

COMMENT: NASAL MYIASIS IN LEPROSY

Sir,

With reference to the paper on Nasal Myiasis¹ and the Letter to the Editor² on the same topic, I would like to report my experience, confirming that even today it is not an uncommon problem. Between 1982 and 1991, while working at a leprosy hospital in western Maharashtra, I saw several cases each year of nasal infestation in leprosy patients. The majority were 'cured' BL or LL cases with atrophic mucosae, but some still had active disease. Most of our cases had slept outdoors but they were not all beggars. They walked unaided into the hospital, so they were not 'almost moribund', unable to flick the flies from their faces,² nor 'in chronic debilitated condition'.¹ Hence, I feel that, rather than their poor general physical condition, it was specific disability due to leprosy that predisposed them to nasal myiasis: first the loss of the sneezing reflex and second their inability to clean the nose properly on account of severe hand deformity.

Most of our patients presented with the complaint of bleeding from the nose and on examination they had a persistent sero-sanguineous discharge from the nostrils, with or without perinasal/periorbital oedema. Some complained of feeling the maggots moving in the nose and sinuses. All were acutely distressed, embarrassed, anorexic and unwell. They had often sought help elsewhere (Primary Health Centre or Civil Hospital) before coming to us.

Treatment such as described by Hussain *et al.*¹ was applied but we preferred Ether to turpentine as it is less nauseating to the patient, yet equally effective. Great importance must be paid to nursing care of such patients: besides skilful nasal lavage, and sympathy, the patient needs to be propped up in bed, to reduce facial oedema, and attention should be paid to fluid balance and oral hygiene.

Apart from fistulae to the skin, complications we saw included excessive bleeding and dysphagia. A lady with nasal infestation vomited about 1 litre of swallowed blood; 2 male patients had total dysphagia, even spitting out their saliva, and required intravenous infusions for 24–48 hours, both were found to have 'quinsy' due to infestation of the tonsils as well as the nose. Occasionally bronchitis followed infestation, presumably as a result of inhaling infected secretions, or debris.

Nasal infestation is largely preventable by adequate hygiene (e.g. daily salt water douching of the nose), but we can surely expect to see it occasionally for many years to come, since there is still a cohort of patients, who, although released from treatment, have residual damage which predisposes them to this condition. Such patients need to be taught nose care (as do newly diagnosed MB cases) and need help from a friend or relative if a hand deformity prevents adequate self care.

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References

- ¹ Hussain S. *et al.* Nasal myiasis in leprosy. *Lepr Rev*, 1991; **62**: 389–4.
- ² Ramanujam K. Comment. *Lepr Rev*, 1992; **63**: 295.