Ocular Complications Following Mumps

The old adage about uncommon manifestations of common disease was brought to the fore recently, when we had two patients with ophthalmic complications of mumps. While standard ophthalmic texts do list them, journal literature carries scant mention. The most recent one we could find, being a case of mumps conjunctivitis reported in 1974(1).

A 12-year-old male child, with mumps, presented with headache, vomiting and neck stiffness. A lumbar puncture showed a picture of viral meningitis. He was put on mannitol. On the third day, as the parotid swellings diminished, he developed bilateral red eyes, photophobia and blurring of vision. On examination, he had vision of 6/18 in both eyes, bilateral ciliary injection, with cloudy anterior chamber and central, circular, sluggishly reacting pupils, 2 mm in size. Fundus and ocular motility were normal. An ophthalmic opinion and slit lamp examination confirmed the features of bilateral iridocyclitis. Topical steroid and atropine therapy were started and the child improved and was discharged three days later. Regular follow up confirmed control of iridocyclitis with return of vision to 6/6 in both eyes.

A 4-year-old female child, with mumps since 4 days, came with bilateral painful swelling of the lateral aspects of upper eyelids since 3 days, starting 1 day after the involvement of both parotid glands. On eversion of upper eyelid, enlarged lacrimal glands were seen. Rest of the eye was normal. The child recovered uneventfully in 5 days without therapy.

Ocular complications following mumps were first described in 1982(2). These include in order of frequency, dacryoadenitis ("Lacrimal Mumps"), conjunctivitis, scleritis, keratitis, iridocyclitis, optic neuritis, retinitis and extraocular muscle palsies.

Iridocyclitis normally occurs at the climax of the general disease or in the beginning of convalescence. Its development is rapid. It is exudative and there is an aqueous flare with cells and small keratitic precipitates; synechiae are relatively easily broken down. Occasionally glaucoma may occur(2).

Dacryoadenitis is nearly always bilateral, acute and subsides in a few days, but complete resolution may be delayed for some weeks(3). Edema and subconjunctival hemorrhage may occur with the onset of diffuse scleritis or episcleritis. A late complication of dacryoadenitis is the keratitis sicca syndrome(4).

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REFERENCES

1. Meyer RF, Sullivan JH, Oh JO. Mumps conjunctivitis. Am J Ophthal 1974, 78: 1022-1024.

2. Duke Elder S, Perkins ES. Diseases of Uveal tract. *In:* Diseases of Uveal tract. System of Ophthalmology, Vol. IX, London, Henry Kimpton Publishers, 1966, p 351.

3. Duke Elder S, McFaul PA. The ocular adnexia. *In:* System of Ophthalmology, Vol. XIII, Part-II, London, Henry Kimpton Publishers, p 607.

4. Hiles DA, Signetti FE. Ocular manifestations in infectious diseases. *In:* Pediatric Ophthalmology, 2nd edn, Vol. II. Ed Harley RD. Philadelphia, WB Saunders Company, 1983, pp 917-918.

Wolman Disease: Suggestions for Effective Treatment

For over a year a female infant affected by Wolman disease and treated by the dietary treatment described below survived far beyond the 3-4 months predictable life span. Although otherwise normal, with time she developed EFA (essential fatty acid) deficiency which can be, and is now, treated by an established procedure which is not antagonistic to the dietary treatment.

The treatment consists of strict cessation of breast feeding and strict avoidance of foods containing any fats and oils (triglycerides and cholesterolesters). Formula feeding should be as free as possible of neutral lipids, but should contain all vitamins.

In order to avoid dermatological complications and stunted growth due to EFA deficiency, about 10 microliter (1/100 of ml) of sunflower oil should be lightly rubbed, once daily on the skin of one arm in infants below 5 kg in body weight. Infants 5-10 kg in weight should be treated by daily doses of 20-25 ml. In bigger children the dose should be about 2 mg/day/kg body weight. The site of oil smearing should be alternated on consecutive days between arms, forearms, thighs and legs.

At present it is not known whether this percutaneous administration of EFA should continue uninterrupted, or if 3-4 weeks of treatment should be followed by intermission of 1 or more weeks. It is proposed that this point should be tested by experience in different cases.

In order to be able to learn about best treatment modalities from a sizable group of patients, it is suggested that treatment of patients and its effects be reported to me every 3-6 months. A report in the name of all participants (after consultation, of course) will be published in due time. Alternately, pediatricians of a country or an area can combine their efforts and results and publish them independently. Also in this case, I would be grateful for information about the cases, which information will be considered confidential.

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Chloramphenicol Resistant *S. typhi*

In one(1) of the recent articles(1-3) on resistance of *S. typhi* to chloramphenicol and other drugs, antibiotic sensitivity was done by Stokes method(4). The authors of other two articles have stated that disc diffusion method was used.