Correspondence

Wegener’s Granulomatosis Presenting as a Tonsillar Mass

SIR,

Wegener’s granulomatosis (WG) is a necrotizing granulomatous vasculitis that typically affects the upper airways, lungs and kidneys. Although it is a systemic vasculitis, localized forms have been described.

A 13-year-old girl presented with cough, shortness of breath, throat pain and intermittent high-grade fever of 2 months duration. Since 20 days the throat pain had worsened and she had also noted, flitting joint pains and transient rash. At admission she was unable to open her mouth, speak or swallow. On examination vital signs were normal. There was severe trismus. A necrotic mass was evident in the right tonsillar area with extensive ulceration of the right side of the soft palate and right anterior pillar. Sinuses and rest of the ENT examination was normal. Vasculitic lesions were present in the hands and feet. Systemic examination was unremarkable.

Investigations showed: Hb: 7.6 gm/dl, total WBC: 8290/cumm, platelets: 525000/cumm, ESR: 106 MM / HR, CRP: 192 mg/1, throat swab: negative, urine routine: normal, creatinine; 0.6 mg/dl, LDH: 323 mg/dl, ANA : negative, c- ANCA 1 in 20 +++, x-ray paranasal sinuses: normal, chest radiograph: normal; high resolution CT chest: trachea normal, few subcentimeter nodules in the superior segment of the left lower lobe. Histopathological examination of the necrotic mass was consistent with WG (Figure 1). She was treated with IV methylprednisolone 250 mg/d for three days and oral prednisolone 0.5 mg/kg/d. Since she had not yet attained her menarche and the disease process was limited, oral methotrexate (7.5 mg/week) was added. She improved within 3 days and was able to open her mouth and speak. The necrotic mass resolved in 2 weeks. At discharge she was eating and speaking normally but was left behind with a deficit in the soft palate; the uvula was pulled to the left (Figure 2).

WG is a small and medium vessel vasculitis with protean manifestations. It is extremely rare in children. Head and neck manifestations, particularly in the sino-nasal tract are common and can affect as many as 90% of patients at presentation.1

Fig. 1: High power view showing dense necrotising inflammation with an area of ill-defined granuloma formation (arrow) and infiltration of vessel walls (arrowhead)

Fig. 2: Open mouth view of the right tonsillar area 2 weeks post treatment (Pre-treatment photographs were not possible as patient had severe trismus). Necrosis of the right soft palate extending onto the anterior pillar of the right fauces. The uvula is not seen as it is pulled to the left.

In contrast oral lesions are less common and include oral ulceration, perforation of the palate, swelling and destruction of the lips.2 Although ischemic and necrotic tissue injuries are the commonest manifestation, tumorous lesions have been described. Goulart et al have reported six patients where in the presenting manifestation was tissue swellings in the retroperitoneum, mediastinum (two), breast, retroorbital tissue (two) and gingiva.3

The patient described not only had necrosis of the soft palate but, also had a necrotic mass in the right faucial area. Although there was possible subclinical lung involvement, there was no kidney involvement. The consistent histopathology and the strongly positive ANCA helped making the diagnosis. A heightened index of suspicion by clinicians is needed in the diagnosis of this localized form of Wegener’s granulomatous vasculitis.

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References
Severity of Erectile Dysfunction and Prevalence of Premature Ejaculation Among Type 2 Diabetic Men Referred to an ED Clinic of a Tertiary Care Centre

Sir,

Erectile dysfunction (ED) is a common condition seen among men with diabetes. ED is a consistent inability of the male to achieve or sustain an erection of sufficient rigidity to permit satisfactory sexual intercourse. Premature ejaculation is the inability to maintain an erection long enough for mutual satisfaction. Erectile dysfunction is undiagnosed and underreported due to reluctance among diabetic patients.¹

In diabetic men, erectile dysfunction usually occurs as a result of microvascular changes and endothelial dysfunction which is the cause of many other complications of diabetes. The aim of this study was to assess the severity of erectile dysfunction and to see the prevalence of premature ejaculation among type 2 diabetic men referred to an ED clinic of a tertiary care centre.

A total of 423 type 2 diabetic men attending the outpatient department of a tertiary care centre and who were referred to the urologist incharge of the ED clinic during a period of one year were selected for this study. Out of 423 patients, 188 (44.4%) patients sought medical advice for any form of sexual dysfunction and were included in this analysis. All relevant clinical and biochemical details were recorded. Written informed consent was obtained from all the study subjects. For subjective information regarding the severity of erectile dysfunction – the International Index of Erectile Function (IIEF) questionnaire was asked to be filled up by the patient. IIEF questionnaire is the gold standard to quantify erectile dysfunction.² A score of 5 – 7 is regarded as severe; 8- 11 as moderate; 12 - 16 as mild to moderate; 17 – 21 as mild and 22 – 25 as no erectile dysfunction.² Presence of premature ejaculation was determined based on a detailed history of the patient according to the definition of Masters and Johnsons.³ Penile Brachial Index was measured by ultrasonogram plethysmography simultaneous audio signal recordings. A penile brachial index value below normal indicating vascular involvement. We found that severe ED was associated with duration of diabetes, poor glycaemic control and blood pressure.

One of the limitations of the study is that report on premature ejaculation is history-based as there were no defined parameters to quantify the same. However premature ejaculation was also present in significant number of subjects who were referred with sexual dysfunction. The prevalence rates will vary based on the settings from where the study subjects are drawn and study needs to be substantiated in a larger cohort.

In summary, the present study reported the severity of ED among male type 2 diabetic subjects referred to an ED clinic. A higher percentage of subjects had the presence of premature ejaculation. Diabetic men are more prone to ED and require special attention regarding evaluation and treatment. Sexual function should be considered as an integral part of overall treatment in diabetic patients.

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Health Hazards of Mobile Phones in Children

Sir,

I wish to create awareness on the cell phone induced health hazards in children. Mukta Kapdi et al (JAPI 2008; 56 : 893 - 897) has discussed all the problems of cell phone related health issues.¹

As shown by increasing number of biological clinical and epidemiological studies the radiations emitted by telephony at levels that people are daily exposed are highly bioactive producing a variety of effects on human beings particularly in children.

Electromagnetic field is an important biotropic factor, affecting not just a human health in general, but also the processes of the higher nervous activity, including behavior and thinking. Radiation directly affects human brain when people use cell phones. For the first time in history, we face a situation when most children and teenagers in the world are
continuously exposed to the potentially adverse influence of the electromagnetic fields (EMF) from mobile phones.

Despite the recommendations, which insist that persons under 18 years should not use mobile phones, children and teenagers became the target group for marketing the mobile communications. The current safety standards for exposure to microwaves from the mobile phones have been developed for the adults and don’t consider the characteristic features of the children’s organism. The WHO considers the protection of the children’s health from possible negative influence of the EMF of the mobile phones as a highest priority task. This problem has also been confirmed by the Scientific Committee of the European Commission, by national authorities of the European and Asian countries, by participants of the International scientific conferences on biological effects of the EMF.

Potential risk for the children’s health is very high and which include:

1. The absorption of the electromagnetic energy in a child’s head is considerably higher than that in the head of an adult (children’s brain has higher conductivity, smaller size, thin skull bones, smaller distance from the antenna etc.).
2. Children’s organs have more sensitivity to the EMF, than the adult’s;
3. Children’s brains have higher sensitivity to the accumulation of the adverse effects under conditions of chronic exposure to the EMF;
4. EMF affects the formation of the process of the higher nervous activity;
5. Today’s children will spend essentially longer time using mobile phones, than today’s adults will.

The following health hazards are likely to be faced by the children mobile phone users in the nearest future: disruption of memory, decline of attention, diminishing learning and cognitive abilities, increased irritability, sleep problems, increase in sensitivity to the stress, increased epileptic readiness.

Expected (possible) remote health risks: brain tumors, tumors of acoustic and vestibular nerves (in the age of 25-30 years), Alzheimer’s disease, depressive syndrome, and the other types of degeneration of the nervous structures of the brain (in the age of 50 to 60).

So there is urgency to defend children’s health from the influence of the EMF of the mobile communication systems. An appeal to the government authorities, to the entire society to pay closest attention to this coming threat and to take adequate measures in order to prevent negative consequences on the future generation’s health is a must in the current scenario.

The children using mobile communication are not able to realize that they subject their brain to the EMF radiation and their health - to the risk. We believe that this risk is not much lower than the risk to the children’s health from tobacco or alcohol. It is our professional obligation not to let damage the children’s health by inactivity.

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