

SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 180 To 181

Fatema Jawad (7/6, Rimpa Plaza, MA. Jinnah Road, Karachi-74400.)

CONTACT LENS ASSOCIATED CROSS INFECTION. Kirmani, K., Rehmatullah, A.F., Mujahid, S. Pak. Ophthalmol., 1989;5:190-197.

A case of cross contamination by lens solution in two sisters using the same disinfecting and rinsing solutions for their contact lenses is presented. The two sisters aged 22 and 24 years reported with cornea! abrasions. Both had pain in the affected eye, epiphora, swollen eyelids, excessive mucous production and decreased vision. Both were using daily wear soft contact lenses. The elder sister, a nurse by profession had the ocular symptoms three hours before reporting to the emergency room. The younger sister, a hair dresser had the complaints since two days and was treated by a general practitioner with topical corticosteroids. Examination of both cases revealed swollen eyelids, matted eyelashes, excessive mucous production, conjunctival infection and excessive tearing in the affected eye. Initially the eye was pressure patched after instilling atropine drops and antibiotic ointment. Fluorescein staining showed a bilateral circular 3.5 mm cornea! abrasion in one girl and unilateral abrasion in the other. Three days later complete healing had taken place and visual acuity was restored with spectacles. The contact lenses and cleaning solution were examined for bacterial and fungal culture. The lenses of the nurse grew klebsiella and pseudomonas multophilia. The younger sister had a growth of pseudomonas multophiia and aeromonas hydrophilia. All bacteria were sensitive to gentamycin and chloramphenicol. The cleaning solution was sterile and the saline could not be tested. Both sisters were giving a final rinse to lenses with normal saline which was removed from a one litre bag and stored in a glass bottle in the bath-room. It was presumed that the source of infection was the normal saline which was contaminated by improper handling. With the increase in use of contact lenses as an alternative to spectacles, the occurrence of microbial keratitis has increased. Trouble-some pathogens as pseudomonas A canthamoeba and fungi have been isolated. Strains of pseudomonas get attached to unworn contact lenses and are not removed even by washing. A canthamoeba a protozoan found in soil and fresh water and resistant to treatment contaminates, water and saline leading to keratitis in contact lens users. A proper patient selection with good lens maintenance will reduce the incidence of corneal infection and ulceration. Corticosteroids should not be used indiscriminately.

MANAGEMENT OF TRACHEOBRONCHIAL FOREIGN BODIES IN CHILDREN.

Saeedullah, Mohibullah, Yousuf, N., Ghani, R. Pak.J.Otolaryngol., 1990;6:167-169.

Fifty two cases of foreign body tracheobronchial tree in children are presented. There were 38 males and 14 females with the youngest patient being 8 months and the oldest 12 years of age. 28 foreign bodies were lodged in the right main bronchus, 20 in the left main bronchus and 4 in the subglottic region and trachea. 40 articles were of vegetable origin with the commonest being peanuts. The non-vegetable foreign bodies included plastic beads, bullets, pellets, meat bone and a needle. All the cases presented with dyspnoea and bouts of cyanosis with the duration of symptoms ranging between 24 hours and 22 days. A rigid paediatric bronchoscope was used and the venturi system adopted. General anaesthesia was administered. There was no mortality. Foreign bodies usually lodge in the right main bronchus and the rigid bronchoscope is the most suitable instrument for their removal. Smaller foreign bodies lodged peripherally are removed by the fibre optic bronchoscope. Bronchoscopy is advised in children with persistent cough and episodes of dyspnoea even when the history is not suggestive of a foreign body.

**CEPHALIC ASPERGILLOSIS INVOLVING PARANASAL SINUSES AND THE SKULL BASK
Zaidi, S.H. Pak.J. Otolaryngol., 1990;6:170-173.**

Seven patients diagnosed as Aspergillosis of the paranasal sinuses have been reported. There were 4 males and 3 females with ages ranging between 12 and 60 years. 4 patients were diabetic, one immunocompromised and one was an old debilitated lady and the last was a healthy child. Proptosis, telorism, unilateral headache, black sanguinous nasal discharge, maxillary swelling, necrotic mass, rapidly worsening vision and lassitude with low grade fever were the presenting symptoms. The CT. Scan showed a mass occupying the Ethmoid and the maxillary antrum pushing the orbit laterally. Degenerative body changes were obvious in 3 cases. Biopsy and special staining confirmed Aspergillosis. Extended radical antrostomy and internal ethmoidectomy was performed in 2 cases, subtotal maxillectomy in 3 cases and bilateral ethmoidectomy and decompression of the orbit in two cases. Amphotericin -B was given intravenously in a dose ranging from 0.5 to 0.9mg per Kg body weight. Five patients were found free of the disease after six months of completion of therapy. One case required a second surgery due to an extensive lesion and the child patient migrated abroad. Rhinosporidiosis was till recently the only recognised nasal fungal infection. Better orientation distinguished aspergillosis as a significant pathology which commonly affects the nose, nasopharynx, ethmoids and the maxillary sinuses. Cephalic aspergillosis is a common infection and spreads through the mucosal blood vessels. Its action is gradual, subtle and silent but aggressive and fatal. It can present as a necrotic mass in the nostril with asanguinous discharge, maxillary swelling, proptosis, fever, headache, lassitude and debility. Biopsy is mandatory for diagnosis and Amphotericin-B combined with surgical ablation has improved the prognosis and reduced the fatality to 21% from 90% two decades ago. A liposome bound form of the drug has proved less toxic and more effective.

RECURRENT LARYNGEAL NERVE PALSY IN ENTERIC FEVER. Soni, N.K PakJ. Otolaryngol., 1990;6:183-184.

Unilateral recurrent laryngeal nerve palsy complicating typhoid fever, a rare feature is reported. The patient was a 20 years old male with high grade fever and dull abdominal pain since 6 days and a hoarse voice for 2 days. He was toxic, dehydrated and stuporous with a temperature of 36°C, and pulse 110/min. The tongue was coated and indirect laryngoscopy revealed left vocal cord paralysis. The pharyngeal reflux was normal. The routine blood and urine tests gave no abnormality. The x-ray chest and of the base of the skull were also normal. A diagnosis of viral fever with recurrent laryngeal palsy was made and ampicillin capsules started. As no improvement was noted after 5 days a further examination and widal test confirmed the diagnosis of typhoid fever. Chloramphenicol therapy was started. Recovery of the recurrent laryngeal nerve started on the seventh day and was complete in two weeks. The recurrent laryngeal nerve which has a long course usually gets involved by a local pathology in the neck or acute infections. Typhoid fever affecting the recurrent laryngeal nerve is a rare occurrence and its pathogenesis is not known. It may be a manifestation of neuritis though usually a sensori-motor or neuralgic form is encountered. The former develops in the convalescence period and the latter may last for months.