SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 229 To 230

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PREDISPOSITION TO RESPIRATORY DISTRESS SYNDROME: DIFFERENCE BETWEEN PAKISTANI AND ENGLISH INFANTS. Arif, M.A., Buston, M.H., Nizami, S.Q. and Babar, I.K. Specialist, 1992; 8:39-42.

All live born infants at Jinnah Postgraduate Medical Centre, Karachi and Birch Hill Hospital, Rochdale, England during the period 1st April, 1980 to 31st March, 1981 were observed for respiratory distress syndrome. There were a total of 6201 babies of which 4057 were born in Karachi and 2144 in Rochdale. Maturity was assessed by Dubowitz Scoring System. RDS was diagnosed by the presence of any two signs of tachypnoea, cyanosis, grunting, chest wall retraction, accessory muscle use and flaring of alaenasi. Idiopathic RDS was classified if RIDS developed in the first 24 hours of birth, deflated chest, symmetrically diminished air exchange and x-ray findings. HIPS was detected in 13 Karachi infants and 12 Rochdale babies, though the low birth weight infants (<2500 G) formed 20.8% in Karachi and 8.8% in Rochdale. None of the 56 LBW Asian infants born in Rochdale developed BPS. Gestational age and birth weight have been associated with TEDS. This study revealed a lesser predisposition of the Asian infants to TEDS than the European babies.

DYSENTERY STUDY IN PESHAWAR DISTRICT: A PILOT PROJECt Qazizada, A and Welsby, S. Specialist, 1991; 7:27-31.

A pilot study was conducted in Peshawar, Pakistan to determine the incidence of shigella dysentery and amoebiasis alongwith the sensitivity of the shigella species to antibiotics. Stools from 40 dysentery patients attending the Basic Health Unit of Afghan's Health and Social Assistance Organization, Peshawar and coming in with diarrhoea were asked to collect stool specimens. A proforma was filled for those containing visible blood and the stool specimen was subjected to a microscopic examination and culture for shigclla in 55 Agar. Antibiotic sensitivity was tested. Normal saline and iodine methods were used to detect E. histolytica. Shigella was cultured in 28% of the dysentery stools examined whereas entamoeba histolytica was found in 10% of the specimens. Nalidixic acid had 100 percent sensitivity with cotrimoxazole and ampicillin being 83% and 91% resistant. Shigella is a common cause of dysentery in children. The high incidence of resistance to ampicillin and cotrimoxazole reflects their unnecessary use. Diagnosis of shigella is only accurate when the handling of the stool specimen is prompt.

DYSCHONDROPLASIA WITH HAEMANGIOMATA. Shaikh, S Specialist, 1991; 7:61-64.

Dyschondroplasia or Olliers disease is a cartilage defect whereas haemangiomata are vascular malformations. When both co-exist the disorder is called Maffuci's Syndrome. A case diagnosed of this syndrome at the Dermatology Department of Jinnah Postgraduate Medical Centre in December 1990 is presented. It was a 14 year old girl of Pathan descent with small bluish red cutaneous nodules on the medial aspect and plantar surface of the right foot. These gradually increased in size and coalesced. There was no history of trauma or drug intake and family history was non- contributory. The left arm was deformed due to a fracture in childhood. Hard painless swellings were seen arising from the fingers of the left hand which had gradually increased in size. Numerous bluish red cutaneous nodules with a keratotic surface and scaling were found on the plantar surface of the right foot. The nail on the last digit of the left hand was dystrophic and discoloured. The systemic examination revealed no abnormality and the routine laboratory studies were all in the normal range. Radiographs of the hands showed numerous soft tissue shadows in the phalanges compatible with Ollier's disdase and Maffucci's Syndrome. Skin biopsy from lesions of the right foot showed fragments of skin with numerous vascular

channels most of which were cavernous haemangiomas. The phalangeal tumour biopsy gave a diagnosis of chondroma. The angiomatous nodules on the right foot were excised. Amputation of the left hand was advised for the multiple tumours, which the patient refused. Maffucci's Syndrome is a developmental dysplasia with anomalies of cartilage and blood vessels. The haemangiomata seen in the syndrome belong to the group of cavernous angioma. Ollier's disease the second component of Maffucci's Syndrome, involves the growing ends of bone. Normal ossification does not take place, the bone increases in length and cartilage persists in the metaphysis. Multiple nodular tumours are formed which usually appear before puberty. Pathological fractures occur and in severe cases the limb gets transformed into a huge endochromatous mass. All functions may be lost and amputation becomes imperative. Serious deformities are produced but they are compatible with an active life. A high potential for malignancy exists in these cases with a ten percent conversion to chondrosarcoma.

PETROUS APEX ABSCESS. Jalisi, M. Specialist, 1990; 6: 47-48.

The case report of a young male aged 35 years diagnosed as petrous apex abscess or politzer abscess is presented.

The patient complained of a left ear discharge and deafness since 3 months with pain in the left temple and diplopia since one month. On examination he was febrile, the left eye could not be lateralized beyond 90 degrees, the left tympanic membrane had amoist anterior central perforation and tests proved total deafness in the left ear. A CT scan showed extensive osteolysis of the ipsilateral petrous apex.

A radical mastoidectomy was done as the mastoid cortex was extensively eroded by granulations. The tegmen tympani was drilled and curretted to expose the track of infection leading into the petrous apex. The dura covering the anterior surface of the petrous temporal bone was lifted which made a passage for the drainage of the pus. The movements of the left eye recovered after two weeks.

The petrous apex is wedged between the greater wing of the sphenoid and the basilar part of the occipital bone and forms the posterior boundary of the foramen lacerum. On the roof lies the trigeminal ganglion with the abducent nerve crossing nearby. The petrous bone contains air cells in 30 percent people and is connected to the mastoid via the perilabyrinthine cells through the middle ear. Infection in these two areas thus can cause a petrous abscess also.

Diagnosis is confirmed by x-rays of the petro-mastoid complex. Introduction of the CT scan has simplified the diagnosis. Treatment has to be vigorous just as any other intracranial abscess.