Correspondence

Parotid abscess due to Salmonella typhi

A parotid abscess is usually seen as a sequel to acute bacterial parotitis. The risk factors for its occurrence include poor oral hygiene, diabetes, alcohol intake, dehydration and sialolithiasis. The most common organism isolated is Staphylococcus aureus. A few sporadic cases of infection of the parotid gland by Salmonella spp. have been reported in immunocompromised and immunocompetent individuals with a history suggestive of enteric infection.

A 58-year-old man presented to the outpatient department of our hospital with high grade, intermittent fever and a swelling of the left parotid gland along with weakness for 2 weeks. The painful swelling was initially small but had increased in size. He did not have nausea, vomiting, pain abdomen or diarrhoea. He had received acetaminophen and ibuprofen as over-the-counter medicines for a week before coming to our hospital.

The patient had type 2 diabetes and was on oral hypoglycaemic drugs. There was no other significant past medical or surgical history. The family and social history were non-contributory and the patient did not consume alcohol or tobacco in any form.

He was moderately built and nourished, looked sick, had fever (103°F), was dehydrated, had tachycardia and his blood pressure was normal. He had a solitary, oval swelling just below the left angle of the mandible which measured about 6 cm x 4 cm. The skin over the swelling was smooth, stretched and shiny with erythema at the centre. The swelling was tender, warm, firm and non-mobile. There was mild hepatomegaly but no splenomegaly or free fluid. The other systems were normal.

A provisional diagnosis of a left parotid abscess was made. The haemoglobin level was 11.7 g/dl, white cell count 5560/cmm (neutrophils 74%, lymphocytes 19% and monocytes 7%), platelet count 188 000/cmm and erythrocyte sedimentation rate 36. Urine examination showed the presence of sugar, ketone bodies and pus cells. Liver and renal function tests were normal. Fasting and post-prandial blood sugar levels were 242 mg/dl and 309 mg/dl, respectively. HIV test was negative. The patient was started on parenteral ceftriaxone and subcutaneous short-acting insulin and other supportive medicines. A blood culture sent before starting parenteral antibiotics was sterile.

Computed tomography scan of the neck and parotid region revealed a bulky left parotid and submandibular salivary gland with a possible mass effect on the hypopharynx. Fine-needle aspiration showed grey brown pieces of tissue and microscopic examination showed dense granulation tissue amongst groups of normal-looking parotid glands consistent with non-specific left parotid adenitis. A surgical opinion was sought and the abscess was incised and drained. A biopsy of the abscess wall was also taken. Pus culture from the abscess grew Salmonella enteritidis. Laryngorhinootologie 1995;74:581–2.

In our patient, the source of infection of the parotid was unclear. It may have been due to a silent bacteraemic episode or through direct infection of the gland by contaminated food. Dehydration with uncontrolled sugar levels might have predisposed the patient to growth of the organism resulting in the formation of an abscess.

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References


Private practice in India

We read with interest the article on private practice by Anand and a rejoinder by Siva Prasad in the subsequent issue of the Journal. We have watched the changes that have taken place in private practice over the years at various levels, i.e. in corporate hospitals, among doctors of medical colleges, doctors working on their own as private practitioners, doctors working in the villages and quacks everywhere in India. It may not be proper to paint all private practitioners in India with the same brush, but one cannot deny that they are all involved in fierce competition and adopt...
The abortion law needs to be amended

The Bombay High Court in August 2008 rejected the petition of a couple seeking permission to terminate pregnancy in the 26th week as the foetus had been diagnosed to have a serious heart ailment at 24 weeks of intrauterine life. The couple feared that their child, if born, may lead a handicapped and meaningless life. This raises the issue of whether the Medical Termination of Pregnancy (MTP) Act of 1971 needs to be amended.

The Indian law does not define the gestational age at which a foetus should be considered viable. The British parliament in 1929 enacted a law 'The Infant Life (Preservation) Act of 1929', which defines the age of viability as 28 weeks of intrauterine life. Abortion after 28 weeks for foetal abnormalities, akin to euthanasia, is not allowed under the current Indian law. Therefore, I suggest that the time limit for permitting MTP could be increased from 20 weeks to 28 weeks of gestation without any legal and ethical problems.

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Some of the objectives of the MTP Act of 1971 were to reduce the number of criminal abortions, provide abortion for birth control and to safeguard the life of the mother. This Act permits abortion up to 20 weeks of gestation—a limit considered appropriate because at that time an abortion beyond 20 weeks of gestation was considered a risk to the mother. Abortions beyond 20 weeks were permitted only when there was a significant risk to the life of the mother. Abortion is allowed on eugenic grounds, i.e. whenever there is a substantial risk to the future life of the foetus. However, this is permitted up to 20 weeks of pregnancy. It is well known that all the congenital anomalies in a foetus cannot be diagnosed by 20 weeks of pregnancy. With advances in medical sciences, abortion can be done safely even in the third trimester of pregnancy.

The misuse of MTP Act led to an increase in female foeticide. The government then enacted the 'Pre-Conception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act; 1994'. In addition to controlling sex-selective abortions, the very aim of prenatal diagnosis is to prevent the birth of an abnormal child. The PNDT Act does not set any time limit for conducting the tests.

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All the techniques of prenatal diagnosis are complicated and expensive and it takes a few weeks to get results. Considering the socioeconomic and educational background of the average Indian, in many cases the pregnancy is bound to cross 20 weeks by the time the diagnosis of a congenital anomaly is confirmed. Then, if abortion is not allowed after confirmation of a gross abnormality of the foetus, the purpose of prenatal diagnosis is defeated.

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any incentive to attend such programmes and keep themselves up to date.

The importance of rural CME is well-recognized in the western world. The concept of CME should be a central component of medical education for rural health practitioners in India. The organization of CME courses specifically for those practising in rural areas is of vital importance, since it is these practitioners who cater to the healthcare needs of the largest section of our population, i.e. those living in rural areas. An attempt could be made to motivate them by giving them monetary incentives, and they could be granted special leave to attend such events. Attendance of CME programmes could be made a criterion for future promotions. Further, there should be especially designed CME programmes to address the needs of rural India. Appropriate legislation could also be passed to remedy the situation.

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Research opportunities for medical students in India

The article ‘Research opportunities for medical students in India’ is timely and describes in a nutshell the opportunities available to students interested in research. However, all the available opportunities, even if fully utilized, may not add up to more than a few hundred. As for the utilization of opportunities, there is little motivation for medical students to do research in the ‘academic’ culture that prevails in most medical colleges of India. Even the limited opportunities are not brought to the attention of a larger student audience. This is not to take away from the merit of the attempts of agencies that sponsor student research. What we need in India are serious efforts to popularize the culture of research in every medical college, right from the undergraduate days. The inclusion of medical research in the curriculum may be open to debate, but nobody would dispute the relevance of initiating young medical students into the culture of research.

We would like to share the experience of our non-governmental organization (NGO), Health Action by People, in the promotion of student research as part of the problem-solving for better health (PSBH) strategy in a medical college. Our programme is initiated with a 2-day participatory workshop that involves all the students of a particular batch. The students are guided through the process of identifying major health problems, selecting a problem of interest, framing a well thought out research question and evolving an action plan in search of an answer to the question. The students are exposed ‘painlessly’ to the methodology of medical research. The basic principles of design, sampling and analysis are also discussed in the workshop. Since the nodal department is community medicine, most problems identified by the students are oriented to public health. However, projects based on laboratory research are not unusual. Once the formal workshop is over, the nodal department, in consultation with the students, selects at least 25% of the projects developed in the workshop on the basis of their relevance and feasibility. Four to five students form a group to implement a project within 3 to 6 months. The departmental staff assists them with implementation, statistical analysis and the interpretation of data. After completing the projects, the students prepare reports in conformity with the scientific principles of the presentation of research findings.

Health Action by People, which is based in Thiruvananthapuram, has been holding these workshops since 1998. The programme was started in Kerala and has now extended to 67 partner medical colleges in different states of India. Up to now, 189 PSBH workshops have been held and thousands of projects implemented. Over 1500 research reports of implemented projects are available in our office. Many projects have been presented at conferences and some have been published in medical journals. We have hosted three national conferences on undergraduate medical research. On an average, a hundred papers based on student research were presented at each conference. Moreover, distinguished personalities in the medical field are invited to deliver lectures from time to time. In the initial years, funds were provided by the Dreyfus Health Foundation, New York. A heartening development is that many medical colleges have continued to make the PSBH workshops an annual affair, despite the fact that they are receiving no funds from us. The department of community medicine, Trivandrum Medical College has successfully carried forward the annual student research conferences.

The most consistent feedback from the students is that the workshops have exposed them to the world of health research. Participation in the workshops has made them feel more confident about confronting the health problems of our nation. We believe that the programme has ushered in a quiet revolution in medical education and research in India. There is a need for more such initiatives so that Indian medical education can become capable of producing doctors with the right mix of research and clinical practice.

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