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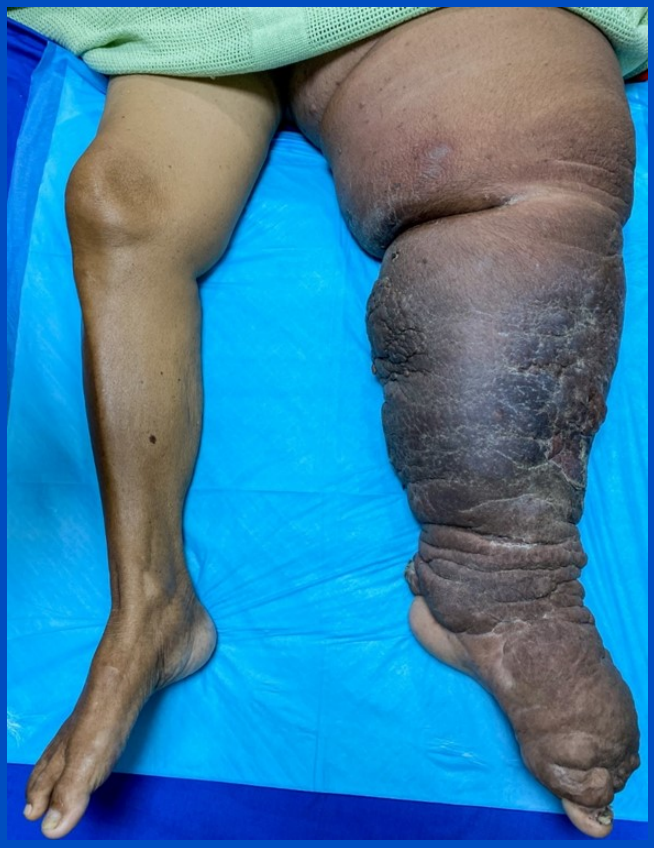

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The Brunei International Medical Journal (BIMJ) is a six monthly peer reviewed official publication of the Ministry of Health under the auspices of the Clinical Research Unit, Ministry of Health, Brunei Darussalam.

The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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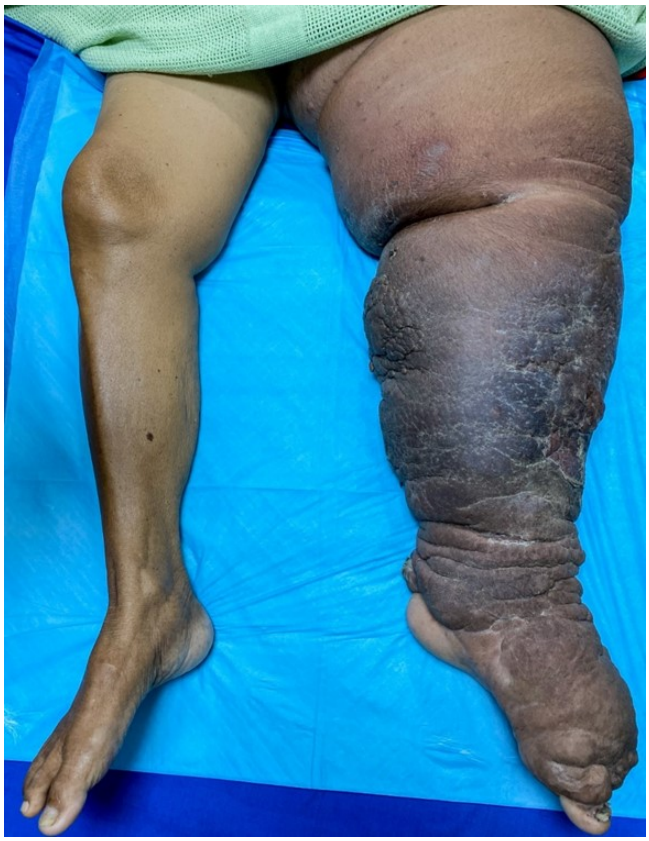

Figure 1

A 71-year-old lady with hypertension, dyslipidemia, and left hemiparesis from a previous stroke presented with fever associated with rigors and chills. She had low grade fever and a grossly enlarged left lower limb with hyperpigmented dry, thickened, hyperkeratotic skin with areas of ulceration. These findings were consistent with skin infection in a grossly deformed leg.

What is the diagnosis?

***Answer**: refer to page 135*

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DISCLOSURE: There is no conflict of interest and consent has been obtained from patient for use of these images.

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(*Refer to page 134*)

ANSWER: ELEPHANTIASIS.

This lady has gross lymphedema or elephantiasis affecting the left lower limb. She revealed that the swelling had started many years ago that gradually worsened over a period of three years. Peripheral smear was negative for microfilaria but previous blood count had mild eosinophilia on one occasion. She was treated for cellulitis and as she resides in a district where filariasis was previously endemic, she was given a course of diethylcarbamazine. She was referred to the plastic service for the management of her grossly lymphedematous left leg.

Lymphatic filariasis or elephantiasis, first described by Ali ibn Sahl Rabban al-Tabbari, a Persian physician in the ninth century as *Daa alFil* (*daa*=disease, *fil*=elephant).[1,2] It is caused by three different species of worms (*Brugia (B) malayi*, *B. timori* and *Wuchereria bancrofti*).[2] Filariasis is endemic to the tropic and affects 120 million people in 72 countries.[3]

Lymphatic filariasis occurs when adult worms deposit in and obstruct the lymphatics, causing lymphedema, leading to hypertrophy and hyperplasia of lymphatic endothelium. Over time, the obstruction becomes irreversible, and the affected limb resembles an elephant's leg.[4]

Diagnosis is made through blood smears examination preferable drawn at night due to nocturnal periodicity of microfilariae or serological test.[3,4] However, these can be negative and lymphedema can develop many years after infection.[4] The prognosis is good if filariasis is recognized and treated early. Affected limbs especially if severe are susceptible to recurrent infections. Surgical treatments involve debulking of skin and creating lymphovenous anastomosis to improve drainage.[5]

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