

Rational use of laboratory test

Sir,

We read the editorial on “Rational use of laboratory tests in dermatology” with great interest.¹ In this article, the editor discussed the way to properly use and interpret several laboratory tests. We would like to share ideas on this issue. Rational use of laboratory investigation is an important consideration in laboratory medicine. Rational use basically means proper investigation and correspondingly proper interpretation of results. The physicians must know the concept of the test and how to interpret the result of the test. Also, the commonly forgotten issue is the preparation of the patient for getting the test. In laboratory medicine, pre-analytical error is common and it is sometimes related to poor preparation of the patients.² Quality assurance to control the laboratory error is usually needed. Nevertheless, rational use of laboratory test also means selection of the test that is cost-effective and affordable to the patient.³ In addition, the availability of the analysis and the turnaround time of the analysis are also matters of concern. Some tests might be useful but not available or have very long waiting time for the results, which is not appropriate for the requirement for prompt management of the problem. In conclusion, there are several considerations in clinical practice for the dermatologists to have rational use of laboratory tests in their clinical practice.

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Conflicts of interest

There are no conflicts of interest.

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Prevention of *Strongyloides stercoralis* hyperinfection in leprosy patients on long-term steroid therapy

Sir,

We read with interest the article entitled “*Strongyloides stercoralis* hyperinfection: An often missed but potentially fatal cause of anemia and hypoalbuminemia in leprosy patients on long-term steroid therapy” by Gupta *et al.*¹ Through this case discussion, the authors emphasized the need for awareness of this often fatal syndrome among dermatologists and leprologists who frequently prescribe corticosteroids for managing lepra reactions. The authors have pointed out that unexplained peripheral eosinophilia in an immunosuppressed individual having abdominal or pulmonary symptoms should raise a suspicion of strongyloidiasis. Here, we would like to discuss the prevention of this fatal complication in leprosy patients on long-term steroid therapy.

Although *Strongyloides stercoralis* generally causes chronic and clinically asymptomatic infection, in the immunocompromised, the parasite number can increase substantially, leading to hyperinfection, dissemination and death if unrecognized. Hyperinfection may develop as early as four days after the onset of corticosteroid therapy and as late as several years, up to 20 years.² Early detection of this infection may alter the fatal course of infection. Leprosy patients living in strongyloidiasis endemic areas may develop a life threatening infection when their leprosy reactions are treated with steroids, without pre-treatment of *Strongyloides stercoralis* infection.³

There is no single ideal screening or diagnostic test for detecting *Strongyloides stercoralis* infection. Stool microscopy to