

Letters to the Editor

Chloroquine Resistance Among Malarial Episodes in Saudi Arabia

To the Editor: Your editorial¹ on chloroquine resistance among Saudis with *Plasmodium falciparum* infections rightly points to the role of sublethal concentrations of drugs, noncompliance of recommended therapeutic regimens, as well as the indiscriminate usage of antimalarial formulations in the emergence of drug-resistant plasmodium strains. To prevent the spread of drug-resistant plasmodium strains, it would be desirable to monitor the potency and bioavailability of different antimalarials offered to the general population. Samples of chloroquine being sold at pharmacies in Dar es Salaam in Tanzania were examined for potency and dissolution rate. The nine brands complied with the USP requirement for chloroquine content, but one did not pass the dissolution test.² In Sudan, bioavailability of one of the five brands sold in chloroquine was lower than the others.³ One would sincerely hope that, like in Sierra Leone, where use of expired drugs is an established practice,⁴ postexpiry antimalarials are not offered to the general population even in remote and isolated locations in Saudi Arabia.

Undoubtedly, poor potency and bioavailability antimalarials would be of no benefit to the individual. This would encourage the emergence of chemotherapeutic resistance among different plasmodial strains. Even patients who are sincere and serious about the compliance of the prescribed treatment would contribute to an increased resistance in the community.

The menace of poor quality antimalarials could be minimized through simple, sensitive drug assay procedures that would not require trained personnel and costly equipment. Recently, a semi-quantitative paracetamol-specific spot test that enables the screening of paracetamol in the field itself⁵ has been standardized. Similar tests for assaying different antimalarial drugs in the field would be useful in remote areas, and could ensure that no poor potency drugs were offered to the general population.

There should be no hesitation in accepting the concept of a central laboratory in Saudi Arabia to tackle national and international issues concerning malaria.¹ Integration of field monitoring of antimalarials by the proposed organization would ensure that potency, dissolution and bioavailability of antimalarials were ideal. Lastly, there are anecdotes on the bitterness or sweetness of different brands of antimalarials in pharmacy stores in metropolitan areas. Regular surveillance of the quality of active ingredients alone would establish if there are any preparations with a

poor potency and bioavailability, but with a sweet taste.

Subhash Arya, MBBS, PhD

Clinical Microbiologist

Center for Logistical Research and Innovation

M-122, Greater Kailash-II

New Delhi-110048

India

References

1. Alrajhi A, Frayha HH. Chloroquine-resistant *Plasmodium falciparum*: is it our turn? *Ann Saudi Med* 1997;17:151-3.
2. Abdi YA, Rimory G, Ericsson O, Alm C, Messele AY. Quality of chloroquine preparations marketed in Dar es Salaam, Tanzania. *Lancet* 1995;346:1054-5.
3. Mahmoud BM, Ali HM, Homeida MMA, Bennett JL. Bioequivalence of five chloroquine brands marketed in Sudan. *Int Pharm J* 1994;8:164-7.
4. Sesasay MM. Expiry date on pharmaceuticals: some worrying realities in Sierra Leone. *Int Pharm J* 1994;8:202-6.
5. Roy J, Saha P, Sultana S, Kenyon AS. Rapid screening of marketed paracetamol tablets: use of thin layer chromatography and a semiquantitative spot test. *Bull WHO* 1997;75:19-22.

Flavobacterium Meningosepticum in ICUs

To the Editor: Kambal et al.¹ have analyzed the isolation of *Flavobacterium meningosepticum* in space and time, and arrived at valid conclusions clinically and epidemiologically. The epidemiological conclusions would have been stronger still if the authors had carried out ribotyping of their *F. meningosepticum* isolates. Ribotyping of the *F. meningosepticum* has been found to be a very useful tool for epidemiological studies concerning *F. meningosepticum* from an outbreak.²

P. Thirumalaikolundusubramanian

King Fahad Central Hospital

Gizan, Saudi Arabia

References

1. Kambal AM, Arora SC, Alzeer A, Babay HH. *Flavobacterium meningosepticum* in ICUs of a teaching hospital in Riyadh, Saudi Arabia. *Ann Saudi Med* 1997;2:240-6.
2. Colding H, Bangsbo J, Fiehn NE, et al. Ribotyping for differentiating *Flavobacterium meningosepticum* isolates from clinical environmental sources. *J Clin Microbiol* 1994;32:501-5.

Reply

To the Editor: We thank the reader for his valid comments. Ribotyping would indeed have been a stronger marker for our epidemiological conclusion, but we did not have the facilities to carry out this method. We were also convinced about the relatedness of our *Flavobacterium*

meningosepticum isolates by the following: 1) clustering of isolates in a certain area; 2) clustering in a certain period of time; 3) the similarity of antimicrobial susceptibility patterns; and 4) the rare isolation of this organism in our hospital before this outbreak.

Dr. A.M. Kambal
Microbiology Department
King Khalid University Hospital
P.O. Box 2925
Riyadh 11461, Saudi Arabia

Melanotic Neuroectodermal Tumor of Infancy in a Child

To the Editor: I read with interest the article on melanotic neuroectodermal tumor of infancy recently published in the *Annals*,¹ and report a similar case.

A six-month-old female was admitted with a rapidly increasing swelling of the left superior maxillae bone. The child's medical history was totally unremarkable. She had no fever. On physical examination there was an enlargement of the left side of the face sited on the left maxilla from the midline to the area of the deciduous molar and hard palate. Laboratory studies were normal, and in particular, no urinary excretion of vanillylmandelic acid could be found.

Radiographs of the skull and facial bone revealed a radiolucent lesion in the left anterior maxilla with a tooth germ inside the lesion. The radiolucency occupied all of the left maxillary sinus (Figure 1). A CT scan of the skull showed a solid mass. The lesion was surgically removed under general anesthesia. It showed a brown cystic tumor with ectopic dental germs of ectopic location. The patho-

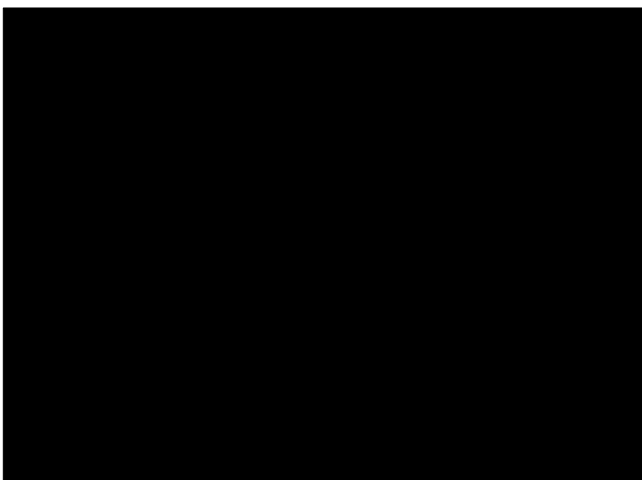


FIGURE 1. Frontal view of the facial bones: radiolucency occupying all of the left maxillary sinus.

logical diagnosis was melanotic neuroectodermal tumor of infancy. We have added some references²⁻⁴ for the general interest of readers and also for practitioners who may encounter this condition.

Christine Hoeffel, MD
Radiology Service
Hôpital Jeanne d'Arc
BP 303-54201 TOUL Cedex
France

References

1. Belagavi CS, Kubeyinje KP, Mohammed JH. Melanotic neuroectodermal tumor of infancy in a child. *Ann Saudi Med* 1997;17:382-3.
2. Cutler LS, Chaudhry AP, Topazian R. Melanotic neuroectodermal tumor of infancy: an ultrastructural study, literature review and re-evaluation. *Cancer* 1981;48:257-70.
3. Mosby EL, Lowe MW, Cobb CM, Ennis RL. Melanotic neuroectodermal tumor of infancy: review of the literature and report of a case. *J Oral Maxillofac Surg* 1992;50:886-94.
4. Pettinato G, Manivel JC, D'Amore DSG, Jaszcz W, Gorlin RJ. Melanotic neuroectodermal tumor of infancy: a re-examination of a histogenetic problem based on immunohistochemical flow cytometric and ultrastructural study of 10 cases. *Am J Surg Pathol* 1991;15:233-45.

Isolated Breast Lump of Tuberculosis Etiology

To the Editor: Primary tuberculosis (TB) disease of the breast is rare. Clinically, lesions may be mistaken for breast carcinoma. Regional lymph node involvement is common, and occasionally these nodes are intramammary.

We report an isolated TB breast lump in a fit female patient. We think it is important to consider TB etiology in patients presenting with breast lumps and/or abscesses. A 20-year-old female patient was seen at the surgical outpatient department complaining of painless lump in the left breast of four months' duration. She stated no other symptoms and had not experienced any significant illness previously. On examination, she looked healthy, of moderate physique and not anemic. Systemic examination revealed no abnormalities apart from a firm, painless mobile lump measuring about 2 cm x 4 cm on the lateral upper quadrant of the left breast. The nipple and skin were normal. Provisional diagnosis of fibroadenoma was suggested and the patient was admitted to hospital for excision biopsy.

Through a circumareolar incision, the lump was excised and sent for histopathological study. A granulomatous lesion with a positive acid-fast bacilli typical of TB was reported. Thorough investigation for TB in other organs or body systems proved negative, apart from a high erythrocyte sedimentation rate (ESR). The patient was started on anti-TB therapy for six months.

Following treatment she remained in good health and there was no recurrence of the breast lump after one year of follow-up. The ESR dropped to within the normal range. We think that early suspicion of breast TB will save patients the long list of surgical and medical TB complications.

Hassan A.A. Musa, FRCSI

Department of Surgery
King Faisal Hospital
P.O. Box 146
Taif, Saudi Arabia

References

1. Amaout AH, Shousha S, Metaxas N, Husain OA. Intramammary tuberculosis lymphadenitis. *Histopathology* 1990;17:91-3.
2. Sopena B, Arnillas E, Garcia-Vila MM, Climent A, Miramontes S. *Infection (Germany)* 1996;24:57-8.
3. Tan KK, Tan TH. *Singapore Med J* 1988;29:271-5.
4. Keane FB, Ryan TD. *Ir Med J* 1978;71:416-20.

The Management of Acute Respiratory Infections: Saudi National Protocol for Diagnosis and Treatment

To the Editor: The *Annals of Saudi Medicine* recently published a book review on *The management of acute respiratory infections in children: practical guidelines for outpatient care*.¹ The choice of the book for review was an excellent one, as acute respiratory infection (ARI) is a leading health problem globally, and in many countries is a leading cause of morbidity and mortality. The editors of the book need to be congratulated for their attention to this group of diseases for which culturally adapted national guidelines could be instrumental in significantly reducing morbidity and mortality arising from ARI in this country. ARI will remain a global challenge to health planners and professionals for some time to come.²

The World Health Organization guidelines³ book review stated that the book was meant for health staff of outpatient care in first-level healthcare facilities. This letter is to draw the attention of the readers to the *National Protocol for Diagnosis and Treatment of Acute Respiratory Infections among Children in Health Centers and Small Hospitals in Saudi Arabia*.⁴ In a study of health centers in Saudi Arabia, 31% of the diagnoses made were found to be upper respiratory tract infections. The total ARI cases would, therefore, be even larger, as lower respiratory tract infections would be added to the upper infections. This national protocol was developed for Saudi Arabia after an initial rapid assessment survey in five regions, which showed high incidence rates of ARI and high rates of antibiotics use in the health centers. The survey also showed that there were no doctors with any

special training on the management of ARI in the regions surveyed. The national protocol is designed to be a manual for health center doctors and nurses in Saudi Arabia. The National Scientific Committee on ARI supervised the development of the national protocol, which was reviewed by scientific personnel from WHO, UNICEF, the Saudi universities, and the regional and central Ministry of Health, in order to ascertain that the material was technically sound and suitable for practical implementation in Saudi Arabia. It is envisioned that this book will not only be helpful to government health centers and hospitals, but also to polyclinics, dispensaries and small hospitals in the private sector who deal with primary care conditions.

Continuing medical education will be needed to update physicians' knowledge and practice for ARI. Workshops have already been held to motivate the leaders in different regions, who will play a key role in administering the ARI protocol. Training is in progress, so that eventually at least one physician from each health center will be trained by the year 2001 all over the Kingdom. Quality assurance programs will be using selected indicators from the national protocol, which will help the evaluation and monitoring of the protocol.

A recent survey by the Ministry of Health showed that the incidence of ARI was very high in Saudi Arabia (Saudi Family Health Survey, 1996-1997). It is expected that with the implementation of the national protocol on ARI, both mortality and morbidity due to ARI will be reduced, and it will be instrumental in the cost-effective management of ARI. This will also have an impact on the reductions of community resistance to antibiotics.

Dr. Tawfik A. Khoja, MBBS, DPHC, FRCGP

Director General, Health Centers
Ministry of Health
Riyadh 11176
Saudi Arabia

References

1. Frayha H. Review of "The Management of Acute Respiratory Infections In Children: Practical Guidelines for Outpatient Care," by World Health Organization, 1995. *Ann Saudi Med* 1997;17:264-5.
2. Campbell H. Acute respiratory infections: a global challenge. *Arch Dis Child* 1995;73:281-3.
3. World Health Organization. The management of acute Respiratory infections in children: practical guidelines for outpatient care. World Health Organization, 1995.
4. Khoja TA, et al. National Protocol for Diagnosis and Treatment of Acute Respiratory Infections Among Children in Health Centers and Small Hospitals. Riyadh: Ministry of Health, 1997.
5. Khoja TA, et al. Quality of Prescribing Primary Care Centers in Saudi Arabia. *J Pharm Technol* 1996;12:284-8.

Granulomatous Lobular Mastitis: Clinicopathological Study of 12 Cases

To the Editor: I have read with interest the article by Drs. Kfoury and Bhlal.¹ It was unfortunate that the maximum follow-up period in the study was only 12 weeks. This is a relatively short period for a disease which is notoriously known for its high rate of recurrence. Also, it would have been interesting to assess the outcome of surgical excision in these patients. This may have been more difficult because of the short follow-up period. In the absence of such data, this article should have been entitled a "pathological" and not a "clinicopathological" study.

In a busy general practice I have encountered only one such case in the past five years. This patient remained well without recurrence three years after a wide excision of a right breast lump which was proven to be granulomatous lobular mastitis. She recently presented with a breast abscess that was drained surgically and has healed, leaving a small discharging sinus. Treatment with prednisolone was declined by the patient. The sinus has now closed spontaneously.

Granulomatous lobular mastitis is a major management problem. As indicated by the authors, it is a benign inflammatory condition of unknown etiology which affects young child-bearing females, and in which granulomas are confined to breast lobules.² An autoimmune process has been proposed. It is rare, but commonly confused with breast cancer, especially with the presence of axillary lymphadenopathy.³ Steroids have been used for the treatment of this condition with good effect.⁴ Salama et al. reported recurrence within two years in all patients who were treated surgically, requiring further excisions. In addition, severe breast pain recurred in 50% of cases. Use of prednisolone 60 mg orally for more than three weeks produced no response.⁵

Although excision of the mass lesion and abscess drainage has been advocated as the treatment of choice by some authors,⁵ this has been challenged by others⁶ who treated their patients conservatively after confirming the diagnosis by core biopsy or fine-needle aspiration cytology. Abscesses are aspirated or drained by way of mini-incisions.

It is quite clear that this condition remains a major management problem for clinicians dealing with affected females. It was hoped that this series of 12 cases from a tertiary referral center would add more information and shed more light on the best form of treatment for this distressing condition, but unfortunately, in my opinion, the article has failed to do so.

Dr. Abdul-Wahed Meshikhes, FICS, FRCSI
Department of Surgery
Dammam Central Hospital
Eastern Province, Saudi Arabia

References

1. Kfoury H, Al Bhlal L. Granulomatous mastitis: a clinicopathological study of 12 cases. *Ann Saudi Med* 1997;17:43-6.
2. Watt PCH, Spence RAJ. *The breast in pathology for surgeons*. Bristol: Wright Publishers, 1986:294.
3. Kessler E, Wolloch Y. Granulomatous mastitis: a lesion clinically simulating carcinoma. *Am J Clin Pathol* 1072;58:642-6.
4. De Hertogh DA, Rossif AH, Harris AA, Economou SG. Prednisolone management of granulomatous mastitis. *N Engl J Med* 1980;303:799-800.
5. Salama IMA, Al Homsy MF, Daniel MF, Sim AJW. Diagnosis and treatment of granulomatous mastitis. *Br J Surg* 1995;82:214.
6. Dixon JM, Chetty U. Diagnosis and treatment of granulomatous mastitis (letter). *Br J Surg* 1995;82:1143.

Reply

To the Editor: We read with interest Dr. Meshikhes' letter concerning our article on granulomatous lobular mastitis. We would like to thank him for his point of view, and give our explanatory comments concerning this matter.

It is true that the follow-up of the patients reported in the article was only 12 weeks. This was due to the fact that the patients failed to report on the date of the follow-up. Attempts were made to call the patients at home, but unfortunately, since these cases were mostly retrieved from old files, this attempt failed.

It has been stated very clearly in the literature that steroids are beneficial in the treatment of patients with granulomatous mastitis. It has also been stated that the optimal management of these patients is by wide local resection and that, in case of recurrence, additional surgery is beneficial. On the other hand, each case must be considered separately and the most appropriate treatment given accordingly. The methods of treatment were clearly given in our article and are similar to what has been reported in the literature. Although it has been suggested in some recent articles that conservative management of these patients is preferred, more cases and longer follow-up periods are required to support these new methods of treatment.

Hala Kfoury, MD, FRCPA
Department of Pathology
and Laboratory Medicine (MBC-10)
King Faisal Specialist Hospital
and Research Centre
P.O.Box 3354
Riyadh 11211, Saudi Arabia
Lulu Al Bhlal, MD, FRCPA
Department of Pathology
King Khalid University Hospital
Riyadh, Saudi Arabia