BRIEF REPORTS

The purpose of this department is to facilitate the reporting of interesting cases and observations that otherwise might not be recorded.

THE ULCERS OF LEPROSY

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Until two years or so ago a feeling of despair always came over me when a patient with huge neglected ulcers, so common among sufferers from leprosy, entered the clinic. Now I always assure such patients that they can certainly be cured if they will give their cooperation.

The first step is, as always, diagnosis. To treat, for instance, a syphilitic or varicose ulcer as though it were due to leprosy is to court failure and discourage the patient. As far as I have been able to learn, an ulcer due to leprosy always begins by a wound of some kind, often a mere scratch, in an anesthetic area. Because there is no pain no matter what the patient does, he neglects the injury and it becomes continually worse, even to the extent of involving the bones and poisoning the patient by absorption from necrotic tissue. Not a few leprosy patients die from this cause. They would be said to die of leprosy, but really they die of septicemia caused by neglect.

The first postulate, therefore, is that an ulcer due to leprosy is in an anesthetic area. Nearly always the leprosy bacillus can be found. To do so may sometimes require many smears, especially in early cases, but with perseverance they will always be found except in the so-called "burnt-out" cases and in those that are well on their way to recovery.

Syphilitic, varicose, and other nonleprotic ulcers must obviously be treated as they would be in other patients. Ulcers which are really due to leprosy must be given special treatment directed toward that condition, and in addition such treatment as would be given to chronic ulcers occurring in patients who have no special disease. If, for instance, there is necrotic bone it must be removed, and necrotic skin or flesh must be treated with

antiseptic solutions and dressings. I have found that these must always be mild, for there is no pain sense to act as a danger signal. I have gotten the best results with solutions of copper sulphate, varying in strength from 0.5 to 2 percent, according to the ulcer to be treated. The patients are given a plentiful supply of this solution and are instructed to change the dressings several times a day. It would be ideal to have a nurse to do that, but my clinic has never been able to afford such a luxury. However, it is only a small minority of patients who cannot be inspired with sufficient enthusiasm to take a fair amount of care of their own lesions. They are rewarded and encouraged by rapid improvement.

But all of the above avails little without treatment of the disease which in the first place was the cause of the lesions. The treatment must be both local and general. For the local treatment I have found that intramuscular injections of the iodized ethyl ester of chaulmoogra oil around the ulcers give the best results. These injections never exceed 0.5 cc., but they are repeated as often as is possible without damaging the tissues. If there is any sign of redness, or if the patient complains of pain, there must be a delay of a few days before giving another injection. The parts some inches removed from the site of the ulcer itself, if anesthetic, must be treated with intradermal injections of the same preparation. The intramuscular injections not only combat the disease but induce a hyperemia which promotes healing.

Because in advanced cases every tissue of the body may be invaded by the organisms, treatment must always be systemic as well as local. In the mildest cases intradermal injections are to be given wherever there are anesthetic areas of skin, the dosage being as great as the patient will welcome without uncomfortable reaction. No less essential is the raising of his resistance by plenty of good food, supplemented by as much cod-liver oil as he is willing to take.