

vagal activity from the oesophageal plexus to the nucleus solitarius in the medulla is associated with swallowing food. Efferent parasympathetic fibres to trigger peristalsis have a cardioinhibitory effect and lead to bradycardia, hypotension and vasodilatation. Severe cardiac conduction disturbance may cause loss of consciousness¹. Over one hundred cases have been described in literature², despite having been first reported³ in 1793.

The management of swallow syncope should include the withdrawal of any medication that slows the rate of cardiac conduction or causes vasodepression. Anticholinergic medications such as atropine have been trialed with a view to prevent bradyarrhythmias by inhibiting vagal tone. However, results have been inconsistent, and many drugs have undesirable side effects and are therefore poorly tolerated².

Eighty-five percent of reported cases of swallow syncope had either sinus bradycardia, sinus arrest, SA block or AV block. Implantation of a permanent pacemaker is increasingly used for patients with swallow syncope⁴. Whilst permanent pacemaker implantation does not correct the cause of the condition, it has been demonstrated to be an effective treatment.

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4. Figure 1 (a) and (b) showing 2nd degree heart block. On both occasions, the patient had documented that she had been eating a meal.
5. Basker MR, Cooper DK. Oesophageal syncope. *Ann R Coll Surg Engl*. 2000; **82**(4):249-53.

FOLLICULAR LYMPHOMA OF THE RECTUM

Editor,

Non-Hodgkin's lymphoma compromises a diverse group of

malignant neoplasms, rarely involving the colorectum.^{1, 2} Follicular lymphoma is a common subtype and constitutes 1%–3% of all primary gastrointestinal tract lymphomas.^{1, 3} There are very few cases reported of recurrence of follicular lymphoma in the rectum.⁴ Rectal follicular lymphoma is difficult to diagnose due to limited available data, low clinical suspicion and non-specific symptoms. It also has variable growth pattern and ill-defined histopathological picture, making it difficult to distinguish from benign proliferative lymphoid lesions.³

This 67-year-old lady presented in January 2010 with a right neck mass. Initially she was managed with watchful waiting for putative atypical lymphoproliferative disorder, but in August 2011 histopathology confirmed follicular non-Hodgkin's lymphoma which was treated successfully with chemotherapy. In May 2016 she presented with worsening faecal incontinence and a palpable rectal mass. Clinically,

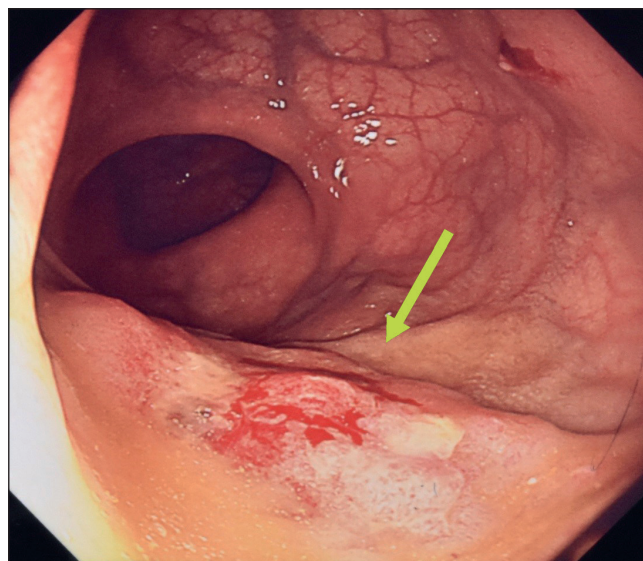


Figure 1 - Endoscopic appearance of low rectal lesion (arrowed)

this appeared to be a low rectal adenocarcinoma. [Figure 1 – Endoscopic appearance of low rectal lesion (arrowed)]. Magnetic resonance imaging (MRI) and computed tomography (CT) confirmed this rectal tumour extending to the anorectal junction with a radiological staging offered at – T3N1Mx. [Figure 2 – MRI view (coronal) demonstrating the low rectal lesion]. The initial biopsy showed a probable high-grade lymphoma, but two subsequent biopsies demonstrated only chronic inflammation. Another biopsy in December 2016 confirmed the presence of a low-grade follicular lymphoma. The patient was clinically stable and given the locality of the disease and the significant risks of chemo/radiotherapy a ‘watch and wait’ approach was chosen. However, her symptoms progressed and in January 2018 she had low-dose radiotherapy in the pelvis. As of September 2018, the patient has had a relapse confirmed and is under the ongoing care of haematology/oncology. Gastrointestinal tract follicular lymphomas have usually inert clinical course. Patients can present with various non-

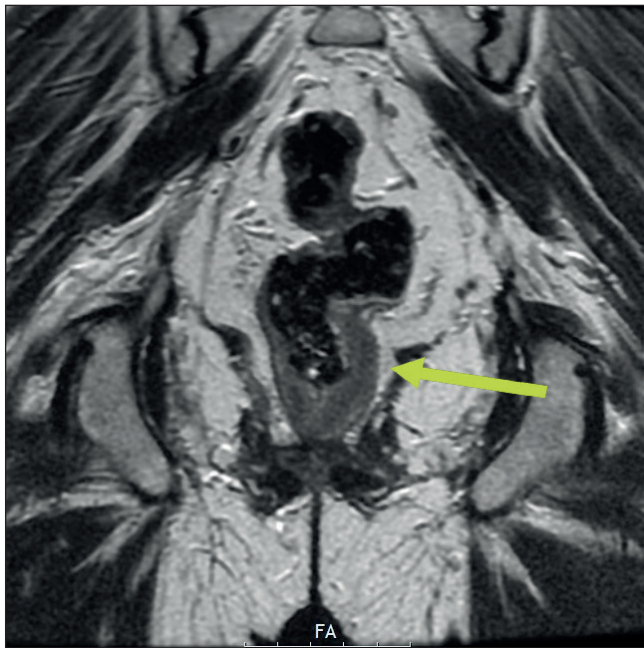


Figure 2 - MRI view (coronal) demonstrating the low rectal lesion

specific symptoms, but faecal incontinence has not been previously reported in the literature.^{1,2,5} The histopathological evaluation of colorectal follicular lymphoma can be difficult. It is not uncommon for initial histological misinterpretation and requirement of multiple biopsies before the definite diagnosis. This case emphasises the challenge of accurate histopathological diagnosis. Suitable biopsy samples and immunophenotyping analysis are recommended for accurate interpretation of the pathological diagnosis of follicular lymphoma.^{4,5} The management of gastrointestinal follicular lymphoma is not well established because of its rarity, but multidisciplinary approach should be undertaken. In this patient, after a watchful period, local radiotherapy was implemented with good effect. This appears in accordance to general consensus, as intestinal follicular lymphoma is usually approached as nodal follicular lymphoma and a watch-and-wait strategy or radiation therapy can be applied in case of limited disease.¹

In conclusion, rectal follicular lymphoma is a rare presentation, but important to consider in the differential diagnosis of rectal lesions. Endoscopists should remain alert whenever they observe ambiguous lesions in the colorectum and consultation with pathologist is advised to ensure appropriate immunostaining. Histopathologists should also maintain high clinical suspicion in differential diagnosis of follicular hyperplasia of mucosa-associated lymphoid tissue.

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TACKLING ANTIMICROBIAL RESISTANCE (AMR) - IN VITRO EFFECT OF SODIUM CHLORIDE ON ANTIBIOTIC SUSCEPTIBILITY IN CLINICAL PSEUDOMONAS AERUGINOSA ISOLATED FROM PATIENTS WITH CYSTIC FIBROSIS (CF)

Editor,

Relatively little is known about the potential interactions of cystic fibrosis (CF) co-therapies on antimicrobial susceptibility in CF respiratory pathogens, particularly inhaled/nebulised interventions, including those aiding sputum clearance, in particular, hypertonic saline (HTS). Whilst such interventions are not designed *per se* as anti-infectives, the effect (if any) of such molecules to CF patients' microbiological status and the potential effect on antibiotic susceptibility merits careful monitoring. Hence, we examined the effect of hypertonic saline on the *in vitro* antibiotic susceptibility to clinical *P. aeruginosa* from adult CF patients.

P. aeruginosa isolates (n=50) from adult CF patients were examined and were obtained from freshly expectorated sputum specimens submitted by adult CF patients, as part of the routine microbiological workup. Antibiotic susceptibility of each isolate was assessed employing standard CLSI disk diffusion assay,¹ against the antibiotics listed in Table 1, in the presence of sodium chloride (0.6M) and without supplementation, where 0.6M NaCl was chosen as a surrogate for NaCl concentration in sputum following HTS treatment. Resulting zone of inhibition were measured (mm) and compared statistically employing a two-tailed paired t-test, where p values <0.05 were considered significant, as shown (Table 1).

There was a significant effect on antibiotic susceptibility when supplemented with NaCl (0.6M). For each class of antibiotic examined, there was a statistically significant increase in zone size, ranging from a 19.3% increase with tobramycin to an 81.8% increase for piperacillin/tazobactam, with a mean increase of 60.1% over all classes of antibiotics examined.



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