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# 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.[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.[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 *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 *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.[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.

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