Thalidomide is the best-known human teratogen. Although withdrawn from the market in 1961, thalidomide was remarked after 1965 in several countries, for the treatment of erythema nodosum leprosum. Thalidomide has a potent immunomodulatory property and has now a number of approved and off-label uses in dermatologic, oncologic, infectious and gastrointestinal conditions. In the U.S., FDA approved the use of thalidomide in 1998, but no cases of thalidomide embryopathy were registered after that (Uhl et al., 2006).

Castilla et al. (1996) reported 33 thalidomide-affected children (cases) born after 1965 in endemic areas for leprosy in Brazil. Since 1994, thalidomide prescription and dispensing in Brazil have been presumably controlled. Since then, no new cases have been officially registered (Pamugarten and Chahoud, 2006). However, the Teratogen Infor-
mation Service Porto Alegre recorded three new cases of thalidomide embryopathy born in Brazil since 2005.

CASE REPORT

Case 1
Case 1 was a male, born in 2005, and the third child of a young, nonconsanguineous couple. Family history was negative for malformations. His father was on regular treatment with thalidomide for ENL. His mother was healthy and apparently took the thalidomide without being aware of her pregnancy. Upper limbs: bilateral phocomelia, rudimentary fingers, and absence of both thumbs. Lower limbs: bilateral femoral, fibular, and tibial hypoplasia; right foot with halux duplication; left foot with halux digitalization. The child had a normal karyotype.

Case 2
The second case was a female, born in 2006, and the second child of a nonconsanguineous marriage with no family history of malformations. Her mother was using thalidomide periodically since 2003 for the treatment of ENL. Upper limbs: bilateral phocomelia with radial absence, rudimentary digits, and absence of both thumbs. The child died due to a severe congenital heart defect. She had a normal karyotype.

Case 3
Case 3 was a male, born in 2006 from a gemelar, unwanted pregnancy from a 17-year-old mother. She took thalidomide from her mother, who was being treated for multiple myeloma. The first twin was born without thumbs and died shortly after birth due to severe urinary tract defects and pulmonary hypoplasia. The second twin had bilateral symmetrical upper limb defects with radial, ulnar, and humeral hypoplasia, absence of thumbs, and two rudimentary digits. The child had a normal karyotype.

CONCLUSION
It is noteworthy that in two of the three cases the mother was not the person on treatment but used thalidomide by proxy, that is, through the well-recognized popular habit of sharing medications. Considering that these three cases were not registered through a systematic surveillance system, but came to our attention through a series of coincidental random events, it can be assumed that the actual occurrence of babies affected by thalidomide continues being as frequent as indicated 10 years ago by Castilla et al. (1996). As endemic areas for leprosy are usually not covered by birth defects surveillance systems, health authorities should be aware of the occurrence of these new cases to reinforce policies to avoid thalidomide exposure during pregnancy.

REFERENCES