form and it has a score of 3 on Naranjo ADR probability scale. Since simvastatin is metabolised by hepatic CYP3A4 enzymes, the liver injury probably compromised the metabolism of simvastatin resulting in high levels of this drug. These high levels of simvastatin could have caused the massive rhabdomyolysis seen in this patient. Another possibility could have been a viral infection that caused upper respiratory tract symptoms leading to severe hepatitis, and eventually causing rhabdomyolysis due to high levels of simvastatin. This raises concern regarding the use of statins as a very close monitoring for unexpected adverse drug interactions might be required for patients on statins and other drugs. Concerns have been expressed regarding the use of statins in octogenarians for primary prevention of CAD as there may be increased risks of myositis, rhabdomyolysis, and cancer in the elderly. The above described adverse event was reported to the Food and Drug Administration of USA.

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References


Disseminated Penicillium marneffei infection in a human immunodeficiency virus-infected individual

Sir,
Prevention and treatment of opportunistic infections continues to be a major public health strategy among HIV-infected people in developing countries. Awareness of clinical manifestations and the cutaneous stigmata of opportunistic infections are pivotal in the diagnosis of many opportunistic infections in resource-limited areas. Increasing numbers of Penicillium marneffei infections have been documented in HIV-infected individuals from the northeastern part of India. This infection has been predominantly reported from Southeast Asia where it has been reported to be the third most common illness that defines Acquired Immuno Deficiency Syndrome.

We describe a patient who presented with fever, weight loss and typical umbilicated papules proven to have disseminated P. marneffei infection on histopathology and culture. A high index of suspicion in the presence of typical skin lesions can lead to early diagnosis.

A 43-year-old man from Assam presented with low-grade fever, weight loss and skin lesions. He had not previously been tested for HIV antibody or virus. On examination, he was wasted, pale with oropharyngeal candidiasis, and had multiple erythematous papules on the face, upper back and extremities. Most of the papules had a necrotic centre with scabs. Systemic examination was normal. His haemoglobin was 9.5 g/dl and total white cell count was 4400/mm³ with normal differential count. The chest radiograph was normal. HIV-ELISA was reactive. Biopsy of the skin lesions revealed histiocytic granulomas with yeast-like organisms. Fungal culture grew pigment-producing fungus, Penicillium marneffei. Markers of immune suppression like CD4 counts and viral load were not done due to financial constraints. The patient showed clinical improvement with itraconazole 200 mg orally twice daily. The option of antiretroviral therapy was discussed with the patient but was deferred due to financial constraints.

Penicillium marneffei is a dimorphic fungus causing opportunistic infection, potentially life-threatening in immunocompromised individuals. P. marneffei was first isolated from a species of bamboo rat (Rhizomys sinensis) from Vietnam in 1956 and later, from other rodent species. The common clinical features are fever, weight loss, anaemia, hepatosplenomegaly, and popular skin lesions. The typical cutaneous papules with central necrotic umbilication may be present in about 70% of patients. While this a useful point, molluscum contagiosum and lesions of cryptococcosis can show similar features especially if they are inflamed or irritated. Hepatosplenomegaly, lung and bone involvement are other features of disseminated penicilliosis. Diagnosis is confirmed by fungal culture or histopathology. P. marneffei produces a distinctive red diffusible pigment and is the only dimorphic member of the genus Penicillium. As P. marneffei is an emerging pathogen, a high index of suspicion is warranted in areas which have geographic proximity to Southeast Asia, northeastern India and Bangladesh. History of travel and immigration from endemic areas are major clues to diagnosis as illustrated in this case.

In severe cases treatment with amphoterocin B is necessary followed by prophylactic azole maintenance regimen. Itraconazole is an option to be considered in a less sick patient as corroborated in our case.

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Letters
Adolescent breast lymphoma – apparently aggressive presentation with favourable outcome

Sir,

Primary breast lymphoma (PBL) is a rare entity making up less than 0.5% of breast malignancies. The occurrence of PBL in adolescence is rare. Anaplastic large cell lymphoma (ALCL) is an unusual variant with apparently aggressive features. We report such a case with a very favourable long-term outcome.

A 15-year-old girl presented in 1981 with a 5-cm ulcerating lump in her left breast of five months duration (Stage 5 adolescent development). There was no axillary lymphadenopathy (Figure 1a). Wide local excision with split skin graft coverage was done (Figure 1b). Grossly, a 5-cm mass of ulcerating pale tissue was seen. Microscopically, sheets of malignant “epithelial” cells with anaplastic arrangement, conspicuous pleomorphism and mitoses were seen (Figure 2a) which was interpreted as a medullary or encephaloid carcinoma. She was treated with oral cyclophosphamide for 31 months and prednisolone for seven months. Neither adjuvant radiotherapy nor tamoxifen was offered. She remains well with two healthy children at 22 years of follow-up.

Review of the histology was done as the patient was referred to our hospital. The blocks were preserved and further sections were cut. Immunostaining was performed using standard procedures with a streptavidin-biotin detection system. Heat-mediated antigen retrieval was used where appropriate. Immunocytochemistry showed that the cells failed to stain with antibodies to cytokeratin (CAM 5.2, AE1/AE3) (Figure 2b) and S100 protein. There was focal staining for epithelial mem-

References