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Letter to the Editor

Letter to editor in response to: lepromatous leprosy in primigravida with early onset pre-eclampsia in third trimester: a rare case report

Sir,

We read with great interest the case report on lepromatous leprosy in a primigravida with early-onset pre-eclampsia in the third trimester.[1] The authors have brought attention to a rare and interesting clinical scenario. However, certain aspects of the case report need some clarifications.

The report describes the patient presenting with "multiple-colored elevated lesions" on the abdomen, upper, and lower limbs for 15 days, accompanied by intense pain and intense pruritus, with some lesions exhibiting necrosis. While leprosy lesions typically exhibit mild or no pruritus, the presence of "intense pain" and "intense pruritus" is atypical and raises questions about potential alternative or coexisting diagnoses. Necrosis occurs only in lesions related to reactional states and very rarely in leprosy per se. Considering the short duration of eruption and the clinical picture described, the most likely diagnosis is a severe form of type 2 reaction (erythema nodosum leprosum), which is a serious condition with severe systemic symptoms that were not observed in this patient.[2]

Due to the suboptimal quality of the uploaded images, it is challenging to precisely identify the skin lesions.

A comprehensive neurological and musculoskeletal examination is crucial in all cases of suspected or diagnosed leprosy, which is absent in this case report.

Regarding the initial management, it would be beneficial to clarify the diagnosis for which injectable prednisolone 20mg daily was prescribed (this formulation is not available in India). Moreover, the patient was already receiving intramuscular steroids for lung maturity of the baby; however, the dosage, duration, and rationale for using injections prednisolone; instead of oral administration are not specified.

The histopathology findings described in the report lack details specific to leprosy or reactions, and the type of leprosy in this patient based on histopathological evaluation is not provided.

The report mentions significant improvement in the lesions within seven days of initiating multidrug therapy (MDT). However, MDT alone is not known to produce rapid resolution of leprosy lesions, particularly in the reactional state. The dose of steroids administered is certainly inadequate for controlling the present reaction. It is unclear whether the patient continued to receive prednisolone alongside MDT, as systemic corticosteroids in adequate doses administered over weeks is the treatment of choice for managing reactions.[3] The exact diagnosis and management of leprosy with type 2 reaction appear ambiguous and not in accordance with the WHO guidelines.[3]

Contact screening is a crucial aspect of leprosy management.[4] The authors should indicate whether the patient had any known contact with leprosy cases within her family, neighbourhood, or social setting.

The assertion that a biopsy is mandatory for all pregnancy-associated eruptions may not be entirely accurate.

Another issue pertains to the title of the case report; the relevance of the third trimester or pre-eclampsia to the occurrence of leprosy in a pregnant female is unclear. In both instances, there is no direct correlation between leprosy and pre-eclampsia.

Finally, the conclusion could be refined to provide evidence-based methodology for diagnosis and management strategies as practical guidance for clinicians and obstetricians.

We hope the authors find these suggestions constructive and helpful in enhancing the clinical and academic impact of their case report.

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