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Your questions answered

In response to feedback from our subscribers, we are introducing a new section in Leprosy Review *in which questions on leprosy-related problems will be answered by experts in the field. This first question is answered by Dr Patricia Rose.*

Question: A man attended our rural leprosy clinic 10 months ago with swollen ear lobes and the nodular lesions of lepromatous leprosy. Nerve trunks were enlarged but not tender; slit skin smears were positive. The patient was started on MB MDT and for the first 4 months of treatment progress was uneventful with steady improvement in his clinical condition. The patient then began to experience severe ENL with painful nerves and typical skin rash. We tried to control the ENL by adding 40 mg prednisolone daily to his MDT and reducing by 5 mg a fortnight. Although the initial response was satisfactory, it proved impossible to reduce the dosage of prednisolone below 25 mg daily without a recurrence of ENL. Nothing but a return to a higher dosage of prednisolone relieved the patient's nerve pain. At the moment, our patient seems to be trapped on a see-saw, rocking in and out of ENL every few months, according to the prednisolone dosage. The ENL is becoming increasingly difficult to control and we are afraid that our patient is liable to both nerve damage and steroid side-effects. What can we do to ensure control of the ENL without incurring steroid damage or fixation?

Answer: ENL is best regarded as an illness spanning 4 or 5 years with the potential to cause severe nerve damage. Unfortunately, prednisolone, though relieving nerve pain, does not cure the illness and if given continuously is associated with a plethora of dangerous side-effects. The most useful drug at present available for field use is clofazamine but because this takes about 10 days to be effective, it is useful to give prednisolone at the same time for a short course, reducing the dosage by 10 mg a fortnight from 40 mg daily. Clofazamine is maintained at 300 mg daily until prednisolone has been withdrawn and the patient has been free of ENL for a month while on clofazamine alone (with MDT but without steroids). Only then can the clofazamine be reduced by 100 mg a month, provided always that the patient remains free of ENL. It is important that the patient understands that ENL is a long-standing illness and that attacks will undoubtedly recur but that, with adequate and prompt treatment, the severity of the illness can be controlled and attacks will become less frequent and less severe with time. It is also important to check regularly for nerve damage and to ensure that the patient knows how to contact the programme out of clinic hours so that treatment of ENL can be initiated as soon as an attack occurs. The patient should not have to wait for a clinic day in order to receive treatment.

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