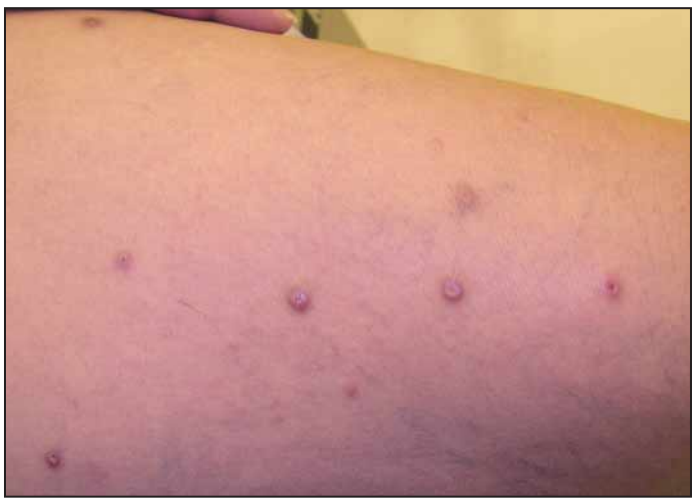

Courtesy Dr. Michael Kalisiak

This 57-year-old Asian woman presented with a dozen dull, erythematous papules and nodules on her extremities and numerous well-demarcated, faintly erythematous patches on her chest and back. She had had symptoms of peripheral neuropathy for the past 10 years.

Peripheral Neuropathy Can Be Clue to Leprosy

BY JEFF EVANS
Senior Writer

A history of idiopathic peripheral neuropathy may reflect underlying leprosy, Michael Kalisiak, M.D., said at the annual conference of the Canadian Dermatology Association.

The diagnosis of leprosy is often delayed in the United States and Canada because of the low prevalence of the disease. Most cases in such countries occur in immigrants from endemic areas or in people who have traveled extensively.

The time from infection to diagnosis ranges from 3 months to 40 years, but it averages 2-4 years for leprosy, said Dr. Kalisiak, a second-year dermatology resident at the University of Alberta, Edmonton.

Leprosy's clinical manifestation—purely cutaneous or neural or localized or a mixture—may vary depending on the immune response of the patient and can have a wide range of differential diagnoses, he noted during a poster session at the conference.

He described the case of a 57-year-old Asian woman who presented with a recent eruption of a dozen dull, erythematous papules and nodules on her extremities and numerous well-demarcated, faintly erythematous patches on her chest and back. She had had symptoms of peripheral neuropathy for 10 years.

The woman's origin from Singapore and her extensive history of living in nine countries from age 26 to 39 years until she immigrated to Canada was crucial in leading to her diagnosis of borderline lepromatous leprosy.

Her countries of residence included Iran, Trinidad, Scotland, United States, Indonesia, the Netherlands, and Norway, with brief periods in Kenya and Ecuador; some of these countries have an intermediate incidence of leprosy.

For 3 years prior to her skin manifestations, the patient visited neurologists for her neuropathic symptoms, which initially occurred as numbness and occasional pain in her left anterior thigh and later spread to her left hand and left and right lower legs.

She also reported decreased grip strength in her left hand. The neurologists discovered many motor and sensory deficits in those areas but excluded any common causes of neuropathy after extensive testing. Their diagnosis was idiopathic polyneuropathy, Dr. Kalisiak said.

On staining with hematoxylin and eosin, skin biopsies of the faint erythematous patches showed mild, nonspecific perivascular and periappendigeal infiltrate, whereas biopsies from the nodules contained a heavy infiltrate in the deep dermis and beyond. Fite's stain revealed numerous lepra bacilli in the biopsy specimens (in red on biopsy of a nodule).

Nasal scrapings also tested positive for acid-fast bacilli and polymerase chain reaction confirmed the presence of *Mycobacterium leprae*.

Dr. Kalisiak and his colleagues began daily treatment with 600 mg of rifampin, 100 mg of dapsone, 50 mg of clofazimine. The regimen also included gabapentin for neuropathic pain that will be continued for at least 1 year.

"Undiagnosed peripheral neuropathy should prompt consideration of leprosy as a diagnosis," concluded Dr. Kalisiak, who received the best poster award at the conference. ■

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