in such women who present in spontaneous labour. We have found no literature regarding the subject of management of women with mesh repairs in subsequent pregnancies and needs looking into. We wish to highlight that the clinical awareness of herniated gravid uterus in an incisional hernia sac, which is a delayed, but rare complication of an abdominal wall closure will prevent delay in its diagnosis and treatment.

REFERENCES


CEFOPERAZONE / SULBACTAM INDUCED HYPONATREMIA

Sir,

Cefoperazone is a commonly used broad spectrum semi-synthetic third-generation cephalosporin with a potent bactericidal activity against a wide range of gram-positive and gram-negative bacteria. We here like to report a case of hyponatremia induced by cefoperazone/sulbactam.

A 70 - year old female presented with high fever (103°F), dysuria, urgency and frequency of micturation. Investigations revealed: hemoglobin 11 g/dl, total leukocyte count (TLC) 12.1 x 10⁹/L (neutrophils 90%, lymphocytes 10%) and her urine analysis confirmed E. coli infection. She had no significant past medical history. As her urine culture and sensitivity test reported the bacterium to be highly sensitive to cefoperazone/sulbactam, she was therefore treated with cefoperazone/sulbactam combination (2 gm bid. i.v. every 12 hours).

Following the second dose of the injection, the patient became drowsy. Her serum sodium level was 116 mEq/L, plasma osmolality was 240 mOsm per kg, urine osmolality was 300 mOsm/kg, when she was again treated for acute UTI with cefoperazone/sulbactam 6 months after the above mentioned initial episode. Her hyponatremia also normalized on that occasion following stoppage of cefoperazone/sulbactam. The laboratory reports in this patient on both the occasions also suggested that the hyponatremia was due to inappropriate antidiuretic hormone secretion. This combination was particularly used for the second time because the cause of the prior episode was only a suspicion and most importantly, her bacterial cultural sensitivity tests were markedly sensitive to these drugs, the other antibiotics were either mildly sensitive or resistant. Although there are several causes of hyponatremia, however in the case presented here, occurrences of hyponatremia following cefoperazone treatment, and the normalization of hyponatremia after stoppage of the drug on two separate occasions are strong evidences in support of the role of cefoperazone in the development of hyponatremia. Finally, application of the Naranjo probability score (≥ 9) indicated a
highly probable relationship between hyponatremia secondary to cefoperazone therapy in this patient.\[3\]

The known adverse effects of cefoperazone are reported to be thrombocytopenia, neutropenia, gastrointestinal hemorrhage, hemolytic anemia and Stevens Johnson syndrome.\[4,5\] There are also reports of transient drug-induced fever, diarrhea and rash associated with this drug.\[8\] Although drug induced hyponatremia has been reported before,\[2\] but to our knowledge, this is a rare case of hyponatremia induced by cefoperazone/sulbactam combination. Finally, hyponatremia is a serious disorder,\[8\] therefore the probability of this adverse effect should be considered while treating patients with cefoperazone/sulbactam combination.

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EXTRANODAL NON-HODGKIN’S LYMPHOMA OF THE PARAPHARYNGEAL SPACE

SIR,

A 40-year-old male presented with diminished hearing, occasional tinnitus and intermittent pain in the right ear of two-year duration that was gradually increasing. Intraoral examination revealed a large right parotid mass bulging pushing the entire soft palate into the midline, which was normal on palpation. Parotid gland was normal and there was no appreciable cervical lymphadenopathy. Computed tomogram scan revealed a right parapharyngeal space (PPS) mass involving the nasopharynx and oropharynx. [Figure 1] The medial and lateral pterygoid plates were eroded and minimal infratemporal fossa infiltration was present. Magnetic resonance imaging revealed a large lobulated hyperintense mass on T1-weighted images in the PPS extending from the skull base to the level of the mandible. [Figure 2] Fine needle aspiration cytology (FNAC) was inconclusive. On exploring the PPS a diffuse mass filled the entire PPS with indistinct planes with the adjoining structures. The palatine tonsils however appeared separate from the mass. A biopsy of the mass was performed which on frozen section examination was suspicious of a low-grade lymphoma and hence further excision was not performed. The final histology revealed atypical lymphoid cells forming nodules and involving the parapharyngeal muscles and soft tissues. [Figure 3] The cells were CD20 and Bcl2 positive and CD43, CD3, CD5, CD23, CD10 negative. Based on the immunohistochemistry and morphology a diagnosis of extranodal marginal zone NHL was made. After relevant staging investigations patient was grouped as stage II EA and received six cycles of adriamycin, cyclophosphamide, vincristine and prednisolone (CHOP) chemotherapy, followed by radiotherapy (46 Gray in 23 fractions over 32 days). At two-year follow-up the patient is asymptomatic and was controlled clinically.

Only 10% of patients with NHL present with extranodal disease in the HN sites.\[5\] Primary malignant lymphomas of the PPS are rare and reported in the literature as isolated case reports or part of larger series of parapharyngeal space tumors.\[2,3\]

These extranodal NHL are predominantly B-lymphocyte origin and only 11% are low grade.\[4\]

Distinction of lymphomas from carcinomas and other cancers of the head and neck are critical in designing treatment. There are no pathognomonic radiological features of PPS lymphoma however imaging is useful in excluding other common tumours of the