characteristics results in delivering low entry dose and deposit the majority of their energy at the end of their path, yielding a typical dose energy peak called ‘Bragg peak.’ This steep fall-off allows for the delivery of high radiation doses to the tumor and sparing of tissue beyond the tumor. All our patients underwent PT as a part of curative management and tolerated the treatment well. One patient treated with CSI had grade III neutropenia managed conservatively, whereas others did not experience more than grade II toxicities. Mean dose to hippocampus for all our patients was less than 30 Gy, below the accepted threshold for intelligence quotient preservation [6]. All patients could resume their normal schooling after the treatment, with no impact so far in their educational activities, and maintained quality of life. However, neurocognitive assessments were not available for two out of the three patients, and could not be planned due to the logistic challenges because of the ongoing COVID-19 pandemic.

We have successfully implemented PT in the treatment of ICGCT in India. PT should be considered as a treatment option for optimal management of these curable tumors. Further follow up is required to assess the long-term sequelae of treatment in these patients.

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Acute Meningoencephalitis in a Child Secondary to SARS-CoV-2 Virus

We report a case of cerebrospinal fluid (CSF)-proven severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) in a child with acute meningoencephalitis.

An 11-year-old boy presented with one day history of fever, headache, vomiting and altered sensorium. There was no history of cough, fast breathing, rash or abdominal pain. On examination he was hemodynamically stable with a Glasgow coma scale (GCS) of 9 (E3 V2 M4). There was no cranial nerve paresis and he had signs of meningeal irritation (neck stiffness and positive Kernig’s sign). In motor functions, he had increased tone with brisk reflexes and extensor planters in both lower limbs. Fundus examination was normal. Child was managed in pediatric intensive care unit as per the standard protocol for acute febrile encephalopathy with empirical broad-spectrum antibiotics and acyclovir along with other supportive care. Blood investigation showed severe lymphopenia (absolute lymphocyte counts 700/mm³) and raised inflam-matory markers (C-reactive protein-18 mg/dL, lactate dehydro-genase-4000 U/L, ferritin-2400ng/ml, D-dimer-51091 ng/mL) with deranged liver functions. CSF examination showed pleo-cytosis (75 cells) with lymphocytic predominance (80%), very high protein (696mg/dL) and normal sugar levels. The RT-PCR test for SARS-CoV-2 was done on a nasopharyngeal swab and CSF because of the outbreak situation and was found to be positive in both. CSF was negative for other neurotropic viruses (herpes, varicella and entero virus). A head contrast enhanced computed tomography (CECT) scan was normal.
Hepatic Visceral Larva Migrants Causing Hepatic Artery Pseudo-Aneurysm

Visceral Larva Migrants refers to migration of second stage nematode larvae through human viscera most commonly the liver and lungs. This entity usually presents with fever, abdominal pain, hepatomegaly and respiratory symptoms. Here we describe hepatic visceral larva migrants causing hepatic artery pseudoaneurysm and presenting with upper gastrointestinal bleeding and its management.

Parasitic infections of liver are commonly encountered in clinical practice and can have myriad presentations posing a clinical diagnostic challenge. Hepatic visceral larva migrants (VLM) is one such entity presenting with prolonged fever and liver involvement especially in areas endemic for the parasite. Hepatic artery pseudoaneurysm is a complication described mostly with traumatic liver injury and post-surgery [1]. We describe this complication secondary to hepatic VLM and its successful management.

A 12-year-old girl presented with high grade fever, jaundice and right upper abdominal pain with progressive abdominal distension associated with weight loss for four months and a history of recurrent black tarry stools requiring blood transfusions. She was resident of a rural area and her family of seven lived in an overcrowded house, belonged to lower socioeconomic status with poor hygiene practices, consumed vegetarian diet and had exposure to pet animals in neighborhood. On examination she was underweight (BMI 12.5 kg/m²), febrile and tachypneic, had severe pallor with pedal edema and no skin lesions. Systemic examination revealed firm tender