SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 25 To 27

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ADVERSE EFFECT WITH OVERDOSE OF HALOFANTRINE: A CASE REPORT.Bokhari, S.N.H., Specialist, 1991;7:35-37.

The case of ayoungman who developed ventricular fibrillation with halofantrine is presented. The patient was 18 years of age weighing 35 kg. He came in with fever, headache and vomiting of 7 days duration, an erythernatous rash on trunk since 4 days and drowsiness since one day. Examination revealed grade I coma, palpable spleen, sign of bilateral pneumonia with a small right pleural effusion, swollen and tender right elbow joint, painful hip joints and meningeal irritation signs. A provisional diagnosis of pneumonia, meningi tis and arthritis was made. Laboratory tests showed Hb to be 9.6 Gm, TLC 9200, serum K 2.8 meq/L and serum calcium 7.8 mg% with the other results being in the normal range. The ECG was normal and the x-ray chest confirmed the pneumonia. CSF analysis revealed low glucose, high protein and relative lymphocytosis. No organism was isolated from CSF or sputum. Parenteral antibiotics were started which gave good results. The patient became fully conscious, intensity of the fever decreased but continued to be febrile. Blood was checked for malarial parasite which was reported as positive. As chloroquin and fansidar did not give the desired results so halofantrine was administered in the recommended dose of 500 mg 6 hourly for 3 doses. After two doses the patient developed cardiac arrest twice with a generalised seizure. He was resuscitated successfully. He again developed a cardiac arrest after the third dose. The ECG after resuscitation showed a prolonged Q-T interval (0.6 sec) which normalised in 12 hours. Halofantrine, a new antimalarial introduced in Pakistan, has proven effectiveness against resistant malaria. The reported side effects are drowsiness, headache, cough, diarrhoea, abdominal pain, vomiting, dizziness, fever and pruritus. In the presented case the dose given was presumably much higher than the maximum recommended dose of 25 mg per kg body weight The prolonged Q-T interval could be attributed to halofantrine overdose leading to ventricular fibrillation and convulsive seizure. Halofäntrine has been in use since 1976 and is found to be well tolerated even in children but in a dose of 16-24 mg/kg. Experience with overdose is little and with the availability of the drug over the counter is a. definite risk. It is thus recommended that the dose should be prescribed according to the body weight only.

HAND INFECTIONS IN DIABETICS. Ahmad, I., Specialist, 1991;7:5-14.

Sixteen diabetic and 4 non-diabetic individuals were admitted to Mayo Hospital, Lahore, with severe hand infection, between July, 1988 and June, 1990. There were 10 males and 6 females with the age range between 44 and 78 years in the diabetes group. The second group had 2 males and 2 females with ages between 18 and 47 years. The diabetes was of a duration between 6 months and 22 years. Infection of the hand started due to a trivial trauma. In the past history 3 cases had had a carbuncle and 3a-myocardial infarction. Eight diabetics had a right hand insilvement, 5a-left hand and 3 bilateral infection. In the non-diabetic group 3 cases had the right hand and one the left hand infected. Culture and sensitivity studies revealed staph. aureus, strep. viridans, pseudomonas and E. coli. The web space infection was the most common in diabetic patients involving 10 hands. All patients were given respective antibiotics for one week. Diabetes was stabilised with Insulin. Local treatment was done with Insulin and drainage, debridement of slough, decompression of involved space and elevation in a plaster cast. Antiseptic dressings were applied daily after washing with a savlon solution. Three diabetic patients developed wet gangrene of the finger and two dry gangrene. These needed amputation. The duration of hospitalization varied between 8 and 48 days for the diabetics and between 4 and 8 days for the non-diabetic group. Five of the diabetics were lost to follow-up and some of the

remaining 11 cases took upto 6 months for healing. In the non- diabetic group 2-3 weeks were required for complete resolution. All patients from the diabetic group developed stiffuess of the fingers and some degree of residual deformity. It is an established fact that diabetics are more prone to infections. The reason has been attributed to a disturbed general and local immunity, defective leucocyte function, tissue hyperglycaemia, anaesthesia of the area, circulatory insufficiency and delayed wound healing. Serious sepsis of the hand in diabetics is not a common occurrence. They occur in a slightly older age group in tissues which are ischaemic and anaesthetic. Duration of diabetes seems to have a linear relationship with the frequency of hand infection. The long standing diabetes has its influence of vascular and neural insufficiency. The right hand was more involved due to its dominance and liability to trauma. Multiple hand spaces were infected in the diabetics compared to the single space in non-diabetics due to a poor tissue resistance. Staphylococcus aureus was the infecting organism in most of the diabetic hands. This causes slough formation in the pulp spaces leading to necrosis. Gangrene was encountered only in the diabetics and it was due to occlusion of the digital vessels. Radial pulse was palpable in all cases and the gangrene did not extend into the palms. The course was more protracted in the diabetics and some patients took months to heal. Finger stiffness and fiexion deformity make diabetic hands infection a serious and crippling disease and calls for better management. Diabetics should take good care of their hands and avoid even minor trauma. In case of infection broad spectrum antibiotics should be started immediately. Abscesses if formed should be drained early. Diabetes should be managed with Insulin till clearance of infection. Physiotherapy should be started early.

CLINICO-EPIDEMIOLOGICAL STUDY OF LEUKAEMIA IN MULTAN. Noor, A.N., Masood, M. Pak.J.Med.Res., 1989;28:232-242.

A study was conducted to determine the clinic epidemiological aspect of leukaemias in the region of Multan. 105 patients diagnosed as leukaemia and admitted in the Department of Medicine, Paediatric Medicine and Oncology of Nishtar Hospital, Multan were analysed. A detailed history was recorded, a systemic and general examination carried out and laboratory tests done which included peripheral blood and bone marrow analysis. The diagnosis of the various leukaemias revealed 63 patients to have chronic leukae mia, 38 had the acute disease and 4 cases were of the miscellaneous type. In males half of the cases were in the age group 11 to 40 years whereas the females belonged to 21-40 years range. Majority of the cases came from the poor class and belonged to Multan and Muzaffargarh. The prominent clinical features included fever, bleeding tenden cy, masses in neck and axilla, generalised pains and aches, weakness, mouth ulcers, pallor and in two cases unilateral prop tosis. Hepatosplenomegaly was found in 28 cases. One patient had pulmonary tuberculosis; one developed paralytic ileus and one case died of haemorrhagic pericardial effusion. The 4 cases of the miscellaneous group had multiple myeloma. There were 2 males and 2 females and all above 60 years of age. The total leucocytic count in the chronic ieukaemias ranged between 100,000 to 400,000 per ul. with 11 cases having a count less than 100,000. In the acute leukaemias the TLC was usually less than 100,000/ui. The platelet count in acute leukaemias was less than 100,000/ui whereas the chronic cases had a higher count with no bleeding tendency. 2 cases presented with acute lymphoblastic crisis. Serum uric acid was found raised in 7 cases only. The acute lymphoblastic leukaemia cases were managed with yin cnstine and prednisolone initially followed by mercaptopurine and methotrexate. Cranial irradiation was carried out after chemotherapy. Despite the intensive therapy 95 percent of the cases died within 2 years. Thioguanine, cytarabine and duanorubicin are used in acute myelo blastic leukaemia cases. These drugs are very toxic and the prog nosis is not very favourable. The chronic myeloid Ieukaemia cases in the presented series were managed with either radiotherapy alone or a combination of radiotherapy and chemotherapy with busuiphan, mercaptopurine or thioguanine. The chronic lymphocytic leukaemia patients received chiorambudil. 5 of 13 cases died due to complications. The incidence of leukaemia shows a rising trend in Pakistan and grçater awareness is needed to fight this cruel killer. With the chemotherapeutic agents being expensive and the non-availability of bone marrow transplant facility the outlook of leukaemia cases is not very promising.

NON-HODGKIN'S LYMPHOMA IN SOUTH PUNJAB (Retrospective analysis of 148 patients). Javed, A.A., Gurchani, S.A. Pak.J. Med. Res., 1989;28:223-231

A retrospective study of 148 cases of non-Hodgkin's lymphoma was made at the department of Radiotherapy, Nishtar Medical College, Multan. Classification according to Rappaport and staging was done. There were 120 males and 28 females with the median age being 40 years. The average duration of symptoms was 8 months and 79 percent of the cases had a painless lymphadenopathy in the neck and axilla, 12 percent had a painful abdominal mass and 4 percent had paraplegia. Fever, night sweats and weight loss were present in 46 percent of the cases. The histopathology revealed a diffuse pattern in 134 patients and nodular pattern in 2 cases. The rest had a mixed lymphoma. 71 percent of the tumours were over 10 cm in diameter. 95 patients had primary nodal involvement in the neck and axilla whereas 53 had primary sites in the gastrointestinal tract, Waldeyer's ring and spinal cord. 33 patients had stage I disease, 22 were in stage 11,48 in stage III and 45 patients had stage Wdisease. Only 77 cases could be followed up for an average of 7 months and each receiving a minimum of 3 cycles of chemotherapy. 30 patients had a two years disease free survival. 10 cases were reported died. The studied cases show a preponderance of diffuse histologic types of non-Hodgkin's lymphomas with 62.8 percent being in the advanced stage. This is similar to figures from other Asian countries. The median age of the patients in this series is lower than those reported from the west where it is between 55 and 60 years. The male predominance in the study again differs from the western countries where the incidence is nearly equal in both sexes. The high relative frequency of non-Hodgkin's lymphoma at primary extranodal sites matches the incidence from the Middle East and Turkey. The poor response to follow-up could be attributed to financial factors. Failure to achieve a complete dose of chemotherapy was basically due to lack of funds leading to a poor prognosis of the disease. The intermediate grade lymphomas which were encountered most have a high relapse rate and a low five year survival. The new chemotherapeutic drugs are not available and facilities to monitor drug plasma levels are lacking. Majority of these patients belonged to lower socio-economic status which is again a reason for high prevalence of poor prognostic types of lymphomas.