Letters to the Editor

A CASE REPORT: DUAL MYCOBACTERIAL INFECTIONS IN A PARAGUAYAN PATIENT DUE TO MYCOBACTERIUM LEPRAE AND MYCOBACTERIUM FORTUITUM

Sir,

A 32-year-old Paraguayan male patient presented himself at the governmental dermatology clinic in Asunción, Paraguay with typical, sharply demarcated tuberculoid leprosy lesions. They were distributed over the dorsum, the left upper and right lower extremities. The lesions showed loss of tactile and thermal sensations. In addition, there were several elevated ulcerations on the dorsum of the right foot. A lesion located on the left shoulder was histopathologically classified as borderline-tuberculoid leprosy (BT). The patient was started on multidrug therapy (MDT) with the daily dosage of brodimoprim 200 mg, of rifampicin 600 mg and of dapsone 100 mg.\textsuperscript{1,2} He was enrolled on this therapy trial on a voluntary basis, and 1 month later showed a distinct worsening of the infiltrated ulcerated skin lesions on the dorsum of the right foot. They fluctuated on touch. It was decided to aspirate them. The drained material had a viscous, cheesy consistency, was green in colour and mixed with blood. Direct microscopical examinations of the aspirate—stained with gram and methylene blue—revealed no bacteria. The Ziehl–Neelsen staining on the other hand showed numerous rods (4+). The cultures for bacteria other than acid-fast bacilli were negative. In the aspirate numerous leucocytes were to be seen, unexpected findings in a cold abscess found in BT.\textsuperscript{3,5} Therefore, additional investigations were undertaken and MDT was stopped. The infiltrated ulcers on the dorsum of the right foot were re-aspirated and the material sent to the Research Institute for Experimental Biology and Medicine Borstel (Borstel, Germany). The results of the bacteriological cultures were positive for \textit{Mycobacterium fortuitum}, i.e. an environmental bacterium. The organism was resistant to rifampicin, isoniazid, streptomycin and ethambutol. A blood sample was also drawn. No HIV antibodies were detected in ELISA. The treatment of the patient with ofloxacin was recommended. The drug, however, was not available locally. In the mean time the patient’s condition deteriorated rapidly. The lesions on the dorsum of the right foot became worse. The recommended ofloxacin was replaced by norfloxacin (800 mg daily). After 2 days of therapy he showed some signs of improvement. The treatment was continued for a period of 8 weeks. At the time of this report, the lesions caused by \textit{M. fortuitum} have completely subsided and the BT lesions have also disappeared.

It is known that environmental mycobacteria may be found on the skin of healthy individuals and in lesions of leprosy patients without causing disease.\textsuperscript{6} We point out in this report the problems which may arise in such infections. We also want to emphasize that appropriate bacteriological diagnosis and treatment recommendations in infections due to environmental mycobacteria may be life-saving for leprosy patients.

Chief of the Leprosy Laboratory of the German Leprosy Relief Association, Asunción, Paraguay, P.O. Box 661, Asunción, Paraguay

Director of the Leprosy Department of the Ministry of Health, Asunción, Paraguay

V. G. W. BALLESTREM & A. G. ALVARENGA
OPERATIONAL RESEARCH AND ITS AIMS

Sir,

In an effort to encourage more submissions on this topic we would like to express how useful the exchange of ideas in the field would be and that Leprosy Review would be well placed for doing this.

The basic aim of operational research is to carry out work to improve the operational efficiency as well as the effectiveness of leprosy work. This could be issues such as the packaging of drugs and their distribution; major reviews of the operation of a leprosy programme. Many simple studies are done looking at the compliance rates which involved interviewing field staff and patients, reviewing reports on the programme and then making simple changes which are effective in improving treatment and compliance. Other projects include looking at trials of health education materials, and validation of diagnostic criteria.

These projects are worth reporting for the benefit of others working in the field because they could have important effects on other programmes if this kind of information were shared.

The Leprosy Mission SE Asia
Katong, PO Box 149
Singapore 9143

K. JESUDASAN & W. C. S. SMITH

CONSIDERATIONS IN THE INTEGRATION OF EYE CARE INTO LEPROSY CARE SERVICES

Sir,

Courtright & Lewallen1 rightly draw attention to the often neglected subject of the integration of eye care into leprosy services. I would like to comment on their selection criteria for the need of an eye-care programme within a leprosy-control programme.

A common and easy to recognize eye complication in leprosy, with good prospects for treatment, is lagophthalmos due to facial nerve damage. Most lagophthalmos is the result of reversal reaction in borderline patients (BT, BB, BL) and occurs either before registration or shortly (within 6–12 months) after the start of antileprosy therapy,2 that is early in the disease and among young patients. At least half of such patients belong to the paucibacillary BT group. Overall, facial nerve damage, will exist or develop in 2–3% of all newly registered leprosy patients, in spite of multidrug therapy (MDT).