171 Wegener’s Granulomatosis - A Case Report
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A 45 year old female presented with chief complaint of recurrent epistaxis for one and half year, which was being treated as chronic sinusitis with associated CSOM. Detailed inquiry revealed following history: Chronic dry cough, progressive breathlessness and weakness - 1 yr; recurrent haemoptysis - 1 month; oral and nasal ulcers, painful dysphagia, hoarseness of voice - 2 weeks polyarthritis - 1 week. Neurologic symptom were progressively cumulative sensory deficit of distal parts of limbs and muscular weakness over one year. Patient’s left lower limb was especially very weak and was unable to stand. Physical examination - Low general condition, mild pallor. No lymphadenoathrophy, cyanosis, purpura, skin nodule. Patient was febrile (101°F) with tachycardia (106/ min) mild hypertension (BP-160/100mm Hg). Symmetric polyarthritis involving shoulder, hip and knee joints were present bilaterally. Chest - Harsh vesicular breath-sound with expiratory rhonchi and scattered moist sounds. CNS - Bilateral sensorimotor distal peripheral neuropathy with asymmetrically more weakness of left lower limb. ENT - Review: bilateral maxillary sinusitis with nasal mucosal ulcers, laryngitis. Investigations revealed: Hb -12.3 G%, ESR - 90mm, mild polymorphonuclear leucocytosis. Urine R/E: Alb + RBC + Blood urea - 41 mg% and marginally raised S. Creatinine (1.7mg%). ECG - NAD. Chest X-Ray - Bilateral soft infiltrative shadows, especially perihilar and lower zones. X-Ray RNS - Bilat maxillary sinusitis. Serological parts: C-ANCA and CRP positive. ASO, Rheumatoid factor and ANA - negative. IgA - raised. Case was diagnosed as Wegener’s granulomatosis. Treatment with cyclophosphamide and corticosteroid was initiated. Patient however developed acute anterior myocardial infarction soon on sixth day and expired, apparently due to acute coronary vasculitis. The case is reported for its rarity. The classical triad of upper and lower respiratory tract involvement and renal involvement is hallmark of Wegener’s Granulomatosis. In the present case, evidence of various other systemic involvement was noteworthy.

172 A Cluster Bomb
Rakshith KC, Nagaraja MV, Menon Krishnakumar, Verma Muralidhar
Kasturba Medical College, Manipal

A 45 year lady who was a known case of bronchial asthma on oral bronchodilator presented with multiple joint pains since 2 years. Joint involvement was symmetrical, involving large and small joints with h/o morning stiffness. There was also h/o lower limb proximal muscle weakness. X-rays showed periarticular osteoporosis, RA factor was positive (titer 1:80), ESR was high (135 mm), CRP was positive (24). On investigating her we found she had iron deficiency anemia with low Hb (8.5), low MCV, low serum iron (31), low ferritin (12.1) and high TIBC (270). Thyroid function test suggestive of primary hypothyroidism with TSH of 99. Patient had significant postural fall in blood pressure with low basal levels 5.3 mcg/dl. Hence ACTH stimulation test was done which showed inadequate response to ACTH stimulation. Basal ACTH levels were also high suggesting primary addison’s disease. She was treated with DMARD’s steroids with maintenance dose, thyroxin and inhaled bronchodilators. Above case is presented with a intention to highlight how a cluster of autoimmune diseases can deceptively be present together and the necessity to recognize them for timely intervention.

173 An Unusual Presentation of Primary Amyloidosis
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Amyloidosis, also known as lardaceous or waxy disease, is a deposition of insoluble, fibrous amyloid proteins, mainly in the extracellular spaces of organs and tissues. Kidney, gastrointestinal tract, heart, skin and nervous system are commonly involved in amyloidosis. Involvement of other systems such as lungs, musculoskeletal system, endocrine system, lymph nodes etc. is uncommon. We report a case of primary amyloidosis with involvement of organ systems not commonly involved and who was offered treatment with good initial response. A 48 year female presented with 3 year history of progressively increasing bilateral lower limb swelling, multiple subcutaneous lesions over back and neck, macroGLOSSIA and constipation. There was no history of cardiorespiratory or renal symptoms. There was no history of fever, diabetes, hypertension, chronic infection, fibrinosis. On examination, she had macroGLOSSIA, bilateral inguinal and axillary lymphadenopathy and lower limb lymphedema with overlying skin changes. There were multiple subcutaneous nodules all over the body with pseudohypertrophy of muscles. Biopsies taken from inguinal LN, subcutaneous nodule, tongue and biceps muscle showed amyloid deposits. There was no evidence of cardiac, renal or nervous system involvement. CECT abdomen revealed thickening of colon and rectal wall. Patient has received two cycles of chemotherapy with cyclophosphamide and prednisone with substantial decrease in macroGLOSSIA and muscle pseudohypertrophy. This was an unusual presentation of primary amyloidosis. Except for macroGLOSSIA, that was characteristic, other manifestations were unusual. Commonly involved organ systems were spared in the presence of amyloid deposits at rare sites. Such atypical presentations of amyloidosis should be kept in mind so that early diagnosis can be established and treatment initiated before any major organ system involvement occurs.

174 Clinical and Immunological Profile of Primary and Secondary Antiphospholipid Syndrome in a Tertiary Care Service Hospital
Shanmuganandan K, Sharma Ajay, Mishra DK, Kumaravel S, Srihi KPS
Command Hospital (SC) and Armed Forces Medical College, Pune.

Aim: To study and analyse the various clinical and immunological of primary and secondary antiphospholipid syndrome (APS)

Material and methods: This observational study was conducted at Rheumatology and Haematology departments of Command Hospital (SC), Pune from Aug. 2000 - May 2003. All patients fulfilling the American College of Rheumatology (ACR) criteria for antiphospholipid syndrome were included in the study. Detailed, clinical evaluation and investigations were done to confirm the diagnosis and to document various thrombotic manifestations. These included complete blood count, urine analysis, ESR, CRP, ANA, RF, ANA profile, antiphospholipid antibody tests, lupus anticoagulants, and phospholipid dependent coagulation tests, in addition to imaging and Doppler modalities.

Observations: Forty-five patients fulfilled the ACR criteria and were included in the study. Mean age of patients was 37 years (range 18-65 years) and mean duration of disease was 3 years (range 1-52 months). The cohort consisted of 38 females and 12 males. Primary APS was present in 40% and secondary in 60%. Systemic lupus erythematosus was the commonest cause of secondary APS. 5 patients had catastrophic
To study the clinical profile of infectious fevers (Non-HIV) in patients admitted to medical units of Govt. Stanley Medical College, Chennai.

Object of the Study: To study the clinical profile of infectious fevers (Non-HIV) in patients admitted to medical units of Govt. Stanley Medical College Hospital, Chennai.

### Features

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**Conclusion:** Antiphospholipid syndrome is an important acquired thrombophilic disorder with protean manifestations.

### Infectious Disease

#### 175 Study of Clinical Profile and Antibiotic Response in Enteric Fever

Chowta MN, Chowta KN
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**Introduction:** Over the last few years there has been an impression that patients with enteric fever, on ciprofloxacin tended to take longer to defervesce. Objective of the present study is to evaluate the clinical profile and pattern of response to various drugs used in the treatment of typhoid fever.

**Methodology:** A retrospective analysis of adult patients suffering from typhoid fever was done at KMC Hospital, Attavar during the year 1999-2001. Diagnosis of patients was based on clinical features, Widal test and blood culture. The sensitivity pattern of blood culture was recorded. The mode of presentation, clinical course, treatment history, laboratory investigations reports, antibiotic administered, response to therapy and the complications were recorded.

**Results:** Total numbers of 44 cases of typhoid fever were studied. Fever was present in all patients (100%). Hepatomegaly was detected in 18% patients and splenomegaly was present in 34.09% patients. Widal test was suggestive of enteric fever in significant titres in 88.6% cases. Blood culture was positive in 25% cases. Resistance of S. typhi to amoxycillin, chloramphenicol, ampicillin and cotrimoxazole was significantly high. However ciprofloxacin which was considered as the first line drug after multidrug resistant typhoid, also showed resistance in 18.1% of cases. Sensitivity to ceftriaxone was 100% in our study. Average duration of treatment was 12 days with ciprofloxacin, 14 days with chloramphenicol and 10 days with third generation cephalosporins. Steroids were given to 2 patients for myocarditis. Defervescence period was 8 days with ciprofloxacin, 10 days with chloramphenicol and 6 days with third generation cephalosporins.

To conclude, indiscriminate use of drugs in typhoid fever should be discouraged. Appropriate antibiotic indicated by sensitivity tests should be employed to prevent the development of resistant strains of S. typhi.

#### 176 Clinical Profile of Infectious Fevers (Non-HIV) - A Prospective study of 361 Cases

Shivakumar S, Emmanuel Bhaskar M, Jayachandran R, Sukumar C
Dept. of Medicine, Stanley Medical College, Chennai.

**Object of the Study:** To study the clinical profile of infectious fevers (Non-HIV) in patients admitted to medical units of Govt. Stanley Medical College Hospital, Chennai.

**Methodology:** Patients of all age groups, both male and female, satisfying a fixed entry criteria were included in the study. Two groups were analysed: a) Fever of <1 week with organ dysfunction, b) Fever of > 1 week with/without organ dysfunction. Patients with HIV seropositivity and other non-infectious cause were excluded.

**Results:** Of the 361 cases, 195 (54.0%) were diagnosed and 166 (46%) were undiagnosed. 75% were male. Mean age was 26 years. Among the diagnosed cases, 100 (51.3%) cases were due to tuberculosis, followed by pneumonia - 30 (15.4%), malaria - 25 (12.8%), leptospirosis - 16 (8.2%), enteric fever - 9 (4.6%), rheumatic fever - 5 (2.6%), liver abscess - 5 (2.6%), pyogenic meningitis - 3 (1.5%) and infective endocarditis - 2 (1%).

**Conclusion:** Tuberculosis is still a major problem in our part of the country despite active health care measures. The number of undiagnosed fevers are on the rise, probably due to partial treatment prior to admission, leading to diagnostic difficulties.

#### 177 Bilateral Facial Palsy - Initial Manifestation of HIV Infection

Chatterjee M, Sarma PSA, Gowardhan HK, Shashikumar R, Ghorpade A, Das MN, Tamer SK
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A thirty years old male presented with bilateral facial weakness of four days duration. He was treated for herpetic gingivo-stomatitis with acyclovir two weeks back. On clinical examination no other significant findings could be detected excepting bilateral lower motor neuron facial nerve palsy and scattered discrete right cervical lymphadenopathy. FNAC of the lymph node revealed reactive hyperplasia while serological tests for human immunodeficiency virus were positive with a depressed CD-4 count. Because of rarity of such clinical entity the case will be reported in detail.

#### 178 Hit Hard, Hit Early Current Trends in Management of HIV Infection

Viswanath BM
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Nearly twenty years of experience has proved that untreated HIV infection leads inexorably to immune dysfunction and ultimately death in the vast majority of cases. Advances together with years of suffering and hard work, research have brought us to the point where an estimated 40% of patients undergoing HIV treatment with combination therapy in USA have viral loads of less than 400 copies/ml. The effectiveness of current therapy is reflected by the decline in HIV mortality, although this gain has been largely confined to Europe and US. After the approval of protease-inhibitors in early 1996, mortality and morbidity dropped precipitously. With the present regimens, it is now possible to hope that HIV infected patients may live a normal life span.

An attempt has been made in this presentation to overview the current guidelines in the management of HIV infection, mainly focusing on, when to initiate therapy? and how to monitor the progression of the disease?. The greatest deterrent for combination therapy in India is the cost. The cost of treating opportunistic infection like tuberculosis is added to this, it is evident that these drugs can be used only in the select category of patients. Hence, current drugs available in India and the implications of cost of therapy have also been addressed.