incidence of pneumothorax. The cough reflex is absent and postoperatively there is less active cough. Bronchial anastomoses heal poorly and are often fragile. Hence airway pressures should be kept low during mechanical ventilation.

As a consequence of refined technique and better care, these patients have a long survival rate and they often return to the operating theatre for cardiac catheterisation, angiography and other incidental surgeries such as appendicectomy, herniotomy or dental procedures. A careful assessment and attention to the aspects highlighted above, may aid in successful anaesthetic management of these cases.

References

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UTILISING RESIDUAL 2% METHYL CELLULOSE

Dear Editor,

I would like to disseminate through this letter a simple way to utilize leftover 2% Methylcellulose.

Most anterior chamber (AC) intraocular surgeries, mainly cataract removal with intraocular lens implantation, involve use of viscoelastics. Viscoelastics are critically essential to any procedure involving AC manipulations as they help maintain AC, protect corneal endothelium and assist in breaking synechae, if any. 2% Methylcellulose, though not strictly a viscoelastic, is used most frequently for this purpose and comes pre-filled in a syringe. Almost invariably some of it remains unspent at the end of the surgery and has to be discarded.

I have been autoclaving this residual 2% Methycellulose and accumulating it over 3-4 surgical sessions. This viscous transparent 2% solution can be diluted with equal or three-fourth volume of 4% lignocaine, commonly used as topical anaesthetic. The resultant solution is an excellent coupling fluid for application of contact lenses e.g. Goldmann-3-mirror and Abraham's lens.

Not only can one tailor the viscosity of the solution according to one's preference, there is also a distinct advantage of constant topical anaesthesia. This becomes important in cases of laser photocoagulation where prolonged topical anaesthesia is required. Of course, preventing a wastage has its own charm.

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MULTIPLE MENINGIOMA

Dear Editor,

This refers to article 'Multiple Meningiomas' published in Medical Journal Armed Forces India 1999;55:263-4.

Firstly the lady was 50 years old as known to us and as seen on CT scan (Fig 1A) of the case report. Secondly the patient had presented with severe headache and vomiting due to raised intra cranial pressure even CT Scan (Fig 1B) shows severe hydrocephalus. Lastly I had the opportunity to operate this lady, two of her three lesions were operated, the one arising from tentorium (not cerebellum) on left, was confirmed histopathologically to be meningioma. The right CP angle tumour was found to be schwannoma on histopathology. The third seen in the falx was too small to be operated, so histopathologically not confirmed. I fail to understand, how this case can be labelled a case of multiple meningioma.

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REPLY

Dear Editor,

This refers to article 'Multiple Meningiomas' published in Medical Journal Armed Forces India 1999;55:263-4.

The lady was 50-years old mother of a serving soldier, age typed as 28 years is wrong and deeply regretted.

Hydrocephalous was associated due to primary pathology of intracranial SOL's and hence not emphasized.

All the 3 lesions showed similar CT findings and Imaging diagnosis of multiple meningioma was offered on the basis of CT imaging as the case report was essentially depicting the imaging aspect. It is after surgery that the lowermost lesion came out to be a schwanoma which shows similar finding on CT as meningioma.

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SAY NO TO MMR; EPIDEMIOLOGICAL REASONS

Dear Editor,

There are some practitioners who advocate Measles, Mumps and Rubella (MMR) vaccinations among infants. The epidemiological impact of this in our country can have adverse consequences. The following clinico-epidemiological factors have to be considered.

Measles is a severe disease in infancy and milder in older children and adults, therefore measles vaccine has a well earned placed in the Universal Immunisation Programme (UIP).

Mumps on the other hand, is a mild disease in infancy and more severe during adulthood. Orchitis occurs in about one in four males who develop mumps after puberty and may lead to sterility [1]. In developed countries, 85% of infections occurred in children younger than 15 years prior to widespread childhood immunisation-now disease occurs in young adults, producing epidemics in colleges/workplace [2]. Why should we repeat the mistakes of developed countries? More so as we cannot afford immunisation at puberty/adulthood as advocated by Western medical literature [3]. Having the disease in childhood is preferable to escaping it then and possibly acquiring it in adult life when protection afforded by