LETTER TO THE EDITOR

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To
Editor –in- chief
Bangladesh College of Physicians and Surgeons

Sir,

I would like to thank you for publishing the article 'Systemic lupus erythematosus simulating kikuchi-Fujimoto disease' in your journal vol 32(4), 2014, p-231-234. We read this article thoroughly with keen interest that it is not common in our country. The article is very nice, content are full of information and well presented. It is beneficial for medical professionals because the characteristic self-limiting form of necrotizing lymphadenitis and systemic illness of kikuchi- Fujimoto disease (KFD) must be recognized and the possibility of other diseases including SLE should always be considered in case of patient with fever with cervical lymphadenopathy. The clinical and immunological features required for diagnosis of Systemic lupus erythematosus (SLE) are well documented and specific. Though rare in our country, but in our setting, early exclusion of SLE in a patient with KFD should be our practice. We have some observations about case report which are cited below.

Some authors believe that there is a connection between KFD and lupus [1] based on:

a. KFD can precede, coincide, or evolve with the diagnosis of lupus; b. patients with KD may present rash and leukopenia; c. lymphadenopathy is a common clinical manifestation of both conditions; d. Kikuchi's histiocytic necrotizing lymphadenitis is pathologically indistinguishable from lupus lymphadenitis and e. immunohistologic findings also are similar in both diseases.[2] 45% cases of KFD is concomitantly associated with SLE[3]. In title the authors raise the possibility that Systemic lupus erythematosus simulating kikuchi-Fujimoto disease. So, my query is that whether it is simulating or association. How we can differentiate association and simulation of both the diseases.

Histiocytic necrotizing lymphadenitis may be an initial feature of lupus. Differentiation between KFD and SLE is imperative because of significant differences in treatment and prognosis. So, SLE must be excluded before specific diagnosis. Why not it is a case of SLE only.

Although tuberculosis is one of the most important cause for fever and cervical lymphadenopathy in our country, but we also should consider other possibilities. Accurate diagnosis of this condition is essential in preventing unnecessary emotional and mental distress. Where MT –ve and histology was not conclusive, in this situation, early initiation of anti tubercular therapy before complete diagnosis is justified or not.

The disease is prevalent in Japan, but isolated cases are reported in America. Europe and Asia [4]. So, I again thank to authors for sharing their experience with us.

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2. Dr. Aparna Das
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Author's Reply

To
Editor –in- chief
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Sir,

We thank Associate professor Dr. Md. Titu Miah and Associate prof. Dr. Aparna Das for their valuable comments regarding the case report. We do agree that

KFD can precede, coincide, or evolve with the diagnosis of lupus. Clinically, KFD is typically characterized by lymphadenopathy (predominantly cervical), acute fever and other systemic features. Extra-nodal involvement is less common, although reported [1]. ANA is usually negative. The clinical and immunological features required for diagnosis of SLE are well documented and specific. Lupus lymphadenitis has been reported in between 12% and 59% of patients with SLE, but in contrast to KFD, is rarely the presenting feature [2]. In our case ANA, Anti ds DNA were positive from the very outset. Features of serositis appeared during the acute illness. On review, many describe the association of KFD diagnosed concomitantly with or following the diagnosis of SLE which in all probability represent lupus lymphadenitis [3]. We wanted to show that SLE can simulate on its presentation like KFD.

Our patient presented with high rise of temperature. After 7 days, we started antibiotic keeping in mind that there might have underneath infection. We used multiple antibiotics but fever was not responding. FNAC from cervical lymphnode was granulomatous inflammation. MT test is a non specific test for Tuberculosis. Fever, lymphadenopathy, FNAC of lymph node reports, high TB prevalent geographical distribution led us starting empirical Anti tubercular chemotherapy as the patient was not responding to antibiotics and she was toxic. But as soon as the clinical and biochemical pictures become evident, we stopped the anti tubercular drug and started specific management for SLE.

We again thank for their opinion.

Regards,
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To
Editor in Chief
Journal of Bangladesh College of Physicians and surgeons

Sir,

Thank you for publishing the article "Self Monitoring of Blood Glucose (SMBG): cornerstone of Diabetes management –Bangladesh perspective". I must thank Professor Z A Latif, renowned Endocrinologist of our country, for this well written and informative and witty article. We have gone through it. It was a privilege for us to enrich our knowledge. Diabetes is a global pandemic[1] and a difficult to treat disease. The myth that diabetes is a disease of the rich is easily refutable with the fact that eighty percent of the Diabetic patients live in the middle and low income countries.[2] The disease is growing fast in our country as well as in the south east Asia. 12% of adult Bangladeshis are diabetic[3]. By 2035 people with diabetes in this country will be around 123 million. 71% increase than that of 2013.[2] These astonishing figures are enough for a wake up call to the health care providers and policy makers of Bangladesh. It is easily imaginable the burden and economic impact in the society and Individual level. Blood glucose control is of utmost important to retard or slow the progression of micro and macro vascular complication. This is the cornerstone of management of Diabetes.[4] Self monitoring of blood glucose(SMBG) is recommended in almost all international guideline including IDF, ADA, CDA and AACE. SMBG adds valuable information regarding glycaemic control. It complements to the HbA1C in the way that SMBG distinguishes fasting, pre and post parandial hyperglycemia.[5] SMBG also gives feedback of the effects of food choices, activity and medication including oral Anti diabetic agents. SMBG is recommended for insulin treated type 1 and type 2 diabetes. It also helps to assess effectiveness of oral anti diabetic agents and permit better adjustments of its doses. SMBG indirectly helps in good control of HBA1C too.

In Bangladesh only 21.1% diabetic patients practice home blood glucose monitoring. [6] This DiabCare study was conducted in the various branches of Diabetic Association, Bangladesh. The scenario is definitely worse in the rest of the country. The barriers of SMBG in practice have been assumed in this article. These are

lack of awareness of patients and unwillingness physicians to prescribe SMBG. Cost of monitoring blood glucose is definitely a strong barrier for SMBG for a large group of patients in our country. Role of testing urine sugar has been strongly denied in this article as well. In the recommendation section the author has stressed upon the understanding and partnership between the diabetic patient and the physician to set up targets of treatment and the way to achieve this. Greater sharing of information and skill encourage the patient to adopt the practice of SMBG. The author acknowledges the role of physicians as health educator in our country. The accuracy of the home testing should be assessed by simultaneous measurement of Blood sugar in lab and clinics. Patients receiving insulin for 3 or more times should test blood glucose 2-3 times daily with a full glucose profile(3-4times) on weekly holidays. These can be increased on the basis of the decision of the physician. Pregnant lady on insulin should check blood glucose at least 3 times daily, pre meal tests on the alternate days and 3 post meal tests in the intervening days. It is also said here that patients with life style modification should do SMBG weekly. In Bangladesh most of the patients are afraid of introduction insulin. Many of them can not buy insulin. It will be a burden for them to purchase a reflow machine and its strip regularly. They must be scared of doing self testing of blood glucose. In the context we have few queries. These are as follows.

a) Is there any alternative of SMBG for low income group of population who cannot afford the reflow machine and its strip ?

b) If there is any customized schedule for SMBG practice for Bangladeshi population?

c) What will be the SMBG schedule during Ramadan?

We express heartfelt thanks to Professor Z A Latif for the nice and updated review on the practice of SMBG. It will enrich the readers undoubtedly.

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Author's Reply

a] Regarding first question, it can be said that Self - Monitoring of Blood Glucose (SMBG) is a little costly for patient. But in an analysis of BIRDEM record it has been postulated that more than 70% of the patients can afford glucometer, but it is the lack of awareness, education and motivation that are the most prominent barriers. However, cost of glucose strip can be minimized in most cases if they maintain good lifestyle which will reduce the need for more frequent testing. Here I like to draw attention to another point. It is known that analogue insulin is costlier but has got fewer side effects like life-threatening hypoglycemia. For fear of hypoglycemia both the physicians and the patients are using less than optimum dose which leads to poor glycemic control and ultimately various life threatening complications. On that basis cost benefit analysis favors analogue insulin. SMBG is already a scientifically validated essential tool for diabetes management and all diabetes management guidelines recognize it as such. SMBG carries multiple benefits for diabetic patients as I have summarized in my article. So considering the cost-benefit ratio, I have recommended SMBG practice which are well accepted internationally. However I do agree that may be some patients who find it difficult to purchase even the required anti diabetic medications, let alone glucometer.

b] There is yet no customized schedule for SMBG practice in Bangladeshi population. To my knowledge there is no SMBG protocol in any institutions across Bangladesh. Physicians prescribe SMBG based upon clinical knowledge and experience. But all these are actually assumptions because we do not know the ground reality exactly as there are no large scale population based studies. What I wrote in my article was from small scale local studies and clinical experience. But there should be a study to assess the prevailing situation. There are international guidelines as I have mentioned in my article, but I also described why we need local guideline since the socio-economic and cultural factors operating in Bangladesh are vastly different form the developed world, where these SMBG guidelines were developed.

c] SMBG is recommended during Ramadan for diabetic patients who are fasting. Only thing that I couldrecommend that the testing should be done as at least in the evening/pre Iftar (to avoid hypoglycemia), post Iftar and pre sehri time. However it should be noted that every patient is different and it is important to individualize the testing frequency, considering medications used and using the standard SMBG protocols as a guideline. For further reference I would recommend viewing the 'Ramadan Prospective Diabetes Study: the role of drug dosage and timing alteration, active glucose monitoring and patient education', published in *Diabetic Medicine* Journal in 2012 where active monitoring of blood glucose was identified as one of the important ways to avoid acute complications. Also testing blood glucose while fasting is overwhelmingly approved by Muslim religious scholars. So fasting is not a barrier to SMBG. So it is necessary to educate and motivate the patients in this regard.

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