Reply from the authors

Our patient had persistent pain for 8 days. On examination, she had tachycardia, with tenderness and guarding in the upper abdomen, suggesting acute abdomen. Abdominal paracentesis was performed because we suspected an abdominal emergency (like hollow viscus perforation). Sonography was inconclusive and we wanted to avoid X-ray of the abdomen in view of the pregnancy.

The bile duct was dilated at surgery, otherwise T-tube placement would not have been possible. CBD diameter of 5 mm was the sonography finding, not at surgery. Tense and distended gall bladder can be seen in patients who have been starving.

ERCP was attempted immediately after the first surgery, but was abandoned since the stone was too large (3 cm) for removal by ERCP and we did not want to prolong the exposure to radiation. During re-exploration cholecystectomy was done with removal of the CBD stone by CBD exploration.

D J Balsarkar

Underestimation of cost of hepatitis B vaccine in India

The calculation used by the authors of the Consensus Statement of the INASLI for the low cost of hepatitis B vaccination does not add up. They cite an article published 11 years back pertaining to the cost of the plasma-derived vaccine, which is not widely used any longer in the country. That article says that if 4 million doses of the plasma-derived vaccine are used, the price could come down to $0.10 per dose. The INASLI authors state that 'extending this model further', they think that if 20 million doses are used, the price would come down to $0.10 per dose. It however defies logic that a vaccine manufacturer who sells 4 million doses (at $0.50/dose) for 2 million dollars will sell 20 million doses (at $0.10/ dose) also for 2 million dollars!

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References

Reply from the authors

I agree that the calculations are based on a rather old publication. The consensus statement is based on the figures and observations provided by various experts in the field; it would therefore be necessary for us to refer your concerns to the expert group again.

S K Sarita

Nonspecific jejunitis

I read with interest the report on nonspecific jejunitis by D'Cruz et al. This is an ill-defined disease entity. During my postgraduate days I have seen similar illness in prepubescent children, with seasonal peaking during May-June. A peroperative finding of free and clear peritoneal fluid with fiery red upper small intestine was a signal for simple closing of the abdomen and postoperative treatment with antibacterial agents. Any attempt at biopsy was an invitation to disaster.

Of the 8 cases reported by the authors, 4 were treated conservatively. The diagnosis in these 4 cases could at best only be speculative. Of the 4 operated cases, my guess is that in only two cases was bowel resected and sent for histological examination. One case showed resolving vasculitis and the other showed chronic inflammation, akin to inflammatory bowel disease (Crohn's disease). The report does not specify which case had Type I and which one had Type III reaction feature. Six cases had mild clinical presentation. What compelled the authors to perform laparotomy in 3 uncomplicated cases?

We need a more focused clinico-pathological study of this entity.

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Reference

Reply from the authors

Nonspecific jejunitis in children has been known by different names, and reports of similar pathology in adults have termed it as pigheal. Some of the other terms include necrotizing enteritis, acute segmental enteritis, etc.

Although definite diagnosis is based on operative and histologic findings, a clinical diagnosis is made by elimination in the presence of symptoms out of proportion to signs and associated occult or manifest gastrointestinal bleed. Surgery is indicated for acute or chronic complications. In the four cases we had operated on, two had signs of peritonitis and two had severe near-total involvement of the intestine. We agree with Dr Das that, unless indications for resection are present, there is no role for routine biopsy for diagno-
sis. The two patients in whom we had histology had undergone resection for perforation and stricture.

One of these patients had type I reaction and the other had type III reaction. Earlier reports have suggested that necrotizing enteritis is a type I or III hypersensitivity reaction to some undefined factor. Steroids have been used in some series.

We agree that further research is required to answer the questions of etiopathogenesis, definite diagnosis and treatment.

Anand Alladi

Intestinal ascariasis: a new CT sign

The CT scan imaging feature of intestinal ascariasis as described in literature1,2 is cylindrical filling defects within contrast-filled bowel loops. The intestinal tract of the roundworm itself is seen as a thin thread of oral contrast within the tubular filling defects. The intestinal tract of the worm is difficult to visualize in the routine 10 mm axial sections because of volume averaging.

We describe an additional CT finding of intestinal ascariasis that we encountered in a 14-year-old boy. In this case multiple worms were seen in the jejunal loops lying both along and perpendicular to the imaging planes. When the worm is imaged perpendicular to the imaging plane it appears as a rounded filling defect within the contrast-opacified bowel loops. A central hyperdensity, which is the opacified intestinal tract of the worm itself, may be visualized, giving a 'target-like' appearance (Fig). The intermediate hypodense area is the eelomic cavity of the worm that lies between the body wall and the intestinal tract.

CT scan of the abdomen is not the modality of choice to diagnose intestinal ascariasis; however, familiarity with the CT appearance of the worm helps in identifying this problem in unsuspected cases.

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References

Fig: 'Target-like' appearance of ascaris lying perpendicular to imaging plane