Non-01 Vibrio Cholerae

A new strain of *Vibrio cholerae* has been responsible for several outbreaks of the disease in India and Bangladesh recently(l,2). This V. *cholerae* non/01 strain (designated as V. *cholerae* 0 139 Bengal) poses a potential threat for future. Widespread disease caused in India by 0 139 serotype marks the first time that a non 0 1 strain has. been associated with large epidemics(3,4).

The amount of toxin produced and the diarrhea caused by 0 139 serotype are very similar to that caused by *V. cholerae* 01. This new serotype is sensitive to tetracycline, ampicillin and chloramphenicol, but is resistant to co-trimoxazole (98%), and furazolidine (86%), the latter two agents often used to treat cholrea(2,5). In India even in children, tetracycline for three days or single dose of doxycycline should now be preferred(4).

Additionally the immunity to 01 is not protective against 0 139 serotype and the current killed cholera vaccine is not expected to protect against this new strain(3). The greater speed of travel and large population migration may hasten the spread of this disease. Close monitoring by the public health authorities of different States and Union Territories thus becomes essential.

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Apert Syndrome with Partial Post-Axial Polydactyly and Unilateral Choanal Atresia

Acrocephalosyndactyly type-I or Apert syndrome is a rare anomaly resulting from fusion of coronal, sagittal and lamboidal sutures associated with either soft tissue or bony fusion of digits of hands and feet(l).

We report here a one day old full-term male child who was brought with the complaints of feeding difficulty and abnormality of hands and feet. He was the third child of non-consanguinous parents without any significant antenatal or family history. The child weighed 2.7 kg with a head circumference of 33 cm, chest circumference of 32 cm, mid-arm circumference of 10.5 cm and a crown-head length of 43 cm. He had acrocephaly with complete fusion of coronal sutures and widely separated sagittal and

lambdoid sutures. The other features were hypertelorism, anti-mongoloid slant, bilateral proptosis, divergent squint, prominent nose, large low-set ears, syndactyly of 2nd to 5th digit of both hands and feet with a partial post-axial polydactyly of right hand(Fig. 1*)*. The palate was high-arched with a midline furrow. Left-sided choanal atresia and right sided choanal stenosis were also present. Systemic examination revealed an atrial septal defect of ostium secondum variety confirmed by echocardiography. X-ray of skull confirmed decreased antero-posterior diameter with fusion of coronal sutures. X-rays of hands showed symphalangia of middle and proximal phalanges of 3rd and 4th fingers with partial synostosis of terminal phalanges of the same two fingers on both sides. X-rays of feet showed synostosis of distal ends of metatarsals of 2nd and 3rd toes on both sides. The supernumerary finger on right hand revealed no osseous element. Ultrasonography of head and abdomen revealed no abnormality. Karyotyping was normal.

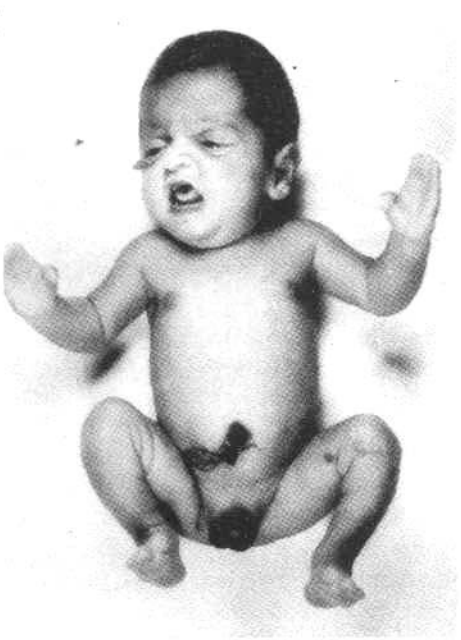

Fig. 1. Clinical photograph showing the characteristic features.

Apert syndrome was described by Apert in 1906(2). The mode of inheritance can be either autosomal dominant or recessive. Sporadic cases have also been reported due to new mutation. The cranial sutures fuse prematurely at variable periods and prevent the growth of skull antero-posteriorly and laterally, thus compensatory growth occurs superiorly with an increased vaulting and a rounded appearance—acrocephaly(3). The facial anomalies result from mid-facial hypoplasia which include shallow orbits with proptosis, telecanthus, strabismus, maxillary hypoplasia, prominent jaw, high arched palate or cleft palate. The severity of syndactyly may vary from soft tissue fusion of two or more digits or complete fusion of all five digits. There may be bony synostosis of varying degrees associated with complete soft tissue syndactyly(l). Rarely, partial polydactyly has been reported with Apert syndrome(4). The other associations reported with Apert syndrome can be of congenital heart defects, deafness, anal atresia and anomalies of vertebral column(5). The present case had a partial post-axial polydactyly of right hand which is uncommon. In carpenter syndrome the polydactyly is of pre-axial type and commonly of the feet, while the hands have brachydactyly and syndactyly(3).

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