SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 149 To 150

Fatema Jawad (Sughra Bai Millwala Hospital, North Nazimabad, Karachi.)

CEREBRAL MALARIA. Rehman, S., Siddiqi, M.A., Khan, F.M. ,Imran, M. Pakistan Paediatric Journal, 1986; 10: 213-218.

Six children between 3 and 10 years of age were diagnosed as cerebral malaria in the Paediatric Department of Lady Reading Hospital, Peshawar. All had positive cerebral signs as convulsions, irritability, drowsiness, neck rigidity and yomiting. All had anaemia and splenomegaly, except one child. Positive smears for P. Falciparum was obtained in all the patients. Treatment was given with parenteral chioroquin and good response was had in all cases. A patient should be labelled as Cerebral Malaria when CNS signs are present with a positive smear of Plasmodium Falciparum. A child having cerebral manifestations with a positive smear of Plasmodium Vivax should be labelled as Malaria with cerebral signs. Chioroquin resistance should be suspected if the response to treatment is not satisfactory.

PARALYTIC ILEUS IN PAEDIATRICS. Arain, A. A. Pakistan Paediatric Journal, 1986; 10:180-183.

113 cases with paralytic ileus, admitted in Nawabshah Medical College Hospital from January 1983 to December 1985, are presented. 74.3 percent were males and 25.5 percent were females, with the maximum number of patients in the age range of one to three months. 77.8 percent were the outcome of acute gastroenteritis. The remaining were secondary to acute respiratory infection and other causes. 47.82 percent of the cases had hypokalaemia with serum potassium below 3.8 meq/L and 8042 percent had serum sodium below 136 meq/L with 39.12 percent having hyponatraemia with levels below 130 meq /L. Mild acidosis was present in 19.56 percent of patients. Significant acidosis was encountered in one case only. 55 of the 113 patients with paralytic ileus expired. 40 cases recovered, 15 left against medical advice and 3 were transferred to the surgery department. It was concluded that correction of electrolyte levels should be the main aim of therapy in Paralytic ileus. All replacement fluids should have adequate amounts of Potassium. The bowel should be decompressed by nasogastric tube suction and passage of flatus tube. Broad spectrum antibiotic cover should be given.

BIRTH WEIGHT OF NEONATES DELIVERY AT BARAWAL VICTORIA HOSPITAL, BAHAWALPUR. Sarwar, S.A., Mazhar, A. Pakistan Paediatric Journal, 1986; 10: 172-179.

The data of 416 newborn babies from a continuing study in the Obstetric Department of B.V. Hospital, Bahawalpur, to assess the birth weight is presented. The aim of the study is to determine the effect of maternal age, parity and socio-economic conditions on the weight of newborns and finally to formulate a percentile chart for birth weight from our own population. 416 deliveries consisting of 388 single, live births after full term pregnancies and the rest 12 live births after full term twin deliveries and 16 pre-term deliveries were included in the study. A detailed antenatal, obstetric and family history was completed for each mother. Babies were examined thoroughly and their weight, head circumference and height were recorded. There were 227 males and 189 female neonates. The overall mean weight in the newborns was 3.1 ± 0.7 kg with males being 3.1 ± 0.6 kg and females 2.9 ± 0.7 kg. The mean birth weight for single live birth increased with increasing age of the mother and then decreased after 40 years of age. Babies of primiparas and second paras had a lower birth weight and the birth weight was directly proportional to the family income. The mean birth weight of rural mothers was higher than their urban counterparts. The overall low birth weight (2.5 kg and below) incidence in single born full term babies was 9.5 percent and that in twin and preterm pregnancies it was 14.1 percent. Percentile values calculated and compared with American Standards proved that 50th percentile of our general population falls at 25th percentile of Americans. Also the values in the higher income groups are

similar to American standards thus indicating that: if the nutritional status and general health of our population is improved the growth pattern of our new born babies can be compared to their western counterparts.

CLINICO-HAEMATOLOGICAL STUDY OF BETATHALLASAEMIA MAJOR IN CHILDREN. Bhutta, I.I., Chughtal, MA., Zafar, M.H., Bhutta, A.T., Mazhar, A. Pakistan Paediatric Journal, 1986; 10:184-190.

116 children admitted in the Paediatric Department of Nishtar Hospital, Multan, in the period January 1979 to December 1983 and suspected to be having Beta-Thallasaemia were studied. Complete clinical history, family history, physical examination and haematological assessment was made in every case. Red cell fragility, reticulocyte count, red cell morphology and serum bilirubin was done in each patient. Bone marrow was studied in a few selective cases. Hb-F in patients and Hb-A2 in parents were estimated by electrophoresis on cellulose acetate paper and this formed the basis of diagnosis of Beta-Thallasaemia major. Of the 116 patients, 87 had findings consistent with betathallasaemia. The ages at the first hospital visit ranged between 3 months to 10 years with a pre-ponderance of boys. Consanguinous marriages were positive in 80 percent of the parents and growth retardation was present in all patients. Fever was a common complaint where as cough and dyspnoea occurred in 55 percent and generallsed oedema, CCF and malnutrition was found in 17 percent of the cases. Anaemia and hepatosplenomegaly were constant signs. The red cells of the thallasaemic children showed significant haemolytic morphological changes. The reticulocyte count was high and Hb levels between 2 — 6 g/dl. Serum Iron was 83 ± 28 and Hb-F had a mean value of 45%. 112 family members had a high Hb-A2. A large number of these children had complications due to anaemia, infections and repeated blood transfusions. On follow up 25 died in a period of five years. Blood transfusion being the only treatment of Thallasaemia major posed many practical problems. Lack of donors for fresh blood and the irregularity of the parents in bringing the child to the hospital resulted in keeping the Hb levels around 6.8 g/dl against the desired 12g/dl. Chelation therapy for iron overload was not given to any child as it was not found necessary due to under transfusion. One child was subjected to splenectomy. This series studied showed a high early mortality the reason being low number of transfusions, repeated chest infections and CCF due to severe anaemia. The prognosis of Thallasaemia major being poor, prevention is the solution by genetic counselling and avoiding cousin marriages.