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HAEMORRHAGIC CHICKEN POX WITH PNEUMONITIS

To the Editor,

A 50-year-old man reported with complaints of fever of one week and skin and mucous membrane lesions of about 4 days duration. The individual had consulted a private practitioner prior to hospital referral and was treated with antibiotic and systemic steroids. There was no history of diabetes or any other systemic illness. He did not give any history of atopy or skin illness in self, family or immediate contact. The lesions appeared first on the trunk and then gradually extended over the peripheral parts. He had developed mucous ulcerations of the eyes, mouth and nasal cavities. This was accompanied by swelling and inability to open both eyes. The lesions tended to appear in crops and each crop was accompanied by fever of moderate grade.

Examination showed an averagely built, middle aged male individual. His temperature was 102°F and blood pressure was130/20 mm Hg. Bilateral oedema of both legs was present. Systemic examination showed diffuse coarse crepts over both lungs. Dermatological examination showed involvement of face, trunk and extremities showing multiple bilaterally symmetrical vesicular lesions, some discrete, while others showing confluence with clear to turbid fluid. Some lesions showed crusting, while others blood stained fluid with haemorrhagic borders. A few ecchymotic areas could be seen over the trunk. The mucous membrane of the eyes showed congestion with periorbital oedema. Superficial ulcers with petechial haemorrhages could be seen over the soft palate, pharyngeal walls and vestibule of mouth. Bilateral pitting oedema was present over both feet. Hair, lymph nodes and nails were normal.

A clinical diagnosis of varicella was made. Haematological and biochemical parameters were within normal limits. HIV test was negative. Tzanck smear from one of the blisters showed presence of balloon cells.

He was treated with I V ampicillin, gentamycin, Inj. cephalexin & I V acyclovir along with other supportive measures. After 2 days of hospital admission he developed delirium and started showing abnormal behaviour. A CSF Examination done at this stage was normal. On 4th day he had a massive bout of haematemesis, developed coma and expired. X-ray chest showed widespread 10 mm diameter nodules, some discrete and others confluent bilaterally. No hilar opactities or lymph node enlargement was seen. Nodules had ill defined margins. No cavitation was seen within any nodule.

Chicken pox though fairly common in children, occurs occassionally in adults and is known to be more severe in adulthood. Our patient had severe involvement of skin and mucous membranes along with pneumonitis and possible meningeal involvement. Pneumonitis, though unusual, occurs and is characterised pathologically by interstitial scattered lesions with nodular haemorrhagic areas. Microscopy shows characteristic findings of focal peribronchial necrosis, intracellular inclusions and bibrinoleukocytic exudates.[1]

Haemorrhagic varicella is rare. This disease is accompanied by high fever and a

haemorrhagic diathesis manifested by haemorrhagic blisters, petechiae, epistaxis, ecchymosis, and haematemesis. This is known to occur commonly in immunosupressed individuals. Our patient had received a short course of systemic steroids and had no history suggestive of any immunocompromisations.

Varicella pneumonia, except for debilitated children is a disease of adults. They have been described as being peribrochiolar or alveolar nodules, having fluffy or ill-defined margins, showing early coalescence, with segmental or lobar distributions, with a butterfly/bats wing pattern and an air bronchogram or alveologram. Nodules usually simultaneously appear and disappear in different areas or become confluent. They usually resolve in a week or ten days but can persist for months or longer. In 2% of patients, these calcify.

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TATTOOING PRACTICES IN KUMBH MELA

To the Editor,

Tattooing, a worldwide practice, usually involves the dermal introduction of pigments by multiple punctures using needles. This can lead to complications and infections as gangrene, tuberculosis, syphilis, verruca vulgaris, sarcoidosis, melanomas etc,[1-3] besides the problems associated with it's removal.

The present study highlights the unregulated and unhygienic tattooing practices of 5 identifiable tattoo artists during Kumbh mela at Ujjain. This mela has great religious sanctity and occurs once in 12 years. Recently, about 20 million pilgrims visited this mela from 17th April to 16th May 1992.

All the 5 identifiable tattooists were males with a mean age of 49 years. 80% belonged to backward castes, 60% had no formal education and were practicing it ancestrally. None of them had received any scientific training of tattooing and were observing no asepsis procedures as they were totally ignorant of its potential hazards. After tattooing the tattoo site was wiped with a cloth piece or their hand and oil was applied. The tattoo artists were smoking bidis in between their clients and resuming their work without hand washing. The tattooing was done by a needle operated machine. The work of the tattooists is mainly centered on pilgrimages and fairs, where there are large congregations and they move from one fair to another as opportunities permit.

The aforesaid observations clearly depict that the observed tattooing practices were totally unregulated and were potentially conducive to the accidental introduction of infections. Strategies directed at educating the general public on this issue may not be logistically feasible nor desirable in the presence of pressing public health problems. However, it seems prudent to train and monitor the tattoo artists for adherence to asepsis procedures as disinfection, autoclaving and use of disposables along with prohibition of tattooing for minors.

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