

L1, L2 and L3. The incidence of symptomatic vertebral haemangiomas, however, remains unknown<sup>4</sup>; 100 cases had been reported world wide up to 1994<sup>6</sup>.

Primary haemangiomas of the bone are usually solitary. In a necropsy study<sup>10</sup>, the tumour was single in 66.5% of cases; in 32.8% of cases there were 2–5 lesions and in 0.7% more than 5. There are very few published cases of symptomatic bony haemangiomas at multiple sites. Karlin and Brower<sup>2</sup> reported a patient with involvement of spine, skull and ribs, with symptoms resembling those in our patient.

Haemangiomas of bone usually have characteristic radiological features. On plain radiographs a typical striated 'honeycomb' or 'sunburst' appearance is observed<sup>1</sup> and their resemblance to a metastatic tumour has been remarked before<sup>4</sup>. In our patient the plain radiographs did not show any specific abnormal changes. Although the MRI showed features compatible with a haemangioma, the bone scan demonstrating 'hot spots' in the ribs favoured the diagnosis of a metastatic lesion.

Embolization is a useful treatment in this condition. In some patients it is sufficient in itself; in others, subsequently requiring open surgery, it helps considerably by reducing operative blood loss.

This case highlights the value of a plain CT scan in difficult cases, in helping to distinguish multiple primary haemangiomas of bone from metastatic disease. A similar error was made on radiographs in a patient from a series from the National Hospital, with fatal results<sup>11</sup>.

## Doctor, there are maggots in my nose

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Myiasis is a condition in which dipterous fly maggots invade living tissues or body cavities. In human beings, the most common site is the eye. We report the case of a man who sought advice after blowing two small maggots out of his nose.

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## CASE HISTORY

While lying near a swimming pool on the Spanish Mediterranean coast, a man of 64 felt a sudden strike into his nose. Soon after, he developed mild dyspnoea, cough and a sore throat, leading to an acute episode of angio-oedema. He was asthmatic, on salbutamol and prednisolone 10 mg daily. On admission to hospital he was treated with intravenous steroids and dexchlorfeniramine. Blood tests revealed only a leucocytosis ( $12.9 \times 10^9/L$ ). He was discharged after 24 h. Two weeks later a foreign body sensation remained with sneezing, a constant burning sensation and loss of sense of smell. Attending our department, he brought with him two maggots that he had blown out of his nose.

Rigid nasal endoscopy revealed another two larvae, one in each nostril. These were removed by douching with normal saline. Sinus X-rays were normal. On examination under general anaesthesia, we saw inflammatory changes of



Figure 1 Maggot in nostril

the nasal mucosa but no more larvae. At this point a breach of the cribriform plate occurred with cerebrospinal fluid leak. Computed tomography showed intracranial air but there was minimal mass effect and the patient made a satisfactory recovery.

The maggots, white and 20 mm long, were identified as second instar larvae of *Oestrus ovis* by Dr Martin Hall from the Natural History Museum.

#### COMMENT

Myiasis due to *Oestrus ovis* (the sheep nasal bot fly) is a common affliction of sheep and goats. Most reported cases in man,

however, have been found in urban dwellers<sup>1-3</sup>. Acquisition near swimming pools seems common, and may be related to the use of skin creams<sup>3</sup>. In the UK, all previous cases have been imported, and ours is only the second affecting a Briton in which the larva matured beyond the first instar stage (the full cycle is through first, second and third instars, pupal stage and finally adult fly). In the earlier case<sup>2</sup> the patient was immunocompromised and steroid therapy in our patient may have allowed the larvae to progress.

In man, nasal myiasis is a self-limiting infestation<sup>1,4</sup>. The patient is usually aware of the fly's strike into the nose to lay eggs. Commonly, the infestation lasts two weeks and causes moderate to severe nasal discomfort with obstruction, rhinorrhoea and a burning sensation. Angio-oedema requiring hospital admission is an unusual presentation. In the past, local treatment with a mixture of turpentine and chloroform, nasal washing with saline, and manual removal of larvae was used<sup>5</sup>. Today the endoscopic approach is effective<sup>2</sup>; however, in our case rupture of the cribriform plate was a serious complication that could have resulted in cerebral infestation.

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