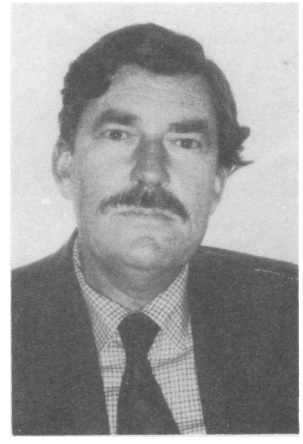

CASE REPORTS

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1. HERPES SIMPLEX EYE INFECTION

A 23 year old first team rugby front-row forward presented on the 26th March, 1980 with a clinical Herpes Virus Hominus infection at the base of his neck on the left side. Laboratory examination confirmed the diagnosis of Herpes Simplex Virus which was isolated from the swab taken and Idoxuridine 0,1% ointment was prescribed for local suppression of the viral reaction. He was advised to stop participating in contact sports until all signs of infection cleared.

He presented on the 23rd April, 1980 with a very red and painful right eye which he thought had been caused by a foreign body which could have happened in a rugby match. He had not participated in rugby for 2 weeks after he had been seen previously, and thought that all infection had cleared up. He had no clinical signs of active herpes on his face or neck. The eye was stained with Fluoroscein Sodium and three active dendritic ulcers were clearly identified on the cornea. He was referred for opthalmic opinion and treated with 30% Sulphacetamide eye-drops as well as local Idoxuridine ointment. He had daily examination of the cornea and there was continuous improvement. The opthalmic surgeon was completely satisfied with the result by the 12th May, 1980 and the patient was discharged. The patient was asked to report back at weekly intervals and not to participate in contact sport for an indefinite period.

There has been no recurrence since the original herpes eruption on the neck and with the pressures from coaches and players, etc., it is extremely difficult to decide when a contact sports player, who has active Herpes Hominus, should resume playing.

We see more and more cases of Herpes Hominus Virus infection especially amongst rugby players, every season, and the numbers who are not diagnosed must be numerous. Control is very difficult and I ask every case I see with herpes of the face or neck to have a prescription or a tube of Idoxuridine with him at all times in case of a sudden eruption close to the eye or discomfort of the eye without obvious reason – the Idoxuridine to be used until seen by a doctor.

Our results using Levamisole (with weekly blood count control), B.C.G. vaccinations, and antiviral agents like "Virobis" for recurring Herpes virus have been disappointing.

2. TEMPORAL ARTERY TRAUMATIC ANEURYSM

A 21 year old rugby forward who presented on the 12th May, 1980 with a left-sided pre-auricular swelling which he claimed had appeared on the evening prior to consultation. This had followed a light-hearted seven-a-side rugby match in which he claimed there had been no injury. The patient had been "lightly concussed" in a rugby match prior to consultation, having received a punch to his left temple. (The offender's hand had been broken!). The patient had decided not to play contact sport for a month after this, having been advised to lay off early in the season following definite concussion in a rugby match (examination and observation for 24 hours in an accident unit).

The tumour was a one centimetre pulsating swelling, which was diagnosed as a traumatic aneurysm of the left superficial temporal artery and was confirmed on exploration under local anaesthetic. Both vascular branches were ligated.

There had been complete resolution of the aneurysm. The patient has been advised to stop playing contact sport.

Van der Spuy, Levy and Levin, in the South African Medical Journal of the 19th July, 1980, found that Cimetidine (Tagamet, SK & F) may be of value in herpes keratitis in a dosage of 1,000 mg to 1,600 mg daily for ± 4 weeks.