Perhaps Professor Scadding could comment on the pulmonary prognosis?

JGS: I believe that the prognosis is potentially good, and of course he could regain normal lung function. He must, however, have exceptionally active disease: the onset was rapid and we have seen that he had a positive result with the Kveim test despite treatment with prednisolone 60 mg a day, which would usually suppress the formation of granulomas. His ethnic origin also militates against as good a prognosis; I would like to know whether the ethnic origin was stated in the study of thrombocytopenia in sarcoidosis.

TMC: The ethnic origin was not stated in that study.

AJR: You rightly say that there were no platelets present in peripheral blood, but you showed a trephine biopsy specimen of bone marrow in which there were platelets present. Why did you not look for the presence of platelet associated IgG at that site?

TMC: The bone marrow showed plenty of megakaryocytes rather than platelets. In fact, the site of

formation of platelets from megakaryocytes is disputed, and there is evidence that they may bud off from the megakaryocyte extramedullary site. It would of course have been most interesting to carry out the immunofluorescence studies on the marrow aspirate to see whether the megakaryocytes express the epitopes that were recognised by the platelet associated IgG.

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Lesson of the Week

Late complication of undetected odontoid fracture in children

M Serdar Alp, H Alan Crockard

Patients with odontoid fractures should have long term follow up as late complications can occur

Injury to the craniocervical junction in children is probably underdiagnosed. Management of odontoid fractures is controversial, and there is no commonly accepted treatment.¹⁻⁶ Schatzker *et al* reported rates of non-union in odontoid fractures as high as 62%,⁴ and thus there is always the possibility of long term complications. We report on a patient who presented with complications 14 years after sustaining an odontoid fracture.

Case report

A seven year old girl sustained a head injury and limb fractures in a road traffic accident. She was drowsy with reactive pupils, and all four limbs were transiently flaccid, and she required ventilation for five days. Radiology did not show a cervical fracture, and it was thought that her neurological condition was due to a brain injury. She improved, with no intellectual impairment: she had a mild hemiparesis of the left side without facial palsy but could run and play with her peers.

At the age of 15 her condition began to deteriorate, and she had increasing difficulty in walking. A neurological opinion noted severe spasticity in all four limbs, but this was considered to be secondary to her head injury. No cervical radiology was performed. The neurological deterioration progressed over the next six years and caused difficulty in swallowing and choking and recurrent chest infections. There were psychosocial problems that dominated her management, and anorexia nervosa with a spastic tetraparesis secondary to her head injury was diagnosed, incorrectly.

At the age of 21 she weighed 24 kg, had difficulty in breathing, and had not walked or stood up for nine months. Her vital capacity was less than 500 ml and her speech barely audible. A cervical radiograph showed pronounced type II atlantoaxial deformity (fig 1), and she was transferred for neurosurgical evaluation. A computed myelotomogram showed pronounced compression of the neuraxis with the spinal cord reduced to a thickness of 1-2 mm by a fixed deformity of the odontoid peg (fig 2), the tip that had not united being closely applied to the arch of C1.

Because of the pronounced anterior compression anterior decompression was considered mandatory, and the backward displaced odontoid peg was removed by a microsurgical transoral procedure. Skull traction was applied, and some weeks later posterior occipitocervical fusion was performed to provide stability. Postoperatively the patient required ventilatory support for five weeks, but she improved slowly. Six months after surgery she was able to walk with a stick and her vital capacity had increased 2 litres.

Discussion

Diagnosis of odontoid fractures is quite difficult; they are often missed because the patient is unconscious or has associated trauma to the head.¹⁻⁶ Such

FIG 1—Lateral cervical radiograph. Arrows indicate anterior displacement of atlas and fractured odontoid tip relative to axis

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FIG 2—Computed myelotomogram performed by injecting contrast into cerebrospinal fluid to outline spinal cord and dural sac, which are severely angulated over proximal odontoid peg (indicated by arrow)

patients may have neurological symptoms that range from tetraplegia to occipital neuralgia. When a patient presents with one of these symptoms after trauma the primary care team should adopt a high level of suspicion to the possibility of a broken neck.

In children, diagnosis of craniocervical junction injuries is particularly difficult as they may be initially purely ligamentous or cause difficulty in interpretation owing to incomplete ossification. Anteroposterior, open mouth, and lateral cervical radiographs must be taken while the patient is in the neutral position. Even in patients with apparently normal radiographs neurological and radiological examinations must be repeated

regularly and the possibility of late complications considered in children.

Handicapped children may have important psychological problems, but doctors should not lose sight of obvious neurological signs, particularly if they are progressive. In the case we describe here late deterioration of the patient was thought to be secondary to head trauma; this is rare, whereas late deterioration secondary to craniocervical injuries is common. As the patient's spinal cord was compressed anteriorly by the displaced odontoid peg it seemed logical to remove the compression by an anterior route, transorally,^{7,8} the subsequent instability being treated by a posterior stabilisation.

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MULTICULTURAL MEDICINE

The evil eye

A 21 year old Irish midwife visited a Hindu mother with a week old son in the east end of London. The Germans have a piercing gaze and the English look one steadily in the eye, but the Irish look falls in between the two, which is why in England people say that an Irish person has "Irish smiling eyes." In Britain complete lack of eye contact is considered to be a sign of serious emotional disturbance,¹ but in Eastern cultures (Asian, Chinese, African, and South American) it is a sign of respect. Patients of ethnic minorities are said to be unintentionally excluded from receiving psychotherapy because of such basic cultural differences. The Irish midwife not only looked steadily into the father's eyes during the conversation and told the mother that her husband was lovely and looked smashing, she also told the family that they had a lively baby and that he had his father's lovely eyes. The Irish habit of flattery is so well known that any non-Irish person who flatters someone is often said to have kissed the Blarney stone. The midwife came out of the house feeling happy that she had made a successful visit and was unaware that she had caused the family great stress.

The grandmother, who witnessed the whole episode, consoled the parents and said that she strongly disapproved of the midwife's behaviour. They decided never to let that midwife into their house again. The grandmother obtained three dry green chillis to dispel what they thought was "the evil eye" cast by the midwife. She waved the chillis over the body of the father and another three chillis over the whole length of the baby. A small bonfire was then lit in the back garden to burn the chillis. The six chillis were so dry owing to the hot weather that they burnt instantly and this confirmed the suspicion that the evil eye had been cast. The boy had to be taken to the temple for more rituals to be carried out by the pandit baba to ensure his future safety and good health. According to this Hindu ritual, if the green chillis do not burn there was no spell, but if they do it confirms the existence of a spell from the evil eye. This ritual is followed by fumigation of the house by burning aromatic herbs.

Hinduism is the oldest religion in the world. According to its teaching, when a person dies he or she has to be cremated (never buried) and the pile of wood for the cremation can be lit only by a male descendant, preferably a son or grandson or, as a last resort, a male child of a relative. This is why a Hindu family will go to great lengths to have a male child. It is in no way an act of sex discrimination as we know it in Britain. A woman who is

menstruating is not considered fit to perform any sacred rituals. The symbolic holy task of lighting the funeral pyre is therefore the privilege of a male, as was the case when Rajiv lit the fire at the cremation of his mother, Indira Gandhi. It is only fair that everyone's religious beliefs are respected.

The evil eye is a worldwide concept, but in Eastern cultures it is believed to be the cause of a sudden illness, accident, or misfortune. All strangers, especially women, who stare at innocent victims, such as healthy children, women wearing golden jewellery, or young men, are supposed to possess evil powers and to be able to cast spells. The evil eye has become a phobia, and people hide their worldly possessions for fear of it. A family who hide a newborn boy from a health visitor can be misunderstood, and their behaviour may result in the child being placed on an "at risk" register under the United Kingdom's child protection laws. Reassuring or counselling families in this situation can be very rewarding.

Victims of the evil eye believe that they are controlled by someone from outside and that they are being watched. The Egyptian *fellahins* live in great fear of the evil eye and in Israel this fear is associated with depression.² In Britain many ethnic minority groups retain their cultural and religious beliefs, and even if they become Westernised they retain such superstitions. Hospital doctors, general practitioners, and other health professionals should try to understand the different cultures of their patients and not try to change them. Non-Europeans may have a stronger belief in the evil eye and may also believe that they can be harmed if other people envy them. Standard psychiatric textbooks that I consulted did not mention the evil eye, but that does not mean that the superstition does not exist in British practices and clinics. The practice of medicine goes beyond the textbooks, and doctors should not hesitate to read other literature, particularly when dealing with patients from other cultures.³ Knowledge is power, and no doctor should be without it. We should ensure that ignorance does not cause us to be caught up in a web of misunderstandings during transcultural medical consultations.—BASHIR QURESHI, *general practitioner, Hounslow, London*

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