the blood pressure in the right arm was 97/58 mmHg, in the right leg 95/55, and in the left leg 100/60. A radionuclide angiogram using ^{99m}Tc showed equal perfusion of both legs.

Discussion

Thrombosis of the abdominal aorta is a rare complication of catheterisation of the umbilical artery.¹ Untreated it is usually fatal, and surgical thrombectomy is the accepted management.^{2,3} The operation is, however, associated with appreciable operative mortality and morbidity, and thrombosis may recur.⁴

In this case an aortogram was performed to confirm the aortic thrombosis. The absence of femoral artery pulsation made the landmarks for percutaneous puncture of the femoral vein difficult. Though there might be concern about passing the catheter through the thrombus and possibly dislodging it, extensive experience of coronary angioplasty in adults with recently occluded coronary arteries has not confirmed this.

Streptokinase is a recognised alternative to thrombectomy in children with arterial thrombosis⁵ and we have used it successfully. Haemorrhage from the arterial puncture site is the main complication, but the incidence may be reduced by careful management. We recommend that streptokinase should only be given if the fibrinogen concentration is greater than 1.5 g/l, and that this should be checked after two hours, and subsequently at four hourly intervals. If the fibrinogen concentration falls below 1.0 g/l the infusion should be stopped and

heparin given.⁶ When the fibrinogen concentration rises above 1.0 g/l the streptokinase infusion may be restarted. We have found a decrease in the fibrinogen concentration is usually associated with successful thrombolysis.

This case shows the value of streptokinase as an alternative to operation in the management of aortic thrombosis following catheterisation of the umbilical artery.

We thank Dr PJ Todd for permission to report this case.

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Correspondence to Dr SA Qureshi, Department of Paediatric Cardiology, Royal Liverpool Children's Hospital, Liverpool L7 7DG.

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Acute transient myositis due to Toxocara

S S WALSH, W J ROBSON, AND C A HART*

*Accident and Emergency Department, Royal Liverpool Children's Hospital (Alder Hey) and *Department of Medical Microbiology, University of Liverpool*

SUMMARY Two children presented with spontaneous, isolated swelling of the lower half of the left leg; this was diagnosed as acute myositis of unknown aetiology. Further investigations showed antibodies to *Toxocara*. The symptoms resolved within 72 hours and the children were discharged on no treatment.

The genus *Toxocara* comprises parasitic helminths that are capable of causing either asymptomatic or

symptomatic infection in humans. The two common manifestations of infection are visceral larva migrans and ocular larva migrans. Organs affected in the former category include the liver, lungs, brain, and heart. We describe two children in whom infection presented as acute myositis. To our knowledge this association has not been described previously.

Case reports

Two children, a girl aged 1½ and a boy aged 2½, both local children, presented to our department

within a six month period. In each case the parents had noticed the spontaneous onset of isolated swelling of the lower half of the left leg. The children were otherwise asymptomatic.

Examination showed diffuse, non-tender, firm swelling of the muscle bulk posterior to the length of the left tibia and fibula. There were no associated overlying skin changes. Initial investigation was by radiography of the left tibia and fibula and blood was taken for a full blood count and erythrocyte sedimentation rate. The results are shown in the table.

Both children were diagnosed as having acute myositis of unknown aetiology. They were discharged home and reviewed a week later. In both cases the symptoms had resolved within 72 hours of the initial presentation. Both remained completely asymptomatic thereafter.

Further investigations were performed to find the cause of the eosinophilia. The boy had antibodies to *Toxocara* alone while the girl showed evidence of infection by both *Toxocara* and *Trichinella spiralis* (table). We believe, however, that the similarity of the symptoms in both children, the transient nature of the myositis, the absence of circumorbital oedema, and the high titres of *Toxocara* antibody indicating active infection, combine to favour a diagnosis of toxocariasis rather than *Trichinella spiralis* infection in her case.

As both children were diagnosed as having toxocariasis they had formal ophthalmic examinations, which were normal. They required no specific treatment and were discharged to the care of their family doctor.

Table Results of investigations performed on two patients with myositis

	Girl	Boy
Radiography of tibia/fibula	Normal	Normal
Full blood count:		
Haemoglobin (g/l)	109	125
White cell count ($\times 10^9/l$)	16.0	15.0
Neutrophils (%)	15	39
Lymphocytes (%)	50	22
Eosinophils (%)	30	35
Erythrocytes sedimentation rate (mm in the first hour)	20	12
<i>Trichinella spiralis</i> antibody titre	1/128	Nil
<i>Toxocara</i> antibodies (ELISA)*		
Acute	1.12	1.01
Convalescent	0.45	1.5

*An ELISA score of 0.7 indicates active infection.

The actual source of infection remained undetermined in either case.

Discussion

Although the parasite *Toxocara* was originally identified in 1782, it was not until 1952 that infection of humans was first documented.¹ Its prevalence in the population is uncertain but one study showed that 2% of apparently healthy people are infected with *Toxocara*.² Infection is clinically manifest as visceral larva migrans or ocular larva migrans. There are important clinical and epidemiological differences between the two entities. The former presents in children less than 4 years of age, usually with an associated history of pica. Minor symptoms of malaise, fever, and cough in the presence of hepatomegaly and appreciable eosinophilia are usual. However, more serious morbidity has been described when the myocardium³ and central nervous system⁴ are affected.

Ocular larva migrans typically occurs in adults in the absence of evidence of visceral larva migrans and no associated eosinophilia. It is possible that the immune response occurring in chronically infected children protects them against ocular disease.

The diagnosis of toxocariasis should be considered in a child whose white cell count shows appreciable eosinophilia. Currently the best method of making a laboratory diagnosis is the enzyme linked immunosorbent assay (ELISA). It has a sensitivity of about 80% and a specificity of 90%.⁵

Neither of the children reported was offered treatment. Controversy exists over the effectiveness of antihelminthic drugs to relieve symptoms and eradicate infections. As the natural course of the disease seems to be self limiting most workers elect to treat only severe or life threatening infections.

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Correspondence to Dr SS Walsh, Department of Child Health, The Medical School, Framlington Place, Newcastle upon Tyne NE2 4HH.

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