Mycobacterium ulcerans on the rise: practical tips for diagnosis

A/Prof Daniel O'Brien

Cases of Mycobacterium ulcerans (Bairnsdale ulcer) from the Bellarine Peninsula continue to increase so we thought it would be a good opportunity to add some practical tips for diagnosis.

1. Not all cases are ulcers; up to 15% may present as non-ulcerative forms such as subcutaneous nodules, raised skin plaques or areas of cellitis. Be wary of cellitits presenting around exploration sites such as the elbow, knee or wrist (including the back of the hand) in people with exposure to the Bellarine Peninsula, especially if not responding to initial antibiotics.

2. For the ulcerative form of disease the diagnosis can usually be made easily with a dry swab of the edges of an ulcer sent for PCR which is highly sensitive. However, in the non-ulcerative cases, the PCR of the surface should often be negative. For non-ulcerative cases the best diagnostic approach is to do a biopsy of the lesion and send it for AFB stain, mycobacterial culture, histopathology and PCR.

3. In anyone with an unusual or non-healing lesion of the skin consider ulcers or plaques or areas of cellulitis. Be wary of cellitits presenting around exploration sites such as the elbow, knee or wrist (including the back of the hand) in people with exposure to the Bellarine Peninsula, especially if not responding to initial antibiotics.

Table 1: The Alvarado score for appendicitis. A score of 4 or less makes appendicitis unlikely, 5 or 6 is 'compatible' with appendicitis; 7 or 8 indicates probable appendicitis while 9 or 10 indicates very probable appendicitis.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Number of points</th>
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<tbody>
<tr>
<td>Migratory abdominal pain in the RIF</td>
<td>2</td>
</tr>
<tr>
<td>Anorexia (or ketonuria)</td>
<td>1</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>1</td>
</tr>
<tr>
<td>Tenderness in the RIF</td>
<td>1</td>
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<tr>
<td>Rebound tenderness</td>
<td>1</td>
</tr>
<tr>
<td>Temperature over 37.3</td>
<td>1</td>
</tr>
<tr>
<td>Leukocytosis (WCC&gt;10)</td>
<td>2</td>
</tr>
<tr>
<td>Neutrophilia or left shift on the film</td>
<td>1</td>
</tr>
</tbody>
</table>

Maximum score=10

Although current treatments for M. ulcerans achieve high rates of cure, they continue to evolve. We are still defining, by means of clinical experience and research, the best treatment options with respect to drug regimens, dosing schedules, the role of surgery and the management of immune reconstitution syndrome. Therefore we would kindly request that all patients diagnosed with M. ulcerans are referred to the infectious diseases service at Geelong Hospital for further assessment prior to the commencement of treatment.

The GOCATS bulletin is a collaborative effort between Barwon Medicare Local, Pathcare and Barwon Health. The bulletin provides evidence-based region-specific information about communicable diseases in the Geelong area and also incorporates other non-communicable conditions of interest and importance. The bulletin will be produced on a quarterly basis.
Right Iliac Fossa Pain in Women: The Obstetric and Gynaecology Approach

Dr Moses Abe MBBS, MRCP, MRCOG, FRANZCOG
Consultant Obstetrician & Gynaecologist. Monash IVF Clinician.

Dr Moses Abe, a consultant Obstetrician & Gynaecologist is now based in Geelong. He completed training in Obstetrics, Gynaecology and Reproductive Medicine in the UK & Ireland. He accepts all public & private gynaecological referrals ranging from colposcopy and incontinence to advanced laparoscopy.

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Right Iliac Fossa Pain in a Female – An Infectious Diseases Approach
Amanda Wade MBBS, FRACP Infectious Diseases Physician

The flowchart below summarises the results of a study published in 2006 of 300 consecutive women of child-bearing age referred with RIF pain to general surgeons at a district hospital (Rennie ATM, 2006).

References:

Right Iliac Fossa Pain in Women: The Obstetric and Gynaecology Approach

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In primary care, RIF pain is common, and often poses a diagnostic dilemma. GPs frequently face the difficult decision regarding when to refer and to whom.

Triaging:
Most RIF pains are chronic or subacute. The majority of these are benign.
Gynaecological causes are characteristically lower down in the RIF, non-colicky, and tend to radiate inferiorly. Ectopic pregnancy must be ruled out in all women of reproductive age with unexplained RIF pain. Pain associated with menstrual irregularities and vaginal discharge especially in women between the age of 18 and 25 years is highly suggestive of PID. Irritable bowel syndrome is a diagnosis of exclusion.

Clinical cardinal signs of sinister acute/subacute RIF pain are:
1. Progressive nature
2. Peritonism
3. Poor response to analgesia

These should prompt immediate referral to hospital.

Continued next column