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Vaccinia and its transmission: eyecare practitioners

To the Editor: Variol virus belongs to the family Poxviridae, subfamily Chordopoxvirinae, and genus *orthopoxvirus*, which includes vaccinia (smallpox vaccine) and several other animal poxviruses that cross-react serologically.¹ Vaccinia virus is the live virus used in the smallpox vaccine, it helps the body develop immunity to smallpox.² Because the virus in the vaccinia is live, it can be inadvertently transmitted from the recently vaccinated person to other people.³ Bandages, clothing and hands that touch the vaccination site before it heals can become contaminated and transmit the virus to another person.⁴ For that reason, the vaccination site must be cared for carefully to prevent the virus from spreading. Also, the vaccine can have side effects. Most people experience normal, usually, mild reactions that include a severe rash, fever, tiredness, blindness, headaches and backaches. However, other people experience reactions ranging from serious to life threatening.

A 7-year old boy was brought to the family doctor with an erythematous and swollen left eye, which was initially thought to be a pimple that developed below his nose. The boy's mother noted discharge from his left eye. In addition, he had a low-grade fever and complained of having a headache.

The treatment of this patient was the administration of the vaccinia immunoglobulin (VIG) together with systemic antibiotics. During the treatment the ophthalmologist was assessing the eyes. In this case, the recent history of a family member being vaccinated against smallpox confirms the diagnosis of vaccinia.⁵ The incubation period for smallpox is seven to 17 days (mean 10 to 12) days. The prodromal phase, which lasts for two or three days, is characterised by severe headache, backache, and fever, all beginning abruptly.⁶

People should be warned not to touch their eyes or any part of their bodies after touching the vaccination site. A vaccine, like any medication, can cause serious problems, including those that we do not yet know about, as well as eye infection due to spread of vaccine virus to the eye, which can lead to loss of vision.⁷ (Shortened)

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References

1. Brock TD, Madigan MT, Martinko JM and Parker J. *Biology of Microorganism*. 7th ed. London: Prentice Hall International, 1994.
2. Sepkowitz KA. How contagious is vaccinia? *N Engl J Med* 2003 348 349-446.
3. Breman JG, Henderson DA. Diagnosis and management of smallpox. *N Engl J Med* 2002 346 1300-1308.

4. Maki DG. Smallpox and the ophthalmologist. *Arch Ophthalmol* 2003 121 710-711.
5. Regan TD, Norton SA. Diagnosis of smallpox. *N Engl J Med* 2002 347 690-691.
6. Kwon N, Raven MC, Chiang WK, Moran GJ, Jui J, Carter RA and Goldfrank L. Emergency physician's perspectives on smallpox vaccination. *Acad Emerg Med* 2003 10 599-605.
7. Neff JM, Lane JM, Fulginiti VA, Henderson DA. Contact vaccinia-transmission of vaccinia from smallpox vaccination. *Jama* 2002 288 1901-1905.

Chronic Schistosomal Haematobium Appendicitis

To the editor: W O, a 17 year old male was admitted to our surgical ward with a working diagnosis of acute appendicitis. He was referred with a 4 day history of nausea, vomiting and abdominal pain in the right iliac fossa. On physical examination the patient was apyrexial, pulse 76bpm and BP 140/67. Abdominal palpation revealed right iliac fossa guarding and tenderness. Laboratory investigations (FBC&UEC) were within normal limits. An appendicectomy was performed and findings of perforated retrocaecal appendix which was gangrenous at the tip were noted. Subsequent histology revealed "acute phlegmonous inflammation with necrosis involving all the layers of the appendix with perforation. In addition many **schistosome eggs**, mostly viable, and a few with a terminal spine, were present in the submucosa and muscle wall. These formed inflammatory granulomas.¹ Regrettably our patient discharged himself from hospital and did not attend his follow up clinic appointment.

Acute appendicitis must be considered in the differential diagnosis of any patient who has signs and symptoms of peritoneal irritation and is the most frequent surgical emergency affecting the abdomen.²

Schistosomiasis, is a water borne trematode infection and is one of the world's most widespread parasitic diseases.² Schistosomiasis of the appendix was first described by Turner in 1909.³ Most cases are attributed to *Schistosoma haematobium* although mixed infections involving *S.haematobium* and *S. mansoni* have been reported.³

The pathogenesis of schistosomiasis as a cause of appendicitis has been well described by Satti et al in 1987.⁴ Two pathogenic pathways of schistosomal appendicitis have been described. First "granulomatous acute appendicitis" is caused by an immunological reaction to the ova, resulting in tissue necrosis and tissue eosinophilia, occurring particularly early on.^{4,5} Second, "obstructive acute appendicitis" is caused by chronic inflammation and fibrosis around dead eggs causing obstruction of the lumen and increasing the risk of infection from faecal contamination.^{4,5} This may occur in the late phase and may happen several months or even years later.⁴

The diagnosis of schistosomal appendicitis is essentially a retrospective one, since the clinical presentation and operative findings closely resemble that of acute pyogenic appendicitis.³ Patients generally do not present with haematuria and in a study performed in Saudi Arabia none had hepatosplenomegaly or a present or past history of jaundice.² Interestingly but also an unexplained finding was the absence of *Schistosoma* eggs in the urine despite the fact that most cases were associated with *S.haematobium*.²

In conclusion, the confirmation of Schistosomal appendicitis is purely a histological one as there are no pathognomical clinical or operative findings to support the diagnosis.³ Physicians and surgeons alike are reminded that Schistosomiasis is a cause of much morbidity and the diagnosis must be entertained in patients with recurrent abdominal pain particularly those from endemic areas.

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References

1. Kitinya J; Laboratory Report; NHLS Polokwane 22/02/05
2. Al-Kraida A; Giangreco A; Shaikh MU; Shehri-AL A. Appendicitis and Schistosomiasis. *British Journal of Surgery* 1998, vol75, January 58-59
3. AdebamowoCA; Akang EEU; Ladipo,JK; Ajao OG. Schistosomiasis of the Appendix. *British Journal of Surgery* 1991, Vol78, October 1219-1221
4. Satti MB; Tamimi DM; Al Sohaibani MO; Al Quorain A. Appendicular schistosomiasis: a cause of clinical acute appendicitis? *J Clin Pathol* 1987;40:424-428
5. Doudier, B et al. Schistosomiasis as an unusual cause of appendicitis. *Clinical Microbiology and Infection*. Volume 10,number 2, February 2004.