in Lanzhou, China (8). Variation may be due to different geographic and age distributions of the virus. Another study reported that frequencies of WUPyV in URTIs (6.7%) and LRTIs cases (7.1%) were comparable (10). However, we found the incidence of WUPyV in patients with LRTIs (16.1%) was higher than in patients with URTIs (4.4%). Among WUPyV-infected patients with LRTIs, 71.4% were <1 year of age, which was comparable to populations investigated in other studies (2,3,6). Although ≈60% of outpatients with URTIs were >5 years of age, none was WUPyV positive. This finding suggests WUPyV may play a major role in young children, especially infants, with LRTIs.

Most WUPyV infection has been detected during late winter and early spring (2,4,5) although other research showed no seasonal distribution (6). We found 2 peaks, in April and December 2008 (L. Xiaoyan et al., unpub. data). We also detected 1 WUPyV-infected case in September 2008, which suggests WUPyV could also occur in summer months.

Frequency of WUPyV co-infection with other pathogens varied from 42.1% to 79.7% (4–6). Although we showed a co-infection rate of 71.4%, there were 8 (28.6%) of 28 patients with respiratory illness in whose specimens we detected only 1 virus, WUPyV. No WUPyV was detected in samples from 43 control patients, whereas in patients with LRTIs and URTIs, infection rates were 16.1% and 4.4%, respectively. These findings suggest WUPyV may be a potential pathogenic agent in children with acute respiratory tract infections. More comprehensive case–control investigations are needed to determine the association of WUPyV infections with respiratory diseases.

This work was supported by Tianjin Municipal Science and Technology Commission (grant no. 07SYSYSF05100).
A total of 24 persons in Katipunan were interviewed regarding history of capillariasis and their eating habits. Fourteen residents reported having eaten kinilaw (raw freshwater fish soaked in vinegar and garnished with salt, ginger, and lime). Seven of the persons interviewed had a diagnosis of capillariasis, and 6 had >1 relative with a diagnosis of capillariasis. All of the previously diagnosed case-patients were treated with albendazole (400 mg tablets). Most patients were instructed to take 1 tablet 1×/day for 20 days; others were instructed to take 1 tablet 2×/day for 5 or 10 days.

The drug of choice for treating patients with capillariasis is mebendazole, 200 mg 2×/day for 20–30 days. An alternative treatment is albendazole, 400 mg 1×/day for 10 days (7,8). Variations in the treatment regimen used for patients with capillariasis at the study site suggest a need to train health professionals on the diagnosis, treatment, and follow-up of cases, and on disease prevention and control. Guidelines on proper laboratory techniques for diagnosis of capillariasis; treatment protocols and supportive measures; and protocols for detection, follow-up, and treatment for relapse cases must be developed.

Rates of infection with protozoans and soil-transmitted helminths at the study site are high, which indicate fecal contamination of food and water. A review of records from the Katipunan rural health unit indicated that 76% of households in this municipality have access to toilets. Only 11% of households have water connections (level III). Fifty-seven percent of households have access to communal faucets (level II), and 31% have access only to rivers or springs (9). Therefore, increased access to toilets and safe water is needed. Local ordinances concerning ownership and use of toilets must be strictly enforced, and evaluation and rehabilitation of existing toilet and water systems must be conducted.

In spite of efforts concerning information, education, and communication on capillariasis, many residents continue to eat raw or poorly cooked freshwater fish. Concurrent infection among household members, including those in younger age groups, was observed in this study. These findings result from the fact that consumption of kinilaw has become widely accepted and is consumed as a viand (choice food) by families. Thus, information, education, and communication campaigns must be intensified. A promising approach is through collaboration with other agencies. For example, the Department of Education in the Philippines may become involved in dissemination of information on capillariasis to students and in early detection and treatment of infected school children.

### Acknowledgments

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**Table. Parasites detected in Katipunan, Zamboanga del Norte, the Philippines, February 2008**

<table>
<thead>
<tr>
<th>Parasite</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trichuris trichiura</td>
<td>64 (31.1)</td>
</tr>
<tr>
<td>Entamoeba coli</td>
<td>49 (23.8)</td>
</tr>
<tr>
<td>Ascaris lumbricoides</td>
<td>46 (22.3)</td>
</tr>
<tr>
<td>Endolimax nana</td>
<td>14 (19.9)</td>
</tr>
<tr>
<td>Hookworm</td>
<td>34 (16.5)</td>
</tr>
<tr>
<td>Blastocystis hominis</td>
<td>21 (10.2)</td>
</tr>
<tr>
<td>Giardia lamblia</td>
<td>19 (0.2)</td>
</tr>
<tr>
<td>Entamoeba histolytica</td>
<td>14 (6.8)</td>
</tr>
<tr>
<td>Capillaria philippinensis</td>
<td>10 (4.9)</td>
</tr>
</tbody>
</table>

*A total of 205 parasites were detected by using the formalin–ether concentration technique.*
Buruli Ulcer Lesions in HIV-Positive Patient

To the Editor: Mycobacterium ulcerans disease (Buruli ulcer) is a neglected and emerging tropical disease (1). It often leads to extensive destruction of skin and soft tissue with the formation of large ulcers (2). In 2004, the World Health Organization (WHO) recommended the combination treatment of rifampin/streptomycin for patients with this disease (3). According to WHO, development of new antimicrobial drug treatment is one of the major advances since the establishment of the Global Buruli Ulcer Initiative (1). Treatment with rifampin/streptomycin for ≥4 weeks can inhibit the growth of M. ulcerans in preulcerative lesions (4). In other patients, despite 4 weeks of treatment, lesions may deteriorate. Whether this treatment is less efficacious in persons with HIV infection is unknown.

In August 2008, a 35-year-old man was referred to the Medical Centre of the Democratic Republic of Congo for assessment of chronic ulcers. Lesions had appeared 12 months earlier when the patient was living in Kafufu/Luremo, a new endemic focus of Capillariasis philippinensis. Southeast Asian J Trop Med Public Health. 2000;31:478–81.

The patient was positive for HIV by the Determine HIV-1/2 test (Abbott Laboratories, Dainabot Co. Ltd., Tokyo, Japan), the Uni-Gold HIV test (Trinity Biotech PLC, Bray, Ireland), and the Genie II HIV-1/HIV-2 test (Bio-Rad, Marnes-la-Coquette, France). Results of PCR for M. ulcerans and Ziehl-Neelsen staining were positive for all specimens obtained during the 8 weeks of initial treatment. The patient died 2 weeks after treatment ended, just when antiretroviral treatment had been scheduled to begin.

Although the patient did not respond clinically to treatment with rifampin/streptomycin, whether the treatment also failed microbiologically is more difficult to prove. Results of PCRs performed during treatment remained positive. However, PCR does not differentiate between living and dead M. ulcerans bacteria. Therefore, our positive results suggest, but do not prove, treatment failure. The positive culture after 2 weeks of treatment also suggests treatment failure but cultures obtained at 4 and 8 weeks were contaminated. However, culturing M. ulcerans bacteria is difficult, especially if samples must be transported (7).

Patients with Buruli ulcer may also be infected with HIV. In a study conducted during January 2002–Au-

References

3. Belizario VY Jr, de Leon WU, Esparaz NG. Buruli Ulcer Initiative (1). Treatment with rifampin/streptomycin for ≥4 weeks can inhibit the growth of M. ulcerans in preulcerative lesions (4). In other patients, despite 4 weeks of treatment, lesions may deteriorate. Whether this treatment is less efficacious in persons with HIV infection is unknown.

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