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Letter to the Editor

Dear Sir,

I feel this makes and interesting reading because of the accurate and detailed description given by an educated patients, and that is why I am sending to you.

A Patient's description of her conditions and symptoms.

Female Indian aged 51 education level 10th standard, a good command of English language.

In 1969 the patient noticed few hypo-pigmented patches in the arms and legs. Further she complaint of burning sensation in the soles and moderate pain around the elbow.

Family history: the father and one sister has been diagnosed and treated for Hansen in the previous year.

The patient was examined by a Prof. of Dermatology at a General Hospital. A skin-smear was done and found to be positive for acid fast bacilli (no details as to the score of BI). The patient was advised DDS mono-therapy 10 mg daily from early 1969 till 1981. In 1981 the skin smear was found to be negative.

As the patient did not notice any change in her symptoms, she approached another Dermatologist who advised daily dose of Rifampicin (probably 450mg as per description of the capsule) and DDS 100mg daily from 1982 till 1984.

As the skin smear was found to be negative on 6.10.1984, the treatment was stopped.

In October 1994 what appeared as a severe allergic reaction was noticed on the face.

The patient was referred to an Allergologist. The complaints at that time were:

1) Both soles burning while walking. Sense of stickiness as if walking on wet sand.
2) Left wrist heavy and numb.
3) All fingers of both hands: swollen, stiff, painful, the pain pricking in nature.
4) Shooting pain in all the joints of the hands.
5) Both eyes painful and red.
6) Pain in the face: mainly in the zygomatic area. Pain is so severe that patient avoids washing or rubbing her face because even a gentle touch triggers the pain.
7) Both elbows and fingers give unbearable pain if come into contact with a hard surface like a table, walls, floor.

The patient was referred to a Neurologist and admitted into a General hospital Neurology Dept. in November 1994 for one week; various blood tests were done.

The patient was on Prednisolone 40 mg. OD, which gave relief as long has taken.

Under neurologist care from July 1995 to Feb. 1996.

The patient took pain-killers too on-and-off till 18.9 1996.

At this time the patient was referred to me.

A detailed examination made me and the conclusion was:

A BB case with polyneuritis; treatment appeared to be incomplete.

Therapeutic regimen advised: MDT(WHO) for six months along with Clarithromycin 250 mg. bid for 3 months. Inj. Kenacort every 15 days for 3 months. Most of the symptoms subsided and there were no significant no side effects. However pain in the Left foot was still present. The patient was advised decompression of Posterior Tibial nerve and artery. This was done by me in Feb 1997. A major problem was found on the operation table: the posterior tibial artery was crossing over and compressing the nerve. The artery could not be cut, obviously, and hence a total decompression could not be done. This however explains the constant burning and pain while walking.

This was explained to the patient. The patient was advice again low dosage steroids and B complex TID for three months.

The pain subsided but the stickiness of the sole is, however, present but diminished. She is out of therapy from July 1997 till now. No major complaint except for the paresthesia of the soles, which is an unsolved problem and, probably, not solvable.

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