# Recombinant Factor VII

Sir,

The paper by Teh *et al*[1] stated that recombinant factor $VII_a$ was used for the first time in the region for a patient with acquired haemophilia at University Hospital, Kuala Lumpur. For the record, the first use of factor $VII_a$ in an acquired haemophilia in Malaysia was for a 26-year-old man with life-threatening retroperitoneal haemorrhage at Subang Jaya Medical Centre in March 1992. The case was presented as an oral paper in the first National Conference of Haematology in April 1994 and published as a case report[2] in Annals of Academy of Medicine (Singapore) in 1994.

## References


1. Teh A, Leong KW, Bosco JJ, Koong PL and Jayarane S. Acquired Haemophilia – A Therapeutic Challenge. Med J Malaysia 1995;50 : 166-70.

2. SC Ng. Activated Recombinant Factor VII in the Treatment of Retroperitoneal Haemorrhage in a patient with Factor VIII inhibitor. Ann Acad Med Singapore 1994;23 : 901-2.



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# Chylothorax 2° to Tuberculosis

Sir,

Chylothorax is a rare condition. Tumour accounts for about 50% of cases. Tuberculosis is not a common cause of chylothorax. We report a case of chylothorax in which all the other common causes were ruled out and which responded to anti-tuberculous therapy.

A 40-year-old Chinese lady presented with a recent history of non tender left neck swelling, associated with low grade fever, night sweats and mild dyspnoea on exertion. There was no history of tuberculosis or contact with tuberculous patients. Clinically there was some fullness on the left side of the neck and findings consistent with a left pleural effusion.

Investigations revealed a raised ESR at 80 mm/hour and 150 mm/hour on 2 consecutive examinations. Mantoux test was positive at 16 mm. A chest X-ray confirmed a left pleural effusion. Pleural tap revealed milky fluid which was alkaline (pH 7.92) and consistent with exudate (Albumin 32 gm/L). Lipoprotein electrophoresis showed presence of chylomicrons and VLDL. The Sudan III stain was positive.

### Pleural Fluid

| | | |
|---|---|---|
| Total Cholesterol (TC) | : | 7.25 mmol/L |
| Triglycerides (Tg) | : | 29.00 mmol/L |

### Fasting Serum Lipids

| | | |
|---|---|---|
| Total Cholesterol (TC) | : | 4.32 mm/L |
| Triglycerides (Tg) | : | 1.10 mm/L |

The IFAT (Indirect Fluorescent Antibody Technique) for filariasis showed normal titres. Bronchoscopy was normal. She was started on a trial of anti tuberculous treatment ($2HR^2/4RH$) and discharged one week later. At follow-up after two weeks, she had CT scan Thorax/Abdomen which was normal. A repeat CXR done two weeks later showed the effusion had cleared. She was then put on a full 6 months course of treatment and is presently doing well on follow-up.

The only other condition which may present similarly is pseudo-chylothorax. Some of the points in

differentiating between chylothorax and pseudo-chylothorax are as follows[1]:

| | Chylothorax | Pseudo-Chylothorax |
|---|---|---|
| **Presentation** | More acute | Always chronic |
| Pleural surface | Smooth | Thickened/ calcified |
| Cause of opalescence | Chylomicrons | Cholesterol crystals or lecithin-globulin complexes |
| Triglyceride levels | High (> 110 mg $dl^{-1}$) | Usually low |
| Cholesterol | Low | Usually high |
| Chylomicron on lipo-protein electrophoresis | Yes | No |

We feel that our patient had chylothorax as the presentation was rather acute, the triglyceride levels in the pleural fluid was very high despite a normal serum triglyceride level and there was presence of chylomicrons on lipoprotein electrophotesis with a positive Sudan III stain.

The mechanism by which TB causes chylothorax is unclear although a possibility is the extrinsic compression of the thorcic duct by inflamed nodes[2]. The CT scan (Thorax) in our patient was normal but it may have missed the enlarged nodes as it was done 3 weeks after anti TB-treatment (by which time the nodes may have regressed).

Finally, this case illustrates that although tuberculosis is common in our country, it can still surprise us with atypical presentations.

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## References

1. Sasoon CS, Light RW. Chylothorax and Pseudochylothorax Clinics in Chest Medicine March 1985 : 163-71.

2. Bessone LN, Ferguson TB, Burford TH. Chylothorax Ann Thorax Surgery 1971;12 : 527-50.