

Letters to the Editor

[The Editor is not responsible for the views expressed by the correspondents]

Monkeypox as a global health emergency — A threat after COVID-19 pandemic

SIR, — Monkeypox is a rare zoonotic disease caused by the monkeypox virus that belongs to the Poxviridae family¹. While the source of infection is primarily zoonotic, and the disease condition is usually seen in Central and West Africa since the 1970s. Recently, there is a rapid spread of Monkeypox all over the world due to climatic change, widespread global travel, and waning herd immunity due to the cessation of smallpox vaccination². Re-emergence of monkeypox across nations had made World Health Organization declare it a public health emergency of international concern (PHEIC) in July 2022³. As the disease is mild and not fatal, there are debates on declaring it as a PHEIC as it creates panic among the public but considering the reservoir of infection, pandemic potential and susceptible population declaring monkeypox as PHEIC is the need of the hour. India has reported nine confirmed cases of Monkeypox, including one death (4th August 2022)⁴. In India, the recent COVID-19 pandemic has equipped us to battle any outbreaks in the future. As we expect more emerging and re-emerging infections in the future, strengthening molecular laboratories will help in the early detection of the disease and containment. Currently, around 70% of the human population is susceptible to Monkeypox infection². During the COVID-19 pandemic, a significant gamechanger in controlling the outbreak was a quick roll-out of mass vaccination campaigns. As per the CDC recommendations, two FDA-approved vaccines namely JYNNEOS (Imvamune or Imvanex) and ACAM2000 may be used for the prevention of Monkeypox infection⁵. But the data regarding the effectiveness of these two vaccines in the current outbreak is not available. Hence it is imperative that budget allocation for conducting vaccination effectiveness studies should be implemented in endemic countries where we have an increased incidence of Monkeypox infection.

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Laparoscopic repair of a symptomatic direct inguinal hernia in an apparently healthy boy

SIR, — Inguinal hernia is a common paediatric surgical problem and over 99% of them in children are indirect. The direct inguinal hernias are secondary to other diseases and it's extremely rare in apparently healthy children¹. The incidence in full-term babies is estimated at 1-5%, it is six times more common in boys, the right-sided hernias is more than three times that of left-sided hernias while the bilateral hernias are more common in premature infants². A direct hernia involves herniation of intra-abdominal content through a weakness in the posterior wall of the canal, known as Hesselbach's triangle. A direct hernia is found medial to the inferior epigastric vessels, while an indirect hernia is found lateral to these vessels³.

A 5-year-old boy has noticed a swelling in the right groin with a change in size with coughing or straining and it got painful at times especially during defecation and urination as he has chronic constipation in the background. On examination, the patient had reducible, non-tender, non-transilluminated, positive cough impulse, to get above the lump was not possible, was medial to the internal inguinal ring in the Hesselbach's triangle and diagnosed as right direct inguinal hernia. Right testis was fully descended, of normal size, site, lie and texture. The silk glove sign was negative. At laparoscopy, the direct inguinal hernia defect could be seen in the Hesselbach's triangle (Fig 1). Posterior wall repair and ligation of the hernial sac was performed. The patient was discharged home same evening and at follow up is well.

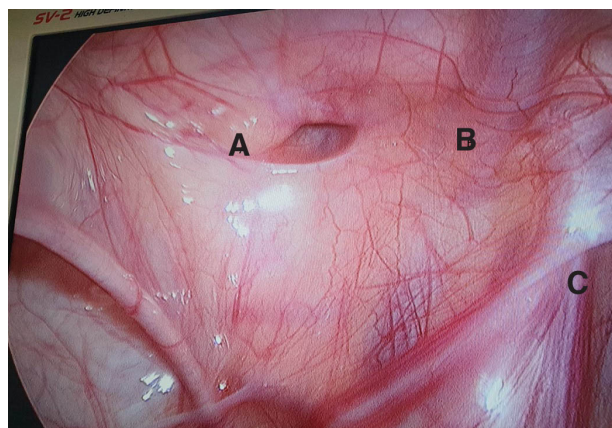


Fig 1 — Findings during laparoscopy of right direct inguinal hernia. (A) The defect in the centre of Hesselbach's triangle. (B) note that this image depicts a right direct inguinal hernia as the inferior epigastric vessels are lateral to it (to the right of the image in this view). (C) Closed deep inguinal ring on the right internal inguinal area

The advantages of the laparoscopic approach may include a lower risk of cord damage, less pain, better cosmetic results and less of postoperative complications. Our patient had congenital colocolic motility disorder and bowel dysfunction which is a known risk factor for the development of a hernia⁴.

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Cardio Respiratory failure cited as — The cause of death, is it a misnomer ?

SIR, — Two types : (1) Heart and Lungs are in intimacy a SINGLE ORGAN for supply of oxygenated blood to tissues and organs. They may have pre-existing diseases singly or severally like Valvular defects, Septal defects, IHD, Cardiomyopathy, Endocarditis and then Bronchitis, Bronchiectasis, Pneumonia, Pleural effusion, Pneumothorax and so on. Death may ensue primarily from these diseases.

(2) Heart and Lungs are healthy.

Separate disease conditions bring the patient to terminal stage leading to death.

The core crisis created behind death is metabolic derangement of Acid Base Balance with dysfunction of the K pump regulating expulsion of Na from the cell to extracellular space and transfer of K into the cell.

Thus metabolic acidosis is created. Liver Kidneys try to control the situation but when these vital organs are in compromised condition acidosis becomes irreversible. Cardiac and Cerebral cortex are vulnerable to such irregularities. They succumb.

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SIR, — The original article entitled "Perception of undergraduate medical students about the current medical curriculum in India" Vol 119, No 9, September 2021, Page No 27. This study is a need of the hour for new Competency Based Medical Education (CBME) which was implemented in 2019 by a National Medical Council (NMC). Such study we need to encourage to as whole in a different part of India.

The author has mentioned all three professional year students and interns as study participants. But this new curriculum was started 2019 batch. So interns were not being part of this CBME study. The study was conducted in 2021 (Feb-March). Similarly in 3rd professional CBME students have not entered. The Study would be better if only focused on the first professional year. And compare with traditional (Previous curriculum) method of curriculum and CBME curriculum of first-year students. The Second professional year is also not completed when data was collected but they were taught some of the competencies of final year subjects.

The Author also has mentioned the involvement of Government and Private colleges in the student ratio, but no comparison was mentioned between them. Because many of the colleges as mentioned by author infrastructure facilities like skill lab not at established. Therefore the implementation of the CBME curriculum is challenging for medical faculty unless until all the colleges are following implementation as per NMC. Till one batch of students will come out with this curriculum. It is very difficult to give an opinion regarding this CBME curriculum. The Author has not mentioned which parts of India, students were enrolled so that in the future remaining part of the students can be covered. It is very important to take the perception of students and faculty regarding the CBME curriculum.

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Beard Folliculitis due to Klebsiella pneumoniae

SIR, — Topical steroid damaged/dependent face (TSD) can be described as temporary or persistent facial skin damage brought about by the unreasonable, non-selective, unsupervised, or protracted use of Topical Corticosteroids (TC) causing numerous skin pathologies and psychological dependence on TC¹. TC has anti-inflammatory and immunomodulatory effects. TCs have formidable antipruritic, atrophogenic (dermal and/or epidermal), hypopigmentary effects on the corium and can lead to remarkable undesirable effects if used immethodically². Another facet of TCs squandering is its beautifying application specifically in amalgamation with bleaching creams to make the skin light coloured. Absurd use of TCs induces numerous skin changes chaperoned by psychological dependence³. Since the facial skin is comparatively thinner and there is an sebaceous glands as well, it leads to an escalated percutaneous absorption of drugs . As face is the most uncovered part of the human body it is most blameworthy



Fig 1 — Multiple follicular pustules around the beard area

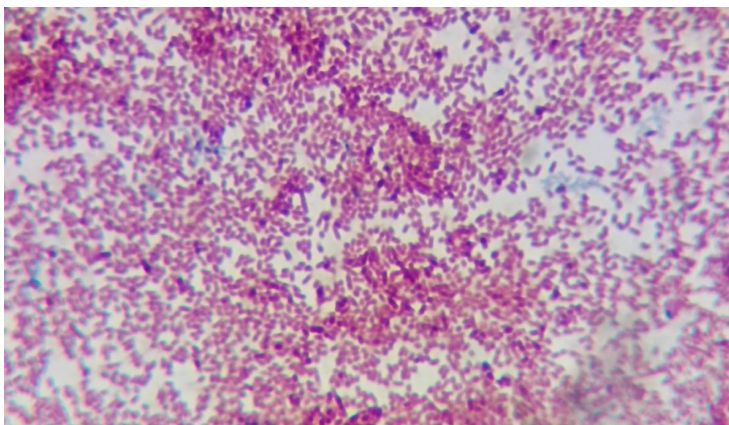


Fig 2 — Gram Negative Rods of Klebsiella pneumoniae under microscope

to consequences of UV rays, pollution, friction caused by cleaning and rubbing and use of different medications and cosmetics⁴. On pulling out TCs there is loss of vasoconstriction, resulting in a fixed vasodilatation, which is accountable for the flare which can be seen morphologically after withdrawal of the drug⁵.

Here, we present a 24 years male who presented to us with multiple follicular pustules around the beard area. This patient has history of application of topical mometasone furoate cream since last 3 to 4 years everyday for 1 to 2 times. The patient applied mometasone furoate on suggestion by some friend due for acne spots and scars. The clinical image was consistent with folliculitis (Fig 1). Pus for gram staining and culture and sensitivity testing was sent. Antibiotic susceptibility test was done using disk-diffusion method. After gram staining, gram negative rods were observed under microscope (Fig 2). On blood agar mucoid colonies were seen (Fig 3). On sensitivity testing, the organism was found to be sensitive to few oral antibiotics like Minocycline, Fluoroquinolones, cotrimoxazole and other intravenous antibiotics. The causative organism was *Klebsiella pneumoniae*, a rare respiratory pathogen. Based on the sensitivity reports, the patient was started on oral Minocycline 100 mg once daily for 20 days. The patient responded well and the patient was followed up after 20 days, he responded well with resolution of all the lesion. The lesions started to resolve. Astonishingly, patient again reported to us with appearance of new lesions once the antibiotic was stopped. This type of recurrent beard folliculitis with a respiratory pathogen is not only rare but peculiar too. This is a rare case of recurrent beard folliculitis caused by *Klebsiella pneumoniae* due to prolonged use of mometasone from last 3 to 4 years in this COVID era. The most common organism causing beard folliculitis is *Staphylococcus aureus*⁶. Acquiring this pathogen might be related to loss of cutaneous immune surveillance to specific respiratory organism. Those organism could be layering on the skin surface due to close vicinity to oral and nasal aperture; and not involving the forehead. *K Pneumoniae* is rare cutaneous pathogen causing folliculitis in and around mouth; especially notable post topical corticosteroid (mometasone furoate) abuse for long term.

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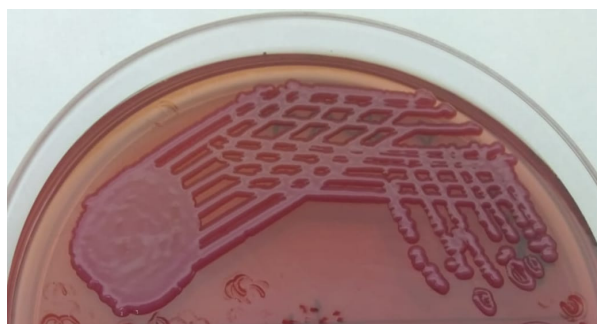


Fig 3 — Mucoid colonies of Klebsiella pneumoniae in blood agar

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