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BILATERAL NERVE ABSCESSES IN A CASE OF LEPROMATOUS LEPROSY IN ZAIRE

As mentioned by Gelber and Zacharia (1) nerve abscesses in leprosy are rare and are usually seen in tuberculoid patients, only exceptionally in lepromatous leprosy. Gelber and Zacharia described the first case of bilateral ulnar nerve abscesses (1). We here present a second case. M.M., a 31 years old male, was living in a village at 350 kms from Kisangani, Zaïre. There had been no leprosy control activities in the area since 1979. The patient had been suffering from lepromatous leprosy since 1966, at the age of 11 years and had been treated with dapsone 100 mg per day from march to july 1979.

On examination in january 1986 he showed erythematous infiltration of trunc, back and arms, nodular infiltration of the face, madarosis, gynecomastia and hemorrhagic rhinitis. The bacterial index (BI) in the skin was 4.

All peripheral nerves were swollen and tender. Both the ulnar nerves showed abscesses: one of 10×5 cm extending from 3 cm above the epicondylus, while on the right side there was a second of 5×5 cm. The distal absces on the right arm was fistulized.

According to the patient these abscesses had been present for about one month and apparently had appeared without a reactional episode. The 3 abscesses were drained, the pus showed a BI of 5.

A biopsy of the wall revealed an œdematous fibrous tissue with a moderately dense infiltration of plasma cells and histiocytic cells. Scattered eosinophils were present but neutrophils were not observed. In the deeper parts a nerve was seriously thickened and its inner structure replaced by granulation tissue consisting of giant cells and epithelioid cells. It was quite evident that these lesions were focal and limited to part of the nerve only.

Roy Choudhury and Srinivasan (2) mention 4 mechanisms of nerve abscess formation in lepromatous leprosy, 1°: erythema nodosum leprosum (ENL) in the nerve, characterized by the presence of polymorphonuclear leucocytes, 2° acutely developing abscesses due to an exacerbation of an existing lepromatous lesion, with numerous acid fast bacilli, polymorphs being absent, 3° necrosis in a lepromatous granuloma, similar to the previous type but with a chronic evolution, 4° iatrogenic after peri- or intraneural injections.

The case we present here did not have ENL, and polymorphonuclear leucocytes were absent from the neural biopsy, the patient had not been treated with neural injections. It should thus belong to either the second or third category described by Choudhury and Srinivasan. However the presence of tuberculoid granulomatous tissue does not fit into these pictures.

It could be that the patient during 7 years without antibacterial treatment (1979-1986), had developed successive upgrading and downgrading

reactions, some leaving tuberculoid granulomatous tissue and others leading to abscess formation.

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