(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 pangi* [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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SUPRASELLAR PAPILLARY SQUAMOUS EPITHELIOMA (PAPILLARY CRANIOPHARYNGIOMA)

Dear Editor,

This with reference to the original article on the subject published in MJAFI 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.

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Reply

Dear Editor,

1. This refers to article 'Suprasellar Papillary Squamous Epithelioma (Papillary Craniopharyngioma)' published in MJAFI 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.

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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.