# SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 51 To 53

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**SERUM LIPIDS AND LIVER FUNCTION TESTS IN CHOLESTEROL GALL STONE DISEASE.**

Hameed, M., Tayyab, M., Khan, H., Ahmad, I. Pak.J.Med.Res., 1990;29: 163-166.

A study was conducted on 47 cholesterol cholelithiasis cases and 40 normal controls to evaluate the biochemical pattern of serum lipids and liver function tests and to determine thepossible role of serum lipids in cholesterol cholelithiasis. The cholelithiasis patients had clinical signs and the diagnosis was confirmed by cholecystography or ultrasonography. The 40 controls were excluded by ultrasonography. Ten milliliter of blood was collected in the fasting state for estimation of cholesterol, HDL-C and triacylgycerol by the enzyme method. Total lipids were measured by suiphosphospho-vanillin reaction. Bilirubin was tested by the diazo reaction, alkaline phosphatase by Babson's phenolpthalein monophos. phate method and alanine transaminase by Reitman and Frankel method. Total proteins were estimated by Biuret reaction. The average cholesterol levels were 216, 220 and 219 mg%, in males, females and all cholelithiasis subjects whereas in the normal controls it was 199, 177 and 182 mg%. Serum triacyiglycerol was 119, 129 and 128 mg% in the stone formers and 116, 111 and 112 mg% in the normals. Mean serum HDL-C was 24, 26 and 26 mg% in the gall stone subjects whereas the control had values of 41, 42 and 42 mg% in the males, females and total group. Serum total lipids were significantly elevated in females and all subjects of the cholelithiasis group. The liver function tests were in the normal range in the stone formers and the control group. However, the bilirubin and alkaline phosphatase in the former were slightly higher than the latter. The raised lipid values within the normal range in cholelithiasis patients were consistent with other such studies conducted in the country. It has been suggested that hepatic cholesterogenic activity is increased in cholesterol gall stone disease which decreases bile acid synthesis. Enzymatic activity is altered causing increased biliary secretion of cholesterol and lithogenicity of bile. The low HDL-C values observed in the stone formers in the study matches the results of other workers. A low HDL-C level could be considered as a marker to gall stone disease as it is for coronary heart disease. Further studies are needed for its significance. The relatively high value of serum bilirubin and alkaline phosphatase could be attributed to the mild cholestasis and obstruction to bile flow due to gall stones.

**IMMUNOLOGICAL STATUS OP THE PATIENTS WITH BRAIN TUMOURS. Dawani, K., Tayyab, M. Pak.J.Med. Res.,1990;29:167-170**.

As the brain has been labelled as an immunologically privileged site so to study neuroimmunology, 37 brain tumour patients were selected for estimation of blood glucose, immunoglobulins and protein electrophoresis. Glucose was measured by the oxidase method while immunoglobulins and protein electrophoresis were assayed on sera stored at -40°C by RID technique and Kohin\'s method respectively. There were 26 males and 11 females with the maximum patients being in the group 31 to 50 years. 8 cases were below 10 years age. There were 10 housewives and 8 students with the rest having other occupation besides 2 infants. Statistically the blood glucose and serum proteins showed no significant difference from the normal levels. Serum IgG concentration was found to be very much lower than the control subjects with the malignant cases having a still lower level than the benign ones. These findings are comparable to work done by others. IgG suppression has been attributed to im-munosuppressive effect of neoplastic process. The patients included in the study were also on steroid therapy simultaneously which is also a contributing lictor.

**VARIABLE PRESENTATIONS OP SYSTEMIC LUPUS ERYTHEMATOSUS. Iqbal, F.**

**Pak.J.Med.Res., 1990; 29:184-186.**
3 patients, all young females, diagnosed as systemic lupus erythematosus are presented. The first was 22 years old who came in with fever, difficulty in chewing and swallowing, painful swelling of the lips and tongue and a skin rash since 7 days. On examination the girl was pale with a bUtterfly rash on her face. Ulcers were present on the lips, tongue and hand palate. Vaculitic lesions were seen on the periungual region and finger pulps. Cervical and axillary lymph nodes were enlarged. Hepatomegaly was present and she was febrile with a temperature of 100°F. The laboratory investigations gave a positive L.E. factor, ANA and rheumatoid factor. There was proteinuria with 800 mg proteins in 24 hours urine. The hepatic enzymes were raised, Hb 1OG% and the renal biopsy showed mesangial glomerulonephritis. Steroid therapy was started to which she responded well. The second patient was a 25 year old woman with a month's history of shortness of breath, central chest pain, joint pain and loss of hair. On examination she was pale and toxic with 10 1°F temperature, raised JVP, muffled heart sounds, increased cardiac dullness, pericardial rub and swollen joints. The ESR was 85 mm in 1st hour, liver function tests were deranged and serological tests gave a positive result for RA. factor, ANA, LE cells, DNA antibodies. Steroid therapy was instituted which gave good results. 10 months later the pericardial effusion recurred and Imuran was added to the drug regime. The third case was a 28 year old female who gave a history of fever, facial rash and loss of hair since one month. A day earlier she developed weakness of her left face, arm and leg. The temperature was 99°F with a butterfly rash on the face with left hemiparesis and facial palsy was observed. Serological studies confirmed the diagnosis of SLE. Steroids and physiotherapy gave remarkable improvement. Systemic lupus eryrthematosus, a connective tissue disorder was first described by Kaposi in 1872. The LE cells were isolated by Hargraves in 1948. Recently B cells, T cells and macrophage dysfunction has also been noted. As the mode of presentation of SLE is variable so the revised criteria for diagnosis are the presence ofany4 out of the 11 included. These are malar rash, discoid rash, photosensitivity, oral ulcers, arthritis, serositis, renal disorder, neurological disorder, haematological disorder, immunologic disorder and antinuclear antibody. There is no absolute cure for SLE. Remmissions follow relapses and flare-ups are prevented by appropriate therapy. Chloroquin and steroids are mainly used though each has its side effects. Maintenance therapy with 5-10mg of steroids may provide a control of symptoms. Azathioprine is used in cases with diffuse proliferative nephritis and cyclophosphamide is reserved for the seriously ill. Early diagnosis and treatment gives a better prognosis and survival rate.

**TOXIC EPIDERMAL NECROLYSIS DUE TO NIMORAZOLE. Kakakhel, K.**
**Pakj.Med.Res.,1990; 29:245-246.**
The case of a female patient who developed toxic epidennal necrolysis due to Nimorazole is presented. The 32 year old woman was admitted in the DHQ Teaching hospital Abbottabad with mucosal lesions in the oral cavity and vagina after administration of Nimorazole 24 hours earlier. Nicolsky sign was positive. The skin biopsy showed a necrotic epidermis, a subepidermal blister and a lymphohistiocytic infiltrate around the blood vessels in the dermis. Treatment was started with 200 mg hydrocortisone daily and i/v fluids and antihistamines. Oral feeding could be started after 36 hours and complete re-epithelization occurred in 10 days. There was a history of a similar episode with the same drug 2 years ago. Toxic epidermal necrolysis (TEN) is charactensed by wide spread erythema and bullae and may be caused by a number of drugs. Lymphoma, leukaemia fumigants and contrast medium are also associated with it. The pathogenesis is still not known. Aggressor lymphocytes sensitized to epidermal cells may cause epidermal necrosis. A high mortality rate is due to renal complications, disseminated intravascular coagulation, gastrointestinal bleeding and extensive skin loss. Corticosteroids are helpful and should be given early. Modern burn treatment improves the prognosis.