, Chauhan G. Nerve abscess in children and adults leprosy patients. Analysis of 145 cases and review of the literature. *Acta Lepr*, 1996; **10(1):** 45–50.

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