# SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

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**CARCINOMA OF GALL BLADDER - A STUDY OF 112 CONSECUTIVE CASE& Mubarik, A., Ahmed, M., Khan, A.H>, Mansoor, A. PakA.F.Med.J.,1990;43:1-7.**

In a study of 1384 cholecystectomy specimens examined in a 5 year period at the Armed Forces Institute of Pathology, Rawalpindi, 112 showed carcinoma. It was an incidence of 1.2% of all malignancies. All the cases of carcinoma of the gall bladder were reviewed from the stored slides prepared from biopsies in the period June 1984 to June, 1989. The data of the patients was recorded from the available documents. The age range of the patients was between 25 to 88 years with 27 males and 85 females. Most of the patients complained of upper abdominal pain of six months duration. 8 percent of the cases had symptoms for over 3 years. Only 6 cases were suspected of having malignancy before surgery. Gall stones were found in 44 cases, 25 gall bladders had no stones and 43 specimens were only a small portion of the gall bladder. 98 patients were diagnosed as adenocarcinoma, 5 squamous cell carcinoma and 9 were undifferentiated. The incidence of carcinoma of the gall bladder has been found to be higher in the Pakistani population as compared to the western world. This has been reported in earlier studies also. It is also found at an earlier age and is more common in females. The diagnosis of carcinoma of the gall bladder is not suspected clinically. So it is imperative that a high index of suspicion should be kept in all cases of chronic cholecystitis. The presence of stones in 64 percent of the specimens shows the high association of gall bladder cancer and gall stones. It has been suggested that stones may contain a carcinogen or they may act on a susceptible mucosa damaged by long standing cholelithiasis.

**FALSE ANEURYSM - A CASE REPORT. Hamdani, S.&H., Saleem, T. Pak. A.F. Med. J., 1990; 43:13-14.**

A 29 year old male acquired a comminuted fracture of right tibia and fibula in a road traffic accident. A year later he noticed a small pulsatile swelling on the mid-lateral aspect of the right leg. The swelling enlarged and became painful with the passage of time. Four years later the young man had sudden pain in the right leg, the swelling became tense and his foot got numb. The x-ray showed a well united fracture of the right tibia but the middle third of the fibula was replaced by a soft expanding mass. Femoral anglography showed an extra vascular mass partially compressing the posterior tibia! artery and completely compressing the anterior tibia! artery. Exploration was done and the mass was found to contain an organised blood clot. The eroded ends of the fibula were projecting into the cavity. The posterior tibia! artery was plugged with a clot. This false aneurysm of the posterior tibia! artery was repaired and the cavity packed. A smooth recovery followed. False aneurysms or traumatic aneurysms are produced by tangential laceration of an arterial wall leading to extravasation of blood in the surrounding tissue. The haematoma liquefies and fibrous tissue forms the walls of the aneurysm. It presents as a large mass causing pain and paralysis. Pulsation is not found as the cavity is occluded. Surgery should be performed especially when signs of nerve compression are present or there is a danger of rupture. The artery involvedshould be dissected, temporarily occluded, clot evacuated and the arterial defect repaired. Long term results are excellent.

**BONE TRANSPOSITION (A CASE REPORT AND REVIEW). Qurehi, A.G. Pak.A.F. Med.J., 1990;43:20-23.**

Gun shot injuries can cause extensive damage to tissues. A bone involved has an open fracture with a greater chance of infection and osteomyeitis complicating it. A case is presented where a gun shot injury caused extensive loss of bone and soft tissue. The patient was a 25 year old male with a history

of a gun shot injury to his right forearm 9 months back. Conservative treatment had been given initially and afew days later a big piece of the shaft of the radius was removed. After 6 months of hospitalization the patient ended up with multiple discharging sinuses and äeformity of the right hand. On examination there was loss of soft tissue from the right forearm with multiple discharging sinuses. The right hand was adducted with dislocation of the inferior radio-ulnar joint. The sinuses were excised and wound debrided and then surgery was performed. The two ends of the radius were exposed and curretaged. The lower end of the ulna was inserted into the marrow cavity of the lower end of the right radius after excising the head of the ulna. This compensated the bone loss and restored the function of the wrist and hand. Non-united fractures are managed either by internal fixation or bone transplantation. A dtogenous bone grafting may either be compact bone grafting or cancellous bone grafting. The cancellous transplant is used for osteogenesis and filling of bone gaps and if the fracture is unstable, fixation is achieved by using a plate. Cancellous bone is also completely resorbed in case of infection and new bone is laid down whereas a dead compact bone forms a sequestrum. In the presented case cancellous bone graft was not possible due to lack of space in the forearm secondary chronic infection. The only alternative present was to fix the ulna shaft after excising its lower end, into the lower end of the radius. This not only reconstructed the right forearm but also made it functional.

**ACOUSTIC NEUROMA- A CASE REPORT. Ahmed, B. K.A.F.Med., J., 1990;43:27-29.**

A 37 year old male presented with a history of unilateral progressive deafness and tinnitus in the left ear since eight months. Local ENT examination was non-revealing. Pure tone audiogram gave a result of moderate sensorineural deafness in the left ear. The x-ray of the internal auditory meat! was normal. Complete audiological assessment showed sensorineural hearing loss of 60 dB of the left side. There was a rapid tone decay, stapedial reflex decay and left canal paresis which all together indicated a retrocochlear lesion involving the eighth nerve. A CAT scan with contrast was performed which revealed an ill-defined lesion at the left cerebellopontine angle. A posterior craniotomy was performed and a tumour arising from the left auditory nerve hanging in the left cerebellopontine angle was excised. Postoperative recovery was uneventful except for a left facial nerve paralysis which recovered partially later. Tone decay measures the phenomena of auditory adaptation. A tone decay of 15 dB/minute raises a suspicion of retrocochlear lesion. A rapid tone decay is significant for a cerebellopontine angle lesion involving theeighth nerve. Abnormal tone decay is seen in acoustic neuroma, multiple sclerosis, viral neuritis and intracranial aneurysm pressing on the cerebellopontine angle. Reversible tone decay has been described in eighth nerve neuritis. It is thus advisable to perform a tone decay test on every case presenting with unilateral sensorineural deafness and tinnitus. The test is simple and inexpensive requiring only a pure tone audiometer.