

Letter to the Editor

Treatment of Tularemia during pregnancy

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It has been of great interest for us to read the original article by Mengeloglu *et al.* entitled ‘Evaluation of patients with tularemia in Bolu province in northwestern Anatolia, Turkey’ [1]. They have presented specific peculiarities of an epidemic that affected Bolu province, which is geographically located in northwestern Anatolia, Turkey.

Although tularemia in pregnancy has recently been increasingly reported [2-5], the number of pregnant women among the 393 patients with tularemia reported by Mengeloglu *et al.* was not indicated. Unfortunately, even though it is vital for the pregnant woman and the fetus to receive the optimal medical treatment, there is not enough reported data on this subject. We have recently published two cases on tularemia during pregnancy [4,5]. The first patient presented with a large abscess on the cervical area and pseudoptosis [4] and the second patient had an acute dacryocystitis with a large abscess [5]. They lived in central Anatolia, which is an endemic area for tularemia. The first patient, an 18-year-old woman with 16 weeks gestation, was referred to our hospital with an abscess on the neck. The abscess was surgically drained through an incision. The patient refused the aminoglycoside or quinolone treatment because of the potential side effects on the fetus; thus, the cefuroxime protocol (500 mg a day for 6 weeks) was administered [4]. The second patient, a 27-year-old woman with 18 weeks gestation, was referred to our hospital with purulent conjunctivitis and an abscess secondary to acute dacryocystitis caused by tularemia. The purulent conjunctivitis was treated with gentamycin eye drops. Systemic treatment for tularemia was not administered to this patient due to

potential side effects on the fetus. However, the dacryocystitis was drained surgically through an incision and a ciprofloxacin-impregnated sponge was placed in the wound tissue daily over the first week. She was also treated with oral amoxicillin/clavulanic acid [5]. Both patients recovered without any complication.

Surgical drainage of abscesses is rarely required in nonpregnant patients unless therapy is delayed. However, we believe that surgical drainage of large abscesses is vital in pregnant patients to prevent possible severe complications caused by tularemia, such as osteomyelitis, pneumonia and meningitis. These may arise as a result of refusal of optimal treatment by the patient due to the risk of drug side effects on the fetus. If the abscess material is not properly drained and the area treated, infection may spread to adjacent or distant tissues. A deep cervical abscess might compress the vital structures such as trachea. It would be interesting to know whether there were any pregnant patients in the study of Mengeloglu *et al.* and if so how they were treated.

In conclusion, health professionals should be observant for these possible complications in pregnant patients with tularemia.

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