however, it does not render the skin surface absolutely sterile. Alcohol is a highly volatile substance and majority of it evaporates within few seconds of application on the skin surface. Some would argue that the application of spirit would lead to the absorption of the same and would therefore have deleterious effects on the vaccine containing the live-attenuated tubercle bacilli. Being of a volatile nature, majority of the spirit would vaporize quickly and whatever little that enters the deeper skin structures would prove more efficacious against pathogenic microorganisms that may have entered inadvertently, without undue inactivation of the vaccine bacilli.

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Isolated Idiopathic Unilateral Paralysis of Soft Palate and Pharynx

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Isolated unilateral palatal (velopalatopharyngeal) palsy is a clinical rarity. We report this entity in a 10 year old boy, two weeks after an episode of acute tonsillitis. The child was managed with a short course of prednisolone with complete recovery in eleven days.

Key words: *Palatal paralysis, Rhinolalia, Tonsillitis*.

Idiopathic unilateral palatal paralysis is a rare disorder. Since its first description in 1976, 35 cases have been described [1]. The disorder typically affects boys at ages of 2-3 years with sudden onset rhinolalia and nasal regurgitation of fluids [2-5]. We report a 10-year-old boy with this illness.

CASE REPORT

A previously well, immunized, 10-year-old boy, presented with fever and sore throat of four days duration. Examination revealed bilaterally inflamed tonsils. A throat swab was sent for analysis, and the child was given injection benzathine penicillin

(intramuscularly; one dose) and acetaminophen (per orally). Throat swab revealed group-A beta-hemolytic (GABH) streptococcal infection. Viral studies could not be performed due to non-availability of facilities. The child became asymptomatic on seventh day after presentation.

The child was again brought, two weeks from the onset of first symptoms, with rhinolalia, nasal escape of fluids from the right nostril, and dysphagia. There was no recurrence of fever, or sore throat. Examination revealed deviation of uvula to right with absent gag reflex on left side of pharyngeal wall (***Fig* 1**). Rest of neurological examination and laryngoscopy was normal. Cerebrospinal fluid examination and magnetic resonance imaging (MRI) of brain and cervical spine revealed no abnormality.

The unilateral paralysis of soft palate and pharynx was thought to be idiopathic in origin. The child was started on oral prednisolone (2mg/kg/day). The steroids were tapered from 6th day and stopped on day 15. The symptoms started improving on day four of steroids and the child was completely asymptomatic nine days after starting steroids. The palatal palsy recovered completely by eleventh day from the onset of symptoms. There was no recurrence of symptoms for two years that the child was followed.

DISCUSSION

We consider that vagus is the most probable nerve affected. The mode of involvement of vagus is not known but two mechanisms have been hypothesized: viral and vascular [5]. An infectious/ postinfectious cranial neuropathy seems likely as isolated palato-pharyngeal palsy is well documented as a post-diphtheritic complication. The clinical features of diphtheria were not present in our patient and also, he was completely vaccinated. There have been sporadic reports of palato-pharyngeal palsy in children following infection with herpes, varicella, and hepatitis A [3]. However, definitive evidence in the form of positive viral serology/ culture could be demonstrated in only five of the twelve cases with a febrile prodrome [3,5]. In our case, the child had acute tonsillitis with a positive throat culture for GABH streptococci two weeks prior to palatal palsy.

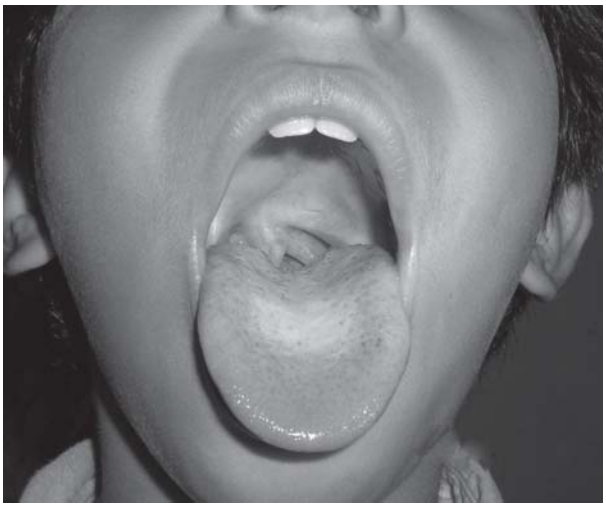

FIG. 1 *Uvula deviated to right on phonation.*

The literature search did not reveal any association between GABH streptococcal infection and palatal palsy. However, co-infection with a virus cannot be ruled out since viral culture/serological studies could not be carried out.

The second hypothesis has been proposed by Lapresle, *et al*. [8]. They demonstrated the existence of ischemia in the roots of the glossopharyngeal and vagus nerves. The cause of this ischemia is not known and viral infection induced vasculitis cannot be ruled out. Either of the aforementioned scenarios would lead to lower motor neuron neuropathy manifesting as palatopharyngeal incompetence. The higher incidence of the condition in childhood is possibly due to immature neural tissue that is rendered more susceptible than in adults.

Other possibilities considered were Guillain-Barre syndrome, vascular insults, posterior fossa tumors, syringobulbia, and inflammatory diseases affecting brainstem nuclei. Detailed pharyngeal and neurologic examination, evaluation of cerebrospinal fluid, and MRI of the brain and upper cervical region were unremarkable. We consider the paralysis in our case to be idiopathic because all the evaluations were negative.

The prognosis of the disorder is excellent with complete recovery in >85% cases [5], and only one recurrence reported till date [7]. There is no specific treatment; oral glycerol and steroids have been used

and complete recovery has been reported even without any treatment [3]. We managed the case with short course of steroids without any side effects, and the child started improving from day four and the recovery was complete by day eleven. Several reports suggest initiation of recovery by tenth day and reversal of pharyngeal weakness by 4-7 weeks without the use of steroids [3,5]. Nonetheless, further reports focusing on the therapeutic aspect are desired, before a recommendation is made.

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Esophageal Diverticulum Secondary to Impacted Foreign Body

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We report a two year old child who developed a large esophageal diverticulum over a period of ten months following ingestion of a multispiked leaf of *Quercus semicarpipholia*. Though the endoscopic removal of foreign body was successful, it did not relieve the symptoms and patient required surgical resection of the diverticulum. Patient is asymptomatic after 4 months of follow up.

Key words: *Child, Diverticulum, Esophagus, Foreign body.*

Foreign body ingestion is frequent in children, especially between six months to three years of age owing to their inherently inquisitive nature [1]. Though majority of ingested foreign bodies traverse the gastrointestinal tract without any adverse effects, occasionally they can get impacted resulting in various complications [2]. A two years old child is reported with an impacted woody tree leaf in esophagus, producing a valve effect causing partial obstruction and development of a large, secondary esophageal diverticulum over a ten months period.

CASE REPORT

A two year old male child was brought with history of persistent vomiting following any solid food ingestion and progressive weight loss for the last ten months. The child had a normal growth and development till fourteen months of age when he had sudden choking with cough while playing. The initial two vomitings contained small amounts of fresh blood but later it contained only the ingested