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Response to Letter to the editor by Divya Kamat et al

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In response to the letter forwarded by Divya Kamat et al regarding paper by Guliankar et al - 'A Rare Case of Erythema Nodosum Leprosum Presenting Clinically as Type 1 Reaction' (Guliankar et al 2020), the contributing authors would firstly like to thank them for in-depth reading and review of our article. All responses and discussions to our case report are much appreciated. We would like to discuss few arguments pointed out in the above-mentioned letter.

We have titled the paper in question as a case of ENL presenting clinically as type 1 reaction. In agreement with the letter authors, it was indeed a case of ENL as supported by the history and histopathology reports. However, at the time of presentation to us, the clinical picture was that of Type 1 reaction, hence the case was reported.

The patient had a history of recurrent, red, painful, nodular lesions with systemic symptoms of fever and generalised body ache during each episode. He had taken multiple treatments in the past, the details of which were not available to us. However, during the present episode, the lesions were diffuse, red, and infiltrative, distributed over face, trunk and extremities. There were no fresh crops of painful nodular lesions as typically seen in ENL. Moreover, the persistent nature of these lesions since 15-20 days, as opposed to the evanescent nature of ENL lesions, led us to believe that the current episode was clinically different from the previous episodes as described by the patient.

Thus, on the basis of history and clinical picture of the current episode, a presumptive clinical diagnosis of downgrading Hansen's disease in Type 1 reaction was made.

Simultaneously, skin biopsy specimen was collected from one of the infiltrative lesions on back and sent for histopathological confirmation of diagnosis.

While the clinical examination findings of diffuse lesions over the entire body, madarosis, nerve thickening, impaired sensations etc suggest sub-polar LL disease; the presence of a single well defined erythematous plaque, with central sharp margins and peripheral sloping, along with the presence of satellite lesions remain characteristic of the borderline nature of the disease, downgrading to the lepromatous spectrum. Such an ambiguous clinical picture may be due to previous inadequate treatment taken by the patient, the details of which were not available.

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Regarding the issue of treatment administered, the patient had already been started on systemic corticosteroids at the time of admission. Thalidomide was added after the histopathological diagnosis of ENL was reported. Although the patient might have responded to prednisolone alone as well, thalidomide is reported to show better improvement and less frequent recurrence of reactional episodes (Kar and Gupta 2016). We agree that the effect on neuritis is less pronounced, but it is known to quickly reduce the fever and number of skin lesions (Kumar and Kar 2017). As our patient was male, and the skin lesions were still present and diffuse, we opted to put him on thalidomide additionally after appropriate preliminary examination.

In conclusion, despite being confirmed as ENL, this case had presented with the cutaneous lesions more in resemblance to type 1 reaction. As we are well aware of the diverse presentations of ENL (Vijendran et al 2014), the purpose of reporting this case was to bring forward yet another ambiguous presentation, that may lead to erroneous diagnosis and treatment if not evaluated in detail.

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