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CORRESPONDENCE

This department is for the publication of informal communications that are of interest because they are informative and stimulating, and for the discussion of controversial matters. The mandate of this JOURNAL is to disseminate information relating to leprosy in particular and also other mycobacterial diseases. Dissident comment or interpretation on published research is of course valid, but personality attacks on individuals would seem unnecessary. Political comments, valid or not, also are unwelcome. They might result in interference with the distribution of the JOURNAL and thus interfere with its prime purpose.

Gilbert's Syndrome (Criggler-Najjar Type) with Hansen's Disease of the Dimorphous Type

TO THE EDITOR:

I would like to report a case of Gilbert's syndrome, a rare disease, in association with Hansen's disease of the dimorphous (borderline) type.

In May 1978, a 25-year-old Muslim male patient was brought to our clinic and presented with the following features:

Erythematous, papulo-nodular lesions over the face, trunk, and back with severe constitutional symptoms of fever, abdominal pain, anorexia, and vomiting. Attacks of such symptoms had occurred episodically at irregular intervals for the last 15 years. He had been examined and investigated by numerous physicians. He had had yellow discoloration of his skin and eyes since childhood. No family history of a similar condition could be detected. Some family members, including his mother and two sisters, had had jaundice in childhood, and the elder sister had died of pyrexia of unknown origin with hepatic failure at the age of 30.

Direct (conjugated) serum bilirubin was 1.6 mg/dl with a total serum bilirubin of 9.3 mg/dl. Fecal urobilinogen was increased. Serum bilirubin tolerance test (with 400 g of Calori diet) showed slight change in bilirubin level. Post prandial blood sugar was 95 mg/dl; serum alkaline phosphatase, 14 units/dl (K.A.). Total serum protein was 7.42 g/dl with an albumin of 5.20 and globulin of 2.22. The A/G ratio was 2.36. Glucose-6-phosphatase (whole blood) was 139 ml/10^9 erythrocytes (normal = 131 ± 12).

Routine blood examination showed a white blood cell count of 4000 mm^{-3} with a hemoglobin of 17.8 g/dl (118%), and an erythrocyte sedimentation rate (ESR) of 48 mm/hr. The prothrombin time was 13.6 sec. The red cell fragility test and a reticulocyte count were within normal limits. The bone marrow showed mild erythroid hyperplasia. The VDRL was negative.

A slit smear examination revealed numerous acid-fast bacilli. Histopathological examination of a skin biopsy revealed dimorphous (borderline) hanseniasis.

This case is of interest because of the combination of Gilbert's syndrome and Hansen's disease which produces great difficulty in management. The patient's obvious intolerance to most of the commonly used anti-Hansen's disease drugs has remained a great problem. The patient's jaundice was aggravated when attempts were made to use drugs like dapsone (DDS), thiacetazone (T.B. 1), ethionamide, cycloserine, and rifampin. The patient improved on clofazimine 100 mg three times weekly along with prednisolone, 5 mg three times daily.

To my knowledge, this type of case has not been reported from India.

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