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MALARIA - LIKE FEVER WITH INTERMITTENT RIFAMPICIN

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A case of borderline tuberculoid Haneen's disease on MDT developing hyper pyrexia and other malaria - like features, till now undescribed is reported.

Key Words : Leprosy chemotherapy, Malaria, Rifampicin, Flu-like syndrome

Introduction

'Flu-like syndrome' has been reported in tuberculosis patients on intermittent rifampicin therapy.[1,2] The first case of such a syndrome was reported in a leprosy patient on MDT by Naafs and Matemera in 1986.[3]

We are reporting a case seen by us in 1991, who was on MDT for borderline tuberculoid Hansen's disease and who developed hyperpyrexia with chills and rigors each time on the day of rifampicin intake.

Case Report

A 55-year old male patient was diagnosed as having borderline tuberculoid Hansen's disease and was bacteriologically negative on slit skin smear examination. He was put on dapsone 100 mg daily and rifampicin 600 mg once every fifteen days on empty stomach. Following two months of institution of MDT, patient attended the clinic regularly. However, when for the next two months patient did not report, he was contacted. He informed that he had developed "resistant malaria". This was diagnosed by a reputed internist who prescribed him pyrimethamin 75 mg and sulphadoxine 1500 mg daily, but without any response.

On eliciting detailed history, it was revealed that the intermiltent fever occurred every alternate sunday, the day rifampicin was taken. Two hours after rifampicin was taken, patient used to develop chills and rigors associated with a sharp rise in body temperature to a maximum of 104.5°F. There was gradual defervescence accompanied by sweating over the next six to eight hours till temperature touched the baseline. There were no respiratory symptoms, body aches, joint pains, neuritis or new skin lesions. We suspected rifampicin to be the culprit with this presumption, we gave the patient a challenge dose of 600 mg of rifampicin alone under supervision. The whole sequence of complaints described above were reported. To rule out any chance of coexisting malaria, a peripheral sinear for malarial parasite was made which was negative. Rifampicin was stopped and the patient was given only dapsone and clofazimine. During follow up during the next six months patient did not develop any fever.

Discussion

The patient described above had developed fever without any exacerbation of skin lesions, arthralgia or neuritis. He self medicated his fever but when the symptoms progressed and chills and rigors developed, the patient consulted an

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internist, presuming that the latter will be more competent to manage his fever. He did not even report to his treating leprologist considering that it was not his domain. Based on the fact that the patient was from an area endemic for malaria and his symptoms fitted into its clinical picture, he was put on antimalarials. When no response was obtained, he was diagnosed as a case of "resistant malaria". Fortunately the patient was educated and aware of the importance of continuing anti leprosy treatment which he did not stop. If he had discontinued rifampicin, he would have been passed off as a case of malaria. Further if the patient would not have been retrieved, this important information would have been missed.

It is generally believed that patients on intermittent rifampicin according to WHO recommended MDT regimen do not suffer from serious untoward reactions.[4] Our regimen differed from WHO regimen in that we used rifampicin once in fifteen days.

The literature on rifampicin as intermittent therapy, whether for tuberculosis as leprosy, describes a "Flu-like syndrome" in which it is presumed that respiratory symptoms and myalgias are important features. These, however, were missing in our case, symptoms of our patient filled typically into a "malaria-like syndrome".

As MDT is being used in most developing countries, where malaria is also endemic, the development of malaria-like fever as a side effect of intermittent rifampicin therapy should be kept in mind.

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