We report the therapeutic results with Octreotide, a somatostatin analogue, in two subjects who became resistant to the usual medication. The trial arose from previous experience with diabetic diarrhoea, also a dysautonomic manifestation. In FAP we accept that there is a blind loop phenomenon with bacterial overgrowth and a mild malabsorption as in diabetic dysautonomic diarrhoea.

The first patient, a 53 year old man whose disease had began four years previously, had diarrhoea (7 times per day) for six months, orthostatic hypotension and loss of weight (3 kg). The other patient, a 43 year old man whose symptoms started seven years ago, had less severe diarrhoea (4 times per day) for two months sufficient to cause psychological disturbance and deterioration in orthostatic hypotension. The diarrhoea in these patients was painless and watery and the stools contained no blood, pus or mucus.

Octreotide 0.05 mg was administered by subcutaneous injection every 12 hours. The first patient was treated for 15 days which resulted in an improvement in his diarrhoea (3 times per day and stools semi-formed) and orthostatic hypotension; his weight also stabilised. The second patient was also given the same therapy for seven days. The diarrhoea became less frequent (twice per day) and the stools semi-formed; orthostatic hypotension also improved as did his psychological state. This patient reported mild nausea during the treatment. Each injection improved symptoms after 30-60 minutes and relief continued for 24-48 hours. After this period, the mild deterioration experienced in both patients was controlled with the usual therapy during the three to four months follow up.

Octreotide should be considered in the treatment of refractory diarrhoea in FAP.

Angiostrongylus cantonensis

I believe that the authors of a case report of Angiostrongylus cantonensis occurring in a brain abscess of a patient from India have misidentified the parasite and that this does not represent a case of human angiostrongyliasis but is in fact a case of sparganosis caused by a tapeworm parasite of the genus Sparganum. I suggest this alternative diagnosis for the following reasons: 1) Although A. cantonensis infection is common in south east Asia, many parts of the Pacific region and other parts of the world, I know of no published reports of the parasite occurring in India although I have heard anecdotally that rat infections have been seen there. I do not believe any human infections have been previously reported in India. 2) The clinical picture described in the report is at variance with what we generally see in eosinophilic meningoencephalitis associated with A. cantonensis infection. When the authors state "this case is unique in that the patient presented with focal neurological manifestations . . ." it agrees with a diagnosis of neurocystercerosis or sparganosis but not Angiostrongylus. Thus a brain abscess picture with a single focal lesion, no reported eosinophilia in blood or CSF, is far more consistent with the diagnosis I suggest. 3) Finally, the lesion pictured in figs 2 and 3, and in particular 3 which is supposed to be the actual worm, do not illustrate a nematode. The tegument of the tapeworm is clearly seen in fig 3 and its histological features are consistent with a larval tapeworm and certainly have no features of a roundworm in section. I would suggest that at a slightly higher magnification calcareous corpuscles would be clearly visible in the tegument which are unique to cestode tissue. You can barely make them out in fig 3 now but it is too low in magnification to be absolutely certain. The fact that the authors state that the worm was living and motile when the lesion was opened suggests sparganosis rather than cystercerosis. In addition there is no bladder visible which you see with cystercerosis.

Angiostrongylus cantonensis infestation in a patient from India: report of a case.

Matters arising

Angiostrongylus cantonensis

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