Cerebral infarction in a 17-year old boy - is it truly primary APLA syndrome?

Sir,

The grand-round case by Kubba S et al. in July issue of the Journal was interesting.1 We would like to offer some remarks.

First, while determining the appropriate therapy for patients with stroke and patent foramen ovale (PFO), a distinction has to be made between those with an ‘innocent’ PFO and those with a causative PFO. This has important treatment implications.2 The index patient does not come under the second group i.e. the subset that needs consideration for closure of PFO. Valvular lesions and bradyarrhythmias themselves can account for stroke in this case. Closure of PFO in these cases will not require these patients from being on oral anticoagulants, if lupus anticoagulant (LA) was presumed to be truly positive. However if mitral valve repair is being planned, concomitant PFO closure can be contemplated.

Secondly, different authors have found variable positivity of LA varying from 16%-40% in stroke patients. Positivity does not carry any significance if patients are on warfarin. The status of warfarin therapy at the time of sampling is not clear in the index case. Moreover, quantitative estimation should have been done as false positivity is reported with various conditions. Medium or high titles only help to identify patients at risk for thrombosins.3 Attributing mitral regurgitation and, even complete heart block (CHB) to LA in such a setting appears incorrect. Lifelong oral anticoagulant therapy, with its antecedent risk, is not advisable without proper evaluation in such patients.

In the index case, the history of syncope justifies permanent pacemaker implantation (PPI). But, not all patients with isolated CHB should receive PPI, unlike what is mentioned in the article. Congenital third-degree atrioventricular block in an asymptomatic neonate, child, or adolescent with a narrow QRS complex of acceptable rate and normal ventricular function is only a class 2 b indication for PPI.4

Namboodiri KKN, Krishnamoorthy KM, Rajeev E
Department of Cardiology, Sri Chitra Institute of Science and Technology, Thiruvananthapuram, India.
E-mail: kknamboodiri@sctimst.ac.in

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Colletotrichum dematium keratitis

Sir,

Fungal keratitis caused by rare emerging organisms pose diagnostic and therapeutic challenges. Colletotrichum spp. belonging to class Coelomycetes is one such rare fungus.1 Although only rarely pathogenic to humans, Colletotrichum spp. have been generally associated with some form of trauma. They manifest as keratitis2 or subcutaneous lesions,1 although a case of invasive infection has been reported.3 Here we report a case of fungal keratitis caused by this rare fungal species.

A 25-year-old woman presented with pain, redness and decreased vision in the right eye of 15 days duration, following trauma with stones. On examination, her uncorrected visual acuity was perception of light with inaccurate projection of rays in the right eye and 20/20 in the left eye. Slit lamp biomicroscopy of the right eye revealed lid oedema with conjunctival congestion. The cornea had an epithelial defect and an underlying stromal infiltrate measuring more than 8 x 8 mm. The infiltrate was dry, raised, plaque-like with hyphate margins and surrounding corneal oedema (Figure 1). Scrapings from the cornea were subjected to microbiological processing as described by us earlier.4

Direct examination of corneal scrapings in KOH/calcofluor white, Gram and Giemsa stain revealed septate, hyaline, fungal filaments with chlamydospores (Figure 2a). Growth of dull grey fluffy fungal colonies was observed on blood agar, chocolate agar, Sabouraud dextrose agar (SDA) and potato dextrose agar (PDA) within 24 hours. The colonies on PDA developed black granules on further incubation (Figure 2b).

Microscopic examination of the cultures demonstrated falcate conidia (>15 mm long, 3-4 mm broad) and conidiomata, with characteristic erect, unbranched, and darkly pigmented setae (Figure 2c). The fungus was identified as Colletotrichum dematium.5

On confirmation of fungal keratitis in direct smear examination on Day 1, the patient was started on 5% natamycin eye drops half hourly, 1% atropine sulfate eye drops twice daily and oral ketoconazole 200 mg twice daily. The patient was followed up for two months, and on her last visit, her best corrected visual acuity was counting fingers at one meter in the right eye, the cornea had healed completely with a vascularized scar.

Several species of Colletotrichum have been reported to cause infection in humans, including keratitis.2 The large and sickle-shaped conidia of C. dematium distinguishes it from other species of Colletotrichum but it may be confused with the macroconidia of Fusarium spp. though colony characteristics and presence of conidiomata and setae distinguish this isolate from Fusarium. The white fluffy colony with black powdery surface may mimic Aspergillus niger. Although there have been reports of successful treatment of keratitis with amphotericin B
natamycin eye drops coupled with oral itraconazole. The value of natamycin eye drops in the treatment of *C. dematium* keratitis has also been emphasized in a recent publication wherein four patients responded to this treatment. The identification of this fungus may augur a favourable prognosis with antifungal therapy and this new corneal pathogen should be considered as one of the aetiological agents of mycotic keratitis.

**Joseph J, Fernandes M*, Sharma S**
Jhaveri Microbiology Center, Prof. Brien Holden Eye research Center, Hyderabad Eye Research Foundation, *Cornea and Anterior Segment Services, L. V. Prasad Eye Institute, L. V. Prasad Marg, Banjara Hills, Hyderabad - 500034, India.

Correspondence:
Savitri Sharma, MD. E-mail: savitri@lvpei.org

**References**

Carcinoma prostate presenting as pleural effusion with metastatic pleural mass

Sir,
A 49-year-old male, presented with dry cough for three weeks. He was febrile for ten days and was breathless for two days. He also gave history of urinary hesitancy (off and on) for the past four months. He was tachypnoeic (RR-23/min), febrile (38°C) with clinical features suggestive of right-sided pleural effusion. A clinical diagnosis of infective right-sided pleural effusion was made.

Chest radiograph showed right-sided pleural effusion with suspicious parenchymal mass in the right lower lung zone. Right-sided intercostal tube drained two litres of haemorrhagic fluid. The pleural fluid had a glucose concentration of 168 mg/dl, total protein concentration of 5.8 gm/dl and albumin level of 3.3 mg/dl. On microscopic examination the fluid demonstrated presence of 65 cells per cubic mm. These were predominantly lymphocytes. No organisms or malignant cells were seen. A contrast CT scan thorax revealed thickened pleura with nodular appearances. A CT guided fine needle aspiration of the pleural nodule was done. A diagnosis of malignant mesothelioma was offered initially. In the hospital, the patient

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