SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 111 To 113

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CHOROIDAL DETACHMENT IN PAN-REFINAL PHOTOCOAGULATION

Ahmed, M.M.

J. Pak. Acad. Ophthalmol., 1986;2: 23-25.

Pan-retinal photo-coagulation was carried out in a single session in cases of Diabetes Mellitus, retinal vein occlusion and extensive Eales disease. All the four patients with Diabetes Mellitus developed choroidal detachment. Choroidal effusion following pan-retinal photo-coagulation in diabetes have been attributed to aseptic inflammation of choroidal vasculature which has a similar microangiopathy as the retinal microvasculature.

Panretinal photocoagulation was carried out with Xenon are of 3-4.5° size at 4-S power setting of clinitex log-2. It had been done previously in multiple sessions, reduced later to three and other to two sittings. Eventually a single session with 400 or more applications was carried out in four diabetic patients of which 3 were males and one was a female. All of them developed large peripheral choroidal detachments which settled spontaneously after 2 to 3 weeks.

The previous records of 1796 diabetic cases photocoagulated in 2 to 4 sessions showed no patient to have had choroidal detachment. They had received 200 or less application in each sitting. It was also noted that single session application in cases of Eales disease or central retinal vein occlusion did not produce choroidal detachment.

This trial went to prove that diabetic retinopathy of Pakistani eyes could not tolerate a single session of 400 or more applications or pan-retinal photocoagulation and invariably resulted in choroidal detachment. This did subside spontaneously but there is always a risk of residual detrimental effects on the retinal function. It is therefore best to spread out photocoagulation in 2-3 sessions at-least at a weeks's interval with upto 200, 3-4.5° field applications per session.

INTRAMUSCULAR KETAMINE IN THE OUT PATIENT CLINIC

Odetoyinbo, 0.

Pakistan Journal of Otolaryngology, 1986;2: 136-139.

Intramuscular Ketamine was used for short duration anaesthesia on 160 children for various minor procedures in the otolaryngolocial out patient clinic of the University of I.F.E. Nigeria. The ages of the children ranged from 3 to 8 years, 103 were boys and 57 girls. The body weights varied from 10 to 26 kg. The patients were examined physically and those cases having a history of convulsive disorder, cardiovascular or respiratory illness were excluded. Ketamine was injected intramuscularly in a dose of 4 mg. per kg. body weight to a maximum of 100 mg. Pulse and respiration were monitored every 5 minutes till the patient had recovered fully.

The procedures performed were removal of foreign body from the ears, nose and throat, antral lavage, reduction of nasal fracture, drainage of quinsy and periauricular abscess and incision of septal haematoma or abscess.

The patients had negligible side effects and with the anaesthesia lasting for about 20 minutes the short procedures were performed very conveniently.

This trial proved that Ketamine in a low dose and injected intramuscularly is a safe anaesthetic for minor surgery. It is simple to use in the outpatient clinic. Precautions necessary for any anaesthetized patient are essential also for cases undergoing ketamine anaesthesia

SURGICAL MANAGEMENT OF ATROPHIC RHINITIS

Afridi, M.A.K.

Pakistan Journal of Otolaryngology, 1986; 2 : 3-5.

186 patients with atrophic rhinitis were treated with polythene inlay in the floor of the nose through a sublabial approach. Prior to the surgery the patients were examined in detail and X-ray of the paranasal sinuses was done to exclude infection. Serological tests were carried out to rule out syphilis.

The surgery was performed under general anaesthesia. The incision extended from the midline to the canine fossa on either side of the gingivolobial junction. The periosteum was cut and elevated from the anterior surface of the maxilla and the floor of the nose. Polythene of 1.5 cm x 2 cm. was introduced through the incision into the floor of the nose sub-periosteally 112
on both sides after which the incision was stitched, Uquid paraffin packs were placed in the nasal fossae for 48 hours to prevent haematoma formation. Antibiotics were given systemically to avoid infection and liquid paraffin drops were instilled for two weeks.

A follow up after one month showed 90 percent of the cases to be clinically satisfactory. The nasal mucosa had returned to normal though the nasal fossae were still roomy. The symptoms of nasal obstruction, scabbing and foul smell had also subsided. A number of patients fell out in the six months follow up but again 78 percent were clinically satisfactory.

Atrophic rhinitis is a common disease in this part of the world and the sufferers are usually young females. The etiology is disputed. Infectious fevers, hormonal imbalance, heredity, malnutrition and race have been blamed for it. A variety of methods for treatment have been used ranging from glycerine and cortisone nasal drops to nearly twelve types of surgical operations which includes the subperiosteal polythene inlay in the nasal floor. This is a ten minute surgery with no disfigurement and short hospitalization. The polythene acts as an irritant causing a subclinical inflammation. This increases the glandular activity and vascularity of the nasal mucosa which causes it to revert to its normal state.

AKHTAR'S TECHNIQUE OF D.C.R. Khan,A.J. Pakistan Ophthalmology, 1986; 2:29.

79 patients who underwent Akhtar's Dacryocystorhinostomy, a modified and simpler DCR, have been presented. A blocked nasolacrimal duct leading to epiphora is had in adults due to stenosis of the lower punctum, chronic canalicular inflammation or chronic dacryocystitis. In newborns 70 percent normally have a closed nasolacrimal duct which opens up as the body grows. Sucking, crying and chewing are helping factors.

Akhtar's D.C.R. is preferably carried out under general anaesthesia. A nasal packing with surgical gauze soaked in normal saline and an antibiotic is done. on the side where surgery is to be performed. The procedure of D.C.R. is carried out under an operating microscope. A concave incisions is given 10 mm from the Medical canthus. The Orbicularis muscle is dissected and the Medical palpebral ligament is cut midway thus exposing the sac. The Sac is removed after leaving the lateral wall with the opening of the common canaliculi. The lower and upper puncti are dilated and a 1mm silastic tube is pushed through the lower punctum and canaliculi on one side and upper punctum and canaliculi on the other side. The opening in the nasal cavity through the ethxnoid bone is enlarged by a bone nibbler. The two ends of the silastic tube are tied to the packing through this opening into the nasal cavity. It is then brought further down and the two ends of the tubing are left in the nasal cavity in a length so that they do not project out of the nostril. The wound is closed with interrupted 7.0 silk sutures. The tube is left in place for six months.

Of the 79 cases operated, 50 were between the ages of 40 and 60 years, 10 between 10 and 40 years and 9 between 6 months and 5 years. Akhtar's technique of D.C.R. is a simple and safe procedure. The silastic tubing produces an artificial track which gets epitheliazed. Fibroblastic activity around the silastic tube form a tunnel which gets its surfacing from the nasal epithelium. The tears flow down by capillary action along the walls of the tube. The tube is finally removed by simply pulling it out after instilling local anaesthetic drops. The technique is free of complications and effective for long periods.