# LETTER TO THE EDITOR

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To

Editor-in-Chief

Journal of Bangladesh College of Physicians and Surgeons.

Sir,

I would like to thank you for publishing the article " Haemophagocytic Lymphohistiocytosis in Adult- A Case Report and Literature Review" in your journal . I have gone through it and appreciate the authors for reporting on such a rare and important case. I would like to share some of my observations and comments regarding this case.

Secondary haemophagocytic lymphohistiocytosis (HLH) occurs after strong immunologic activation which can occur with systemic infection, immunodeficiency or underlying malignancy. Epstein-Barr virus infection is most common one linked with HLH. Patient with dengue fever can sometimes develops unusual manifestation in the form of expanded dengue syndrome. HLH is one of the important expanded dengue syndromes.

That 65 years old male presented with drowsiness for 1day with a recent history of high grade intermittent fever in the month of June which is a peak month for dengue infection. In this case report clinical features suggestive of dengue i.e muscle and joints/bones pain, retro orbital pain was not mentioned clearly. Whether patient was febrile throughout the illness or became afebrile within a short period. Initial investigation was suggestive of dengue haemorrhagic fever. Author mention ICT for dengue was negative but I am not fully satisfied with only this statement. Whether NS1 antigen for dengue was done or not, was not mentioned. I would like to know if authors took every step to exclude possibilities of dengue in this case. As dengue fever is a burning public health problem in our country features mimicking dengue should be thoroughly investigate to confirm or refute the diagnosis.

Overall I think the case report and literature review is very much updated, informative. I would like to thank the authors for their hard work.

**References:**

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**Reply**

Thank you very much for going through the article and making your observation.

Our patient presented with drowsiness for 1 day with recent history of high grade intermittent fever and

generalized erythroderma for 6 days. He had no history of headache, body ache, retro orbital pain, myalgia or joint pain which typically suggestive of Dengue fever. Initially dengue fever was one of our differential diagnosis and we did ICT dengue on the day of his admission (6th day of his illness) and it was negative. We know dengue NS1 Ag remain positive for initial 5 days of illness. This test may become negative from day 4-5 of illness. Hence we did not do dengue NS1 Ag as he came to us on 6th day of his illness. His dengue NS1 Ag was done on 2nd day of his illness before admission in our hospital and it was negative. We did repeated ICT dengue but both IgG and IgM were negative.

He was afebrile for 3 days after starting the chemotherapy. Again he became febrile and passed away after 2 days.

I fully agree with you that Dengue is one of the cause of secondary HLH. Clinicians should be aware of the fact that the occurrence of haemophagocytosis could be due to dengue virus infection in areas where the disease prevalence is more like our country.

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