

Biliary Ascariasis – A Letter to the Editor

Sir,

We read with interest "Biliary Ascariasis", a letter to the editor send by PH Ding in your journal 1995;50 : 118-9. His adult patient was treated successfully by endoscopic removal of worm from the bile duct¹.

As opposed to the author, we would like to share our experience in treating biliary ascariasis in a child conservatively and successfully, and sonography as the confirmatory investigation.

Our patient is a eight-year-old girl presented with epigastric pain, vomiting and passing out round worms per rectum. On examination, the abdomen is soft and non-tender. Full blood count showed haemoglobin of 11.4 g/dl, total white count of $9900 \times 10^9 / l$ with normal differential count. *Ascaris lumbricoides* and *Trichuris trichuria* ova are seen in faecal examination. Liver function tests showed a high alanine and aspartate aminotransaminase. Ultrasound showed multiple, long, linear and curved echogenic structures with no acoustic shadowing. A few of these showed long linear central hypoechoic tube. They were within extra and intra-hepatic bile ducts. The gall bladder was distended with thick wall (6mm) with no stones. A diagnosis of biliary ascariasis and acute acalculous cholecystitis were made. He was treated with antihelminthic drugs – Combantrin 400 mg and anti-spasmodic (Buscopan). Repeat ultrasound revealed less in number of the echogenic structures and the gall bladder was normal a week later. She recovered fully and discharged home well after fourteen days hospital stay.

Biliary ascariasis was a predominantly a disease of adult and incidence in children is rare as in our patient, although children are more susceptible to round worm infestation².

It is suggested that children may escape invasion of the biliary tree by worms due to their narrow biliary passages².

Ultrasound was confirmatory in our patient and it is sensitive, accurate, rapid, noninvasive and using no ionising radiation method of diagnosis. Intravenous cholangiography is now an obsolete investigation for suspected biliary ascariasis and was used as an aid to diagnosis before the era of ultrasound. Endoscopic retrograde cholangiopancreatography (ERCP) is an excellent diagnostic tool and should be limited for non-confirmatory sonography.

We agree with PH Ding where conservative management using antihelminthic should be used first. Failing this, removal of worms can then be done using ERCP if the service is available. Surgery only reserved for those cases where the above two therapeutic options failed.

I L Shuaib, FRCR

F Z Hayat, MBBS

Department of Radiology

School of Medical Sciences, Universiti Sains Malaysia
16150 Kubang Kerian, Kelantan

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Post Mortem Caesarian Section

Sir,

Post-mortem Caesarian sections are steeped in mythology and history. Aesculapius, the son of Apollo was removed from the abdomen of his previously killed mother. In 1578 Guilo Cesari Arantius performed a Caesarian operation, delivering a live child from a woman who had been killed in the last month of her pregnancy¹.

A review of the literature of post-mortem caesarian sections showed that there are only rare cases of surviving healthy babies more than 10 minutes after cardiac arrest², the longest being 26 minutes³. It is felt that there is justification to operate regardless of the time interval if signs of fetal life are present.

All maternal deaths in Malaysia for the years 1991 and 1992 were studied. These deaths had been reported under the Confidential Enquiry system into maternal deaths established in Malaysia since 1990. A total of 548 deaths were reviewed. Only one attempt at post-mortem Caesarian section was noted.

The case was a 29-year-old primigravida at 34 weeks of amenorrhoea who was involved in a motor vehicle accident. The mother was clinically dead when brought to hospital but an attempt was made to deliver the fetus as the fetal heart was heard. On delivery, the baby was severely asphyxiated and succumbed soon after. The birth weight was not documented.

A review of the other cases reveals another 18 mothers who died from direct obstetric causes and were undelivered at the time of death. The maturity of the fetus at the time of death was above 36 weeks and the fetus was alive at the time of maternal death. Twelve of the cases died from amniotic fluid embolism, two due to severe pre-eclampsia and four from unspecified causes. It is interesting to note that the attending doctor did not attempt a post-mortem Caesarian section in these cases. It could not be discerned whether consent was refused in these cases.

A maternal death is a tragedy. In the short time that is available to salvage a live fetus, it is usually not possible to get an informed consent from the immediate family due to many reasons. The family may not be present and resuscitative attempts are usually focused on the mother. Socio-cultural factors will also need to be considered before a decision can be taken. The Catholic Church endorsed the use of post-mortem Caesarian section to provide baptism for the infant's soul. A child delivered at the time of maternal death could face rejection by the family.

All obstetricians will need to consider the performance of a post-mortem Caesarian section at some time. It

is obvious that this is an uncommon occurrence in Malaysia.

Acknowledgement

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J Ravindran, MRCOG

Department of O & G, Hospital Seremban,
70300 Seremban

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Low Birth Weight Babies

Sir,

With reference to Dr. C.P. Chia's comments on the low birth weight babies paper published¹, it is unfortunate that he has failed to see the objective of the paper. The paper was an epidemiological study on the existing data available in Lundu District in Sarawak. The paper therefore, did not include association variables like maternal height, maternal weight and many other variables associated with low birth weight, although it is a well know fact that these factors are associated with birth weight of babies. The paper also did not study the gestation age as it was not the intention of the paper.

Secondly his naive comment that antenatal care does not affect birth weight shows his inexperience. The author carried out a regression analysis and looked at several factors which were associated with birth weight, and it was noticed that the weight of the mother, sex