

It was likely that the antibiotics on extravasation from the venipuncture site, bound to cellular elements and persisted as a foreign body for a long period(5). This could have led to the formation of a granulation tissue with chaotic arrangement of collagen fibres and keloid formation.

Such a large keloid in a girl was a cause of worry for the parents since it was not amenable to the available modes of therapy. Thus, extreme caution should be taken while choosing the site for intravenous cannulation. In pubertal, dark-skinned females with a positive family history of keloids, intravenous cannulation should be done at areas with least skin tension. We emphasize close monitoring of the cannulation site for signs of inflammation and position of cannula in the vein, before every injection, to prevent such occurrences. Adequate dilution of drugs, as per manufacturer's recommendations, must be ensured.

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Thermocol Box to Prevent Hypothermia During CT Scanning

The newborns are at a risk of hypothermia during ultrasound studies, echo-cardiography or CT Scanning. Recently we have used thermocol box to avoid hypothermia during CT Scanning.

Cesarean section was performed to deliver a baby with congenital

hydrocephalus at a gestational age of 35 weeks. The baby weighed 2.3 kg at birth. In view of the rapid increased in head circumference, shunt surgery was considered. On 17th day, the neurosurgeon insisted on performing a CT Scan.

The baby was sedated with triclofos. Her rectal temperature was 36.8°C, peripheries were pink and warm when kept in a thermocol box. Her head was positioned for CT Scanning by using gamgee pads and thermocol pieces. The

box was put on the scanning trolley and strapped properly. Subsequently, it was moved into the gantry and the scan was performed. The procedure took 20-25 minutes and at the end of which the rectal temperature of the baby was 36.7°C. The room temperature was 20°C.

We have been using thermocol box for transportation because of its insulating property (1). This time, its radio-lucent property was also put to use.

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Visceral Larva Migrans

Visceral larva migrans is due to entry of nematode larvae in extra-intestinal viscera of unnatural or incompatible host or under unfavorable conditions thereby provoking granulomatous lesions. The condition is rare between the ages of 1-4 years. We report a case of visceral larva migrans in a child who presented as pyrexia of unknown origin.

A five-year-old girl was brought with a one month history of mild to moderate degree of fever, dry cough, loss of appetite and pica. The child had jaundice one year back which lasted for 2 months. There was no history of passing worms. She used to play with a pet dog at home. Examination revealed a febrile child with anemia and mild hepatosplenomegaly. Examination of the fundus was normal.

Investigations showed a hemoglobin level of 6.4 g/dl, total count of 36,000/cu mm with 30% neutrophils, 17% lymphocytes, 53% eosinophils. The ESR was

80 mm at the end of first hour. Liver function tests were normal. The chest X-ray showed parahilar streaking and patchy pneumonia in the right lower zone. Liver biopsy showed alteration of the normal architecture. The parenchyma showed pseudolobules with dense fibrosis and eosinophilic infiltration forming microabscesses. Oval larval forms suggestive of *Toxocara canis* with foreign body giant cells around the parasite and necrotizing vasculitis were observed. (*Fig. 1*). The child was treated with diethylcarbamazine 2 mg/kg thrice daily for 30 days. The fever subsided within a week and the child became totally asymptomatic.

The clinical picture of visceral larva migrans varies from an asymptomatic stage with persistent eosinophilia (1) with or without constitutional symptoms to hypereosinophilia, hepatomegaly, cough, wheezing, pica, fever, anorexia, lassitude, pallor, nephrotic syndrome and pseudotuberculous eye lesions (ocular toxocariasis). Chest X-ray may reveal miliary infiltrates, atelectasis or areas of consolidation. A high leucocyte count