SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 88 To 89

Fatema Jawad (7/6, Rimpa Plaza, M. A. Jinnah Road, Karachi.)

INTESTINAL MYIASIS (MAGGOT INFESTATION OF INTESTINES). Noor, N. A. JAMC., 1988; 1:19-20.

Two cases of intestinal myiasis are described. Both were farmers, middle aged and from Bahawalpur and Multan districts. Both complained of dull abdominal pain with occasional episodes of sharp pain lasting for a few minutes. Both had noticed larvae in their stools. Maggots were seen as active, whitish, headless segmented worms in the freshly passed stools. Treatment was carried out by saline purgation and enemas or castor oil which expelled the larvae. Infection with maggots is caused by invasion of tissues and organs by the larvae of various species of flies. It can involve skin, eyes, connective tissue, nasopharynx, intestines and urethra. Intestinal myiasis results from ingestion of food contaminated with the eggs or larvae of flies some of which survive the passage through the stomach and later matUre in the stomach. Diagnosis is made by seeing the maggots in the fresh stool specimen. Careful handling and covering of food articles is the preventive measure.

CANCER EN CUIRASSE. Kakakhei, K., Saeed, A.K. JAMC., 1988; 1 21 - 22.

A 62 years old male from Kohistan presented with a severely painful skin lesion on the left side of the back of the neck of four weeks duration. The pain was of a boring type and disturbed his sleep. The patient had been a smoker for 25 years but had stopped since 6 years due to a chronic productive cough. General examination was non-contributory and the laboratory tests were within the normal range except for an ESR of 85 mm in the first hour. The skin lesion was an infiltrated plaque, erythematous, non- oozing, brown in colour and slightly tender. There was no ulceration. It extended from the left ear abpve to the clavicle below. A deep biopsy was taken from the site of maximum inifitration. The histopathology report confirmed the clinical diagnosis of undifferentiated metastatic malignant tumour of the skin. The primary site could not be determined. The patient was referred for palliative radiotherapy which gave relief to the excruciating pain. Two weeks later tlte patient developed acute abdominal pain. A repeated chest X ray revealed the primary tumour in the lungs. Intestinal obstruction was diagnosed which was managed conservatively but the patient expired 2.7 percent of the malignant tumours produce skin metastasis which may be the first evidence. It looks like morphoea and histologically the cells lie singly and have large pleomorphic hyperchromatic nuclei. Skin lesions should be carefully examined for infiltration and search should be made for the primary site.

HOOK WORM INFESTATION IN TEN WEEKS OLD INFANT. Wazir, M. D., Shah, S. H., Muhammad,WJAMC.,1988; 1: 23-24.

Hook worm infestation in a ten weeks old infant presented with severe anaemia and dark coloured stools is reported. The baby was breast fed and came from District Mansebra. Fever, cough and pallor had been noted for 15 days. Clinical examination revealed occasional rhonchi in the chest, liver just palpable, weight was 4.5 Kg., Hb 3.8g and WBC 14,000/ cmm with 7 percent eosinophils. Stool analysis towed large number of hook worm ova with positive occult blood. The infant was dewormed with Pyrantel and blood transfusion was given. The mother was also tested and her stool also contained ova of hook worm. The baby improved and was discharged on haematinics. Hook worm infection usually is seen in children when they begin to crawl or walk which brings their skin in contact with larvae contaminated soil. However infants can be infected through the skin of the back if they are laid on infected ground. After penetrating the skin the larvae take 6 to 8 weeks in completing the cycle of travelling to the bronchi, trachea, oesophagus and small gut. One ankylostoma duodenale causes the

loss of 0.15 to 0.26 ml of blood daily. Chest symptoms are found in the early stage with microcytic hypochromic anaemia following later. Prevention should be practiced by effective disposal of faeces and avoiding walking bare foot.

TUMOURS OF THE MIDDLE EAR AND MASTOID. Soul, N.K., Chatterji, P., Khardelwal, B.M. Pak.J. Otolaryng., 1988; 4: 52-56.

Twenty two cases of tumours of the middle ear and mastoid encountered between 1974 and 1985 are presented. Seven were benign neoplasms and of the fifteen malignant tumours, 10 were primary and 5 metastatic. The patients complained of ear discharge and pain. Seven cases came with facial paralysis and one had cervical lymphadenopathy. Radiological studies in the malignant cases towed evidence of bone destruction of varying degree. Four cases were subjected to biopsy of the polypoidal mass before mastoid surgery and were subsequently sent for radiotherapy. The remaining six patients underwent radical mastoid surgery and post-operative radiation. The most common type of malignancy was squamous cell carcinoma. The primary site of the metastatic tumours were 2 in the thyroid, 2 in the nasopharynx and 1 in the Tibia, which were detected subsequently. They were all treated with a combination of chemotherapy and radiotherapy. Of the benign tumours, 2 were osteomas, 2 haemangiomas and one each of adenoma, fibroma and leiomyoma. The adenomas came in as ear discharge and a polypoidal mass in the external auditory canal. Osteoma presented as a post-auricular bony swelling whereas the unusual leiomyoma was seen as a polypoidal mass in the external auditory canal, purulent discharge and deafness. Diagnostic biopsy is essential in each case to determine the plan of further treatment.