

The blood pressure was 200/90 mmHg in right upper limb and 130/90 mmHg in the left upper limb. It was 145/90 mmHg in right lower limb and 140/80 mm Hg in the left lower limb. The radial artery pulse volume was low on the left side. Neck examination revealed a tender and mobile enlarged thyroid. Heart sounds were normal and bruits were detected over the left subclavian artery and abdominal aorta. She had grade II hypertensive retinopathy. ESR and CRP were 18 mm/h, and 10.5 mg/dL, respectively. Serum creatinine, electrolytes, transaminases and the urinalysis were in normal limits. Human immunodeficiency virus (HIV), hepatitis B virus, and hepatitis C virus were negative. Antinuclear antibody titer was 1:320 in a speckled pattern (low positive), extractable nuclear antigens (ENA) and C-antineutrophilic cytoplasmic antibodies (ANCA) were in normal range. Child was negative for HLA B27 and rheumatoid factor. Tuberculin test was negative. Thyroid scan indicated diffuse hyperplasia. Chest CT scan was normal, ECG showed sinus tachycardia, and an echocardiogram showed mild aortic regurgitation. Digital subtraction angiography (DSA) revealed occlusion of left axillary artery, narrowing of left subclavian artery and right external iliac artery, and proximal stenosis of the left renal arteries. She was diagnosed with Takayasu arteritis type V according to the American College of Rheumatology (ACR) criteria [1], and updated angiographic classification[2]. Prednisolone and antihypertensive agents were added to the aforementioned treatment.

This was an unusual association of Takayasu arteritis with Hashimoto thyroiditis. The pathophysiological mechanism underscoring the association between these two diseases remains unclear. Cell-mediated immunological mechanisms play an important role in both diseases. Pro-inflammatory cytokines such as tumor necrosis factor (TNF)- α , interleukin (IL)-6, IL-8, IL-12 and IL-18, are common to both, amplifying the inflammatory process [3,4]. In view of the autoimmune features common to TA and HT, it is reasonable to consider the possibility of a pathophysiological association between them.

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Dengue Arthritis in a Child

A 28-months-old boy was admitted with fever of five days and passing black colored stools one day prior to admission. The child was conscious, irritable, with petechial lesions over trunk and abdomen. Palms and soles were erythematous. He was febrile and had tachycardia, wide pulse pressure (50 mm Hg), and hepatomegaly. The child was diagnosed as a case of severe dengue based on a positive NS1 antigen, and positive dengue IgM, and clinical profile. The child was treated as per standard WHO protocol; he improved and was discharged home.

The child was readmitted on fifth day, with a diffusely swollen right knee. Movements were restricted. There was anemia (Hb 8.2 g/dL), thrombocytosis (7,00,000 platelets/mm³), and elevated ESR (120 mm). Plain radiograph of right knee revealed widened joint space

with normal surrounding structures. Serological examination was negative for anti-nuclear antibodies and Chikungunya IgM antibodies. Arthrocentesis of right knee revealed turbid fluid, with only five lymphocytes per mm³ without any organism on Gram stain and culture studies. Mantoux test was negative. The diagnosis of dengue arthritis was considered, against the post, viral reactive arthritis which usually involves hip joint. The child was treated with oral acetaminophen. At follow up after 2 weeks, the child was afebrile and playful without any pain or swelling in the right knee.

Dengue affects tendons, muscles, joints and bones. Polyarthralgia in dengue fever is known, but arthritis is rare [1,2]. Dengue and Chikungunya are arboviral infections transmitted by *Aedes aegypti*. They can be transmitted together in areas where both viruses co-circulate [3]. Most of the clinical and laboratory features of patients with chikungunya and dengue fever are similar. Arthritis is the predominant manifestation in

patients with chikungunya fever compared to dengue fever [4]. Differentiating chikungunya with dengue fever is important as the former is a self-limiting acute illness whereas the latter has dreaded systemic complications. In view of relative well-being of a child, positive dengue IgM, negative serology for chikungunya, and normal arthrocentesis study, the diagnosis of dengue arthritis was made.

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Unusual Foreign body “Live Fish”

Incidence of foreign bodies' (FB) ingestion is usually greatest in children aged 6 months to 6 years [1]. The spectrum of presentation varies widely from sudden death due to respiratory obstruction to accidental finding during routine investigation. Occasionally, we also find younger children may be “fed” foreign bodies by older children [2].

A 6-month-old male infant was brought to our emergency room by parents with sudden onset of difficulty in breathing. Further history revealed accidental self ingestion of whole live fish given in baby's hand by his elder sibling while cleaning the aquarium at home. Incidentally this was witnessed by the father. On examination, baby was afebrile, cyanosed with increased breathing efforts and saturation was 76%. General physical examination was normal. On systemic examination, there was bradycardia and bilateral air entry was absent. Within a minute, baby developed labored breathing. Immediately baby was taken for intubation. While passing laryngoscope for intubation, we noticed pooling of blood in the oral cavity. After suctioning, the tail part of the fish was visible in the throat. The fish was removed with help of Magill forceps with gentle manipulation. Chest movements improved with good air entry on auscultation. Post-removal, vitals were stable. Baby maintained saturation without oxygen. Chest X-ray was taken to rule out aspiration. Antibiotics were started and supportive care continued. Baby was observed for 24 hrs in intensive care unit and discharged on third day on stable vitals; follow-up after a week was uneventful. Fish was 6.5 cm in length and 3 cm in breadth, and blood stained.

The enhanced risk of aspiration in this age group is attributed to inherent anatomic and physiologic characteristics like inadequately developed posterior dentition, immature neuromuscular mechanisms of deglutition, airway protection and the ubiquitous tendency of putting objects into the mouth. An unattended vulnerable child and easy access to small objects are also contributory [1,3]. The majority of ingested foreign bodies will pass spontaneously [4]. Walvekar, *et al.* reported one case of accidental ingestion of live fish in infant, where it was ‘bathini fish medicine’ used for treatment of asthma [5].

Keeping aquariums at home has become a trend in modern lifestyle. Usually children are interested to watch, touch and play with this kind of live objects. This unusual case emphasizes the importance of caregivers' special attention to this vulnerable age group and also importance of timely diagnosis and intervention.

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FIG.1 Blood-stained fish immediately after removal.