UNUSUAL PRESENTATION OF BONY METASTASIS OF THYROID

Dear Editor,

This refers to the article 'Unusual presentation of bony metastasis of thyroid (Case Report)' by Lt Col Kailash Chand and Lt Col NK Paniker, *MJAFI* 1999;55:75-6.

The legends pertaining Fig 1 and 2 in this article states 'Destruction of right iliac bone', the sections being well inferior to iliac bones hence they are not seen in this sections. The Fig 1 also suggests involvement of right pubic bone, CT picture shows the age of the

patient printed as 62 years whereas the authors state the age as 70 years.

In view of this it is suggested that a radiologist may please be associated with articles where his comments may be useful.

Lt Col HARIQBAL SINGH

Classified Specialist, (Radiology), Command Hospital (SC), Pune 411 040.

REPLY

The observations are well taken. The age of the patient was 70 years. It is regretted that it was printed 62 years on the CT film since the same was written on the requisition form provided to the radiologist by the ward.

The opinion of Lt Col L Satija, Classified Specialist, Radiodiagnosis, Command Hospital (SC) Pune, on the CT scan depicted in the figures, is endorsed.

"The lesion shows involvement of para-acetabular region (which

consists of ileum, ischium and pubic-all the three bones) on the right side with erosion of right ischium. Extension of the lesion anteriorly up to the pubic ramus is also visible".

Lt Col KAILASH CHAND^{*}, Lt Col L SATIJA⁺

^{*} Classified Specialist (Pathology), Military Hospital (CTC), Pune,
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Otitic hydrocephalus-A rare complication of CSOM

Dear Editor,

This is with reference to the article 'Otitic hydrocephalus-A rare complication of CSOM (Case report)' by Lt Col AK Mehta and Surg Capt VK Singh *MJAFI* 1999; 55 : 63-4.

The legend pertaining to Fig 2 in this article state thrombosis of sigmoid sinus, the sections of CT Scan shown (Fig 2) are not at the level of sigmoid sinus hence does not show sigmoid sinus. The arrows depicted point to straight sinus and posterior part of falx cerebri and not sigmoid sinus. It will be appreciated if a CT section

showing sigmoid sinus thrombosis is printed along with the reply to this letter being an uncommon identity. In view of this it is suggested that a radiologist may please be associated with articles where his comments may be useful.

Lt Col HARIQBAL SINGH

Classified Specialist, (Radiology), Command Hospital(SC), Pune 411 040.

REPLY

The legend pertaining to Fig 2 of article entitled "Otitic Hydrocephalus-A rare complication of CSOM" should have read as focal sagittal sinus thrombosis which is consistent with otitic Hydrocephalus and not sigmoid sinus thrombosis. The error is regretted.

Sigmoid sinus thrombosis was also reported in this case as revealed by absence of enhancement of sigmoid sinus on contrast

studies. A radiologist was associated with this case and the CT scan findings were reported by radiologist of the Centre, where CT scan was carried out.

Lt Col AK MEHTA

ENT Specialist, Military Hospital, Bhopal.

SILENT GALLSTONES: TO DO OR NOT TO DO?

Dear Editor,

The editorial on the treatment of gallstones was very informative [1], but it has glossed over a major area by saying that 'management of asymptomatic gallstone is controversial'. Armed Forces are famous for having standing operative procedures' for almost every situation. What is our policy for management of asymptomatic gallstone?

NIH consensus development conference on gallstone had earlier suggested that the silent gallstones should be left alone as a rule [2]. This recommendation is primarily based on a study that followed 123 persons with asymptomatic gallstone over time. At 5, 10, and 15 years of follow up 10 percent, 15 percent and 18 percent persons

became symptomatic and none developed complications of gallstones [3]. It was suggested that 90% patients with gallstone will present biliary pain and not complications in the first instance. Hence prophylactic removal of gallbladder is not a necessity.

Subsequent information adds a new twist to this story. A few studies have suggested that the incidence of biliary pain and complications may be much higher than this [4,5]. A retrospective analysis of our own patients with biliary pancreatitis shows that one of us (ACA) has seen 43 such patients over last decade (1989-99). As per available records 17 of these did not remember having had biliary pain in the past, whereas 14 gave history of previous episodes of biliary pain. In the remaining documents such history was not