Buruli Ulcer Lesions in HIV-Positive Patient

To the Editor: Mycobacterium ulcerans disease (Buruli ulcer) is a neglected and emerging tropical disease (1). It often leads to extensive destruction of skin and soft tissue with the formation of large ulcers (2). In 2004, the World Health Organization (WHO) recommended the combination treatment of rifampin/streptomycin for patients with this disease (3). According to WHO, development of new antimicrobial drug treatment is one of the major advances since the establishment of the Global Buruli Ulcer Initiative (1). Treatment with rifampin/streptomycin for ≥4 weeks can inhibit the growth of M. ulcerans in preulcerative lesions (4). In other patients, despite 4 weeks of treatment, lesions may deteriorate. Whether this treatment is less efficacious in persons with HIV infection is unknown.

In August 2008, a 35-year-old man was referred to the Medical Centre of the Democratic Republic of Congo for assessment of chronic ulcers. Lesions had appeared 12 months earlier when the patient was living in Kafufu/Luremo, a new endemic focus for Capillariasis philippinensis. Southeast Asian J Trop Med Public Health. 2000;31:478–81.


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August 2003 that compared HIV prevalence in 426 patients with Buruli ulcer and 613 controls in southern Benin, HIV prevalence among patients with Buruli ulcer was higher (2.6%, 11/426) than among controls (0.3%, 2/613) (odds ratio 8.1) (8). However, none of these reported HIV-positive patients with Buruli ulcer were treated with rifampin/streptomycin and antiretroviral therapy (8).

A study of 224 patients with Buruli ulcer in Benin that evaluated the WHO-recommended regimen of 8 weeks of treatment with rifampin/streptomycin showed promising results (9). Chemotherapy alone was successful in achieving a cure rate of 47% of patients and was effective against ulcers <5 cm in diameter (9). However, HIV testing was not performed in this study. In Spain, an HIV-positive patient with aggressive, multifocal Buruli ulcer and osteomyelitis was cured by surgery, broad-spectrum antimicrobial drugs (not rifampin/streptomycin), and antiretroviral drugs (10). Relapse was not reported in this study at 6-months follow-up.

For control of Buruli ulcer in HIV-positive patients, patients should be treated with rifampin/streptomycin and antiretroviral therapy to stimulate their immunity. Our report emphasizes the urgent need to evaluate treatment of HIV-positive patients infected with Buruli ulcer with rifampin/streptomycin and antiretroviral drugs.

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Hantavirus Pulmonary Syndrome, French Guiana

To the Editor: Hantaviruses are rodent-borne negative-sense RNA viruses belonging to the Bunyaviridae family, genus Hantavirus. Since the first report of a hantavirus in 1993 in the United States (1), different viruses belonging to this genus have been reported in the Americas (2–5). These New World viruses are responsible for a disease called hantavirus pulmonary syndrome (HPS), a respiratory illness caused by the inhalation of dust contaminated by rodent feces or urine containing the virus (6–8).

Until recently, no information was available concerning the presence of hantaviruses in French Guiana, a French overseas department (administrative unit) in South America. Nevertheless, the description of atypical pneumonia cases not related to any known etiologic agent and the identification of hantavirus reservoirs in neighboring countries led us to con-