plasmid mediated; associated with systemic infection wherein the patient requires hospitalization. We encountered only 11.5% strains of MDR Salmonella in our study. Chloramphenicol resistance was seen only in 11.5% cases probably due to decreased usage of the drug.

In the present study, we have encountered about 100% sensitivity to Ciprofloxacin by disc diffusion method but Nalidixic acid resistance was about 89%. Interestingly, 80 out of 93 isolates of Salmonella typhi (86.02%) and 37 out of 38 isolates of Salmonella paratyphi A (97.36%) were Nalidixic acid resistant; MIC for Ciprofloxacin being more than 1 µg/ml. This implies that Nalidixic acid resistance is associated with higher MIC’s for Ciprofloxacin rendering Fluoroquinolones clinically ineffective in-spite of sensitivity shown by disc diffusion method in-vitro. But most of the microbiology laboratories resort to disc diffusion method for sensitivity testing, making it imperative for a clinician to look for Nalidixic acid sensitivity before prescribing Fluoroquinolones to the patient with salmonellosis.

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REFERENCES

Laryngopharyngeal Dysthesia (LPD) in Oxaliplatin Infusion (OXLP)

Sir,

Oxaliplatin is a third generation platinum analogue; used in adjuvant setting of colorectal carcinoma. It has a low toxicity profile1. But in about 2% of patients it manifests laryngopharyngeal dysthesia. This phenomenon is a sensory discomfort in laryngopharyngeal region, bordering on laryngeal spasm without any anatomical abnormality.

Dysthesia means discomfort. On full work up to rule out RS CNS, CVS no abnormality is present. It resolves spontaneously2 and no intervention is required. Our patient is an elderly woman, with biopsy proved stage III colorectal carcinoma, who was undergoing the state of the art adjuvant chemotherapy comprising oxaloplatin and capecitabine; who at the end of 2 hours infusion of oxaloplatin showed laryngopharyngeal dysthesia which resolved spontaneously.

Since it is a self resolving adverse event Oxaloplatin is not going to be with held; only the infusion of oxaloplatin is planned to be extended.

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REFERENCES

A Rare Clinical Presentation of Caudal Brain Stem Lesion

Sir,

Static and statokinetic reflexes governing the orientation of head in space, the position of head in relation to the trunk and the appropriate adjustment of limbs and eyes to the position of the head, are called in to action by afferent impulses discharged from the receptors situated in vestibular apparatus (semi-circular or utricle), neck muscles, retina and in the body wall or limb muscles. These are complex reflexes concerned with the posture of the extremities and the trunk as influenced by the movements of other extremities, of the trunk and of the head and neck.1

Maintenance of upright posture results from the postural reflexes (i) Local static reaction acting on individual limbs, (ii) segmental static reactions linking the extremities together, (iii) general static reactions resulting from position of head in space. For myotatic reflex arc, stretch of muscle is a stimulus and the receptor involved are annulospiral endings of muscle spindle and the response is of two types, phasic response is quick contraction (white muscle contraction), tonic response is slow (red muscles contraction) responsible for the tone of muscles and finally this tonic response maintains the posture of body.

A, 57 years female, non-diabetic, non-hypertensive, presented with 3 days history of tendency to fall down on right side (unable to sit, stand and walk). Illness was of sudden onset and stationary in nature. There was no history of fever, convulsions or unconsciousness. Bladder and bowel habits were normal. Review of other systems was normal.

On examination: Patient was in lying position, conscious, pulse was 84 per minute and BP 130 / 80 mm of Hg, P / A, C.V.S. and Chest was normal. C.N.S.: Higher mental function, speech, bilateral cranial nerves and bilateral fundi were normal; muscular power, tone, reflexes (superficial and deep), sensations (touch, pain,