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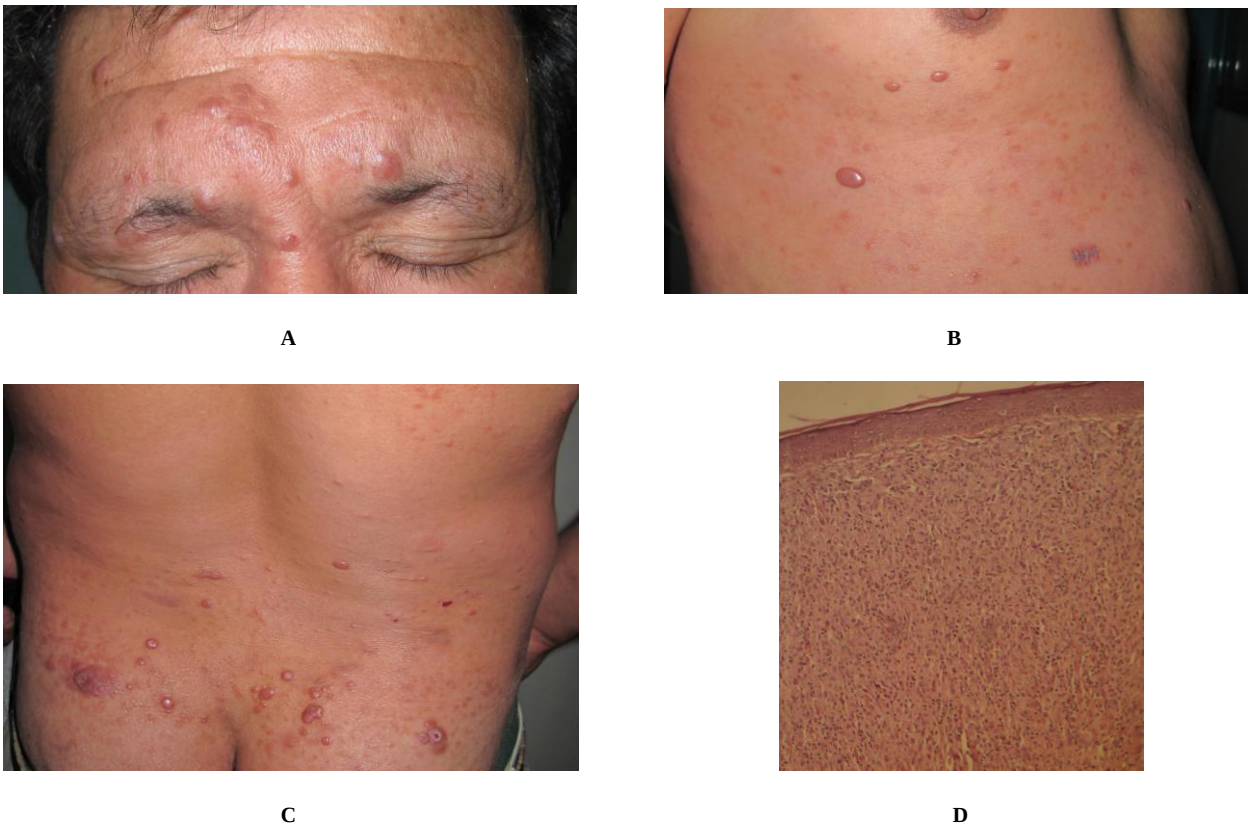
Lepromatous Leprosy: A Commonly Misdiagnosed Disease



A **B**

C **D**

FIGURE 1. Erythematous/coppery papules and nodules appearing on the face and body (A–C), with no apparent granuloma (D).

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A 42-year-old man was referred to our department for treatment with an 8-year history of cutaneous nodules of the face, back, trunk, and buttocks. Physical examination was notable for multiple painless erythematous/coppery papules and nodules with loss of the lateral eyebrows (Fig. 1A–C). There was no variation in the cutaneous sensations of temperature, touch, and pain. The patient came from Afghanistan, an area in which lepromatous leprosy is endemic. Histopathologic examination showed infiltration of foamy histocytes and macrophages extending to the subcutaneous fat separated from the epidermis by the narrow granz zone. Apparently there was no granuloma formation (Fig. 1D). In a mucosal smear from his nose and acid fast staining, numerous acid-fast bacilli were seen and a diagnosis of lepromatous leprosy was made. Cutaneous clinical lesions of lepromatous leprosy include cutaneous/subcutaneous firm, translucent, erythematous/coppery, and shiny papules and nodules appearing over an apparently normal skin[1]. Ocular complications are found in 73% of the patients and loss of eyebrows is the most frequent occurrence[2]. A number of skin diseases may be confused with leprosy. The differential diagnosis of the infiltrated plaque or nodules includes leishmaniasis, syphilis, sarcoidosis, lymphoma, and cutaneous tuberculosis[3]. If any physician sees a patient from an area where this infection is endemic (Asia, sub-Saharan Africa, South and Central America, the Pacific Islands, and the Philippines)[4] and who has unexplained skin lesions, it is important to consider leprosy. This patient was treated successfully with World Health Organization (WHO)–recommended multibacillary multidrug therapy (MBMDT). The skin lesions resolved with minimal scarring.

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