SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 118 To 120

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SURGERY OF PROSTATE IN DISTRICT HEADQUARTER HOSPITAL RAWALPINDI COMPARISON OF OPEN PROSTATECTOMY WITH TRANSURETHRAL PROSTATECTOMY. Zafar, A., Cheema, K., Bashir, R., Ellahi, I. Rawal MedJ., 1990; 18:37-39.

A retrospective study was carried out on 71 patients between the ages 40 and 100 years subjected to surgery of the prostate from March 1987 to March 1988. 21 had transurethral resection and 50 open prostatectomy. 16 patients underwent surgery due toprostatism and 55 due to acute retention of urine. All the cases had a physical examination and haematological and biochemical tests alongwith urine culture, chest Xrays and intravenous pyelogram. Transvesical prostatectomy was done on 47 patients, retropubic prostatectomyin 3 and transurethral prostatectomy on 21 cases. General and spinal anaesthesia was administered to the open prostatectomy procedures. A size 24, three way foleys catheter was used and irrigation was carried out with normal saline. Postoperatively gentacyn 80mg BD or ampiclox 500 mg6 hourly was given. Catheter was removed on eighth postoperative day. The Olympus resectoscope was utilized for transurethral surgery. Sterilised water was the irrigatingfluid. A three way foleys catheter size 24 was inserted and normal saline was used for irrigation. Gentacyn was given postoperatively and the catheter removed on the fourth postoperative day. The average hospital stay in open prostatectomy was 20 days whereas the TUR cases required only 12 days. The complication encountered in open prostatectomy patients were haemorrhage, wound infection, suprapubic leakage and urinary retention due to residual prostate. The TUR cases developed stricture urethra in 2 patients. This comparative study concluded that though TURP is a standard procedure practiced all over the world, it requires special training and equipment. Open prostatectomy is still a safe and easy procedure and bladder stones and diverticulae can be managed simultaneously.

THYROID DISEASE- A SURGICAL PROBLEM. A STUDY OF 845 CASES IN SURGICAL UNIT II, RAWALPINDI GENERAL HOSPITAL Khawja, A.R., Chaudhry, A.R., Iqbal, M., Maqbool, A. Rawal Med.J., 1990; 18:21-25.

The study was undertaken to ascertain the pattern of thyroid disease and to evaluate the goitre. 845 patients presenting with goitre or thyroid related disorders were included. Most of the individuals (618) belonged to Rawalpindi and Islamabad and the rest came from Murree, Azad Kashmir, Attock, Hazara, Chakwal, Jhelum and NWFP. The age range was between 11 and 40 years and there were 699 females. The commonest complaint was an unsightly mass in 617 patients, folloWed by pain (279), dyspnoea (246), dysphagia (187) and toxic symptoms (83). Thirty patients were suspected of having malignancy of the thyroid gland clinically whereas the rest had simple multinodular goitre. Radionucide thyroid scan was performed in 394 cases. 195 had multiple warm and cold nodules, 107 diffuse activity, 78 solitary cold nodule and 14 solitary hot nodule. Thyroid profile done in 394 subjects showed 34 to have grossly raised levels of serum T3 and T4 and 10 cases were hypothyroid with increased TSH. 83 patients had thyrotoxicosis. A biopsy was performed in 328 patients and 20 turned out to be malignant of which 10 were diagnosed as papillary carcinoma. 12 percent of the solitary cold nodules on scan turned out to be malignant. A thorough clinical examination gives the clue to the diagnosis of thyroid enlargements. Most of the benign cases get cured by surgery as m this study. The incidence of thyroid malignancy is comparable with the studies conducted in the western countries.

MORTALITY IN BURNT PATIENTS. Rasool, M.I., Iqbal, M., Khan, M., Mirza, M.W, Ahmed, W, Abbas, F., Ishtiaq, Barlas, KJ. Rawal Med. J., 1990;18:26-29.

A study on 137 burnt cases was conducted between June 1987 and December 1989 in the department of

General Surgery Unit I, Rawalpindi General Hospital, Rawalpindi. The burnt patients after being assessed by the Wallace Rule of Nine were admitted in separate rooms. Fluids were administered according to requirements. The burnt area was washed, blisters punctured and topical drugs used and nursed by the open method. Prophylactic antibiotics were started and ATS injected prophylactically. There were 76 females and 61 males of which 41 females and 22 males died resulting in a mortality rate of 45.98%. The average burnt area in females was 75 percent and in males 65 percent. The surviving cases had an average of 20 percent burns. 22 patients died of septicaemia, 13 due to fluid and electrolyte imbalance and 11 of shock. The average survival was 4.35 percent. In well equipped centres a survival rate of 10 percent in 75% burns has been reported. In this series the mortality was 100% in burnt area of 60%. Properly equipped burn units are lacking in hospitals of Rawalpindi. Bacteria controlled nursing units and trained personnel are an essential requirement to look after critically burnt cases and to reduce their mortality.

CORONARY HEART DISEASE: REVIEW OF 110 CASES. Khan, M.A., Nishtar, M.T. Rawal MedJ., 1990;18:40-43.

A study was conducted on 110 hospitalized patients suffering from coronary heart disease, in the Lady Reading Hospital, Peshawar. There were 95 males and 15 females with ages between 38 and 70 years. 57 percent of the cases belonged to the low income group and 28 percent to the middle income group. There were 35 labourers and 40 individuals had active occupation whereas 70 had sedentary habits. 56 patients were smokers and 27 were obese. 85 cases were categorized as acute myocardial infarction, 15 as acute coronary insufficiency and 11 as angina pectoris. The male dominance in coronary heart disease as seen in this study, is not universal. The low incidence of females could be due to their not having an easy access to the hospitals. Smoking and obesity are well known risk factors for coronary heart disease. A detailed dietary history revealed a high consumption of refined sugar. Chronic strain due to economic, social, cultural and moral forces, insecurity, frustration, frequent illness, hostility and responsibility increases the incidence of coronary heart disease. It has been that anxiety states are associated with a rise in serum cholesterol and other lipids which are a contributing factor to CHD. The study proved that the higher social class individuals had the same incidence of CHD as in western countries. But the poor class individuals also had a big incidence of CHD due to the prevailing stressful conditions and chronic anxiety.

PERNICIOUS SYNDROME OF FALCIPARUM MALARIA AND LEUKAEMOID REACTION. A CASE REPORT. Khan, A.S., Khan, A.R., Rehman, S. Khyber Med.J., 1989;7:45-46.

An eleven year old girl with fever of 10 days duration was referred for evaluation. The child appeared sick and pale. She had a temperature of 100Â° F, pulse 140 per minute, systolic murmur over the entire precordium, hepatomegaly and congested lung fields. Haemoglobin was 7.0Gm% ESR95 mm 1st hour, TLC 55,500/cmm with neutrophils 83%, Metamyelocytes 4% Myelocytes 2%, Band forms 4% and Lymphocytes 2%. The blood ifim was positive for malaria. Gametocytes of Plasmodium falciparum were seen in abundance, about 10-12/HPF. The RBCs were enlarged. Urine was dark coloured with increased bilirubin and urobilinogen. Microscopic examination showed 20-25 RBCs per HPF. Serum bilirubin was 4.2mg% mainly conjugated, ALT 70 units/L, ALP 31.5 KAunits and blood urea 150mg% The patient expired the next day. The patient came from south Waziristan. She was highly toxic due to marked parasitaemia. Anaemia was present due to the high degree parasitaemia and the obstruction or renal, hepatic and pulmonary microvasculature by the infected red cells was responsible for the clinical and biochemical manifestations.

RAPIDLY CHANGING ANTIBIOGRAMS OF BACTERIA CAUSING COMMON INFECTIONS. Rab, F., Akhtar, M. Akhtar, T Khyber Med.J., 1989;7:9-13.

A retrospective analysis of all bacterial culture done in the year 1980 and 1986 was carried out. The study was undertaken to determine the prevalence of resistance and changes in the sensitivity of the microorganisms due to indiscriminate use of commonly available antibibtics which is a frequent practice. In the year 1980 a total of 1061 strains of bacteria were isolated. Of these 391 were E. Coli;

259 Bhaemolytic Streptococci; 161 Proteus Vulgaris, 190 Staphylococcus Aureus, 44 Pseudomonas Aeruginosa, 9 Klebsiella Aerogenes and 7 proteus Morganii. In the year 1986 a total of 1006 strains of bacteria were isolated of which 497 were E. Coli, 151 proteus Vulgans, 143 Staphylococcus Aureus, 83 pseudomonas aeruginosa and 16 B- haemolytic Streptococci. The sensitivity obtained in both the years was compared and it was noted that a significant reduction in E.Coli sensitivity to Kanamycin, Amoxycillin, Ampicillin, Nalidixic acid and Doxycycline had occurred. Staphylococcus aureus had become more resistant to erythromycin, gentamycin, carbenidillin, kanamycin, ampicillin, doxycycline and chioramphenicol. Beta haemolytic streptococci showed more resistance to penicillin, ampicillin and erythromycin while pseudomonas aeruginosa was more resistant to carbenicillin and kanamycin. Similarly proteus Vulgaris was found to be more resistant to kanamycin, nalidixic acid, doxycyclin, amoxycillin and chioramphenicol. Kiebsiella aurogenes had also increased its resistance to kanamycin, nalidixic acid, doxycyclin and chioramphenicol. The results showed that most organisms had developed a resistance to kanamycin, ampicillin, amoxycillin and doxycyclin. Gentamycin was found to be the only antibiotic which was effective against most of the commonly cultured bacteria. This report demonstrated a significant increase in bacteria resistance to antimicrobials. The cause could be attributed to haphazard and over use of antibiotics. The over-the-counter sale of these drugs is another major responsible factor. If this trend continues unchecked, it could be predicted that resistant infections would become a real problem in the near future.

RIGHT VENTRICULAR MYOCARDIAL INFARCTION. TWO CASE REPORTS. Khan, A., Haq, M., Khan, Z.A. Pak. A. F. Med. J., 1989; 42 : 36 -39.

Two cassses of right ventricular infarction are presented. A 70 year old male was admitted with chest pain, sweating and dizzy spells preceded by dyspeptic symptoms. The BP was 90/60 mmHg, JVP markedly raised, third heart sound audible at left sternal border and cardiac enzymes significantly raised. ECG showed Q waves in II, III and a VF with markedly raised ST segment. RV3 and RV4 also showed a marked ST rise and small R. Routine treatment was administered and i/v fluids were given to maintain the CVP at 15-20cm of H2O. Episodes of VF occurred in the following days from which he was successfully resuscitated. Gradual improvement followed and the patient was discharged after 10 days. The second case was of a 60 years old male who came in with epigastric pain, vomiting and dyspnoea since 6 days. Clinical examination showed BP 80'60mmHg raised JYP, third heart sound at the left sternal border, and a palpable liver. Crepitations were audible in both lung bases. ECG had an acute ST elevation in the anterior leads, inferior leads and V3R and V4R. The cardia enzymes were markedly raised. X-ray chest revealed significant cardiac enlargement and pulmonary congestion. Blood urea was 96 mg%. Intravenous Dopamine was given to maintain the blood pressure above 90mmHg I/V glucose saline and later frusemide and isosorbide nitrate were administered. The patient developed a cardiac arrest on the third day and could not be resuscitated. Both the cases were diagnosed as right ventricular infarction alongwith inferior wall infarction. Right ventricular infarction, not a very uncommon condition, can be missed if right sides chest leads of the ECG are not recorded. The diagnosis is crucial because the management is markedly different. RV infarct presents with raiscd JVP, hypotension, palpable liver and triple rhythm which occurs in left ventricular failure also. Diuretic and pre-load reducers are the treatment of choice in LV failure whereas they can prove disastrous in RV failure secondary to RV infarct where CVP has to be maintained at a higher level. RV infarct where CVP has to be maintained at a higher level. RV infarct occurs only in the presence of acute inferior wall infarction where the right coronary artery is occluded. It is thus recommended that in all patients with inferior myocardial infarction right sided chest leads should be recorded.