# LETTERS TO THE EDITOR

## *Dracunculosis medinensis*

***To the Editor***

Dracunculosis medinensis(DM) is a chronic infestation of man due to nematode *Dracunculus medinensis*. High incidence occurs in Rajasthan, Madhya Pradesh, Maharashtra, Karnataka, Andhra Pradesh and Gujrat where people use ponds or step wells for drinking water.[1] Adult female parasite is 60cm to 1 meter in length and 1.5 to 1.7mm in breadth. Man is definite host and cyclops are intermediate hosts which ingest larvae from water. Cyclops are swallowed by man, digested by gastric juice thus liberating larvae which migrate to retroperitoneal tissues especially of legs, arms and back and discharge large number of larvae in water after rupture of burning blister.[2] Shortly before the worm emerges, systemic symptoms of urticaria, erythema, transient rash, cough, dyspnoea, diarrhoea, malaise and pyrexia can appear.[3]

A 35-year-old army man developed itchy painful ulcers on medial side of left foot since 2 months. Eight months back he had been transferred to Punjab from Karnataka. Initially, he developed burning and erythematous tender, itchy 3 x 3.5 cm bulla on left medical malleolus associated with fever, generalised pruritus, urticaria and erythematous rash. Incision and drainage of bulla was done at periphery and slowly ulcer healed with depressed scar after multiple courses of antibiotics, antihistaminics and antiseptic dressings. Three weeks back similar bulla appeared on medial side of left foot which turned into abscess inspite of medication and later ruptured to form A 2.5 cm diameter circular well-defined ulcer with rolled edges, yellowish granulation tissue and visible thread-like worm in its upper wall (Fig.1).

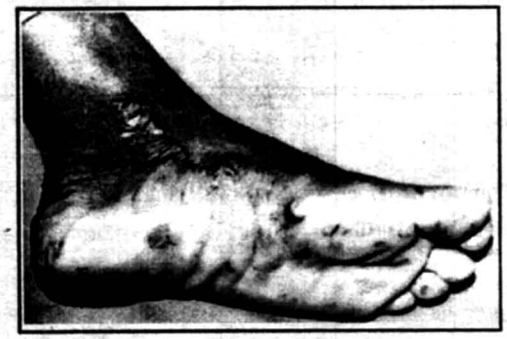

Fig. 1- Serpentine, long wavy cord -like worm, scar plaque with central depression and ulcer with thread like worm on its upper wall are seen on medial side of left foot.

A long tortuous, erythematous to purplish, firm, thread-like cord was visible starting from medial malleolus and running in serpentine manner throughout medial border of left foot and on under surface of toes (Fig.1). In between scar and ulcer, another 2.5cm, firm, subcutaneous nodule was also seen. Clinical diagnosis was easy and worm was slowly extruded after rolling it on thin wooden stick. Patient was fully cured after a course of metronidazole 400mg tid for 20 days.

DM infestation is hardly ever seen in Punjab and therefore diagnosis was missed earlier. Awareness is essential as it can be completely cured with specific medicines. Other drugs used are nitridazole(25mg daily for 10 days) and thiabendazole(5mg/kg for 3 days).[3]

**R R Mittal ,**
**Seema Gupta**
Department of Dermato-Venereology
Rajindra Hospital, Patiala, India

### References

1. Harman RRM. Parasitic worms and protozoa. In: Rook A, Wilkinson DS, Ebling FJG, et al. Textbook of Dermatology. Oxford: Black-well Scientific Publications, 1986;987-1029.

2.Dracunculosis in: IADVL Textbook and Atlas of Dermatology. 1994; Bhalani Publishing House: Vol 1 :322-325.

3. Muller R. Guinea worm disease : Epidemiology, control and treatment. Bull WHO 1979;57:683-689.

## *Metastatic cutaneous adenocarcinoma*

***To the Editor***

A 60-year-old male presented with an asymptomatic erythematous lesion over right side of the forehead of one month duration. Patient was apparently healthy except for moderate degree of prostatism for last 2-3 years. On examination, a firm indurated plaque of 3x4cms size was present over right forehead involving right eye brow without any ulceration or eczematization. There was softening of the underlying bones of the forehead and orbit on the right side. X-ray of the skull showed large osteolytic lesion involving frontal bones and roof and lateral wall of the orbit on the right side just beneath the plaque lesion. Biopsy from the lesion showed poorly differentiated adenocarcinoma where cell of origin could not be ascertained. A thorough search with good clinical examination was done to locate primary site of adenocarcinoma. Skeletal survey of long bones and spine did not reveal any osteolytic lesions. A complete blood count, urine analysis, hepatic and renal function, serum acid phosphatase and x- ray chest were normal. A fine needle aspiration cytology from the prostate did not reveal any malignant focus. On learning about the diagnosis of cancer, the patient left for alternative system of medicine to seek cure and was lost to follow-up.

The skin is involved by metastases in 3-4% of malignant tumors. Most frequent sites of primary tumour being breast, stomach, lung, uterus, large intestine, kidney, prostate glands, ovary, liver and bones.[1] Lesions of cutaneous metastases are usually erythematous than normal skin and with marked induration resembling an inflammatory lesion. Cutaneous metastasis is usually a late and bad prognostic event.[2,3] Reingold reported a series in which survival time was not more than 3 months on the average from the time of diagnosis of cutaneous deposits.[4] It is likely that in present patient skin was involved secondary to the bone metastases as the cutaneous lesion was overlying the bone involved. Because