Karnataka and 258,998 from Maharashtra provinces. In some areas reported attack rates have reached 45% [2].

As there is no vaccine available [2] persons travelling to these epidemic areas should be given adequate advice on personal protection, measures to protect themselves against the bites of the mosquitoes that transmit the virus (including Aedes aegypti), which are active during the daytime.

To avoid mosquito bites:
- Wear full sleeve clothes and long dresses to cover the limbs;
- Use mosquito coils, repellents and electric vapour mats during the daytime;
- Use mosquito nets—to protect babies, old people and others, who may rest during the day. The effectiveness of such nets can be improved by treating them with permethrin (pyrethroid insecticide). Curtains (cloth or bamboo) can also be treated with insecticide and hung at windows or doorways, to repel or kill mosquitoes.
- Mosquitoes become infected when they bite people who are sick with chikungunya. Mosquito nets and mosquito coils will effectively prevent mosquitoes from biting sick people.

As explained earlier, given the strong links between the UK and the Indian subcontinent we feel the awareness regarding chikungunya needs to be increased both in the primary and secondary care setting.

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Histoplasmosis in a child with JRA on low-dose methotrexate

Sir, We read the interesting report of Hunstad et al. [1] that described a 7-yr-old girl who developed histoplasmosis while receiving low-dose methotrexate (MTX) to treat juvenile rheumatoid arthritis (JRA). Low-dose MTX is commonly used for treating patients with JRA or psoriasis and, when used without additional immunosuppressive agents, rarely has been associated with opportunistic infections. Only three cases of acute progressive disseminated histoplasmosis (PDH), each in adults receiving MTX for 4 months, 9 years and 17 years, respectively, have been reported in this setting [2]. In the current report, the authors describe a 7-yr-old with new onset JRA treated during a 3-month induction with prednisolone (0.26 mg/kg/day), naproxen and low-dose MTX. A febrile illness began ‘several days’ after completing a prednisolone taper and while receiving MTX. The authors conclude the manifestation experienced by their patient’s illness best fit PDH and that low-dose MTX was a predisposing factor. We believe the data do not support PDH and are most compatible with acute primary pulmonary histoplasmosis [3].

The presumptive diagnosis of histoplasmosis resulted from chest radiography that demonstrated an isolated pulmonary nodule and mediastinal adenopathy. Histopathological examination of affected lymph nodes showed necrotizing granulomas that contained giant cells and yeast forms compatible with Histoplasma capsulatum. The diagnosis was later confirmed by demonstrating seroconversion of complement fixation and immunodiffusion titers. Evidence presented to support PDH included, ‘persistent fever, splenomegaly, anaemia, elevated ALT and significant antigenuria in the setting of non-diffuse pulmonary involvement’. However, as noted by the authors, the defining feature of PDH is extrapulmonary infection that results from progressive fungal dissemination [1, 3]. This must be distinguished from the early, self-limited dissemination that almost uniformly accompanies primary pulmonary infection and that is aborted by the development of an adaptive cellular immune response to the fungus [3]. In the reported case, neither the laboratory nor radiographic evidence presented was suggestive of extrapulmonary infection. We believe that the low level Histoplasma antigenuria [4] of 3.5 units; (normal range <1 unit; Mira Vista Diagnostics, Indianapolis, IN, USA) was reflective

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