Mycetoma—Time For a Conservative Approach

Sir,

Mycetoma, or Madura foot as it is sometimes referred to, is seen quite commonly in Saudi Arabia. The term Madura foot is an anachronism and should have been abandoned long ago. It is a descriptive term and gives no indication as to the organisms which may be responsible and it implies that the condition affects the foot only, which is incorrect. The diagnosis of mycetoma is usually easy and careful clinical assessment may allow the lesion to be more accurately classified as either actinomycetoma or eumycetoma. However, culture of material from the tissue is mandatory to confirm or establish whether or not a bacterial or fungal infection is the basis of the condition. Is this important? Most certainly. Patients suffering from mycetoma are still treated by amputation before adequate trial of chemotherapy has been given. Whereas previously only the actinomycetoma might have been expected to show response to antibiotic therapy, now with the emergence of the imadazole anti-fungal drugs, there is every reason to prescribe these for the treatment of the eumycetoma in the hope that the condition may be cured or at least prevented from worsening so that amputation is not required.

A patient being treated by us illustrates this point adequately. A 31-year-old male with a history of mycetoma of 15 years duration affecting the right foot around the ankle was referred from the surgical department for assessment. He showed gross swelling of the tissues of the right ankle and dorsum of the foot with numerous sinuses, some of which were discharging pus and blood.

Investigations confirmed that the lesion was a eumycetoma and pending culture and sensitivity results he was started on ketoconazole 200 mg daily increasing after a month to 200 mg twice daily. Culture showed the organism to be Madurella mycetomatis sensitive to intracranial and ecanoazole but not ketoconazole. Itroconazole 100 mg twice daily was therefore started and has been maintained for 9 months. His condition has improved both subjectively and objectively and comparison of serial photographs shows a reduction in sinuses and swelling. He has suffered from no side-effects either subjectively or by laboratory investigations, whereas on ketoconazole a rise in his alkaline phosphatase necessitated reduction in the dose in view of the known hepatotoxicity of the drug.

The message is that there is now a treatment available which can halt the progress of eumycetoma and it should therefore be prescribed in all cases where a diagnosis is established and continued indefinitely with a view to preserving the limb if only until a superior anti-mycotic becomes available.

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Retrovir Prophylaxis for HIV Exposure

Sir,

Parenteral exposure to blood from patients with HIV infection is associated with a seroconversion risk of 0.3%. Even trivial injuries can cause seroconversion. Mucous membrane exposure probably carries an even lower risk. Nevertheless, detectable antibodies imply infection and not protection and most probably all those infected with HIV will develop AIDS some years later. In keeping with global experience, HIV is indigenous in the Kingdom of Saudi Arabia. Among healthy blood donors attending the King Faisal Specialist Hospital and Research Centre (KFSH & RC) the HIV seroprevalence rate has been found to be 0.0099% in a study of 64,294 donations during a 5-year period.2

Approximately 100 Saudi patients with HIV Western blot positivity have been identified at this hospital and currently 65 attend the HIV clinic—the weekly attendance rate is eight to nine (personal observations). At any one time approximately two to three patients with HIV are admitted to this institution. Since 40% of our patients come from outside the Riyadh region, HIV is apparently present throughout the Kingdom and the threat of spread of HIV to health care personnel is likewise universal. Zidovudine (AZT; azidothymidine) is a reverse transcriptase inhibitor with in vitro antiviral activity3 and proven clinical efficacy in established AIDS and possibly in early asymptomatic HIV disease4 and possibly in early asymptomatic infection.5 Since AIDS is inevitably fatal, it is worthwhile attempting to prevent infection after exposure. This letter describes the preliminary results of an ongoing study at the KFSH & RC. Health care workers who sustained an inoculation injury with a needle or sharp instrument or who sustained a mucous membrane or open skin splash with blood or blood products from a patient known to be HIV positive by Western blot were eligible for inclusion into the study. The health care workers report immediately to the Family Health or Emergency Clinics so that zidovudine can be administered as soon as possible (ideally within 2 hours) and at most within 72 hours of the incident. The full informed consent of the recipient is obtained for zidovudine administration and for an HIV antibody test. Zidovudine at an oral dose of 200 mg 4-hourly is administered for 6 weeks. The recipient is seen at 2-week intervals to detect side-effects both symptomatically (particularly GI tract upset) and subclinically (cytopenia and abnormal liver function tests). The recipient is asked about symptoms suggestive of acute retroviral infection (such as rash and fever). HIV antibody tests are repeated at 6 weeks, 3 months, 6 months and 12 months. HIV antibody testing is performed as previously described.5 Since July 1989, an open enrolment study approved by the Hospital Clinical Protocol Committee has been in operation to offer zidovudine prophylaxis to health care workers with needlestick or mucous membrane splashes from HIV patients. Seven individuals over the period July 1989 to February 1992 informed the Family Health and Emergency Service that they had been exposed to blood from HIV patients. One recipient, a female aged 34 was 3 months pregnant and declined zidovudine—she was HIV antibody negative 6 months later. Another female aged 43 refused zidovudine and was HIV antibody negative 5 months later. Of the remaining five patients, zidovudine was started within 6 hours in two patients and within 2–3 days in three patients. Mild epigastric pain/nausea was experienced by two patients. There was no fall in haematological indices apart from one patient whose total white cell count fell by 31% from 8.3 to 5.7 x 10^9/L temporarily over the period of drug administration. There was a slight rise in the MCV in three patients, no liver function abnormality was detected. All five patients completed their course of zidovudine. The period of follow-up was between 6 weeks and 31 months and all five remained seronegative.

Zidovudine (AZT, azidothymidine) is a nucleoside analogue which terminates HIV DNA replication. Our preliminary results suggest that zidovudine is tolerated and is not haematologically toxic when administered to healthy recipients of HIV inoculations/mucous membrane splash injuries. A substantial