

Case report

Lepromatous leprosy presenting with lichenoid papules

Mohammad Omidian, Mohammad Ali Mapar, Zahra Omidian

Department of Dermatology, School of Medicine, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran

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Abstract

A 45-year Iranian man referred to the clinic with a severe itching and multiple papular lesions on his trunk, buttocks and extremities. Symptoms and signs of lesions simulated the clinical features of mycosis fungoides (Cutaneous T cell lymphoma). There were (not any) no typical features of leprosy except a localized patch of numbness on the right hand. Slit skin smear and histopathological slide showed features of lepromatous leprosy. Clinicians practicing in leprosy endemic areas should keep lepromatous leprosy in mind while investigating patients with varied and multiple lesions.

Keywords: Leprosy, AFB, Lichenoid papule

Case history

A 45-year Iranian man referred with severe itching and skin lesions on his trunk, buttocks and extremities from three years ago. Clinical examination showed many lichenoid papules and nodules on his trunk, buttocks, and limbs (Fig. 1). Oral examination also showed a nodular lesion 1×1cm in size on the soft palate (Fig. 2). There was no nerve thickening or any neurological signs and symptoms of leprosy except a localized numbness on his right hand. Madarosis was seen on his eyebrows and eyelashes. Leonine face or any thickening earlobe was not seen. Biopsy specimen from buttocks showed histiocytic infiltration and grenz zon on the upper dermis. Slit-skin smear from frontal skin was positive for Acid Fast Bacillii (AFB) (Fig. 3), and TB test was negative.

Discussion

The case reported here arrived with a severe itching and lichenoid papules on his trunk, and extremities and numbness on the right hand. These clinical signs and symptoms were atypical, uncommon and lesions simulated the clinical features of mycosis fungoides (Cutaneous Tcell lymphoma). He had for a long time been misdiagnosed and had been treated for other dermatoses. Another case has also been reported that a patient with a long history of recurrent rash and leg numbness had initially been diagnosed for systemic lupus, which was later proven to have lepromatous leprosy [1]. Our case showed oral nodular lesion on his soft palate. Oral manifestations usually appear in lepromatous leprosy and occur in 20-60% of cases. They may take the form of nodules (lepromas) that progress to necrosis and ulceration [2]. Lepromatous leprosy is a chronic infection that is presented with varying dermal and neurological symptoms, which can lead to

extensive disability, often with accompanying social stigma [3]. The uniqueness of the clinical dermatologic elements of leprosy recommend that control programs worldwide should diagnose the disease based on the so called main clinical signs; cutaneous neurological lesions with sensory-motor alteration without obligatory bacteriological or histopathological examination [4].



Fig. 1: Lichenoid papules and nodules on the trunk and buttocks



Fig. 2: Nodular lesion on the soft palate

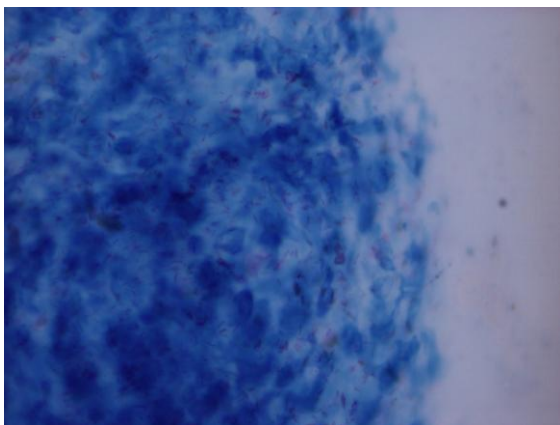


Fig. 3: Slit-skin smear positive for AFB

Our diagnosis (based on clinical suspicion) is confirmed through bacteriological and histopathological analysis [2]. Three dermatological conditions; epidermolysis bullosa dystrophica, granuloma multiform, and mycosis fungoides were diagnosed elsewhere as leprosy either clinically or histologically [5]. The missed diagnosis of leprosy was made and was treated with antilepromatous drugs for one year. After repeated skin biopsy, the diagnosis was compatible with sarcoidosis [6]. The case presented here did not show any typical signs and symptoms of lepromatous leprosy such as involvement of common cutaneous nerves with thickening and/or tenderness with its dysfunction, which is the second clinical sign to diagnose leprosy [7]. It is a reminder that this underappreciated disease should still be considered in the differential diagnosis of skin rash and neuropathy even in nonendemic regions [1]. In conclusion clinicians practicing in leprosy endemic areas should keep leprosy in mind while investigating patients with varied and multiple lesions.

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Address for Correspondence:

Mohammad Omidian, Department of Dermatology, School of Medicine, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran
Tel: +98611 3738159; Fax: +98611 3738153
Email: momidian@yahoo.com