Cutaneous Myiasis

This is in response to the publication on umbilical myiasis in newborn [1]. We would like to share our experience with six cases of cutaneous myiasis. Surgical removal with local anesthesia is the preferred approach. Alternatively, one can use turpentine, liquid paraffin, petroleum jelly, olive oil which creates anaerobic environment and makes the larvae come out which can be removed using tweezers or forceps. We have used turpentine successfully without any side effects using it for a short duration of time. Similiar experience is reported by Kumarasinghe, *et al*. [2]. Occasionally the larva is asphyxiated without emerging. The retained larva can cause an inflammatory response, leading to foreign body granuloma formation (a clump of inflammatory tissues) that may progress to calcification. This necessitates the immediate removal of the larva as they emerge from the tissue. In case of furuncles, digital pressure on both the sides of the lesion is sufficient to expel the larvae. If these measures fail then one can use the surgical removal under anesthesia.

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References

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Nephrotic Syndrome with Atherosclerosis

A 12 year old female child was admitted with generalized convulsions. Following recovery, she developed loss of speech, loss of vision and mental obtundation. She also had gradually increasing severe pin-prick like pain in lower limbs, right more than left, for last 2 months. She was a known case of nephrotic syndrome, diagnosed 5 years back and had been treated from elsewhere irregularly with long continued steroids at varying doses without remission. Her mid-thigh circumference 5 cm above knee joint was 26 cm (right) and 28 cm (left). The femoral pulse volumes were feeble, the right more than the left. There was a discernible temperature difference between the right lower limb and other parts of the body. The blood pressure in both upper limbs was160/100mmHg. It was 104/50 mm Hg in right lower limb and 168/132 mm Hg in the left lower limb.There were a few ulcerative lesions over both thighs. The skin over the right lower limb was thin, atrophic and shiny with loss of hair. Hemoglobin, leucocyte and platlet count and erythroytic sedimentation rate, and cerebrospinal fluid were non-contributory. Urinalysis showed an albuminuria of ++++, plenty of red cells and pus cells 5-8/HPF. Sera for ANA, anti dsDNA, pANCA, cANCA, APLA (IgG&IgM) and HBsAg were non-reactive. There was gross derangement in lipid profile. Both her parents had normal lipid profile.

CECT brain revealed venous infarct in right cerebellar hemisphere and right temporoparietal cortex. Color doppler study of lower limbs revealed extensive atherosclerotic plaque of both lower limbs with vascular compromise, right more than the left. All arteries in the lower limbs, extending from abdominal aorta to dorsalis pedis showed features of gross atherosclerotic changes. No feature suggestive of deep venous thrombosis was detected. Angiography of abdominal aorta and lower limb vessels corroborated the doppler findings. It also revealed a large aneurysm at the bifurcation of the common iliac vessels (***Fig.* I**). Angiography of coronary arteries was within normal limits. Renal biopsy suggested advanced stage of focal segmental glomerulosclerosis (FSGS).

There are a few case reports of premature coronary atherosclerosis in steroid resistant nephrotic syndrome in children [1,2]. But, atherosclerotic blockage of limb vessels in a child with nephrotic syndrome has not been reported before. Diagnosis was more in favour of atherosclerosis of lower limb vessels rather than thrombotic episode because she had symptoms relating to the vascular insufficiency in lower limbs for more than two months before presenting to us. There were also skin lesions suggesting chronic vascular insufficiency.