COMMENT: NASAL MYIASIS IN LEPROSY

Sir,

'Nasal myiasis in leprosy' by Hussain *et al.* (*Lepr Rev*, 1991; **62:** 389–94) makes interesting reading.

It is of clinical interest (and surprise as well) that after nearly 50 years of dapsone therapy and over 8 years of multidrug therapy (MDT), nasal myiasis in leprosy is still 'on the prowl' in the part of India where the authors are working. Perhaps this condition still occurs in other parts of the country but is not documented. It is no wonder that the presentation at a clinical meeting of cases with nasal fistulae arising in the wake of neglected nasal myiasis in leprosy cases caused considerable surprise among the participants. With the advent of chemotherapy in leprosy (be it dapsone monotherapy or MDT), which confers considerable benefit on the nasal lesions and symptoms in the multibacillary cases quite early in the course of treatment, and also better patient care, infestation of the nose with maggots has become a rarity, like leprous laryngitis and the relentlessly progressive destruction of the elements in the anterior segment of the eye. This presentation is most welcome because it serves to bring this now rare, painful and distressing condition to the knowledge of the younger generation of leprosy workers and which incidentally has not attracted much attention in many of the textbooks on leprosy.

Nasal myiasis occurs in lepromatous and borderline–lepromatous cases coming from the lower economic strata of society, who are in a very poor state of health, almost moribund, and who do not have the energy to brush aside the flies. In the 1940s I saw a few leprosy cases with nasal myiasis. I remember distinctly one of these cases for two reasons: 1, It was the lone case from whose nasal cavity I pulled out an incredible number of maggots after the application of turpentine nasal swabs; and 2, This patient, whose nasal problem had become intolerable on a Sunday morning when our Clinic remained closed, sought help from the Government General Dispensary located in the same compound. He told the Medical Officer that 'poochis' (worms) were coming out of his nose and mouth. Without a second look, he was promptly prescribed 'Santonin' and 'Calomel' in divided doses (the then prevailing treatment for ascariasis) on the presumption that the patient was passing round worms from his nasal and buccal cavity. Not an unusual mode of exit for the worms in children carrying belly loads of the parasite.

An interesting observation that has emerged out of this presentation is that, 'occasionally the larvae burrow deep into the floor of the nasal cavity and eat away the bony palate to produce a palatal fistula'. This opens up another concept in the pathogenesis of the perforation of the hard palate in bacilliferous cases. It is indeed amazing that these slender, supple maggots which generally fluorish on dead and decaying soft tissue can nibble away apparently normal bone!

Other sites for the occurrence of myiasis in leprosy in the past were the neglected trophic ulcers over the planter surface and the lateral malleoli and suppurating lesions in the hands and feet. It is of interest to record here, that although the presence of maggots 'jam-packed' under the edges of the ulcers or wriggling about on the surface of the ulcers was frightening and repulsive, their presence was a blessing since they made a 'clean sweep' of the dead and decaying tissue, thereby making the ulcer more presentable.

K RAMANUJAM

11 Doraisamy Road
T. Nagar, Madras 600 017
Tamil Nadu
India