

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

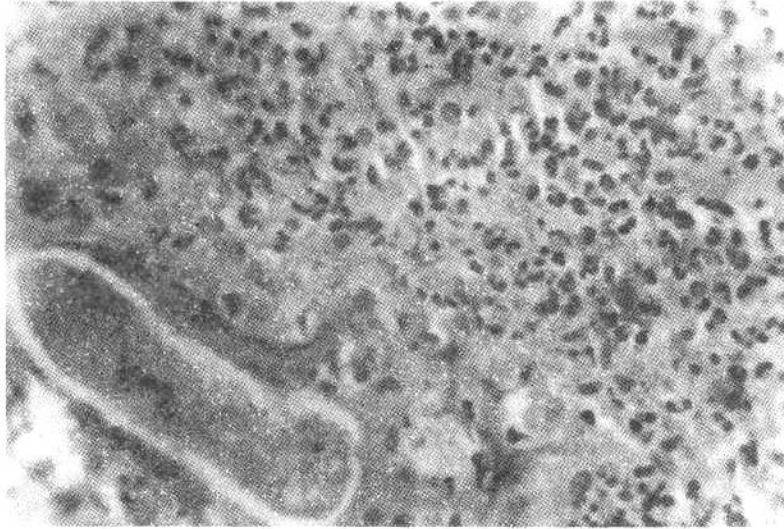


Fig. 1. Photomicrograph from the liver biopsy showing a microabscess around the cut section of the parasite (H & E, magnification 10×40).

with persistent eosinophilia is a characteristic finding(3). The precise diagnosis of larva migrans however depends on demonstration and identification of the larva on the biopsy or autopsy material(2,4). The enzyme linked immunosorbent assay is useful for diagnosis. Therapy with diethylcarbamazine is safe and effective(5).

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