Sir

I read the article entitled “Mucormycosis in Patients without Cancer: A Case Series from A Tertiary Care Hospital in South India” with great enthusiasm. I found that there is no new message or information to the readers from this manuscript and it didn’t add to the existing knowledge on mucormycosis. There are several flaws with study design. Methods did not specify the inclusion criteria for selection of patients for analysis. Author mentioned 200 cases were diagnosed/labelled as Mucormycosis at their hospital by histopathology and microbiology department, during the study period. Out of 200 reported patients only 27 were analysed in this study. Why author excluded the remaining 173 patients from the study even though they are diagnosed by microbiology and histopathology reports? This is associated with significant selection bias in this study and information loses its value as sample does not represent the “All patients diagnosed during study period”. Author also failed to mention about culture results of 27 patients analysed in study. This is also an important and relevant question because of the following facts associated with mucormycosis. Nearly 50% of patients with evidence of mucormycosis on histopathological examination are having sterile tissue culture. This is because of fragile mycelial structure and it is aseptate, easily liable to get damaged during tissue handling. Diagnosis of mucormycosis is generally arrived by clinical presentation, physical examination, radiological evidence of disease along with Biopsy from involved region for histopathology and culture examination from.1

Definition of cure or survival and duration of follow up at specified time interval after diagnosis is also missing in the manuscript. So it is difficult for reader to accept the outcome described by authors in the manuscript. Apart from these problems with study design, details of treatment offered to patients are not mentioned. Readers are interested in dosage and duration of Amphotericin B treatment and follow up of patients after discontinuation of treatment. Readers will appreciate if author had identified prognostic features for favourable outcome to treatment. This is of immense importance to practicing clinicians like duration of symptoms prior to diagnosis and treatment, reversibility of underlying condition, surgical debridement adequate, inadequate and no debridement, etc. Author tried to duplicate the information in given Tables (1 and 2) and it occupies the space without sensible informations. Leucocytosis and high ESR are very non specific laboratory abnormalities and author can’t conclude and suggest looking for mucormycosis in susceptible patients with such a non specific laboratory abnormalities. Overall it is poor quality and disappointing article for standard of JAPI.

References


Reply from Author

Abdul Ghafur

Sir,

India is the Mecca of Mucormycosis. Most reported *Mucor* cases in the global literature are from an Indian centre, PGI Chandigarh. These papers are discussed among the community of infection specialists. However, general physicians are largely unaware of these studies and the extent and seriousness of this dangerous disease. This may be due to the laboratory orientation of these papers, with limited stress on clinical features. Data from other parts of the country is unfortunately very minuscule.

Our team of Infectious diseases physicians are seriously concerned about the late presentation of patients with Mucormycosis to hospitals- an unfortunate situation, no doubt due to the lack of suspicion on the part of general practitioners. How can general physicians suspect this disease, if they sincerely believe that this is a very rare entity? Specialists in the field, including us are to be blamed for this. It is our responsibility to convey the message to medical fraternity that this disease is not rare as thought to be.

We conducted our study without the support of any research grant or research assistants. Selection of patients in our series was not consecutive and of course outcome data was biased. We have very clearly mentioned this in the paper. We have identified more than 200 reports of Mucor in Microbiology and Pathology laboratory registers over the last 10 years, but we could track only 27 cases at the time of data analysis. Many of the positive results were from samples from outside hospitals sent to our laboratory and so we could not track those patients. Most of the selected cases in the series had involvement of infectious diseases department, making it easier to track these files and collect details. Since submission of our paper to JAPI a year ago, we have been collecting details of another series of patients, which include oncology cases as well. We have no doubt that laboratory registers of almost all tertiary care hospitals in the country will have hundreds of hidden Mucor cases, waiting to be unearthed. Enthusiastic young doctors, including the author of the letter are more than welcome to assist us in our humble efforts so that our series is really large enough to reach serious conclusions. We were honest about the number of Mucor reports in our laboratory register and the technical difficulty of dragging ten-year-old files of these patients out of the medical records department, without the help of research assistants.

Come on friends: let us be realistic.

We have made an observation that WBC count and ESR were very high in diabetics with Mucor, even in the absence of ketosis. In fact, we have found this observation very useful in our practice, triggering further investigation and confirming the diagnosis in some cases, which we could possibly have missed otherwise. We thought it our responsibility to let our colleagues know of this finding. This observation, if proven by comparative randomised or non-randomised trials, will be extremely useful in raising suspicion on the presence of this disease, reducing morbidity and the mortality.

We do agree with the authors of the letter that clinicians are very much interested in the favourable prognostic factors and the role of various treatment modalities on the outcome. Unless we do a large scale, multicentre study, preferably prospective and if possible randomised, these questions will remain unanswered.

Our article can serve as a call to action! It is already too late to start a multicentre trial on the clinical features and management of this deadly disease. Research funding agencies like ICMR should take necessary initiatives on the issue, incorporating both public and private sector hospitals and giving adequate importance to clinical studies.

If our paper has stimulated some discussion among clinicians on this deadly and disfiguring disease, we consider ourselves to have succeeded in our humble effort.