SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 272 To 274

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PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAM IN BILIARY CHOLESTASIS –A CASE REPORT. Althtar, M. A., Zaffar, M.P. Pak. A.F. Med. J., 1985;37: 30-32.

Percutaneous transhepatic cholangiography a diagnostic procedure for obstructive jaundice was first reported by Haurt and Doxuan in 1937. Flexible 23 G needles called chiba needles were used for the purpose in 1974 by Okuda. The needle is introduced under local anaesthesia in the 8th or 9th Right intercostal space in the anterior axillary line. It is thrust rapidly and horizontally into the liver. Once a dilated duct is reached and a trickle of bile is obtained, the contrast medium, Conray 280 or Hypaque 45% is injected. A-P and Oblique view radiographs are taken. The procedure has been used therapeutically in in-operable cholangiocarcinoma.

Percutaneous transhepatic cholangiography was performed by the authors on a 40 years old male with a history ofjaundice since 4 months. The physical examination and LFTs were non-contributory and ultrasound studies showed dilated intra and extra-hepatic bile ducts with non-visualization of the gall bladder. The X-ray showed a dilated common bile duct with a filling defect and dilated intra-hepatic bile ducts. Surgery was performed and a stone from the common bile duct was removed with subsidence of jaundice.

PTC is a simple and inexpensive examination which provides an accurate diagnosis for the surgeon. Complications which could be encountered are sepsis and could be prevented by an antibiotic cover with gentamycin prophylactically. Intra-peritoneal haemorrhage is very uncommon but a BT, CT and PT should be done prior to the procedure.

CENTRAL NERVOUS SYSTEM MUCORMYCOSIS- A CASE REPORT. Akhtar, M.A.; Ahmad, M., Mohydin, M.A.Z. Pak. A.F. Med. J.,l982;36:52-53.

Central nervous system mucormycosis, a rare disorder, occurring usually in immunosuppressed individuals and invariably fatal is reported in a young male adult. The 25 years old man was admitted in the hospital with the complaints of headache, pain in the left eye, difficulty in chewing and swallowing, of seven days duration. On examination there was proptosis, a hazy cornea and only perception of light in the left eye. Papilloedema was present on the right side. Paresis of the left 3rd, 4th, 5th, 6th and 7th cranial nerves was noted along with involvement of the right 6th cranial nerve and both 10th cranial nerves. The rest of the systemic examination was non-contributory. The routine blood tests and skull X-ray were normal. An initial diagnosis of intracranial space occupying lesion involving the brain stem was made. A brain scan reported increased activity in the region of the pons implying a tumour. Corticosteroids and Mannitol gave no relief and the patient expired after being in coma for a day.

Autopsy revealed a mass measuring 6 cm x 4.5 cm involving the optic canal, internal auditory meatus, sphenoid bone, eroding the posterior wall of the seila turcia and extending to the pons. Histopathology reported a fungus granuloma suggesting a Mucormycosis of the central nervous system. This condition is difficult to detect as none of the investigations are contributory. Intra-venous Amphotericin is the recommended thug for this infection.

HEPATIC AMOEBIASIS PRESENTING AS ACUTE ABDOMEN. Siddiqi, S.E. Pak. A.F. Med. J.,1986;39:18-21.

A difficult to diagnose case of an amoebic liver abscess presenting as an acute abdomen in a youg man is presented. Fever, severe abdominal pain and vomiting were the presenting symptoms. The patient appeared ill with a temperature of 101°F and a proportionately raised pulse rate. The abdomen was

rigid. The other systemic examination was non-contributory. The TLC was 21 ,000/cmm. As the plain X-ray abdomen did not show fluid levels and the patient was not in a condition of shock, intestinal perforation was ruled out and conservative management was started.
Gradual improvement fpllowed and as the abdomen relaxed, the liver was found to be enlarged, firm and tender. Ultrasound scan reported scattered foci on the liver. Metronidazole Infusion was given in the required dosage and a second ultrasound revealed a localized abscess incthe right lobe of the liver. Aspiration was performed and 500cc of chocolate coloured pus was obtained. Therapy was continued with Metronidazole, Diloxanide furoate and chloroquine and a quick recovery followed.
It is a known fact that 10 percent of the world population have been infected at one time or the other with E. Histolytica. The infecting agents are the cysts passed in the human faeces and in the contaminated food. Amoebic ulceration is most common in the caecum and rectosigmoid colon. The amoeba may pass through the portal circulation and enter the liver and cause a single or multiple abscesses. These contain necrotic liquefied liver tissue which presents as chocolate coloured pus. The abscess can burst into the adjoining structures.
Stool examination is usually negative. Leucocytosis is present and LFTs do not show any gross abnormality. The diagnosis is confirmed by aspirating the typical chocolate coloured pus.
Metroriidazole and chloroquin are the drugs of choice. Di-hydroemetine which was used earlier has been replaced by Metronidazole as it had the risk of cardiotoxicity.

FALCIPARUM MALARIA EMERGENCE OF RESISTANT STRAINS IN PAKISTAN. Anwar, M., Zaheeruddin. Pak. A.F. Med. J., 1984; 36:1-6.

Three cases of falciparum malaria are presented.
The first was a 30 year old male who came in with fever, vomiting, yellow discolouration of the eyes and dark coloured urine of 5 days duration. On examination he was a—febrile, jaundiced and hepatosplenomegaly was present. Hb was 12.5G%, serum biirubin 3.7 mg%, SGPT 20 U/mI and no malarial parasites were seen in the blood film. In a weeks time he became drowsy and anaemic and developed hiccoughs and vomiting. The urine was dark brown and gave a positive result for blood and urobilinogen. Blood urea was 360mg%, serum creatinine 13 .2mg% and the blood film now showed falciparum rings and gametocytes. Parenteral chloroquin, fluid; and furasemide was started and as there was lack of response in three days time, Fansidar was added. As the parasite concentration did not decrease, quinine infusion was initiated. After 3 days the ring form of the parasite disappeared and after 8 days the blood ifim was clear of all forms of P. Falciparum.
The second case, a young man of 20 years came in with fever, yellow discolouration of eyes and epigastric pain. On examination he had a temperature of 100°F, jaundice and anaemia were present and liver and spleen were enlarged. The urine gave positive results for haemoglobin and urobiinogen and the blood film showed ring forms of P. Falciparum and P. Viva. Blood urea was 250mg% and serum creatinine 4 .2mg%. Chloroquin infusion was started and changed over to Quinine on the 3rd day as only the viva rings had disappeared in the blood film. On the 12th day schizonts of Falciparum were also visible in the blood smear. The patient became confused, disoriented, drowsy and eventually comatosed. Fansidar was added to the treatment but the patient expired on the 18th day.
The third case was a 20 year old male with a history of yellow discolouration of the eyes and high coloured urine of 5 days duration. He had fever with chills and had taken chloroquin. At the time of admission he was afebtile, jaundiced, with hepato splenomegaly and urobiinogen in urine. Falciparum parasites were seen in the blood film. Initially Basoquin was given but as the patient became drowsy, quinine infusion was started. In 48 hours the general condition improved. Serum biirubin came down to normal limits in 10 days but the Malarial Parasites persisted till two weeks.
Falciparum malaria is diagnosed by finding the parasite in the blood film. Quinine is the drug of choice especially in resistant cases and it should be continued for 8 to 14 days despite which the gametocytes may be present in the peripheral blood.