Thalidomide and Exfoliative Dermatitis

TO THE EDITOR:

The side effects of thalidomide are too well known ([1-3, 5, 6]) to be listed again here. Dr. Jopling ([4]) has provided a comprehensive list of these side effects. We field workers have recently observed a side effect which, to our knowledge, has never been reported before.

A 50-year-old male Indian leprosy patient, lepromatous (LL) in type as determined by clinical and laboratory tests, is reported. The bacterial index was 4+, 3+, 2+, and 2+ (Ridley scale) on 15 September 1986. The patient was having recurrent episodes of type 2 reaction which responded well to a high dosage of steroids, but seemed to be refractive to a maintenance dosage of 10 mg of prednisolone.

When the patient last reported to our clinic with a new episode of erythema nodosum leprosum (ENL), we decided to try thalidomide. Accordingly, the patient was given 1 tab QID. During the first few days the patient showed some improvement as expected and was quite comfortable. On the fifth day the patient developed erythrodermia associated with a burning sensation all over the body and puffiness of face. The following day the erythema was pronounced; there was scaling and chills were present. Two days later we could see a full-blown clinical picture of exfoliative dermatitis. At this stage, thalidomide was withdrawn and the patient was put on prednisolone. His condition subsided in 10 days.

We would like to point out that no other drugs were being administered to the patient when the exfoliative dermatitis started to develop except dapsone (DDS) 50 mg OD and BC. This drug has been given to the patient for the last 10 years, even during previous episodes of ENL, and never before had the patient reported with exfoliative dermatitis. We feel that in this case there is a direct relation between thalidomide and exfoliative dermatitis since no other drug could be responsible.

—A. Salafia, M.B.B.S., D.H., D.H.S.
Honorary Plastic Surgeon
Vimala Dermatological Centre
Bombay, India

—R. D. Kharkar, M.D., D.D., V.D.
Chief Medical Officer
Maharashtra Lokyta Seva Mandal
Bombay, India

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A Large Hypoanesthetic Patch in Borderline Tuberculoid Leprosy

TO THE EDITOR:

The clinical course of human leprosy is variable and is determined by the cell-mediated immune response of the individual host against *Mycobacterium leprae* ([4]). Hence, the cutaneous manifestations differ according to the type of disease in the leprosy spectrum, ranging from tuberculoid leprosy (TT) to lepromatous leprosy (LL) ([2]). The skin lesions in TT and borderline

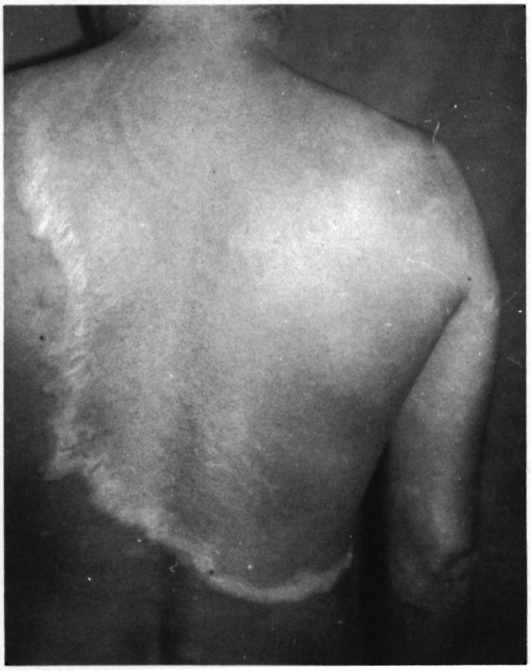

FIG. 1. Large patch on back surrounded by a double-edged irregular border.

tuberculoid (BT) leprosy may be single or few ([1]), and their sizes and shapes are characteristically dissimilar. I would like to record a very large hypoanesthetic patch in a patient with BT leprosy.

A 31-year-old Indonesian male presented with a large hypopigmented patch of several months duration covering about three fourths of the anterior chest, back of chest, and the whole of the right upper limb with extensions to the abdomen and lumbar regions (Figs. 1 and 2). The patch was delineated by an erythematous, well-defined, raised annular ring with irregular inner and outer edges (Fig. 1). It was dry and smooth. The skin at the center was of normal appearance; at the periphery it was hypopigmented. Generally, there was diminished-to-absent sensation for touch, pain, and temperature in most of the affected areas. Hair growth was less at the areola of the right breast which was of normal size (Fig. 2). The right ulnar nerve was tender and enlarged. Mild deformities and associated motor changes due to the involvement of the ulnar nerve ([3]) were seen in the right hand. The area of involvement was assessed using Wallace's "Rule of Nine" for estimating the extent of a burn ([5]):

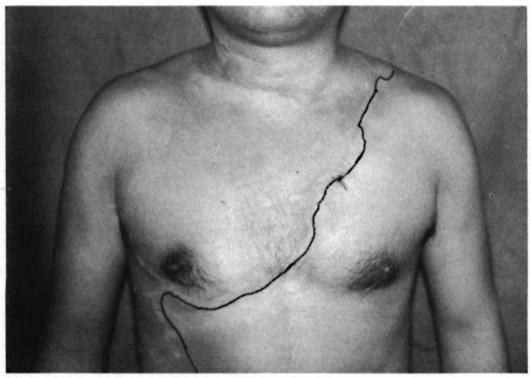

FIG. 2. Course of the ring on front of the body, traced in pen.

Right upper limb	9%
Anterior chest and abdomen	7%
Back of chest and lumbar region	11%
Total affected body surface	27%

The ring whose perimeter was 115 cm started clearly at the middle of the back of the left shoulder, crossed to the right lumbar region, ascended to the right, and ended on the left front of the chest. The face was not involved. Anteriorly, the patch stretched 27 cm longitudinally, 34 cm vertically; posteriorly, the longitudinal extension was 31 cm and vertically, 45 cm. A slit-skin smear for acid-fast bacilli was negative. A skin biopsy confirmed BT leprosy; a lepromin test was weakly positive. The patient received the World Health Organization regimen for multidrug therapy (MDT) for paucibacillary leprosy. An oral steroid was also started which arrested further damage to the right ulnar nerve. With regular physiotherapy, the function of the right hand was restored satisfactorily, although deformity persisted. After 1 year of MDT, he was converted to dapsone monotherapy. During the treatment, the border of the lesion became blurred, ill-defined, and replaced by areas of hypopigmentation which were negative for tinea versicolor. There were no significant changes in sensory impairment. Although BT leprosy is notorious for nerve damage, this case is of interest due to a single patch occupying 27% of the body's surface area which included an upper limb and was surrounded by a border of 115 cm.

—Kader N. Mohamed, M.B.B.S.,
Dip. Derm., Dip. Ven.

Department of Dermatology
Sultanah Aminah General Hospital
80100 Johor Bahru, Malaysia

Present address for Dr. Mohamed: Department of Dermatology, General Hospital, 11060 Penang, Malaysia.

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Arthus-like Phenomenon and Lepromin A—a Case Report

TO THE EDITOR:

We would like to report a case of hyperactive reaction to lepromin A in a polar tuberculoid (TT) leprosy patient.

A female patient reported to our clinic with an erythematous, anesthetic, well-defined patch on the left maxillary area, 2 × 2 cm in size. Skin smears were taken from four sites: right elbow, left elbow, forehead, and patch. The bacterial index (BI) was negative. A biopsy was not done because of the location of the lesion. On clinical and bacteriological evidence the patient was classified as TT. A lepromin test was performed on the left forearm 5 cm distal to the cubital fossa. Lepromin (kindly supplied by Dr. R. C. Hastings, GWL Hansen's Disease Center, Carville, Louisiana, U.S.A.) was injected with a Dermo-O-Jet standardized to inject 0.1 ml with every shot. Fourteen days later the patient reported to our clinic with a) an ulcer covering the whole of the original erythematous patch on the left maxillary area and extending 1 cm beyond the original margin (Fig. 1), and b) a large ulcer over the left forearm (Fig. 2). The ulcer was shaped like a doughnut of variable width whose internal margin had a radius of 5 cm; the

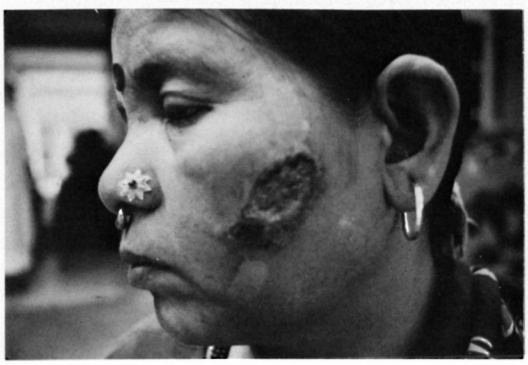

FIG. 1. Ulceration of tuberculoid lesion of the face.

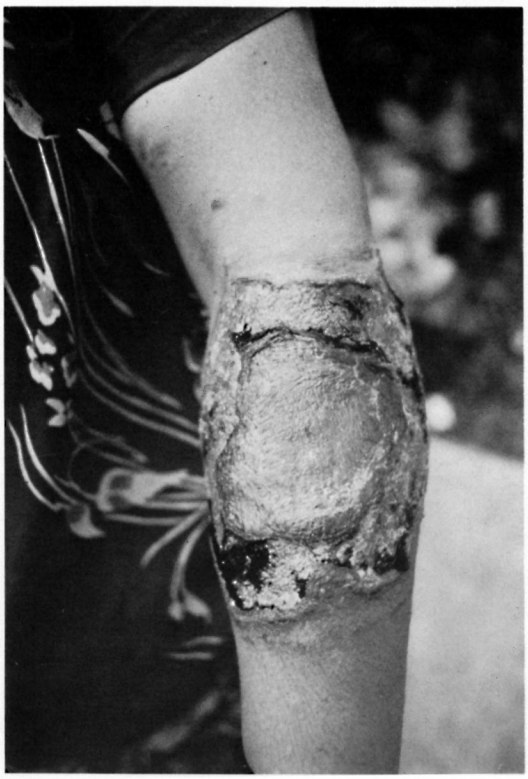

FIG. 2. Ulcer at site of lepromin A injection with Dermo-O-Jet.