SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 72 To 72

Fatema Jawad (7/6, Rimpa Plaza, M. A. Jinnah Road, Karachi.)

SERUM ALKALINE PHOSPHATASE LEVELS IN HEALTHY SUBJECTS AND IN PATIENTS OF VARIOUS LIVER DISEASES. Cheema, T, Chaudhry, N.A, Chaudhry, F.M., Ahinad, M. Pak. A.F. Med. J., 1989;42:17-20.

Astudywas conducted on 184 subjects, 100 normal and 84 with liver disease to determine the serum alkaline phosphatase levels. These are a group of enzymes that catalyse the hydrolysis of a number of organic phosphate esters in an alkaline pH. The enzyme is found in many tissues and its function is unknown. It increases two-fold in pregnancy and its main diagnostic value is in differentiating hepatocellular from obstructive jaundice. High values also occur in certain diseases of the bones and muscles. Of the 84 diseased persons in the study, 42 had viral hepatitis, 11 liver cancer, 10 obstructive jaundice, 8 cirrhosis, 5 hepatic coma, 4 amoebic liver and 4 post hepatitis cirrhosis. Serum was obtained from all individuals and tested according to the method of Bessey, Lowry and Brook. The serum alkaline phosphatase level in the normal individuals was found to be 6± .8 K.A. units with normal range being 3-13 K.A. units. The maximum rise was found in obstructive jaundice cases, 41 ± 11 KAunits. This was followed in decreasing order by liver cancer 35 KA units, amoebic hepatitis 30 KA units, viral hepatitis 23 KA units, post-hepatitis cirrhosis and lastly liver cirrhosis 10 KA units. These findings correlate with the degree of obstructive elements within the liver. The very significant rise of the level of serum alkaline phosphatase in amoebic hepatitis does not correspond to the findings of Sherlock who found moderate rise of the enzyme in amoebic cases. The variation could be attributed to the chronicity of the disease in our country, leading to obstruction in the bile canaliculi.

HAEMOLYTIC-URAEMIC SYNDROME. Akhtar, M.A., Yousuf, M., Rashid, P. Pak. A.F. Med. J., 1989;42:54-56.

Haemolytic uraemic syndrome is characterised by renal microangiopathy with decreased glomerular filtration, proteinuria and haematuria, microangiopathic haemolytic anaemia and thrombocytopenic purpura. A 17 year old male patient was hospitalized with fever since 5 days associated with sore throat, persistent vomiting, oliguria and progressive drowsiness. He had a history of similar episodes thrice earlier with having been haemodialyzed once. Examination revealed mild jaun dice, and a blood pressure of 160/95 mmHg. Urine analysis showed albuminuria, R]3C 10-12/HPF and granular casts, Hb 6.19Gm, TLC 20.1 x 109/L, Platelets 46 x 109/L, blood urea 20 mmol/L, serum creatinine 442 mmol/L. The creatinine clearance was reduced to 23 mI/mm and the serum biirubin raised to 3.8 mg%. No other abnormality was noted in the coagulation screen. Bone marrow examination was consistent with haemolytic anaemia and the isotope renal scan confirmed acute renal failure. Haemolytic uraemic syndrome was diagnosed and conservative therapy with blood transfusion, frusemide and ampicillin was started. Complete recovery was had after 2 weeks. Haemolytic utaemic syndrome occurs in infants, children and young adults and is usually preceded by an infection or may be idiopathic. A familial or hereditary type of syndrome has also been identified where intravascular haemolysis is experienced. Radical treatment is instituted in cases of worsening renal disease. Adults have a higher mortality rate, relapses are common and chronic renal failure is a frequent outcome.

A RARE ANOMALY OF BILIARY TRACT .A Case Report. Malik, A.M., Siddiq, M.T. Pak. A.F. Med. J., 1989; 42:33-35.

A 48 year old female was hospitalized with complaints of fever with rigors, nausea and vomiting of4 days duration. Apast historyof chronic dyspepsiasince 5 years was given. On examination shc was found to be febrile, jaundiced, dehydrated and toxic. Tenderness was present in the epigastrium and

right hypochondrium. The liver function tests revealed serum biirubin 9 mg%, SGPT 190 units/dl and serum alkaline phosphatase 68 units/L Ultrasonography showed multiple gall stones. Surgerywas performed and through aright subcostal incision a gall bladder packed with stones was displayed. After tedious dissection the common bile duct could not be located and its absence was confirmed by a cholangiogram via the cystic duct. An abnormal duct was found entering the gall bladder. Cholecystectomy was performed followed by antecolic choledochojejunostomy. An uneventful recovery followed. Congenital anomalies of the biliary tract are found in about 15% of human beings. These may not produce anysigns and symptoms and are usually diagnosed on the operating table. A per-operative cholangiogram is a great aid in diagnosis, further management and a quick uneventful recovery.