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 capectabine; 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,
recovering after a week and after three weeks she was able to sit, stand and walk.

Body righting reflexes are complex and these are five separate types of reflexes (i) Labyrinthine righting reflexes acting upon the neck muscle, (ii) Neck righting reflexes acting upon the body (iii) Body righting reflexes acting upon the head (iv) Body righting reflexes acting upon the body (v) Optical righting reflexes. Center for (i) to (iv) types of righting reflexes is in brain stem and for optical righting reflexes is cortical.

Sensory impulses from proprioceptors of muscles, tendons and joints are conveyed to the spinal cord by medial division of the posterior roots and connects with the cells of Clarke’s column and further continued upwards in the dorsal (posterior) and ventral (anterior) spino-cerebellar tracts of the same side. Dorsal spino-cerebellar tract through inferior cerebellar peduncle and ventral through superior cerebellar peduncle reaches to the cerebellum. Impulses from flocculonodular lobe of cerebellum passes to reticular formation in brain stem via fastigio-bulbar tract (center for body righting reflexes) and further through reticulospinal tract to anterior horn cells message is conveyed regarding regulation of tone of skeletal musculature of extremities, trunk and neck to maintain the posture of body (vegetative nervous system).2,3

In this reported case, inflammatory lesion with peri-lesional oedema in the right side of caudal brain stem with normal sense of position and vibration and cerebellar functions i.e. sparing right restiform body may have involved the center for body righting reflexes acting upon the right side of the body. Peri-lesional oedema must have subsided with prednisolone and relieved pressure on the center in caudal part of right side of brain stem, may explain the full recovery i.e. she was able to sit, stand and walk properly. Available literature was reviewed, such type of unilateral neurological involvement i.e. unable to maintain upright posture with normal motor and sensory system is not reported so far.

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REFERENCES

Aortic Aneurysm : An Unusual Presentation

Sir,

Nowadays, superior vena cava syndrome (SVCS) is