A MEDITERRANEAN INFECTION RE-VISITED

MEDICAL ANECDOTES - short accounts of interesting cases, some medical disasters, involving pathology and clinical practice, from the recollection of ***Prof. Albert Cilia-Vincenti***

This is 1970 and Professor JV Zammit-Maempel, just before going on holiday for three weeks, sees a 22-year-old in a domiciliary consultation, with fever, constipation and a vague skin rash, and refers him to his ward at St Luke's Hospital with a diagnosis of "?typhoid" and with instructions to start chloramphenicol intravenously. Chloramphenicol in those days was a very popular antibiotic – inexpensive and with the widest spectrum. It did however carry the rare risk of bone marrow damage and fatal aplastic anaemia. I do, in fact, remember carrying an autopsy on a young English woman who was given chloramphenicol in Spain, developing aplastic anaemia and subsequently transferred to London's St George's Hospital where she died, and where the case was presented at the physicians' grand round.

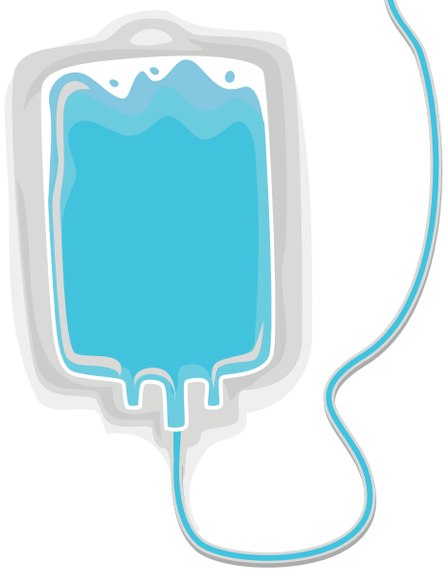
Professor Zammit-Maempel maintained that no aplastic anaemia complication had ever been reported with chloramphenicol delivered intravenously, instead of orally, so a ten-day course of i.v. chloramphenicol was his favourite antibiotic regime. Back to the young man with the "?typhoid" diagnosis; I was the house officer, so we started the patient on the i.v. chloramphenicol, and Zammit-Maempel left on holiday without seeing this patient in the ward. A young senior registrar, recently returned from UK with his MRCP (not common in those days), had joined our firm and was now in charge of the ward.

The patient's pyrexia soon resolved but after a few days it returned. Tests for typhoid were negative. The senior registrar discovered this young man had had a "hole-in-the heart" operation in London when he was a kid, and therefore suspected subacute bacterial endocarditis (SBE). Chloramphenicol was stopped and penicillin started. Fever resolved but returned again after a few days. Leishmaniasis was excluded when a bone marrow aspirate was reported negative. In desperation, a course of tetracycline was instituted, but again, fever went down and returned after a few days. By this time the patient was emaciated and almost moribund, and Zammit-Maempel was due to return from holiday.

As soon as Zammit-Maempel returned, we got him to see this young man who had now been administered religious last rites. The senior registrar reminded Prof that he had referred this patient with a "?typhoid" diagnosis, and which had not been confirmed, SBE was suspected and adequate penicillin course given, Leishmaniasis had been excluded, and we were dealing with a rapidly deteriorating case of pyrexia of unknown origin. Zammit-Maempel leafed through the notes and declared he must be suffering from Leishmaniasis. The senior registrar protested that it had already been investigated and excluded. However, Zammit-Maempel insisted that he was suffering from Leishmaniasis – emphasising the two peaks every 24 hours on temperature chart, neutropenia and enlarged spleen. He reasoned that neutropenia and SBE don't go together. Repeat bone marrow aspirate proved Zammit-Maempel right and i.v. antimony was started.

Fast forward to mid-1980s, I am a consultant surgical pathologist in Winchester, southern England. Dr Anthony Galea-Debono and Mr Anthony Zammit are looking after a young haemophiliac with AIDS in Malta who's got rectal bleeding from "?kaposi sarcoma" bowel lesions. One lesion is biopsied and referred to us. Microscopically the lesion consists of macrophages containing probable Donovan bodies. I sent some slides to Professor Sebastian Lucas in London (a histopathologist with a special interest in exotic infections) to confirm that it was Leishmaniasis, which he does. In the late 1980s, writing a chapter in "Advances in Histopathology", Lucas uses this Maltese case (with due credits) to illustrate the emerging picture of Leishmaniasis complicating AIDS in the Mediterranean.

Fast forward yet again to mid-1990s and I have returned to a consultant pathologist's post in Malta. It is Christmas time and a young bachelor friend of ours returns from work overseas for the festive season. He is, however, ill-looking and says he's pyrexic. A family doctor refers him to St Luke's Hospital where a medical senior registrar suspects he's very immune compromised, excludes Leishmaniasis with a negative bone marrow aspirate, and asks him whether he would take an HIV test. The patient is septicaemic and Professor CP Mallia warns his parents that he's in danger of dying. Patient refuses to have an HIV test, saying that he would commit suicide if it were positive. I reassure him that there is now treatment, if positive. He improves with i.v. antibiotics and goes back overseas. A few days later he phones saying he's feverish and weak again. I insist he gets to the nearest hospital immediately. There he goes into total system failure, almost dies in intensive care, he's found to be HIV-positive, and Leishmaniasis is now diagnosed on a bone marrow aspirate. After a slow recovery, including renal dialysis for a couple of months, he returns to health after lengthy treatment for Leishmaniasis. He of course is still on HIV drugs, but is now in his early fifties, healthy and fit, and has held a number of very senior positions overseas.



Addendum: the update on Cholesterol & Statins (Issue 4) did not clarify that the C-reactive protein (CRP) test referred to in cardiology circles is the high-sensitivity (hsCRP) variety. The normal CRP has little better sensitivity for inflammation than an ESR and is useless for atherosclerosis risk assessment. HsCRP is available in the profiles of some local private laboratories but apparently still unavailable at Mater Dei Hospital.

DIABETES

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November is diabetes awareness month. WHO estimates that 8.5% of the global population suffers from diabetes.[1] Diabetes is a chronic metabolic disease characterized by hyperglycemia resulting from abnormalities in insulin secretion, insulin action or insulin sensitivity. This chronic disease is associated with long term impairment, dysfunction and deterioration of different organs.

There are three types of diabetes:

Type 1 Diabetes in which the individual's immune system destroys insulin-producing cells in the pancreas. This leads to a reduction in the capability of the body to produce insulin, requiring daily administration of insulin. The most common delivery devices are syringes, pens or pumps. Client education is vital and should encompass comprehensive information on caring for and using insulin, prevention, recognition and treatment of hypoglycaemia, adjustments of food intake and self-monitoring of blood glucose. Multiple daily injections is the most common method to attempt to mimick pancreatic insulin secretion.

Type 2 Diabetes results from a progressive increase in resistance of the body to insulin. This type is most common in the middle-aged and elderly, however it is becoming more common in younger populations. Medications such as metformin and sulfonylureas are normally prescribed. However, insulin therapy is given to patients with severe diabetes. In the past insulin was used as a last resort, nevertheless nowadays insulin is prescribed earlier because of its benefits.

The last type of diabetes is ***Gestational Diabetes*** which is the onset of diabetes during pregnancy in an individual with no previous symptoms. This type is caused by insulin defiance during pregnancy and may lead to Type 2 Diabetes.

During the diabetes awareness month, MPSA launches a health campaign to further draw the attention of the public to possible symptoms.

REFERENCE

1. http://www.who.int/mediacentre/factsheets/fs312/en/