

# AN UNUSUAL PRESENTATION OF LEPRAMATOUS LEPROSY

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## INTRODUCTION

Leprosy is a chronic infectious disease affecting all parts of the body but has a predilection for involvement of peripheral nerves, mucosa of the respiratory tract and the skin. Though common in the tropics and sub-tropics it is not uncommonly encountered in the West consequent to jet travel and the increased flow of immigrants from Commonwealth and African Countries. The protean clinical manifestations of leprosy are familiar to practitioners in the tropics. However, an unusual presentation may not only beguile the experienced clinician in the tropics but also his colleagues in the West. We describe here such an unusual case.

## CASE REPORT

A 60 year old male was referred by a dental surgeon from a peripheral government clinic with a diagnosis of squamous cell carcinoma of the cheek of six months duration to the district hospital where he was seen by the consultant dental surgeon. Examination showed a nodule of about 1 cm. by 1 cm. on the right cheek. Intraorally the patient was

edentulous and an extensive granular ulcerative lesion was seen involving the lower right mandibular alveolus, the buccal mucosa of right retro-molar region and extending posteriorly to involve the pharynx. The lesion was also seen to involve the right floor of the mouth, the right ventral surface of the tongue and the posterior aspect of the right hard and soft palate. The entire ulcerated and granular area was red and covered with a slough, and was firm to palpation and slightly tender. The clinical appearance of the lesion was very suggestive of a squamous cell carcinoma. The submandibular glands on the right were enlarged and slightly tender. He had peripheral neuropathy of both feet and a trophic ulcer on the middle of his left sole. A clinical diagnosis of Hansen's Disease and squamous cell carcinoma of the cheek was made and an incision biopsy was done for confirmation. His haemoglobin level was 11 G, erythrocyte sedimentation rate 32 mm/l hour, total white and differential count was normal. His blood urea, serum electrolytes, random blood sugar and liver function tests were normal. The radiological pictures of his chest and right mandible were normal.

The biopsy specimen was reported to be 'tuberculoid leprosy'. The clinical impression of squamous cell carcinoma was so strong that the pathologist's report was doubted and a further two biopsies were done and sent to two different pathologists. The specimens were reported as "non-caseating tuberculoid granulomata". With special

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stains, acid fast bacilli were seen in these specimens.

The patient was diagnosed as having tuberculoid leprosy in 1947 and was warded at a leprosarium till 1952. He was on injection Sulphone till his discharge when he was given Dapsone 200 mg. biweekly and was followed-up by personnel of the National Leprosary Central Programme.

Although the oral lesion looked very much like squamous cell carcinoma, because of the histology report of tuberculoid leprosy he was started with reluctance on Rifamycin 600 mg. daily and Dapsone 100 mg. daily. Within two months the oral lesion had completely healed leaving an atrophic scar over the posterior aspect of the right hard palate, soft palate and retro-molar region. He was continued with Dapsone 100 mg. daily.

## DISCUSSION

Oral lesions in leprosy occurs in about 12 percent of cases. Lepromatous leprosy is associated with a higher incidence than non-lepromatous lesions.<sup>1</sup> Oral lesions occur in long standing and untreated cases. The lesions reported have been ulcerations, nodules, infiltrations and cicatrization. Nodular lesions of lepromatous leprosy have been described as red, brown, brownish-red or yellow in colour. Oral lesions in leprosy occur alone or in groups with normal intervening mucosa. The lesions rarely coalesce and involvement of the cheek, floor of the

mouth and buccal gingiva is extremely rare.<sup>2</sup> To our knowledge there are no reports describing an oral lesion which is so extensive as to have no normal intervening mucosa and which mimics a squamous cell carcinoma macroscopically.

Squamous cell carcinoma and leprosy can co-exist but we recommend that one should keep in mind the possibility that a lesion looking like a squamous cell carcinoma may be due to leprosy after all. Biopsy and histology of such lesions will not only clarify diagnosis but may confirm the presence of a curable lesion like leprosy.<sup>3</sup>

The emergence of resistant leprosy is a new problem to South East Asia. Resistance is due to non compliance, inadequate dosage or true bacterial resistance. Although our patient has been on treatment since 1947, the occurrence of his oral lesion while still on therapy is probably the result of inadequate therapy and poor compliance.

## REFERENCES

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