

Lepromatous Gynecomastia

TO THE EDITOR:

Gynecomastia has proven a disfiguring complication in a substantial percentage of patients with lepromatous leprosy. Discomfort and psychological embarrassment have led to mastectomy in some cases (4, 3, 6). Hormonal therapy has been unsuccessful (5).

The urologist faces a comparable problem of hormonally-induced gynecomastia in patients under treatment for metastatic adenocarcinoma of the prostate. This untoward side effect appears to some degree in every patient placed on estrogen therapy.

In this context, Gangai *et al* (2) have achieved excellent prophylaxis with locally directed, low-dosage external irradiation. (A 300 R dose is administered to each nipple and areola on alternating days for a total dose of 900 R in air.) When given prior to the institution of hormone therapy, gynecomastia has not ensued. However, when similar or even greater doses are administered to patients with established gynecomastia, the results have been uniformly poor (5). Corvalan *et al* (1) have confirmed this observation and advocated administering the 900 R in a single bilateral dose.

No trial of prophylactic breast irradiation in male patients with lepromatous leprosy has been reported. Surely there is no substitute for the prompt instatement of specific chemotherapy in dosage adequate to treat the systemic disease process. However, in those special cases where drug-resistant

bacteria and/or therapy-resistant patients threaten to compromise the end result, prophylactic irradiation of the breast may prove a helpful adjunct. In those areas where gynecomastia remains a significant problem young men with documented lepromatous leprosy may benefit by prophylactic breast irradiation. (Patients with established gynecomastia, however, will probably not improve.) A carefully controlled trial seems worthy of consideration.

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