APPENDIX
INDIVIDUAL CASE RECORD

Case No.  

Date:

1. Name of patient
2. Age/Sex
3. OPD/NRD No.
4. Occupation
5. Address

6. Socio-economic status
   A. Presenting symptoms
   B. Brief history of present illness
   C. Past history:
      - Tuberculosis
      - Diabetes
      - Any other.
   D. Family history:
      H/o active tuberculosis in any family members or known case of tuberculosis of neighbours.

E. Personal history

F. History of Immunisation

G. Examination:
   a. General Examination:
      - General appearance and build
      - Vitals
      - Palor
      - Jaundice
      - Cyanosis
      - Clubbing
      - Hydration
      - Oedema
      - Lymphadenopathy:
         - Cervical
         - Axillary
         - Inguinal
b. Systemic Examination:
- Respiratory
- C.V.S.
- C.N.S.
- Abdomen

c. Local Examination:
- Head
  - Face: symmetry
  - Orbit
  - Eyebrows
  - Eyelids
  - Conjunctiva (Elaborative)
    - Bulbar
    - Palpebral
  - Cornea:
    - Size
    - Shape
    - Curvature
    - Surface
    - Transparency
    - Sensation
    - Others
- Anterior chamber
  - Depth
  - Contents
- Iris:
  - Colour
  - Patterns
  - Others

Pupil
- Lens
- Visual acuity
- Tension - digitally

Investigations:

Blood:
- TLC
- DLC
- HB
- ERBC

Urine:
- Albumin
- Sugar
- Microscopic

Stool - for any ova/ova of helminthic group.

Radiological:
- X-ray chest (P.A. view).

Tuberculin Test:
- Mantoux test.

Any other.
Phlyctenulosis is a characteristic nodular affection occurring as an allergic response by the corneal and conjunctival epithelium to some endogenous toxin to which it has become sensitized.

It is an old disease. Crude description is found in Greek and Arabic literature. Jt. Yuea, 1972 was first to define the nodular conjunctivitis. Wardrop, 1968 depicted the clinical appearance of it. Ivanoff (1986) gave the histological features at first time.

It is known under the wide variety of names but 'Phlyctenular Keratoconjunctivitis' or 'Phlyctenular Ophthalmia' seem to be more appropriate.

It has controversy about its etiology. Various etiology eg. malnutrition, vitamin deficiency, enrich carbohydrate diet, pediculosis, helminthiasis have been stated but tubercular protein as an endogenous factor has been accepted by majority of observers.

Present study has been undertaken, keeping the views of age and sex incidence, clinical presentation of disease, socio-economic status of phlyctenular patients monthly distribution of patients, co-incidence of tuberculosis, tuberculin positivity and association of phlyctenulosis to the intestinal helminthiasis.
There were 56 patients of either sex from 4 to 35 years of age. They were examined properly and investigated. In the light of observations following conclusions were drawn.

- This is a disease of children and young adult individual commonly occurring in first and second decade of life with an average age, 13.8 ± 6.8 (M ± SD) year.

- Females are affected more than males ratio, F : M = 5 : 4, sex differentiation is more marked in second decade, ratio, F : M = 7 : 3.

- Common symptoms are feeling of discomfort, irritation and lacrimation, pain and photophobia are uncommon symptoms and these are present when cornea has been involved. Most important sign is a nodular lesion surrounded by hyperaemic area.

- Conjunctiva, particularly bulbar conjunctiva, is commonly involved. Limbus is the commonest site for development of phlycten. Corneal involvement is due to extension of limbal lesions.

- It affects mainly individuals of low socio-economic status. Rarely occurring in middle and negligible in upper socio-economic class.
There is no definite seasonal occurrence of disease but high incidence is in inter seasonal period between winter and summer, summer and rainy season. The occurrence of disease increases with the rise of temperature eg. higher incidence recorded from March to July and decreases with fall of temperature.

Phytoecular patients showed positive reaction to tuberculin ( Mantoux test) 66.67% indicate hypersensitivity to tubercular protein suggestive of past or present infection with mycobacterium tuberculosis may be one of the factors to indicate phytoecularosis.

Clinically 5.6% cases were found tubercular. Radiologically 66.67% cases were positive, of which 27.6% showed evidence of inactive primary complex and 29.63% showed active primary complex. Radiologically active primary complex cases were insin of hilar lymphadenitis 22.2% and perifocal inflammation with mottling 7.4%. Co-incidence of tuberculosis was found 29.4% radiologically and 5.6% clinically.
Stool positivity in phlyctenular cases and control groups gives insignificant value ($t = 1.64, p > 0.05$), shows no significant association of phlyctenulosis to the intestinal helminthiasis (worm infestation).