ABNORMAL CYTOLOGY REPORT AND FURTHER MANAGEMENT OF PRECANCEROUS LESION : EFFECT OF CHANGE TO TBS

Dear Editor,

We read with interest the article on The Bethesda System (TBS) of reporting by Chatterjee et al [1]. The authors have drawn attention to the important area of cytology reporting. The system aims at standardization of lexicon and clear some grey zone. Undoubtedly, diagnosis and management of the precancerous lesions forms the corner stone of the preventive strategy against carcinoma cervix. Hence it will be pertinent to see if the management strategy for this group is affected by the change in nomenclature from CIN I,II,III to LSIL and HSIL.

The apprehension that the use of the term neoplasia in CIN might be a green signal to perform radical surgery may not be correct. The implication of cervical intraepithelial neoplasia is understood by it's being in use for a long time since introduction by Richards [2]. However, over treatment or rather overzealous treatment of precancerous lesions without being radical is a fact to reckon with which is not likely to be affected by the change in nomenclature.

The problem actually is a lack of logistics to implement a rigorous screening and follow up programme. It was estimated in 1986 that with an increase in resources by 12 times, even 25% of the eligible population cannot be covered by the end of the century [3]. Today the situation is even worse than that estimate. Hence there is a tendency to over treat once an abnormal cytology is reported in the very few who have been able to undergo a screening at some time. 60% of CIN I (now LSIL) are likely to regress and can be managed

by a cytological follow up but the preference will remain to biopsy and go in for local ablation. Similarly HSIL (previously CIN II & III) can be managed by local ablation or conization, but the tendency in our country will be to accept it as an indication of hysterectomy, if the age and parity so permits. Though prevalent approach entails some surgical morbidity, it is unlikely to change under the existing condition with change over to TBS.

The stepping up of the treatment strategy may be a necessary evil to partially compensate for the logistic limitations of implementing a cytology follow up coupled with the problem of loss to follow up in a floating population in our setup.

References

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2. Richart RM. Influence of diagnostic and therapeutic procedures on the distribution of cervical intra epithelial neoplasia. *Cancer* 1966;19:1635-8.
3. The WHO Bulletin 211 Geneva Switzerland. 1986;64:607.

Lt Col SK RATH*, Surg Capt (Mrs) P TARNEJA*,
Col AB CHATTOPADYAYA*

*Reader, *Associate Professor, *Professor, Department of Obstetrics & Gynaecology, Armed Forces Medical College, Pune - 411 040.

Reply

Dear Editor,

I am grateful to Professor and his team of senior Doctors for having taken a keen interest in the article. I agree with the views of the authors that the main problem is a lack of logistics to implement a rigorous screening and followup programme. However we still feel that overtreatment of precancerous lesions particularly LSIL cases (CIN I) should be avoided.

We recommend a practical follow-up schedule for CIN (cervical intraepithelial neoplasia) cases as being followed in the Institute of Cytology and Preventive Oncology, New Delhi.

1. For control subjects -yearly.
2. For CIN 1 & CIN 11 cases - 6 monthly for 4 years.
3. For CIN 111/invasive carcinomas - 6 weeks after treatment and then 6 monthly for 3 years.

4. Follow up of treated cases are undertaken for assessing
 - a. Recurrence
 - b. Disease free survival
 - c. Death
 - d. Side effects of management
 - e. Latest HPV status

Cervical smear examination, colposcopy and cervical biopsy are done during follow-up whenever required.

Reference

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Lt Col T CHATTERJEE

Classified Specialist (Pathology), Base Hospital, Delhi Cantt - 10

TROPICAL PULMONARY EOSINOPHILIA : NOCTURNAL SYMPTOMS

Dear Editor,

This 24 year old serving soldier presented with dry cough, breathlessness, mild grade fever and generalised bodyaches for the last 15 days. On examination he was moderately built, temperature - 37.8°C, Pulse- 90/min regular, BP - 110/70 mm of Hg and throat was normal. Chest did not reveal any wheeze or crackles. Abdomen/CVS/CNS/ - Normal. Next morning patient complained that he was unable to sleep because of dry cough and breathlessness through out the night. Chest did not reveal any wheeze or crackles.

Systemic examination was again normal.

On next day patient had similar complaints and was not able to sleep through out the night. Again clinical examination did not reveal any abnormal finding. On subsequent night, patient was examined : chest had extensive bilateral wheeze mainly in infrascapular and interscapular areas. Bronchodilators were given and investigated further. Haemogram : Hb. 14.0 gm/dl, TLC-8000 per cmm with 18% eosinophils on differential count. Absolute eosinophil count was 1440 per cmm. Blood slide for MF was negative

(twice) during night. Urine examination, chest radiograph and electrocardiogram were normal.

Clinical diagnosis of Tropical Pulmonary Eosinophilia was considered. Diethylcarbamazine was started in low doses, gradually increased over three days to full doses and continued for 14 days. Patient responded well and became asymptomatic within a week, though absolute eosinophil count became normal on 10th day.

Tropical Pulmonary Eosinophilia is a distinct syndrome which is thought to be an allergic reaction to dead microfilaria in the lungs, perhaps a species for which man is an unusual host such as *Dirofilaria immitis* or *Brugia phangi* [1] (normally affecting animals accidentally conveyed to man by mosquitoes). This syndrome affects commonly young male, often during the third decade of life. The majority of cases have been reported from India, Pakistan, Sri Lanka and South East Asia.

Symptoms are usually nocturnal (diurnal variation) in the form of cough, dyspnea, asthmatic paroxysms with fever for weeks to months and pronounced eosinophilia. Among 12 to 25% of individuals there is a tendency to relapse over a period of few years [2]. Microfilarial parasites in the blood are usually absent. There is a rise in all immunoglobulins particularly IgE and antifilarial antibody titres which are characteristically high [3]. Chest X-ray may be normal but generally shows increased bronchovascular marking; diffuse bilateral, indefinite mottling of varying size (2-5mm in

diameter) uniformly distributed in both the lungs [2].

There is usually dramatic relief of symptoms with Diethylcarbamazine (antifilarial drug) within 3 to 7 days, though eosinophilia may take 7 to 10 days or sometimes longer to become normal. Treatment is to be continued for 10 to 14 days or till eosinophil count becomes normal. Sometimes after an interval of years, individuals with relapse require another course of diethylcarbamazine [4].

The typical clinical features include dry cough and wheeze which are solely nocturnal, high eosinophilia very high levels of antifilarial antibodies and a rapid initial response to treatment with diethylcarbamazine are virtually diagnostic of Tropical Pulmonary Eosinophilia (TPE).

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Sqn Ldr AK GUPTA*, Gp Capt CBS BHADORIA*

*Medical Officer Physician, *Commanding Officer, 4 Air Force Hospital, 5 Wing, Indian Air Force, C/O 99 APO.

SUPRASELLAR PAPILLARY SQUAMOUS EPITHELIOMA (PAPILLARY CRANIOPHARYNGIOMA)

Dear Editor,

This with reference to the original article on the subject published in MJAFL 2000;56:158-160, a very interesting reading, however, the post contrast CT scan section of the head at the level of Sylvian fissure (Fig-1) of the above referred article shows a well defined brightly enhancing suprasellar midline mass extending to the third ventricle without any ventricular dilatation. However the authors have described it in the legend to the figure as a "hypodense intracranial uncalcified suprasellar space occupying lesion involving the left thalamus and third ventricle".

To show intracranial hypodense uncalcified lesion figure should have been of a plain scan i.e. without intravenous contrast. However

it is a midline mass and involving the left thalamus and third ventricle as said by the authors but is seen extending laterally towards both the left and right thalami and third ventricle by the mere fact of being space-occupying lesion.

Since MRI was done in this case and being a superior imaging modality having the advantage of direct sagittal and coronal sections, its images should have been included in the article.

Col HARIQBAL SINGH

Senior Advisor (Radiodiagnosis), Command Hospital (Southern Command), Pune - 411 040

Reply

Dear Editor,

1. This refers to article 'Suprasellar Papillary Squamous Epithelioma (Papillary Craniopharyngioma)' published in MJAFL 2000;56:158-160.

2. This is indeed a contrast enhanced scan as evidenced by the notation on the scan as also tentorial enhancement. Non contrast scan was done prior to CECT but has not been reproduced in this article. Hypodensity of lesion was evident in non contrast scan and

was employed for evaluating the density of the lesion. Thalamic involvement was evident in the relevant sections of the scan.

3. Regarding 'calcification', it is once again reiterated that a non contrast scan was originally employed for evaluating the same.

Lt Col T CHATTERJEE

Classified Specialist (Pathology), Base Hospital, Delhi Cantt 110 010.

CANCER SCREENING CAMP : OUR EXPERIENCE

Dear Editor

At this small base with limited laboratory facilities in the Military Hospital as well as the Government Hospital, a Cancer Screening Camp was organized in which ladies above 35 years were offered a blood pressure check, breast examination and a Pap's smear examination. The medical officer went around various units in the base to address the personnel about the aim and objectives behind holding this camp, besides addressing the ladies in the AFWWA

meet. The response was tremendous and a total of 175 ladies reported. The Pap's smear were taken by the gynaecologist from Military Hospital as well as our lady medical officer, and the slides were very kindly examined by the Gujarat Cancer Research Institute, Ahmedabad free of cost.

The significant finding was that only 46 out of 146 smears collected were reported as normal or within normal limits, 99 slides showed varying degrees of inflammation with one reported as Trichomonas. Fortunately there was none with malignant changes.