

Recurrent Parotitis in a Seven-Year-Old Boy

Recurrent parotitis, also known as juvenile recurrent parotitis is defined as recurrent parotid inflammation, generally associated with non-obstructive sialiectasis of the parotid gland(1). The etiology is not clear and in most cases, symptoms resolve spontaneously after puberty. A 7-year-old boy is presented here who had eight episodes of recurrent parotid swelling.

A 7-year-old boy presented with acute swelling of 72 hour duration of his left parotid gland. The child was afebrile and there was an enlargement and tenderness in his left parotid gland. Pressure over the gland did not cause any purulent discharge from the parotid duct. There was no sign of xerophthalmia and xerostomia. Over the previous years, he had 7 episodes of left parotid swelling. There was no family history of recurrent parotid swelling. The patient's blood count, erythrocyte sedimentation rate and serum immunoglobulin levels were in normal limits. HIV serology was negative. Antibodies including anti-Ro and anti-La for Sjögren's syndrome were not detected. Longitudinal paroti sonogram demonstrated heterogenous internal echogenicity and nodular hypoechoic areas reflecting sialiectasis in the left paroti gland. A diagnosis of recurrent parotitis was made and the patient was advised to take high fluid intake especially in the course of an upper respiratory tract infection.

Recurrent parotitis is an idiopathic condition which usually begins between 3 and 6 years of age(1). The disease favors males and the number of attacks changes from one to five per year but there are patients who have 20 or more attacks per year(2). In 80-90% of the patients, the symptoms spontaneously resolve

by puberty(1,3). Although most of the cases have the idiopathic type of the disease, recurrent parotitis might be the first presenting symptom of an underlying common variable immunodeficiency, HIV infection and primary Sjögren's syndrome. Reid, *et al.* reported an autosomal dominant inheritance in a family and this suggests that, at least in some cases genetic factors may be applied in juvenile recurrent parotitis (4). Sialiectasis was previously diagnosed by sialography, but ultrasound superceded this technique. The effects of antibiotics on the natural course of the disease is a dilemma.

In conclusion, although recurrent parotitis is rare in childhood, but it is a fearing condition for the families. Investigation for an immunodeficiency, Sjögren's syndrome, HIV infection and family history is essential in these cases. An ultrasound of the glands is necessary for diagnosis and it can also be used to exclude a solid mass or a stone. The use of antibiotics is controversial and preventing dehydration is very important. Since most of the cases resolve by puberty, reassurance of the family about the benign course of disease is enough.

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Pamidronate Lines

Figure 1 is a radiograph of the left lower limb of a two-year-old child. It demonstrates multiple linear areas of increased bone density at the metaphysis of the proximal and distal femur and circumferential linear thickening of the cortex around the iliac with background osteopenia and a non united fracture of the shaft. He was diagnosed as having Osteogenesis Imperfecta (OI) type 3 in early infancy and was given cyclical Pamidronate therapy for the same. It is likely that the areas of increased bone density correspond to the timings of the Pamidronate infusions.

There has been an increase in the usage of Biphosphonates like Pamidronate to enhance bone density in various disorders associated with osteopenia including osteopathies such as OI, juvenile osteoporosis, Gaucher's disease, hyperphosphatasia, juvenile chronic arthritis and glucocorticoid-induced osteoporosis. They have also been tried for treatment of calcinosis associated with myositis, fibro-dysplasia ossificans, dermatomyositis and scleroderma. Increased bone density, cortical width, reduced fracture rates and improved bone pain are known benefits from Pamidronate therapy in OI(1). A reduced rate of bone turnover due to decreased osteoclast activity is thought to result



Fig.1. X-ray showing multiple linear areas of increased bone density in a child on cyclical pamidronate therapy.