Side-effects

The psychiatric questionnaire which was used included questions relating to the existence of possible side-effects such as fatigue, undue sedation, muscular restlessness, tremor and rigidity, extrapyramidal effects, etc. In no patient, at any rating stage on pimozide therapy, was deterioration of these signs and symptoms noted. Thus, pimozide is well-tolerated and at recommended dosages is possibly free of the extrapyramidal side-effects often encountered with other neuroleptic drugs.

DISCUSSION

In an international double-blind clinical evaluation of pimozide in 180 chronic psychotics, the statistical analysis of the results demonstrated that pimozide therapy provides an important contribution to the maintenance regimen of rehaibilitable psychiatric patients who are sensitive to the antipsychotic and socializing effects of this neuroleptic drug.

Unfortunately, in our trial, the number of patients completing stage I to stage V was small, due to the stringency of the criteria for selection and for progression from one stage to the next. Thus statistical evaluation of these results would have limited value but it is significant that our findings closely approximate those obtained in a large-scale, double-blind, international evaluation which was conducted according to exactly the same trial protocol.

We were particularly impressed by the re-animated facial expression of patients on pimozide therapy as well as their spontaneous inclination and interest to participate in productive activities. This agrees with the re-socializing effect which has been observed by other investigators and one of our patients improved to such an extent that it was possible to assign him as regular escort for patients who had to be taken from our hospital to the general hospital in Pretoria when necessary.

CONCLUSIONS

Of particular interest was the incidentally observed, distinctly greater efficacy of pimozide as compared with the standard neuroleptic regimen which had been previously employed in the treatment of these patients, and as is evident from comparing the results after stages I, III and IV in our trial. Our impressions were re-affirmed during the double-blind phase when 6 of the 8 patients relapsed within 5 weeks of stopping pimozide treatment, which is statistically significant.

It appears, therefore, that pimozide is a potent antipsychotic which is free of side-effects at suggested doses. One major advantage is the ease of administration as a single oral, daily dose which will greatly facilitate maintenance treatment of chronic schizophrenics both in hospital and on an outpatient basis.

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Juvenile Nasopharyngeal Haemangiofibroma

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SUMMARY

An unusual case of juvenile angiofibroma is presented and the methods described whereby it was successfully surgically removed.


Juvenile nasopharyngeal haemangiofibroma, also termed juvenile nasopharyngeal fibroma and nasopharyngeal angiofibroma, is a tumour which is basically haemangiomatic but is clinically a specialized fibrous lesion. The origin has been considered as either fibrocartilaginous tissue of the upper cervical vertebrae or fascia basalis of the pharynx. The pathogenesis is primarily vascular, but the fibrous elements that develop secondarily are responsible for its later sclerotic character.

The tumour is said to develop only in adolescent males and therefore a hormonal aetiology is implicated. The haemangioma becomes manifest during the accelerated growth at puberty but the exact age at which it originates is usually obscure. The tumour grows actively during puberty but may regress later due to fibrous tissue development. Clinically the tumour appears as a single sessile
mass, most frequently situated in the nasopharyngeal recess or on the anterior wall of the sphenoid bone. The covering epithelium has usually undergone squamous metaplasia. The vascular and connective tissue elements vary in amount and this can modify the clinical presentation, altering the vascularity of the tumour.

Malignant change in the tumour is rare. The tumour itself, however, is dangerous due to its vascularity, its location and its tendency to invade contiguous structures, such as the skull, either by way of the basilar foramina or by direct erosion.

The clinical presentation is usually a young male with progressive nasal obstruction, recurrent severe epistaxis and nasal speech (rhinolalia clausa). A conductive deafness may occur due to obstruction of the Eustachian tube orifices. Late features such as broadening of the nasal bridge (frog-face deformity), unilateral prominence of the cheek and proptosis are due usually to extension of the tumour. In this communication we wish to present a case of juvenile angiofibroma and indicate our method of treatment.

CASE REPORT

A 7-year-old male patient presented at the ENT Unit of Groote Schuur Hospital with the initial complaint of a left-sided epistaxis for one day. There had been no previous episodes, but he had an upper respiratory tract infection at the time of presentation. The amount of blood lost was minimal and no definite bleeding focus could be seen on examination. Although the nasal mucosa was ‘shrunken’ using topical vasoconstrictors, no bleeding point could be detected and so the nose was lightly packed with bismuth iodine petroleum paste gauze. The following day a more severe epistaxis occurred and the patient required a transfusion of 2 units of blood. No further bleeding occurred and the plug in the nose was removed after two days.

Three weeks after this episode the patient appeared with a two-day history of a painful proptosis of the left eye associated with a purulent rhinorrhoea. He was pyrexial and ill, with a central proptosis of the left eye. There was limitation of ocular movements in all directions but full ocular movements. There was no meningism but was tender over the ethmoid region on the left and had obvious pus (1 ml) in the nose. X-rays showed an opaque left maxillary antrum and ipsilateral ethmoid with slight haziness of the left frontal sinus. Antrum proof-puncture showed only altered blood in the antrum, probably the nasolacrimal duct which was traumatized at the time of surgery. The tumour was removed (in toto) and also for the episode of acute ethmoiditis, by its obstruction to ethmoid drainage. Tomograms showed lateral displacement of the ethmoid region on the left and had obvious pus draining into the nose. The nose was packed with BIPP and wounds sutured with silk.

Subsequent progress has been excellent. The orbital proptosis rapidly returned to normal and besides some anterior vestibulitis, there has been no further nasal complaint. Epiphora in the left eye has occurred due to obstruction of the nasolacrimal duct which was traumatized at the time of surgery.

DISCUSSION

Juvenile angiofibroma can present in many different ways. In the case presented here it was associated with an acute ethmoiditis. The tumour itself is dangerous, as can be seen by the extensive erosion reported in this case. We do not agree with the statement that as fibrosis increases the danger of severe haemorrhage decreases and thus surgery should be delayed until the patient is 20-30 years of age. With modern hypotensive anaesthesia and monitoring combined with a wide surgical approach the tumour can be safely removed.

Irradiation and oestrogen therapy have been unsuccessful in our unit and thus we favour early surgery in these selected cases.

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