

Abstracts from the Journals of the East

Pages with reference to book, From 46 To 47

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A Study of Naswar and Beera in Multan City. Masood, K., Perv aiz, S., Malik, G.Q., Qadri, M.S.K., Husain, A. Specialist, Pak. J. Med. Sci. 1995;12:69-72.

A suivey was conducted in Multan from March 1993 to June 1994, through an interview schedule to determine the number and social class of people addicted to the various forms of tobacco especially Beera and Naswar. Beera is a mixture of substances withthe main ingredients being tobacco and ash of sheesham leaves. It is placed between the teeth and buccal mucosafromwhere the nicotine is mainly absotned and gives a sensation of pleasure. Naswaris snuff and is composed of tobacco, noshadar, and clove.

The study population was made up of 500 subjects using Beera orNaswar for atleast 2 years. The maximum number of users were in the age range 29-49 years and belonged to the low income group with 88 percent being illiterate. Beera with smoking cigaretes was used by 81 percent subjects whereas Beera and Naswar alone was the intake of 14 and one percent addicts respectively. Beera and Naswar together was taken by 4 percent individuals.

Poor orodental hygiene was found in 36.2 percent addicts and there were two cases of leukoplakia. Beera and Naswar was used more than 5 times daily by 52 percent people. 83.6 percent subjects started using the mixture due. to peer pressure and 16.4 percent due to family influence. Only 5 percent of the addicts made an attempt to get rid of the habit

The use of Beerais acommonhabit inthe Northemareas of Pakistan. It is a significant health hazard as has been identified as a carcinogenic agent. People are ignorant about the harmful effects and use it commonly due to easy and cheap availability combined with peer pressure.

Health education campaigns alongwith some legislative measures should be adopted to control this dangerous habit

Retroperitoneal Hemangiopericytoma: A Case Report. Siddiky, S.A., Islam, A.S.M.A. Bangladesh Med. J, 1993;22:16.

The case of a 45 years old woman with äpainless lump in the leftiliac fossa and finally diagnosed as hemangiopericy torna by excision and light microscopy. is presented.

The patient came inwitha painless lump in the left lower abdomen which had gradually increased in size in the last 3 years. Physical examination showed an intra-abdominal mass of IOx 12 cm size in the left iliac fossa. It was firm, pulsatile, immobile and slightly tender. Extrinsic cormpression was diagnosed on barium studies and ultrasonography revealed a l2xl2 cm mass, with solid and cystic components and not attached to the kidney.

Laparotomy was undertaken and a tumour arising from the retroperitoneal tissue was seen. Total. excision was performed. The pathological examination revealed a circumscribed tumour with numerous thin walled blood vessels of various calibre. There was a big cystic area containing hemorrhagic fluid. Microscopically there was no evidence of malignancy. A rich network of capillaries was seen outside which were spindle shaped mesenchymal cells. The final diagnosis of hemangiopericytoma is made by electron microscopy. But due to non-availability of the facility, light microscopy was used. The ultracellular details strongly indicated the diagnosis. Haemangiopericytoma is a rare tumour arising from the pericytes of Zimmerman. Its diagnosis is made by laparotomy and histopathology. Wide surgical excision is the treatment of choice. Long term follow up is advisable in borderline malignant cases.

Chlamydia Trachomatis: A Cause of Non Gonococcal Male Urethritis. Tariq, W.U.Z., Mehmud, A., Malik, I.A. Pak.J.Pathol., 1995;6:43- 45.

A study was conducted on 38 young males presenting with urethritis, to investigate the role of chlamydia trachomatis as an etiological agent.

Two endourethral specimens were collected from each subject. One was used for a smear on teflon coated slides and fixed in acetone and finally used for immunofluorescence staining. The second one was sent for culture of gonococcus. Five ml blood was collected for HIV antibodies.

Chlamydia trachomatis elementary bodies were demonstrated in 14 cases. There was concomitant infection with Neisseria gonorrhoea in 3 cases. Anti-HIV antibodies were not detected in any patient. All the positive cases were between the ages of 20 and 42 years and had a history of contact with a prostitute. Three cases had contracted the infection from abroad and eleven from within the country. Chlamydia trachomatis is a leading cause of sexually transmitted diseases. The columnar epithelium of the distal urethra gets infected during sexual contact. This then spreads upwards involving the whole urethra. In some cases it extends down the columnar epithelium of the vas deferens into the coiled tubes of the epididymus. As the infection is acquired primarily through sexual contact with female prostitutes, a mass screening programme should be undertaken to treat the infected women. Clinicians should be made aware of the problem to prevent misuse of antibiotics as tetracyclines or erythromycin are the drugs of choice.

Pulmonary Gangrene: A Case Report. Hsu, H.S., Chern, M.S., Chen, C.H., Perng, R.P. Chin. Med. J. (Taipei) 1995;55:476-480.

The case of a 58 year old man diagnosed as pulmonary gangrene is presented. He complained of dyspnoea and cough with purulent sputum for one week. There was no chest pain, fever or haemoptysis. He was a heavy smoker and had a history of chronic ethanol consumption. Physical examination showed diminished expansion of the right thorax with wheezing diffusely on auscultation. The white cell count was 23,300/cu mm with neutrophils predominating. Chest X-ray revealed consolidation of right upper lobe.

Crystalline penicillin and amikacin were started and needle aspiration performed. A foul smelling, chocolate coloured mucus like material was obtained. Aerobic culture of the fluid yielded a growth of klebsiella pneumoniae. CT scan showed a large cavity and an intracavitary mass.

Two weeks after admission and after receiving antibiotics in accordance to the susceptibility test, a drainage tube was inserted percutaneously into the cavity with -15 cm H₂O Emerson Suction. About 100 ml fluid was drained out daily. A bronchopleural fistula was formed with persistent air leakage. The general condition of the patient improved and after 8 weeks the chest X-ray showed a diminished cavity and volume reduction of the right upper lobe. The bronchopleural fistula was managed conservatively and the drainage tube removed on the 90th day and the patient discharged 10 days later. A final chest radiograph showed volume loss of the right upper lobe.

The clinical diagnosis of pulmonary gangrene is made on serial radiographic findings. The three distinct phases being a pneumonic lobar consolidation with bulging fissures followed by breakdown into numerous small abscess cavities and finally coalescence of the small cavities to form a single large one containing sloughed lung parenchyma.

The management of pulmonary gangrene has been controversial. Surgical removal of the necrotic lobe has been used by some scientists whereas others have used medical therapy with success. The first line of management remains as good supportive care, appropriate antibiotics and adequate drainage. Surgical intervention should be reserved for the cases not responding to conservative therapy.