SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 77 To 78

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CLINICAL TRIAL OF ATRACURIUM: A NEW NEUROMUSCULAR BLOCKER: PRELIMINARY STUDY. Jaffery, S., Hassan, I.J. Surg., 1991; 2:17- 18.

A clinical trial with atracurium, an intennediate acting, non- depolarising, neuromuscular blocking agent, on 50 patients randomly selected undergoing general anaesthesia, is presented. Both sexes were included and the age range was 19 to 70 years. 28 cases had a normal cardiovascular, renal and hepatic status, 10 were in renal failure, 2 had ischaemic heart disease, 3 had abnormal liver functions, 2 were critically ill patients and there was one case of head injury. Anaesthesia was induced with i/vpentothal 3mg/kg. Atracurium 0.6 mg/kg i/v was administered to all cases followed by IPPV for 2 minutes and then tracheal intubation was carried out. All cases had a successful intubation. IPPV was maintained throughout surgery with additional doses of atracurium when required. ECG was monitored continuously and respiratory functions assessed. A comprehensive that was recorded. The duration of neuromuscular block was 30 to 40 minutes. Adequate relaxation was obtained in two to two and a half minutes. The onset and duration of action of the drug was similar in all cases including those with chronic renal failure. In cases with liver dysfunction the duration of the block was shorter and lasted for 15 minutes. In 27 cases the dose of the relaxant was repeated after 20 minutes and 23 cases required it before 20 minutes. Two to six re-injections were made depending on the duration of surgery. Fifteen cases developed tachycardia, 4 had hypotension and there were no arrythmias. Only 4 patients required neostigniine for reversal. Atracurium was found to be a muscle relaxant with definite advantages. It has a short half life of 20 minutes and can be used safely in chronic renal failure cases. Reinjections did not lead to any significant increase in blockade and in gastro-intestinal anastomotic surgery the advantage of not using neostigmine which effects the intestinal sutures by the strong peristalsis, is highly desirable.

SURGERY OF THE AMOEBIC LIVER ABSCESS. Shah, S.A., Khaliq, T., Rehman, N., Pasha, T.J. Surg., 1991; 2 :22-2 5.

A retrospective analysis of 42 cases of amoebic liver abscess is presented. 19 patients had taken antimicrobial therapy with unsatisfactory response. 20 cases had received some sort of medical therapy and 3 patients were without any prior medical treatment. A detailed history was recorded inclusive of presenting symptoms with their duration, symptoms of fever, diarrhoea, site of pain with radiation and drugs taken. Point of maximum tenderness and hepatomegaly was noted. Routine blood, urine and stool tests were done alongwith LFTs and amoebic serology. X-ray chest and abdomen and ultrasonography of the abdomen was carried out. CT scan and radionuclide liver scan was done in seleaed cases. Surgical procedures included percutaneous aspiration and open drainage through laparatomy and were indicated in cases with drug failure, bacterial infection, left lobe abscess and impending rupture of the abscess. 37 patients underwent surgery and they received metronidazole and a broad spectrum antimicrobial for 72 hours preoperatively. 5 patients showed a good response with i/v.metronidazole. Follow up was by serial ESR and ultrasound scans. Of the 42 cases, 36 were males and 6 females. The average age was 37.6 years and the duration of symptoms 24 days. 20 individuals had continuous fever, 12 had fever with rigors and 5 had intermittent fever. Diarrhoea was present in 6 cases, path in RHC in 27, pain in epigastrium in 8, pain in both RHC and epigasirium in 5 and pain in right lower chest in 2 cases only. 36 patients had radiation of pain and 8 had clinical jaundice. The mean temperature was 37.9°C and hepatomegaly was elicited in 36 patients. The mean Hb was 9.2G/dl, TLC was 14x109/L, ESR 68 mm 1st hour, serum biirubin 22.2 mmoL/L, serum alkaline phosphatase

63 KA units. The amoebic indirect haemagglutination titre was positive in 22 cases. Faecal microscopy revealed amoebic trophozoites in 2 specimens only. The X-ray chest showed right sided pleural effusion in9 films with the right dome of the diaphragm beingraised in all. Ultrasound scan gave a result of abscess liver in 31 patients only. CT scan done in 3 cases only gave a positive result 37 patients were treated surgically of whom 21 had percutaneous aspiration and 16 had open surgical drainage. Two patients of the second group died, one due to ruptured abscess and peritonitis and the other due to multiple organ failure secondary to poor general health. Two of the 3 patients from the third group responded well to i/v metronidazole and required 17 days in hospital. Surgery patients had a mean hospital stay of 12 days. The first group of patients who had been on antiamoebic therapy required surgical intervention. This could be attributed to inadequate absorption of the drug or rapid rate of metabolic transformation. The second group again had a high rate of surgery due to improper management in the initial stages. The diagnosis of amoebic liver abscess is delayed due to absence of localizing signs. However, amoebic serology and hepatic scanning are invaluable.

PAROTID TUMOURS. P.LM.S. EXPERIENCE. Shah, S.LJ. Surg., 1991; 2:42-45.

Retrospective analysis of 18 patients with a lump in the parotid region is presented. There were 8 males and 10 females with a mean age of 31.5 years. The right parotid gland was involved in 7 and left in 11 cases. All presented with a painless lump with an average duration of symptoms being 3.5 years and with 2 patients having a recurrent growth after surgery performed 10 years ago. Baseline investigations were performed and superficial parotidectomy was carried out in. 13 patients, 3 wide excisions and 2 enucleations. Histopathology revealed 13 pleomorphic adenoma and one each of adenolymphoma, solitary benign cyst, cystic hygroma and sarcoidosis. One patient had squamous cell carcinoma, which responded well to radiotherapy. The average weight of the gland removed was 19 grams. There were 3 cases with regional lymphadenopathy. No distant metastasis or recurrence was noted in the follow-up period. The only postoperative complication encountered was a facial nerve palsy in the case with sarcoidosis. Salivary gland neoplasms account for 3-5% of head and neck tumours. Fine needle aspiration cytology is an inexpensive method for obtaining an accurate diagnosis. Temporary or permanent facial nerve palsy is the single great problem in parotidectomy and the patient should be warned of the risk before hand. A good knowledge of the anatomy of the nerve and locating it before parotidectomywith a careful dissection can protect the nerve from damage.

TRACHEO-BRONCHIAL FOREIGN BODIES IN CHILDREN. Khan, M.NL, Abbasi, Z.,Jan, LA., Khan, S.A., Khan, S.J. Surg., 1991; 2:52- 55.

A study of7O children with tracheo-bronchial foreign bodies, treated by bronchoscopic removal, is presented. 58 cases were below 5 years of age and 12 between 5 and 12 years. Male children outnumbered the females being 47% and 43% respectively. Majority had a strong history of foreign body inhalation and 33 were brought in on the first day. No tracheostomy was required in the series. The storz rigid bronchoscope with fibre optic light source was used. It was noted that 57% of the foreign bodies were lodged in the right main bronchus and 5% in one of the main stem bronchus. 7 children had the foreign bodies from 9 to 18. months duration. These were all removed successfully. Most of the patients were discharged from hospital in 48 hours. One child developed surgical emphysema and had to remain in hospital for 2 weeks. A variety of materials were found as the foreign bodies but betel and peanut constituted the major bulk. Two cases died in the series. One had developed a broncho- oesophageal fistula secondary to an earlier bronchoscopy. The other had completebbstruction of the air passage and expired before any intervention Foreign body inhalation is a common occurrence in children. Early diagnosis and prompt treatment are mandatory. Lack of awareness can delay the treatment and lead to complications. Diagnosis at times is difficult so a patient with recurrent respiratory tract infection and prolonged cough should be endoscoped. An x-ray chest is often helpful. Broad spectrum antibiotics and a short course of steroids is advisable to protect from infection and reduce the oedema.