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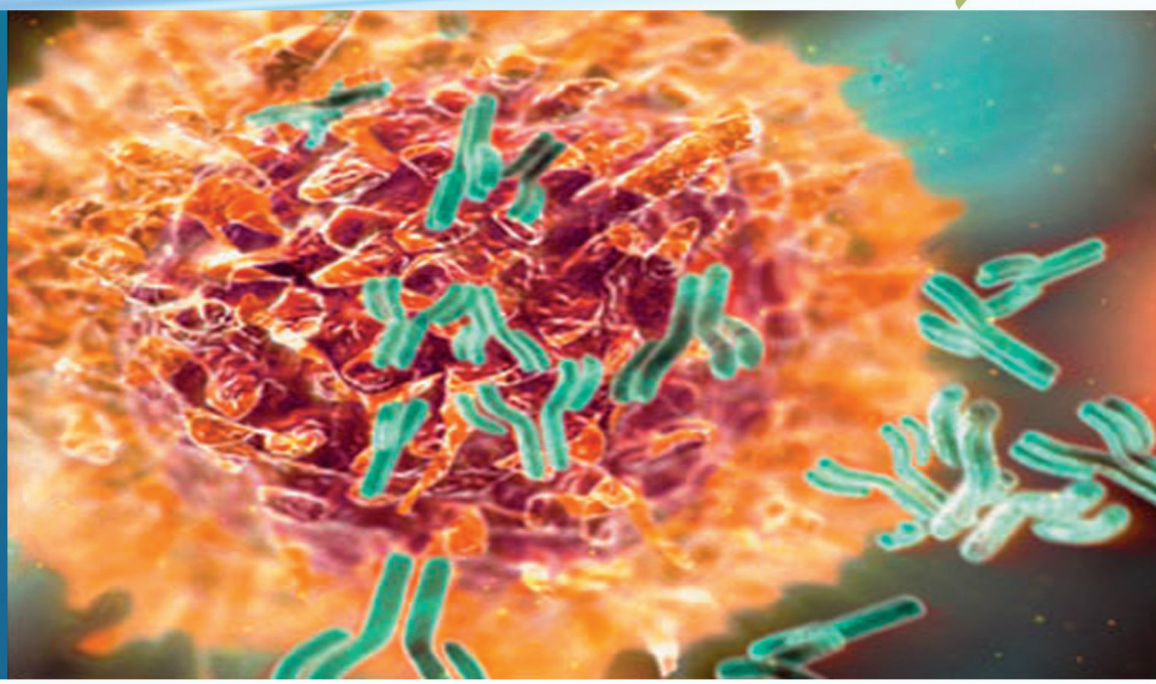

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Journal of the Arab Board of Health Specializations

The Journal of the Arab Board of Health Specializations is a medical journal, issued quarterly, encompassing all medical specializations. It will strive to publish researches of the Arab physicians in order to strengthen the communication and exchange of scientific and medical information within the Arab Countries. Besides, the Journal publishes selected important medical abstracts which have recently been accepted for publication elsewhere, along with their Arabic translation to facilitate communication. The Journal will also publish the activities and news of the Arab Board of Health Specializations.

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1. Manuscripts should report original work that has not been published elsewhere either in print or in electronic form. Work that has been presented at a professional meeting is eligible for consideration for publication.
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4. Arabic terminology should be standardized according to the United Medical Dictionary (UMD) which available at: www.emro.who.int/umd or www.emro.who.int/ahsn
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- Manuscripts should be double spaced in entirety with each section on a new page. Do not use both sides of the paper. Number the pages consecutively from the first page to the last in the following sequence: title page (including the authors' names in both languages along with scientific titles and addresses), abstract, text, acknowledgments, references, tables and legends. Illustrations and explanatory prints should be no larger than 203 x 254 mm (8 x 10 inches). Leave margins of at least 25 mm (1 inch) on each side. All manuscripts should be submitted on CD. The original typed manuscript plus 3 additional copies should be submitted. Alternatively, the manuscript may be submitted by E-mail (jabms@sce-net.org) if it is technically feasible. The authors should maintain copies of all material submitted.
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- Educational and unusual medical images for publication are welcomed.
- Use only standard abbreviations; the full term for which an abbreviation stands should precede its first use in the text unless it is a standard unit of measurement.
- Measurements of length, height, weight and volume should be reported in metric units (meter, kilogram, and liter) or their decimal multiples. Temperatures should be given in Celsius degrees. Blood pressures should be given in millimeters of mercury. All hematologic and clinical chemistry measurements should be reported in the metric system in terms of the International System of Units (SI).
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8. Articles that do not meet the technical requirements of the Journal will not be submitted for review unless they are revised.

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Journal of the Arab Board of Health Specializations

A Medical Journal Encompassing all Health Specializations

Issued Quarterly

CONTENTS

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Letter from the Editor

A H1N1, The Nasty Virus

I know that what I am going to write about this virus and the influenza caused by it, is not new. It is just a reminder especially when we are in the middle of the winter season, when the frequency of the regular seasonal flu increases.

H1N1 virus is a new strain of the pandemic influenza virus which is different from the seasonal flu virus and more dangerous. It is a sub-type of influenza virus A, the most common cause of influenza (flu) in humans.

H1N1 virus is a strain of the influenza virus that is in the past usually only affected pigs, and because humans have little or no natural immunity to this virus, it can cause serious and widespread illness.

The H1N1 virus is contagious and spreads the same way as regular seasonal influenza virus such as when an infected person coughs or sneezes or touches surfaces like counters or doors knobs, the virus is picked up on hands and transmitted to the respiratory system when someone touches the mouth or nose. It is not possible to catch it by eating meat products.

The symptoms are almost always cough and fever, commonly fatigue, muscle aches, sore throat, headache, decreased appetite and runny nose and sometimes nausea, vomiting and diarrhea.

It is believed that the period a person can be infectious is one day before the onset of symptoms and continues for approximately 7 days after symptoms have started.

Prevention of infection is by washing hands, keeping hands away from face, using tissue when coughing and sneezing and dispose of it as soon as possible, keeping surface areas clean and disinfected and staying home if you get sick.

The people who are at greater risk of getting the infection are children under five years of age, women who are pregnant and people with underlying medical conditions such as diabetes and others.

The infection is treated by medications used to treat viral illnesses including the flu. They are effective if taken shortly after getting sick usually within 24 to 48 hours. They can reduce flu symptoms, shorten the length of illness and may reduce serious complications. They are available in two forms: a pill called Tamiflu or an inhaler called Zanamivir or Relanza.

Antivirals are recommended for the treatment of moderate to severe illness and for people at risk of severe disease.

Gettting the H1N1 flu vaccine is the best way to protect against this nasty virus.

I wish all our readers good health and long life.

Professor M. Hisham Al-Sibai
Editor-in-chief
Secretary General In-Charge
The Arab Board of Health Specializations

Original Article

موضوع أصيل

IS THERE A ROLE FOR PROGESTERONE IN PRETERM LABOUR

ƨ‡ĞĥЫƒ ЏĞPdž!ƒ ШŭŽ Ŏ5 LJĂƨkƖɳĂƨĥЫƒ ƨĞIz! ƨĂþ þɳĂŏ ýNj

Ibtissam Y. Khalil Al-Saffar, *MBChB, CABOG;* Raghad Abdul-Halim Al-Issa, *MBChB*

د. ابتسام يوسف خليل الصفار ، د. رغد عبد الحليم العيسى

ƘӨĞIIƐ ţ ƠЈ‡ĐŽ

ƘŮĞơ ŧɳ!Ğƶdž Ŏ5 (salbutamol) Ğkôĥu ƘŭĥIkƖdž! Iƨsơdž!ƒ ŧŏĂþŮƒ LJdž ŧŏþĞôkƵŮƒ ŧƵƨɳ!ƒ ƨ Ƭĺ yðž LJĂƨkƖɳĂƨĥ!ƒ ĈĞƠƵƵƶ ƨĂþ DžôôIk **:ƘӨĞIIƐ Ɛ٩lj**

.þƨsĿdž ý‡Tĥu (salbutamol) Ğkôĥu Kƒƨsơdž LJdž ŧIdžĞ‡!ƒ ŧƵƨɳ!ƒ ĈĞƠƵƶ ƘŮĞơ yðž NJKĿƨĞIdžĂ ŎIJƶs!ƒ ƨ‡Ğĥ!ƒ ЏĞPdž!ƒ

ýŭP Ш!ŗĂ ĈĞƖĿ!ƒ ЏƒƨdžDĂ þô!Ăk!ƒ Dž!Ɩþ Ŏ5 ŎdžôIJƶk!ƒ ŧŏdžUĞ‡!ƒ ĬsTdžĂ ŎdžôIJƶk!ƒ þƒþʒĥu ĬsTdž Ŏ5 ŧƠĂĥuơdž ŧôFƒĂTƵ ŧƖƒƨþ Ĉƒƨɳǫ Džk **:ƘӨĞIIƐ Ƽþư**

:LJôkƵĂdžɳdž Ĭ!ǫ ŴôFƒĂTƵ LJnjdžôƖIk Džk Iƨ‡Ğu IþŮĂ ƘŮĞơ LJnjôþ! ýdžƒĂơ!ƒ ĈĞƖĿ!ƒ LJdž 101 ŧơĥu!ƒ ýdžT .2007 LJƒƨôƨơ ĬkơĂ 2006 ƨƒŖĈ LJdž Iƨks!ƒ

250 (Primolut Depot) 17-hydroxyprogesterone hexanoate ƨĞIzĥu ɳ!ĞƶdžIJ! LJƶuƤ (ŧuƠƨdž 51 ƘŮĞơ!ƒ ŧƵĂdžɳdž!ƒ Ĭ!ĂŮƒ ŧƵĂdžɳdž!ƒ ÜþNjĞT!ƒ ŧƵĂdžɳdž) ŧôĿĞĂ!ƒ ŧƵĂdžɳdž!ƒ ĞdžD .(%5 ƨĂƨkƖ‡þ ýdž 500/ƐIJdž 1.25) salbutamol ĈƒÂþ LJdž Iþdžkƶdž!ƒ ŧôþĞôkƵŮƒ ŧƵƨɳ!ƒ ƨ Ƭĺ yðž ƐIJdž LJôkƵĂdžɳdž!ƒ ŧIJƨĞIdž Kdžk .(%5 ƨĂƨkƖ‡þ ýdž 500/ƐIJdž 2.5) ƠI5 salbutamol LJdž Iþdžkƶdž!ƒ ŧôIJ‡!ƒ ŧƵƨɳ!Ğu ɳ!ĞƶdžIJ! LJƶuƤ þI5 (ŧuƠƨdž 50 ŧUơŭdž!ƒ ŧôĥLjĞɳ!ƒ Kƒƨôλăk!ƒ Ü(YĂĥuƖD Iþdž þƶĥu ĞnjλĂþơ ĂD ÜYĂĥuƖD ĬkơĂ ŧƵĞƖ 48 Iþdž ýŭP Ü Ĭ !ĂŮƒ ŧƵĞƖ 48 ýŭP) IþŮĂ!ƒ ŧ Ăþơ KpĂ ŧ ŏơ LJdž

.ɳ!Ğƶdž!ƒ LJdž YĂuƖD Iþdž ýŭP IþŮĂ!ƒ Ŏλôþơ þIJƵ ŧUơŭdž!ƒ ŊFĞKIJ!ƒĂ ÜDIJŮƒ þIJƵ LJôƨĈIzIJ!

¡(p=0.6) (ŧ ŭλ!ƒ Kƒƨks!ƒ ýŭP) IþŮĂ!ƒ ŧ ĂþơĂ ɳ!ĞƶdžIJ!Ğu Cfĥu!ƒ LJôu Iƨks!! ŧĥƖIJ!Ğu LJôkƵĂdžɳdž!ƒ LJôu ŴôFĞƬơǫ DžĞNj Ƽƨ5 þĂɳĂ Uơŭŏ Dž! **:ĂĞFŧdžIIƐ**

ŧôĥLjĞɳ!ƒ ƨĈĂŮƒ ŧ Ăþơ ЏĞPLjƒ Uơĥ! ăƨPD ŧnjɳ LJdž .(p=0.078) IþŮĂ!ƒ Ŏλôþơĥu ŧôĈLjƶ!ƒ Iþơĥ Ŏ5 IþŮĂ!ƒ Ŏλôþơ ýĂhp ĂD KĞõ5Ă!ƒ KŮþƶdžĂ ƨ‡Ɩ ƠƧ5 ÜƳIJ!ƒ Yƨ Ɩk ŧ Ăþơ Ŏ5 IþƬĥĂ DžĞNj ЏĞPLjƒ Uơĥ! ŧ ŏơ ÜLJĂƨkƖɳĂƨĥ!ƒ yðž ŧ‡ƨĈTdž!Ğu ŧƵƨɳ!ƒ ƨ Ƭĺ DžƒþPkƖƒ þIJƵ salbutamol ƨĈIz!

ŧƵĂdžɳdž þIJƵ Ш!ŗĂ (p<0.05) Ĭ ƨþƬ!ƒ Dž!ŮƒĂ Ü‡ôɳĂônj!ƒ ÜLJĞsɳƨ?!ƒ Ü Σ ƽIJk!ƒ Ƽŏư ŧ Ăþơ Ŏ5 DžĞNj ЏĞPLjƒ yðž Ü(p=0.000) ĈĞôpÚƒĂ LJĞôλʒ!ƒ ÜDžþ!ƒ

Uơŭŏ Dž! Gdž‡ Ü(0.93=p) Yƒþ Ƭ!ƒ ŧ Ăþơ! ŧĥƖIJ!Ğu LJôkƵĂdžɳdž!ƒ LJôu ŴôFĞƬơǫ DžĞNj Ƽƨ5 þĂɳĂ Uơŭŏ Dž! .þNjĞT!ƒ ŧƵĂdžɳdž yðž ŧIJƨĞIdž!Ğu Ĭ ƤƨdžIJ!ƒ

.LJôkƵĂdžɳdž!ƒ Ŏ5 Ĭ ƤƨdžIJ! LJdž Ĭ D þIJƵ ŧƒ2 ŧdžRĂ ƨĂƠk

Ш!ŗ! Gdž! ÜĞkôĥu Kƒƨsơdž yðž LJdžƒƨk!Ğu NJdžƒþPkƖƒ þIJƵ Ŏƶs!ƒ ƨ‡Ğu!ƒ ЏĞPdž!ƒ ƘŮĞơ ŧɳ!Ğƶdž Ŏ5 LJĂƨkƖɳĂƨĥ!ƒ ƨĈIz! ƨĂþ ШĞĿNj LJĂ‡ŏ þp **: ŀƑШƑĦdžŧƨŮĈ**

.ŧŏĂþŮƒ IjŖnj! IĞơƶ!! Iþþnjdž!ƒ IƨƠP!ƒ ŧôĥLjĞɳ!ƒ Kƒƨôλăk!ƒ LJdž þơ!ƒ Ŏ5 IþƒĞ5 LJdž

ABSTRACT

Objective: *To evaluate the role of progesterone in combination with half the usual dose of the β-sympathomemetic (salbutamol) in treatment of actual preterm labour and to compare it with the full dose of β-agonist used alone.*

Methods: *A randomized, controlled trial done at Baghdad teaching hospital and Al-Kadhimiyah teaching hospital, department of Obstetrics and Gynecology–Baghdad/Iraq, during the period from March 2006 to June 2007. One hundred one pregnant women who presented with actual preterm labour were randomly divided into two groups. Fifty-one patients received*

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17 hydroxyprogesterone hexanoate in oil (Primolut Depot) 250 mg with half the usual dose of salbutamol (1.25 mg/500 ml 5% dextrose) regarded as the study group and fifty patients received only salbutamol in the full dose (2.5 mg/500 ml 5% dextrose) regarded as the control group. Both groups were compared for the time of delivery within 48 hours, 48 hours - one week, and after one week, for the maternal side effects of salbutamol and progesterone and for neonatal outcome for those delivered within 1 week.

Results: *There was no significant difference between the control group and the study group regarding treatment-delivery interval within 1st 48 hours, 48 hours - one week, and after one week (p=0.6), nor regarding neonatal death or admission to neonatal care unit (p=0.078). Maternal side effects of β-agonist were reduced when half the dose of salbutamol in combination with a high dose of progesretone was used. There was a highly significant reduction in tachycardia, hyperglycemia, nausea and vomiting (p=0.000), and a significant reduction in shortness of breath, restlessness, tremor and chest pain (p<0.05) in the study group compared to control group. No significant difference existed between the two groups regarding headache (p=0.93). No pulmonary edema developed in either group.*

Conclusions: *Progesterone could have a role in the treatment of actual preterm labour when used in combination with a β-agonist to minimize the potentially life threatening side effects of β-agonists.*

INTRODUCTION

Preterm birth is defined as birth between 20 0/7 and 36 6/7 weeks. It is the number one cause of perinatal morbidity and mortality in developed countries, and these complications are inversely proportional to gestational age at birth.[1]

The incidence of preterm labour in most developed countries has remained frustratingly constant over the past 3 decades at about 5% to 10%, with some regions noticing a small increase above the usual incidence over the last 5 years.[2] Genetic as well as environmental factors may increase the risk of preterm labour.[3]

The use of tocolytic therapy between 24 and 34 weeks gestation is not only to facilitate the in utero transfer of the fetus to a tertiary referral center, but also to enable sufficient time to enhance fetal maturity by the concomitant use of maternal corticosteroid therapy. Tocolytic therapy should be continued if possible for 48 hours to try to maximize the enhancement of fetal lung maturity by maternally administered corticosteroids which also reduce the risk of neonatal intraventricular haemorrhage, necrotizing enterocolitis and neonatal death, particularly in extremely preterm infants.[2] The maximal beneficial effect of steroids is between 24 hours to 7 days after administration.[4] Although treatment of preterm labor with Beta-adrenergic agonists can delay delivery by 24 to 48 hours, the potential risks and benefits to the mother and infant before and after delivery have not been adequately assessed.[5] The perfect tocolytic would be one that; being safe for mother and fetus, could prolong gestation for enough time to achieve a significant reduction of preterm birth, allowing fetal maturation and therefore diminishing perinatal morbidity and mortality.[6]

The most commonly used drugs for the treatment of threatened preterm labour have been the β-agonists. β-agonists are effective in delaying delivery in women in preterm labour for 48 hrs.[7]

β-agonists are associated with maternal side effects of palpitation, tachycardia, arrhythmia, nausea, vomiting, tremor, hyperglycemia, hypokalemia and pulmonary edema.[6,8] The association between the use of β-mimetic drugs for preterm labour and maternal pulmonary edema has been recognized for some years.[9] Fetal and neonatal side effects of β-agonists may include tachycardia, hyperinsulinemia and hyperglycemia.[8,10]

Progesterone is an essential hormone in the process of reproduction. Although the pharmacokinetics and pharmacodynamics of progesterone have been well studied, and since 1935 it has been synthesized and is now available commercially, its use in pathophysiology of pregnancy remains controversial. One of these concerns is the way in which the hormone is administered, with parenteral use proving the best way to obtain optimal

plasma levels. Another concern is the paucity of randomized controlled trials and the different dosages and populations studied.[11] Progesterone decreases the concentration of myometrial oxytocin receptors, which counteract the effect of estrogens. The same is true with respect to the number and properties of gap junctions. Progesterone also inhibits prostaglandin production by amnion-chorion-decidua.[12] Progesterone and 17-a-hydroxyprogesterone caproate (17P) have long been considered important agents in the maintenance of uterine quiescence and have been used extensively in primary and secondary prevention of preterm delivery.[13]

METHODS

This is a randomized, controlled, clinical trial, conducted at the department of Obstetrics and Gynecology in cooperation with laboratory department at Al-Kadhimiyah Teaching Hospital and Baghdad Teaching Hospital/Iraq during the period from March 2006 to June 2007 to evaluate the effect of progesterone in treatment of acute labour. Informed written consent was obtained from all participant patients.

One hundred-one pregnant women with singleton pregnancy between 27 and 34 completed weeks of gestation who have had actual preterm labour were enrolled in this study. All had both, regular painful uterine contractions of at least one per ten minutes and cervical changes in form of cervical dilatation of ≤3 cm and/or cervical length less than 1 cm.

Patients with moderate or severe vaginal bleeding, placenta praevia, rupture of fetal membranes, signs of chorioamnionitis, pre-eclampsia, serious maternal disease, such as cardiac disease, venous thrombo-embolism, severe anemia and fetal death or congenital anomalies of the fetus were excluded from the study.

On admission, detailed history was taken from all patients. The gestational age was determined depending on accurate dating of the 1st day of the last menstrual period and 1st trimester ultrasound scan. Speculum examination was done to exclude premature rupture of fetal membranes, when a vaginal digital examination for assessment of cervical dilatation and effacement was done.

Patients were investigated for haemoglobin concentration, admission random blood sugar (repeated 4 hrs after the start of tocolytic agents), blood urea, serum creatinine, midstream urine analysis, urine for culture and sensitivity, high vaginal swab for culture and sensitivity, obstetric ultrasound, ECG, and serum electrolytes. None of the patients was using any medication except for iron and folic acid supplements and insulin required for diabetic women.

Diabetic patients presented with preterm labour within the study who received β-agonist and a course of steroid, underwent careful monitoring to check for unwanted hyperglycemia and diabetic keto-acidosis and then managed accordingly. The frequency and intensity of uterine contractions and fetal cardiac rhythm were documented by CTG. After one hour of bed rest, fetal heart rate and uterine contractility monitoring, the patients continued to have uterine contractions. They were randomly divided into two groups: Fifty patients were chosen randomly to receive salbutamol 2.5 mg in 500 ml of 5% dextrose started with 1.8 µg per min (7 drops/min) and doubled every 15 minutes according to response of uterine contractions until uterine contractions subsided or the maternal pulse rate increased to 140/min. Maintenance of β-mimetics infusion continued for 48 hrs when the patients responded to treatment. Those regarded as a control group. Five patients in this group were excluded from final analysis as they developed severe side effects of β-mimetics and their tocolytic therapy was changed to nefidipine.

The other fifty one patients received parentral progesterone in the form of primolut-depot (17-hydroxyprogesterone hexanoate in oil acting for 48 to 72 hrs) 250 mg I.M. in combination with half the dose of salbutamol that was given to control group (1.25 mg in 500 ml 5% dextrose) started with a dose of 0.9 µg per min (7 drops/min) and doubled every 15 min according to response of uterine contractions until they subsided, then maintenance of salbutamol infusion continued for 48 hrs if there was response to treatment. Primolut Depot was repeated after 48 hrs if uterine contractions

recurred. Those regarded as the study group.

Women of both groups were closely monitored for uterine contractions, progress of labour, vital signs and maternal side effects of salbutamol (tachycardia, shortness of breath, headache, tremor, restlessness, chest pain, nausea and vomting, pulmonary edema and hyperglycemia). All patients received dexamethasone which consisted of two 12 mg doses administered I.M. 24 hours apart and received antibiotics if they have had source of infection such as chest infection or urinary tract infection.

Follow up of patients was done for one week. Time of delivery was recorded and classified as during the 1st 48 hours of treatment, 48 hours to 1 week of treatment and after 1 week of treatment. Neonates that were born within one week were assessed by the paediatrician to determine their condition and the need for admission to the intensive neonatal care unit. If uterine contractions have subsided, some of the patients were discharged home after 48 hrs and followed up as out patients.

Statistical Analysis

Data were analyzed using the Statistical Packages for Social Sciences (SPSS version 11). The data were presented as numbers, percentages, frequency tables, graphs, mean±(S.D), Chi square test was used to measure statistical significance. p-value of <0.05 indicated the level of significance.

RESULTS

During the period of study a total of 101 were included, out of these patients, 96 completed the study period, while 5 patients were excluded as they developed severe side effects to salbutamol therapy and they were changed to nefidipine.

Table 1 shows the demographic characteristics of the women enrolled in the study. (86.7%) were of low and middle socioeconomic class and (13.3%) were of high socioeconomic class (socioeconomic class was determinened by social and economic status and patient's education). Regarding occupation (73.6%) of them were housewives, (19.4%) were clerks, and (5.95%) were students. With regard to residency (60.4%) were urban and (38.6%) were rural. Table 2 shows the matched characteristics of the studied sample regarding maternal age, gestational age, and parity. Table 3 shows a comparison between control group and study group regarding treatment-delivery interval. (17.7%) of control group delivered within 1st 48 hrs of treatment vs. (17.6%) of study group, (17.7%) of control group delivered between 48 hrs and one week vs. (19.6%) of study group, and (64.4%) of control group delivered after one week vs. (62.7%) of study group, which was statistically not significant (p=0.6).

		Control group		Study group		p-value
		No. (45)	%	No. (51)	%	
Socioeconomic class	Low	26	56	28	56.4	0.12
	Middle	13	30	15	30.3	
	High	6	14	8	13.3	
Occupation	House wife	38	74	40	73.6	
	Clerk	5	18	7	19.4	
	Student	2	6	4	5..95	
Residency	Urban	36	60	40	60.4	
	Rural	19	40	21	38.6	

Table 1. Demographic destribution of sample according to socioeconomic class, occupation, and residency.

	Control group					Study group				
	No.	min	max	mean	SD	No.	min	max	mean	SD
Age	45	16	40	26.20	6.63	51	16	40	26.98	6.55
Gestational age	45	27	35	31.16	2.20	51	27	34	31.14	1.96
Parity	45	0	8	2.20	1.87	51	0	8	2.04	1.80

Table 2. Characteristics of studied sample according to maternal age, gestational age, and parity.

		Control group		Study group		X^2	p-value
		No.	%	No.	%		
Treatment-delivery interval	48 hrs	8	17.7	9	17.6	7.74	0.06
	48 hrs-1 week	8	17.7	10	19.6		
	After 1 week	29	64.4	32	62.7		

Table 3. Comparison between control and study groups regarding treatment-delivery interval.

Side effect		Control group		Study group		X^2	p-value
		No.	%	No.	%		
Shortness of breath	Positive	12	26.6	5	9.80	4.66	0.03
	Negative	33	73.4	46	81.2		
Headache	Positive	10	22.2	11	21.6	0.01	0.93
	Negative	35	77.8	40	78.4		
Tachycardia	Positive	41	91.1	24	47.1	21.2	0.000
	Negative	4	8.9	27	52.9		
Tremor	Positive	18	40	9	17.6	5.91	0.01
	Negative	27	60	42	82.4		
Restlessness	Positive	12	26.7	5	9.8	4.76	0.03
	Negative	33	73.3	46	90.2		
Chest pain	Positive	7	15.5	2	3.9	3.81	0.05
	Negative	38	84.5	49	96.1		
Nausea and vomiting	Positive	14	31.1	3	5.9	10.44	0.001
	Negative	31	68.9	48	94.1		
Pulmonary edema	Positive	0	0	0	100		
	Negative	45	100	51	0		
Hyperglycemia	Positive	31	68.9	10	19.6	23.7	0.000
	Negative	14	31.1	41	80.4		

Table 4. Comparison between control and study group regarding side effects of salbutamol therapy.

Figure 1 shows a comparison between control and study group regarding neonatal outcome. 17.7% of the babies of control group were discharged from the intensive neonatal care unit within the first 24 hrs of their lives vs. 17.6% of the babies of study group. 13.3% of babies of control group needed admission to the intensive neonatal care unit for more than 24 hrs vs. 15.6% of babies of study group. Unfortunately, two babies from control group 4.4% and two from study group 3.9% died after delivery; they were 27 weeks of gestation and delivered before 48 hrs of dexamethasone therapy. 64.4% of the patients of control group and 62.7% of the study group were not delivered after one week of treatment and were discharged from hospital and their neonatal outcome was considered unknown.

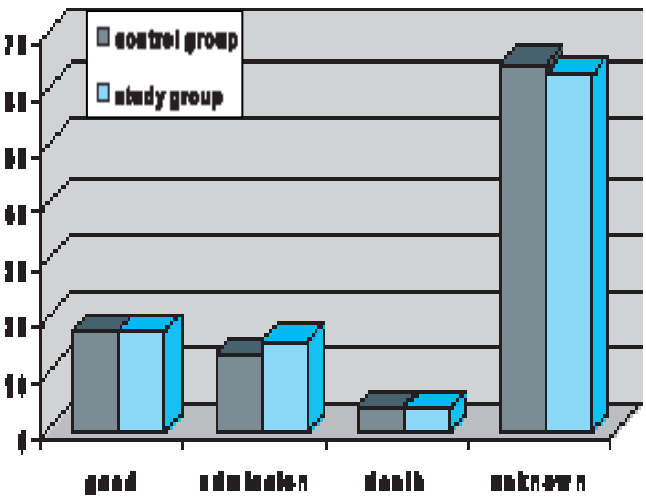

Figure 1. Comparision between control and study groups regarding neonatal outcome.

DISCUSSION

In Utero transfer has been shown to improve neonatal morbidity and mortality and clearly time would be required to move a mother with preterm labour from one hospital to another. The maximum benefit to the preterm neonate from antenatal corticosteroid administration is from 24 hrs to 7 days after the first dose of the course. Suppression of uterine contractions may therefore be an obvious solution to the problem of preterm labour. Ritodrine and salbutamol are associated with significant, potentially life threatening side effects (particularly if given in combination with corticosteroids)[3] and studies to determine ways to decrease these adverse effects are warranted.

Studies examining long-term use of progesterone in women at high risk of preterm delivery have returned encouraging results as a preventative measure.[12,13,14]

In this study 9.3% of patients were ≤ 19 years of age, 14.85 % of them were ≥ 35 years of age while Andrew B. Onderdonk et al. (2002) found that 0.5% of subjects with preterm labour were less than 20 years old, and 4.5% of them were more than 40 years old with 95% of subjects being between the ages of 20 and 39.[15]

The administration of high–dosage progesterone has been advocated as a possible tocolytic agent, but its action is slow and its usage has been abandoned for acute tocolysis except in conjunction with ß-agonists. The combination of both has shown synergistic effects by decreasing the need for high concentration of ß-agonists, which have potentially dangerous side effects.[11]

In the present study we found that there was no significant difference regarding the treatment-delivery interval between control group and study group who delivered within 48 hrs (17.7% vs. 17.6%), 48 hrs to one week (17.7% vs. 19.6%) or after one week (64.4% vs. 62.7%). These findings are comparable with that of G.C. Di Renzo et al (2003), who used ritodrine instead of salbutamol. They found that 87% of control group vs. 85% of study group delivered after 48 hrs, while 65% of control group vs. 68% of study group delivered after one week.[11]

We also found that there was a highly significant reduction in maternal side effects of salbutamol in the study group as compared to the control group including maternal tachycardia (91.1% vs. 47.1%), nausea and vomiting (31.1% vs. 5.9%), and hyperglycemia (68.9% vs.19.6%) p=0.000, and significant reduction in shortness of breath (9.80% vs. 26.6%), tremor (17.4% vs. 40%), restlessness (9.8% vs. 26.7%), and

chest pain (3.9% vs. 15.5%) p<0.05. These results are comparable with the results of the G.C. Di Renzo et al[11] who also found a difference in maternal side effects of ritodrine between control and study group; maternal tachycardia (97% vs. 52%), nausea and vomiting (28% vs. 16%), tremor (26% vs. 12%), chest pain (15% vs. 10%), hyperglycemia (77% vs. 28%). We did not find a significant difference between control and study group regarding headache (22.2% vs. 21.6%) p=0.93.

Erny R et al (1985), did a study made up of 57 women all admitted to hospital between thirtieth and thirty-sixth weeks of gestation for actual preterm labour. They studied the effect of oral progesterone therapy in a dose of (400 mg) of micronised progesterone (Urogestan) vs. placebo. They noticed an improvement in uterine contractility in 42 % of cases one hour after ingestion of placebo and in 75%-88% of patients one hour after ingestion of progersterone. The frequency of contractions decreased significantly in the group treated with progesterone (p<0.001), while they were not significantly decreased in those treated with placebo (0.05 < p < 0.3).[16]

A randomized controlled trial has shown that weekly administration of 17-alpha-hydroxyprogesterone caproate 300 mg/day intramuscularly resulted in a decrease of almost 50% in the subsequent incidence of preterm birth before 32 and 36 weeks, irrespective of the aetiology.[12]

A recent study by Fabio Facchinetti et al (2007), to evaluate wether 17-a-hydroxyprogesterone caproate (17P) treatment affect changes in cervical length concluded that undelivered patients after preterm labor undergo progressive shortening of the cervix which is attenuated by 17P treatment.[17]

CONCLUSIONS

The present study demonstrated that progesterone could have a role when used in combination with ß-mimetics, which are cheap and widely available, to reduce the dose of these agents and thus minimizing their potential life threatening side effects in the treatment of actual preterm labour.

REFERENCES

1. *Berghella V. Prevention of preterm birth. In: Venceno Berghella (ed). Obstetric evidence based guidelines. 1st ed. Informa UK Ltd; 2007. p. 116.*
2. *Svigos JM, Robinson JS, Vigneswaran R. Threatened and actual preterm labor including mode of delivery. In: James DK, Steer PJ, Weiner CP, Gonic B (eds). High Risk Pregnancy Management Options. 3rd ed. Elsevier Saunders; 2006. p. 1304-20.*
3. *Bennet p. Preterm Labor. In: Edmonds KD, (ed). Dewhurst's Text Book of Obstetrics and Gynecology. 7th ed. Blackwell Publishing; 2007. p. 177.*
4. *Goswami K, Thrnton S. The prevention and treatment of preterm labour. In: Studd J, Tan SL, Frank A, Chervenak FA, (eds). Progress in Obstetrics and Gynaecology. Vol.17. Elsevier Science Limited; 2006. p. 14:224.*
5. *The Canadian Preterm Labor Investigators Group [No authors listed]. Treatment of preterm labor with the beta-adrenergic agonist ritodrine. N Engl J Med 1992 Jul 30;327(5):308-12.*
6. *Gyetvai K, Hannah ME, Hodnett ED, et al. Tocolytics for preterm labor: a systematic review. Obstet Gynecol 1999;94:869-77.*
7. *Anotayanonth S, Subhedar NV, Garner P, et al. Betamimetics for inhibiting preterm labour. Cochrane Database of Sysemict Reviews 2004, Issue 4. Art No.:CD004352. DOI: 10.1002/14651858. CD004352. pub2.*
8. *Jeyabalan A, Caritis SN. Pharmacologic inhibition of preterm labor. Clin Obstet Gynecol 2002;45:99-113.*
9. *American College of Obstetrician and Gynecologists. Management of preterm labor. ACOG practical bulletin no.43. Washington, DC:ACOG, 2003.*
10. *Clesham GJ. Grand Rounds-Hammer Smith Hospital. Beta adrenergic agonists and pulmonary oedema in preterm labour must be used with care. BMJ 1994;308: 260-2.*
11. *Di Renzo GC, Rosati A, Mattei A, et al. The changing role of progesterone in preterm labour. BJOG March 2005;112(1):57-60.*
12. *Meis PJ, Klebanoff M, Thom E, et al. National institute of child health and development, maternal-fetal medicine units network. Prevention of recurrent preterm delivery*

by 17-alpha-hydroxyprogestrone caproate. N Engl J Med 2003;348:2379-85.

13. *Meis PJ. 17 Hydroxyprogesterone for the prevention of preterm delivery. Obstet Gynecol 2005;105:1128-35.*
14. *da Fonseca EB, Bittar RE, Carvalho MHB, et al. Prophylactic administration of progesterone by vaginal suppository to reduce the incidence of spontaneous preterm birth in women at increased risk: a randomized placebo-controlled double-blind study. Am J Obstet Gynecol 2003;188:419-24.*
15. *Lieberman E, Ruth RT, Delaney ML, et al. Quantitative microbiologic models for preterm delivery. J Clin Microbiol 2003;41(3):1073-9.*
16. *Erny R, Pigne A, Prouvost C, et al. The effect of oral administration of progesterone for premature labor. Am J Obstet Gynecol 1986;154:525-9.*
17. *Facchinetti F, Paganelli S, Comitini G, et al. Cervical length changes during preterm cervical ripening: effects of 17-a-hydroxyprogesterone caproate. Am J Obstet Gynecol May 2007;196(5):453.31-3.*

Original Article

موضوع أصيل

PREVALENCE OF PSEUDOEXFOLIATION SYNDROME IN YEMEN – HOSPITAL BASED STUDY

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ABSTRACT

Objective: *Pseudoexfoliation syndrome (PXS) is regarded a common disease in Yemen but the prevalence of this condition is not known. This study was conducted to document the prevalence of pseudoexfoliation syndrome in Yemeni patients aged 40 years and older attending an eye center; with emphasis on age, sex and laterality.*

Methods: *During the study period from 01 June 2001 to 31 December 2002 a total of 2000 consecutive patients aged 40 years and above attending Ibn Al-Haitham Eye Center in Sana'a, Yemen were recruited by the author. All the patients attending the clinic had a complete eye exam at the outpatient department. Each patient was examined for the presence of pseudoexfoliation material on the iris or lens capsule on dilated slit-lamp examination.*

Results: *Pseudoexfoliation syndrome was diagnosed in 360 patients (18.0%), mean age 67.3 ±9 years. Males*

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were affected more than females with a male to female ratio of 1.43:1. The prevalence of pseudoexfoliation syndrome increased significantly with age. Bilaterally affected patients were seen more commonly than unilaterally affected.

Conclusions: *This study confirms that pseudo-exfoliation is not uncommon in Yemen and the prevalence rate was 18.0% in this hospital based study. We found that pseudoexfoliation correlated strongly to age. This study gives us an insight into the problem and more care should be taken to tackle its complications namely cataract and glaucoma.*

INTRODUCTION

Pseudoexfoliation syndrome (PXS) was first described in 1917 by Lindberg[1] in a Finnish population. Pseudoexfoliation syndrome is the most common identifiable cause of open angle glaucoma worldwide.[2] PXS is a generalized disorder of the extracellular matrix characterized by production of abnormal basement membrane-like material in several intraocular and extraocular tissues. Despite extensive research, the exact chemical nature of the fibrillar material is unknown. Hypothesis of an accumulation of basement membrane components such as fibrillin has been proposed.[3] It is believed to be secreted multifocally in the iris pigment epithelium, the ciliary epithelium, and the peripheral anterior lens epithelium.[4]

The clinical diagnosis is made by the presence of typical pseudoexfoliation material (PXM) on the anterior capsule surface, pupillary ruff and other anterior segment structures. On the anterior capsule it has a characteristic distribution of a central disc surrounded by a clear zone, surrounded by a peripheral ring-like deposit of granular material. In addition to PXM, other features include endothelial pigmentation, loss of pupillary ruff, iris transillumination, Sampolesi's line, and pigment deposition in the trabecular meshwork.[5]

Pseudoexfoliation syndrome (PXS) is associated with various ocular complications. Elevated intraocular pressure and glaucomatous nerve damage had been demonstrated in patients with PXS[6,7,8] and is known as pseudoexfoliation glaucoma which is the most identifiable form of secondary open angle glaucoma worldwide.[2,9] Glaucoma probably occurs because of local production of PXM and passive deposition of extracellular PXM in the trabecular meshwork.[10] Cataracts were reported to be more common in patients with PXS.[11] Unfavorable factors for cataract surgery such as poor mydriasis,[12] capsular phimosis and opacification,[13] zonular weakness, higher rate of vitreous loss[14] and corneal endotheliopathy[15] have all been reported.

PXS is considered a systemic disease and PXM has been identified in various tissues in patients with ocular PXS.[16,17] Systemic associations reported include deafness,[18,19] hypertension, angina, myocardial infarction, stroke, and abdominal aortic aneurysms.[20] In fact pseudoexfoliation like material has been found in lungs, skin, liver, heart, kidney, gallbladder, blood vessels, extraocular muscles and meninges.[17]

Pseudoexfoliation is rarely seen before the age of 40, and its prevalence increases markedly with age.[21] Although it occurs in virtually every area in the world, a considerable racial variation exists.

Although a weak association between PXS and brown irides has been described,[31] it is generally considered common in Yemeni people. There is no data available on prevalence of PXS in Yemen and this study was performed to determine the prevalence of pseudoexfoliation syndrome (PXS) in Yemen in hospital based setting.

METHODS

After approval from Hospital Ethics Committee, patients above the age of 40 years attending the ophthalmic clinics at Ibn Al-Haitham Eye Center in the period of June 2001 to December 2002 were invited to participate in this prospective study. Ibn-Al-Haitham Eye Center is a regional tertiary care center and affiliated to the University of Science and Technology in Sana'a, Yemen. After informed consent, a total of 2000 consecutive patients were recruited for the study. Patients who were cooperative with examination procedures, and who had no previous intraocular surgery

in either eye were included. Relevant details in medical and ocular history were obtained from each patient.

A complete ocular examination was conducted on all patients including best corrected visual acuity, applanation intraocular pressure measurement, slit lamp biomicroscopy, dilated fundus examination and when indicated Gonioscopy was performed. PXS was diagnosed clinically by the presence of typical pseudoexfoliation material on anterior lens capsule or at the pupil border.

RESULTS

Of 2000 examined patients, 1060 (53.0%) were males and 940 (47.0%) were females with a male to female ratio of 1.13:1. Ages ranged from 41 to 98 years old. Table 1 shows demographic details of patients, wheras Table 2 shows age distribution of studied population.

Three hundred sixty out of 2000 were found to have PXS with an overall prevalence of 18.0%. They were all diagnosed by the presence of typical PXM on the anterior lens capsule or at the pupil margin. Table 3 shows prevalence of pseudoexfoliation stratified according to age groups. 74.4% of cases were bilateral though asymmetrical.

The mean age of patients with PXS was 67.3 years. There were 212 males and 148 females with a male to female ratio of 1.43:1. The age group 61–70 years accounted for the majority of patients (34.5%). The prevalence of PXS increased with increasing age. The prevalence in the age group 41-50 was 9.6% increasing to 18.2% in the age group 61-70 years and 32.4% in the age group above 80 years.

Age range	No. of subjects	Percentage
41 – 50 years	312	15.6%
51 – 60 years	554	27.7%
61 – 70 years	682	34.1%
71 – 80 years	341	17.0%
81 and above	111	5.6%
Total	2000	100%

Table 2. Age distribution of studied population.

Age range	No.	Percentage	Prevalence
41– 50 years	30	8.3%	9.6%
51– 60 years	94	26.1%	17.0%
61– 70 years	124	34.5%	18.2%
71– 80 years	76	21.1%	22.3%
81and above	36	10.0%	32.4%
Total	360	100%	18.0 %

Table 3. Prevalence of pseudoexfoliation stratified according to age groups.

DISCUSSION

One must stress that precise figures on prevalence can only be obtained by studying population groups and that the current hospital based study on patients above the age of 40 years old would lead to bias. In addition, the true figure could have been underestimated, as the clinical signs in PXS are known to be subtle in the early stages. Furthermore, it is regarded difficult to detect PXS in patients with mature and hypermature cataracts.[21]

PXS syndrome prevalence have been reported in different populations and showed extensive variations: Eskimos (0%), China (0.4%), Australia (0.98%), United

	All patients (n=2000)	Patients with PXS (n=360)	Patients without PXS (n=1640)
Age in years	41 – 98 (mean=61.0)	43 – 97 (mean=67.3)	41 – 98 (mean=64.6)
Male to female ratio	1.13 : 1	1.43 : 1	1.08 : 1

Table 1. Demographic details of patients.

States (1.8%), India (3.8%), England (4%), Germany (4.7%), Norway (6.3%), Saudi Arabia (9.3%), Iran (9.6%), Russia (12%), Greece (16.1%), Finland (22%) and Iceland (29%), Navajo Indians (38%).[22-30] This variation is combination of differences due to the criteria used to define examined populations that is, persons over a certain age, patients taken from eye clinics, patients with cataract and glaucoma. Racial difference, the age and sex distribution of the population group examined have also an influence on the results.

Clinical PXS may present unilaterally, as observed in 25.6% of cases. PXS has an increased predilection for cataract and glaucoma and intraocular pressure in both eyes should be regularly monitored.[32]

To the best of our knowledge, this was the first study conducted in a Yemeni population to assess the prevalence of PXS. Our examined population was recruited from the eye clinics and above the age of 40 years. The prevalence of PXS increased with increasing age reaching 32.4% in patients over 80 years of age, nearly tripling from age 41 to 50 years to age > 80 years. Our study confirms the idea that the prevalence of PEX increases with age because of its increasing incidence with age. Although the reason for this age-related increase is unknown, it may result from cumulative years of light-induced damage or from the changes in gene expression that occurs with age. The role of light is unclear, however, as PEX is associated with elastic tissue systemically, including those that have not been exposed to light (e.g. heart, lungs).[17,20]

In neighboring country Saudi Arabia, there was a population based study (1984) which included a subsample of 376 persons aged 40 years or more from 50 different locations. The overall prevalence of PXS was 9.3%.[30]

The prevalence was higher in males than females and this high rate in our study may be due to males seeking medical advice at early stages of eye diseases compared to females. Also majority of Yemeni population lives in villages or small towns and females find it difficult to come to main cities namely the capital Sana'a for medical advice.

CONCLUSIONS

We found that PXS is a common condition in Yemeni people with a prevalence rate of 18.0% in patients aged above 40 years old, 74.4% of cases were bilateral and there was male predilection.

ACKNOWLEDGMENT

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REFERENCES

1. *Lindberg JK. Kliniska undersokningar over depigmenteringen av pupillarranden och genomlysbarheten av iris vid fall av aldersstarr samt i normala agon hos gamla personer [In clinical studies of depigmentation of the papillary margin and transillumination of the iris in cases of senile cataract and also in normal eyes in the aged]. (Thesis). Helsinki, Finland: Helsinki University, 1917.*
2. *Ritch R, Schotzer-Schrehardt U. Exfoliation (pseudo-exfoliation) syndrome: toward a new understanding. Acta Ophthalmol Scand 2001;79:213-7.*
3. *Schlotzer-Schrehardt U, van der Mark K, Sakai LY, et al. Increased extracellular deposition of fibrillin-containing fibrils in pseudoexfoliation syndrome. Invest Ophthalmol Vis Sci 1997;38:970-84.*
4. *Ritch R. Exfoliation Syndrome. Saudi J Ophthalmol 2003;17(1):11-26.*
5. *Prince AM, Rich R. Clinical signs of the pseudoexfoliation syndrome. Ophthalmology 1986;93:803-7.*
6. *Fukisawa K, Sugai S, Inomata H, et al. Relationship between intraocular pressure and age in the exfoliation syndrome. Ophthalmologica 1995;209:199-202.*
7. *Alm A. The role of pseudoexfoliation in open-angle glaucoma. Acta Ophthalmol 2008 Nov;86(7):706-7.*
8. *Kanstas AGP, Jay JL, Marshal GE, et al. Prevalence, diagnostic features, and response to trabeculectomy in exfoliation syndrome. Ophthalmology 1993;100:619-27.*

9. *Rutch R. Exfoliation syndrome. The most common identifiable cause of open-angle glaucoma. Trans Am Ophthalmol Soc 1994;92:845-944.*
10. *Schlotzer-Schrehardt UM, Naumann GO. Trabecular meshwork in pseudoexfoliation syndrome with and without open-angle glaucoma. A morphometric, ultrastructural study. Invest Ophthalmol Vis Sci 1995;36:1750-64.*
11. *Rouhiainen H, Teravirta M. Presence of pseudo-exfoliation on clear and opacified crystalline lenses in an aged population. Ophthalmologica 1992;204:67-70.*
12. *Alfaiate M, Leite E, Mira J, et al. Prevalence and surgical complications of pseudoexfoliation syndrome in Portuguese patients with senile cataract. J Cataract Refract Surg 1996;22:972-6.*
13. *Kuchle M, Amberg A, Martus P, et al. Pseudoexfoliation syndrome and secondary cataract. Br J Ophthalmol 1997;81:862-6.*
14. *Lumme P, Laatikainen L. Exfoliation syndrome and cataract extraction. Am J Ophthalmol 1993;116:51-5.*
15. *Wang L, Yamasita R, Hommura S. Corneal endothelial changes and aqueous flare intensity in pseudoexfoliation syndrome. Ophthalmologica 1999;213:387-91.*
16. *Streeten BW, Dark AJ, Wallace RN, et al. Pseudo-exfoliative fibrillopathy in the skin of patients with ocular pseudoexfoliation. Am J Ophthalmol 1990;110:490-9.*
17. *Schlotzer-Schrehardt U, Koca MR, Naumann GO, et al. Pseudoexfoliation Syndrome: ocular manifestation of a systemic disorder?. Arch Ophthalmol 1992;110 (12):1752-6.*
18. *Cahill M, Early M, Stack S, et al. Pseudoexfoliation and sensorineural hearing loss. Eye 2002;16:261-66.*
19. *Shaban R, Asfour W. Ocular pseudoexfoliation associated with hearing loss. Saudi Med J 2004;25(9):1254-57.*
20. *Mitchell P, Wang JJ, Smith W. Association of pseudoexfoliation syndrome with increased vascular risk. Am J Ophthalmol 1997;124(5):685-7.*
21. *Hiller R, Sperduto RD, Krueger DE. Pseudoexfoliation, intraocular pressure, and senile lens changes in a population based survery. Arch Ophthalmol 1982; 100:1080-2.*
22. *Forsius H. Prevalence of pseudoexfoliation of the lens in Finns, Lapps, Icelanders, Eskimos, and Russians. Trans Ophthalmol Soc UK 1979;99:296-8.*
23. *Kozobolis VP, Popatzanaki M, Vlachonikolis IG, et al. Epidemiology of pseudoexfoliation in the island of Crete (Greece). Acta Ophthalmol Scand 1997;75:726-9.*
24. *Mccarty CA, Taylor HR. Pseudoexfoliation syndrome in Australian adults. Am J Ophthalmol 2000;129:629-33.*
25. *Young AL, Tang WWT, Lam DSC. The prevalence of pseudoexfoliation syndrome in Chinese people. Br J Ophthalmol 2004;88:193-5.*
26. *Arvind H, Raju P, Paul PG, et al. Pseudoexfoliation in south India. Br J Ophthalmol 2003;87:1321-3.*
27. *Nauri-Mahdavi K, Nasrat N, Sahebghalam R, et al. Pseudoexfoliation syndrome in central Iran: a population-based survey. Acta Ophthalmol Scand 1999;77:581-4.*
28. *Cashwell LF Jr, Shields MB. Exfoliation syndrome prevalence in a southeastern United States population. Arch Ophthalmol 1988;106:335-6.*
29. *Faulkener HW. Pseudoexfoliation of the lens among Navajo Indians. Am J Ophthalmol 1971;72:206-7.*
30. *Summanen P, Tonjun AM. Exfoliation syndrome among Saudis. Acta Ophthalmol Suppl 1988;184:107-11.*
31. *Meyer E, Haim T, Gidoni O, et al. Pseudoexfoliation: epidemiology, clinical and scanning electron microscopic study. Ophthalmologica 1984;188:141-7.*
32. *Shingleton BJ, Crandall AS, Ahmed II. Pseudoexfoliation and the cataract surgeon: preoperative, intraoperative, and postoperative issues related to intraocular pressure, cataract and intraocular lenses. J Cataract Refract Surg 2009 Jun;35(6):1101-20.*

Original Article

موضوع أصيل

EXPERIENCE IN CLEFT PALATE REPAIR BY FURLOW TECHNIQUE

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ABSTRACT

Objective: *To evaluate the authors' experience with Furlow palatoplasty and its effectiveness in restoring the continuity and lengthening of cleft palate.*

Methods: *The study was conducted in Plastic Surgery Unit, Mosul teaching hospital during the period from September 1997 till August 1998. Eighteen patients with cleft palate were surgically treated by Furlow techinque. They included 8 males and 10 females with age range between 1 to 12 years.*

Results: *The study revealed that the lengthening of palate achieved ranged from 0.6-1.4 cm (mean 0.9 cm). Furlow technique was used in patients with cleft soft palate, with or without hard palate cleft. Postoperative complications seen in three patients, included bleeding with partial necrosis of flap and fistula.*

Conclusions: *The technique is fairly easy, but demands careful dissection. It is highly indicated in cases of soft palate as it achieved palatal lengthening without tissue dissection from the hard palate.*

INTRODUCTION

The primary aim of cleft palate (CP) surgery is not only to close the CP defect but to push back the palate by repositioning the levator muscle to ensure that normal speech is obtained. Diminishing postoperative maxillary growth impairment is also essential.[1]

The Furlow palatoplasty (FP) includes closing the soft palate in two opposing Z-plasties which constructs a palatal muscle sling across the cleft, and the gain in length along the central limbs of the Z-plasty lengthens

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the soft palate to obtain normal speech.[2]

The aim of this study is to evaluate the authors' experience with FP in order to define the length and ratio of soft palate elongation achieved after CP repair.

METHODS

This study included 18 consecutive patients with variable defects of cleft palate, whom undergone FP in Mosul teaching hospital from September 1997 to August 1998. Seven other patients were excluded from the study because of a wide CP defect width (> 1.8 cm).

Data collected included age, sex, CP defect width measurement pre- and post-operatively, lengthening gained, time of operation and postoperative complications.

A paper ruler was used to measure both a straight-line and a curved distance while the patient was under general anesthesia before and immediately after FP.

RESULTS

There were 18 patients with cleft palate including 10 females and 8 males. The age varies from 1 to 12 years. Only 4 patients were older than 18 months (Table 1). Three patients had other congenital malformations as clubfoot and hypospadias. The defects were classified according to Veau classification shown in (Table 2).[3]

The intraoperative elongation gained ranged from 0.6-1.4 cm (mean 0.9 cm), and the elongation ratio ranged from 28% to 65% (mean 42%). The time taken for the dissection of the flaps and suturing varied from 40 to 85 minutes (mean 65 minutes), with a shorter operating time in the late cases of the study.

Case No.	Age (m=month) (y=years)	Sex	Classification (Veau)	Width of defect (cm)	Side	Length gain (cm)
1	12 m	M	I	1		0.8
2	16 m	M	I	1		0.8
3	15 m	F	I	1		1
4	16 m	M	I	1.2		1.4
5	18 m	M	I	0.8		0.8
6	18 m	M	I	0.7		1
7	12 m	F	I	0.6		0.8
8	12 m	F	I	1.2		1.1
9	12 m	F	I	1		1
10	18 m	M	I	1.1		1
11	11 y	F	II	1.1	Lt	0.6
12	16 m	F	II	1.5	Rt	0.6
13	4 y	F	II	0.4	Lt	0.8
14	18 m	F	II	0.4	Lt	0.7
15	18 m	M	II	0.9	Lt	0.8
16	18 m	M	II	0.6	Rt	0.7
17	12 y	F	III	1.8	Lt	1.2
18	3 y	F	III	1.4	Lt	1.1

Table 1. Results of patients' data.

Veau classification	Type of CP	No. of patients	Defect width (mean)
Type I	Cleft soft palate only	10	0.6-1.2 cm (0.87 cm)
Type II	Cleft soft & hard palate	6	0.4-1.5 cm (0.81 cm)
Type III	Complete unilateral cleft	2	1.4-1.8 cm (1.6 cm)

Table 2. Type of cleft palate defect according to Veau classification and its width.

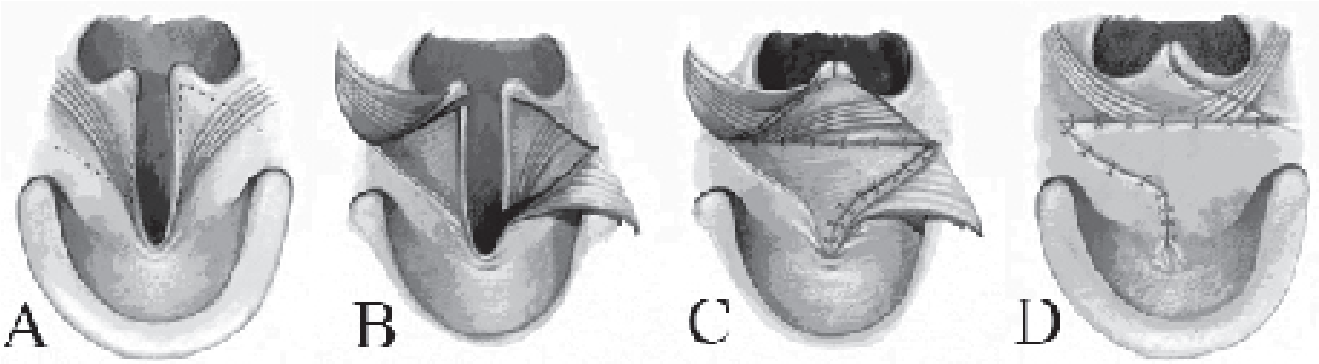

Figure 1. Furlow palatoplasty.
(A) Two mirror-image Z-plasties are drawn with the cleft as their central limb.
(B) The oral-side Z-plasty flaps are elevated with the muscle in the posteriorly based flap and only mucosa in the anteriorly based flap. The nasal flaps are elevated with the remaining muscle in the posteriorly based flap.
(C and D) Transposing the two sets of flaps overlaps the palatal muscles and lengthen the palate.

The complications were oronasal fistula in 2 patients and perioperative minor bleeding in one patient with partial necrosis of anterior mucosal flap, treated conservatively.

DISCUSSION

Although the current consensus, based on an increased understanding of speech development, is that the palatoplasty should be performed at 11-12 months of age,[4] this was not possible in our study with wide range of patients age from 1-12 years. It is mainly due to the late consultation. However, the older children show some technical difficulties in dissection and the perioperative bleeding was slightly more than in infants. This complication, probably due to more adherent mucoperiosteal flaps to the palatal bone in older children.

The primary aim of CP surgery is to achieve normal or near normal speech. Following closure of the cleft, the soft palate should be sufficiently long and mobile with the muscular sling restored to obtain closure of the velopharyngeal (VP) port. Velar length is a significant component of the VP closure.[5]

Furlow palatoplasty (FP) operation lengthens the soft palate by using only soft palate tissue,[2] Figure 1. It can be used for secondary palate lengthening to treat VP incompetence, but also commonly employed for

primary CP closure, especially for isolated clefts of the secondary palate.[4] The goal in treating VP insufficiency is to restore a functional seal between the nasopharynx and oropharynx so that normal speech articulation occurs.[6] McWilliams B, et al showed that subjects who had FP were superior to measures of hypernasality, articulation and total speech scores; and fewer pharyngeal flaps were required by FP subjects.[7]

The mean elongation of palate achieved in our study was 9 mm and the mean elongation ratio was 42%. This elongation is less than achieved by Guneren and Uysal, who achieved 16.1 mm and 69% respectively.[8] This is mainly due to our limited experience in this technique. Although the late postoperative elongation and ratio figures in Guneren study are less due to complete healing, but significant and permanent elongation in velar length was obtained using FP.[8] However, the late postoperative elongation could not be measured in our patients due to the difficulty in measuring palatal length in unaesthetized child and improper follow up of our patients.

However, the measurements of the palatal defect and lengthening may be affected by the edema, from the injection of lignocaine and noradrenaline during operation, and the later shortening of the palatal wound after healing.

The 1.5 cm length by soft palate push back is sufficient to facilitate VP closure. This push back of the palate reposition the levator muscle to ensure that normal speech is obtained.[1] Huang MH, et al found that the mean velar length was 0.46 mm greater, compared to the non-FP. Although this difference was not statistically significant, it may suggest that FP is more effective in increasing velar length compared to non-FP techniques.[9] An increase in length of soft palate of 10±3 mm at the average was gained by Schubert J, et al, immediately after surgery and good speech results obtained in 61% at age of 8 years.[10] Speech evaluation after FP could not be done in our study as it needs few more years to follow up the patients.

As the time taken for dissection of flaps and suturing varied from 40-85 minutes (mean 65 minutes), with a shorter operating time in the late cases of the study. This indicates that this technique is not difficult to learn and experience can be gained with time easily.

The advantage of good maxillary growth of FP over other procedures could not be assessed in our study as it needs at least 10 years to demonstrate the effect on maxillary growth and dental development.[2]

We would like to emphasize that expert nursing care and close supervision with help of parents play a very important role in achieving the best possible clinical outcome for CP surgery in pediatric patients.

CONCLUSIONS

FP is a new technique for CP repair and probably this is the first study of this procedure on a group of patients with surgical evaluation in Iraq.

It is a fairly easy technique that demands careful dissection with few postoperative complications that could be improved with experience and practice.

REFERENCES

1. *Maeda K, Ojimi H, Utsugi R, et al. A T-shaped musculomucosal buccal flap method for cleft palate surgery. Plast reconstr surg 1987;79(6):888-96.*
2. *Furlow LT. Cleft palate repair by double opposing Z-plasty. Plast Reconstr Surg 1986;78(6):724-38.*
3. *Hoffman W, Mount D. Cleft palate repair. In: Mathes S, (ed). Plastic surgery. 2nd ed. Philadelphia: Saunders Elsevier Inc; 2006. p. 250.*
4. *Hopper R, Cutting C, Grayson B. Cleft lip and palate. In: Thorne C, Editor-in-chief. Grabb & Smith's plastic surgery. 6th ed, Philadelphia: lippincott-Williams & Wilkins; 2007. p. 217-18.*
5. *Kumar PA. The use of vomerine flap for palatal lengthening: The modified Nagpur technique. B J plast surg 1985;38:343-6.*
6. *Ysunza A, Pamplona C, Ramirez E, et al. Velopharyngeal surgery: A prospective randomized study of pharyngeal flaps and sphincter pharyngoplsties. Plast reconstr surg 2002;110(6):1401-7.*

7. *McWilliams B, Randall P, LaRossa D, et al. Speech characteristics associated with the Furlow palatoplasty as compared with other surgical techniques. Plast Reconstr surg 1996 Sep;98(4):610-9.*
8. *Guneren E, Uysal OA. The quantitative evaluation of palatal elongation after Furlow palatoplasty. J Oral Maxollofac surg 2004 Apr;62(4):446-50.*
9. *Huang MH, Riski JE, Cohen SR, et al. An anatomic evaluation of the Furlow double opposing Z-plasty technique of cleft palate repair. Ann Acad Med Singapore 1999 Sep;28(5):672-6.*
10. *Schubert J, Bartel S, Hemprich A. Furlow palatoplasty-experiences with 114 consecutive cases. Mund Kiefer Geichtschir 2002 Sep;6(5):309-13.*

Original Article موضوع أصيل

PEDIATRIC ENURESIS: AN UPDATE

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د. كمال فريد عقل

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ABSTRACT

Objective: *The purpose of this review is to update our understanding of enuresis in the light of the recent standardization of terminology of the Childrens International Society.*

Methods: *A literature search was conducted via medline, using the words enuresis, overactive bladder, and incontinence.*

Results: *Enuresis is a common micturition disorder in children. Many children labeled as having enuresis have associated lower urinary tract symptoms. It is of paramount importance to differentiate enuresis from overactive bladder (OAB). When nocturnal enuresis is present in isolation without any lower urinary tract symptoms, it is defined as monosymptomatic nocturnal enuresis (MNE). If it is associated with lower urinary tract symptoms, it is termed nonmonosymptomatic nocturnal enuresis. Lower urinary tract symptoms consists of storage, voiding, and postmicturition symptoms. The term bladder instability is replaced by overactive bladder. When both conditions coexist, treatment is initially directed at overactive bladder symptoms. Once controlled, the treatment of primary nocturnal enuresis is in order.*

Conclusions: *Children with enuresis may have more than one diagnoses. It is important to differentiate primary nocturnal enuresis from overactive bladder since the management is different.*

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INTRODUCTION

The purpose of this report is to update pediatric enuresis in the light of the recent standardization of terminology of the International Childrens Continence Society (ICCS).[1]

The recent standardization of terminology of the lower urinary tract both in adults[2] and children[1] provides a common avenue for clinical practice and research.

The need for such terminology was originally realized in adults,[2] when symptoms such as nocturia, persisted after treatment of prostatic hypertrophy. In such patients, the persistent incontinence was secondary to associated lower urinary tract dysfunction (LUTD).

Lower urinary tract symptoms (LUTS) consist of storage, voiding, and postmicturition symptoms. Storage symptoms consist of increased daytime frequency (>8 voids/day), or decreased daytime frequency (<4 voids/day), daytime incontinence, urgency (sudden and unexpected urge to void), and nocturia (need wake up from sleep one or more times to void).

- OVERACTIVE BLADDER (OAB)

OAB consists of storage symptoms. The term OAB replaces bladder instability.

- NOCTURIA

Nocturia is different from enuresis. Nocturia occurs when a child older than 5 years, must wake up more than once at night to void.[1]

Nocturia may be caused by isolated or various combinations of nocturnal or global polyuria, excessive fluid intake, reduction of nocturnal bladder capacity, and sleep disorders.

Nocturia was redefined as a symptom and a condition by the standardization committee.[1] Nocturnal polyuria was defined as a nocturnal urine volume that is at least 20% of the total urine volume in young people.

- URINARY INCONTINENCE (UI)

UI means uncontrollable leakage of urine. It is divided into continuous incontinence and intermittent incontinence.[1] Continuous incontinence (CI), which is constant urine leakage is usually associated with congenital anomalies such as an ectopic ureter. CI replaces the term total incontinence. Intermittent incontinence, which is leakage of urine in discrete amounts, can be diurnal and/or nocturnal. It is not applicable to children who are younger than 5 years. When intermittent incontinence occurs during sleep, it is termed enuresis.

- ENURESIS

The ICCS defined enuresis as intermittent nocturnal urinary incontinence in discrete amounts during sleep excluding nocturia.[1]

When nocturnal enuresis is present in isolation without LUTS, it is defined as monosymptomatic nocturnal enuresis (MNE). When accompanied by LUTS, it is termed nonmonosymptomatic enuresis (NNME). MNE is divided into primary nocturnal enuresis (PNE), if the dry period is less than 6 months, and secondary nocturnal enuresis (SNE) if it is longer than 6 months.

Kajiwara et al detected concomitant OAB in 23.9% of children presenting with PNE.[3]

Children with combined nighttime and daytime wetting have dual diagnoses. The term diurnal enuresis is obsolete.[1] The differentiation between PNE and OAB is important for the management. Nocturnal enuresis is multifactorial in origin. Pathogenic mechanisms include nocturnal polyuria, small functional bladder capacity, and sleep disorders.[2]

Nocturnal polyuria may be caused by excessive fluid intake, especially in the late afternoon, decreased nocturnal secretion of antidiuretic hormone (ADH), and increased renal solute load. Clues to the presence of nocturnal polyuria include early wetting in the night, passing large amounts of urine, and wetting more than once at night.[4,5]

Small functional bladder capacity may be constitutional, or secondary to constipation or cystitis. Clues to the presence of constitutionally small bladder capacity include urinary frequency and nocturia, an early morning or last half of the night single void, and being dry during shorter periods of sleep.[4,6]

Sleep disorders are known to occur. Enuretics are often described as deep sleepers.

Other contributory factors, in some cases of PNE include obstructive sleep apnea, and attention deficit hyperactivity disorder.

A thorough history is the most important part of the evaluation. Severity of the enuresis is assessed. Mild, moderate, and severe enuresis involves wetting 1-2 times per week, 3-6 times per week, and 7 times per week respectively. Attention should be paid to the presence of associated LUTS. Gastrointestinal history is often ignored. Many parents are unaware that their child has constipation. Snoring suggests obstructive sleep apnea.

Physical examination includes inspecting the lumbosacral area for dimples or hair tufts, the abdomen for the presence of hard stools, a rectal examination, absence of anal wink, and a patulous anus. A focused neurological examination includes gait disturbance, deep tendon reflexes, and perineal sensation.

- INVESTIGATIONS

The only needed investigation for PNE is a urinalysis, to check for glucosuria, a low specific gravity, and the presence of pus cells.

For NMNE, investigations include postvoid measurement, uroflow, bladder capacity. Upper tract imaging is optional.

Urodynamics is rarely needed, except for the child who is resistant to therapy.

- MANAGEMENT OF PNE

Voiding diary is usually the initial step in the management.[7] The purpose of using a diary, usually for few days, is to document the time and amount of voiding, type and amount of fluid intake, and the presence or absence of micturition urgency. It also reveals the presence of nocturnal polyuria.

Behavioral therapy should be attempted before pharmacotherapy. It needs cooperation from the child and parents. It requires an average of six months. A recent randomized controlled trial demonstrated the efficacy of behavioral therapy.[8]

Next is the enuresis alarm, which is beneficial.[9] It has a success rate of 65%, and a relapse rate of 42%. Nocturia replaces bedwetting in one third of responders.[10] The alarm therapy is discontinued when the child is dry for 14 consecutive nights.

Pharmacologic therapy is last. Desmopressin is beneficial (Level I evidence).[11] After being dry for three consecutive months, desmopressin is gradually tapered. Side effects such as hyponatremia,[12] which were reported with the nasal spray formulation of desmopressin,[13] usually do not occur with the tablet or the fast melting formulation. It is important to instruct the child not to drink at night.

If symptoms are suggestive of an accompanying OAB, then treatment with antimuscarinics[14] is initially directed at the OAB.[15,16]

Once diurnal wetting improves, therapy for enuresis is commenced.

REFERENCES

1. *Neveus T, Gontard VA, Hoebeke P, et al. The standardization of terminology of lower urinary tract function in children and adolescents: Report from the Standardization Committee of of the International Childrens Continence Society. J Urol 2006 July;176(1):314-24.*
2. *Abrams P, Cardozo L, Fall M, et al. The standardization of terminology in lower urinary tract function. Neurourol Urodyn 2002;21:167-78.*
3. *Kajiwara M, Inoue K, Kato M, et al. Nocturnal enuresis*

and overactive bladder in children: An epidemiological study. Int J Urol 2006;13:36-41.

4. *Wright A. Evidence-based assessment and management of childhood enuresis. J Paediatr Child Health 2008 December;18(12):561-7.*
5. *Norgaard JP, Pedersen EB, Djurhuus JC. Diurnal anti-diuretic-hormone levels in enuretics. J Urol 1985;134:1029-31.*
6. *Robson WLM. Evaluation and management of enuresis. N Engl J Med 2009 April;360(14):1429-36.*
7. *Brown JS, McNaughton KS, Wyman JF, et al. Measurement characteristics of a voiding diary for use by men and women with overactive bladder. Urology 2003 Apr;61:802-9.*
8. *Dommelen VP, Campagne KM, Rijpstra AEA, et al. The short-and long-term effects of simple behavioral interventions for nocturnal enuresis in young children: a randomized controlled trial. J Pediatr 2009 May;154(5):662-6.*
9. *Glazener CM, Evans JH, Peto R. Alarm interventions for nocturnal enuresis in children. Cochrane Database Syst Rev 2005;2:CD002911.*
10. *Bonde HV, Andersen JP, Rosenkilde P. Nocturnal enuresis: change of nocturnal voiding pattern during alarm treatment. Scand J Urol Nephrol 1994;28:349-52.*
11. *Glazener CM, Evans JH. Desmopressin for nocturnal enuresis in children. Cochrane Database Syst Rev 2002;3:CD002112.*
12. *Robson WLM, Norgaard JP, Leung AKC. Hyponatremia in patients with nocturnal enuresis treated with DDAVP. Eur J Pediatr 1996;155:959-62.*
13. *Robson WLM, Leung AKC, Norgaard JP. The comparative safety of oral versus intranasal desmopressin in the treatment of children with nocturnal enuresis. J Urol 2007;178:24-30.*
14. *Andersson KE, Olshansky B. Treating patients with overactive bladder syndrome with antimuscarinics: heart rate considerations. BJU International 2007;100:1007-14.*
15. *Spee-van der Wekke J, Hirasing RA, Meulmeester JF, et al. Childhood nocturnal enuresis in the Netherlands. Urology 1998;51:1022-6.*
16. *Forsythe WI, Redmond A . Enuresis and spontaneous cure rate. Study of 1129 enuretis. Arch Dis Child 1974;49: 259-63.*

Original Article

موضوع أصيل

ENDOSCOPIC SINUS SURGERY OF ANTROCHOANAL POLYPS: ONE YEAR STUDY OF 17 PATIENTS

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ABSTRACT

Objective: *The aim of this prospective case series study is to assess the outcome of endoscopic sinus surgery on antrochoanal polyps in 17 patients over one year period.*

Methods: *Seventeen patients with antrochoanal polyps were treated in the department of otorhino-laryngology in Al-Jamhoree Mosul teaching Hospital from March 2006 up to February 2007. They had endoscopic transnasal surgery as the method of treatment, and all patients were followed one year postoperatively.*

Results: *Only one pediatric patient had recurrent polyp after 6 months and was subjected to another surgery which was complicated by temporary epiphora. Another patient had adhesions, otherwise all patients had improvement of symptoms, and frequent follow ups over one year showed no recurrence. No major complications were reported in any patient.*

Conclusions: *The endoscopic transnasal surgery of antrochoanal polyp is a minimally invasive technique which is both effective and safe.*

INTRODUCTION

Antrochoanal polyps arise from the maxillary antrum and prolapse through the ostium of the sinus in the middle meatus and they hang either in the nose or if larger into the posterior choana. They occur predominantly in children and young adults.[1,2] Surgery is the mainstay of treatment and endoscopic approach is an effective

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method for treatment.[3] The endoscopic sinus surgery was developed by Messerklinger (1978) and Wigand (1981), and was further refined by Stammberger (1986) and Kennedy (1986).[4] Possible complications of endoscopic sinonasal surgery include hemorrhage, CSF leak, intracranial injury, optic nerve injury, nasolacrimal duct injury and recurrence.[5]

The objective of this study is to assess the outcome of endoscopic sinus surgery on antrochoanal polyps (ACP) in 17 patients over one year period follow up.

METHODS

It is a prospective case series study which included 17 patients treated in the department of otorhinolaryngology in Al-Jamhoree Mosul teaching Hospital from March 2006 up to February 2007, and all patients were followed one year postoperatively. The age ranged from 8-35 years with a mean of 20.7 years. There were 11 female and 6 male patients. Fourteen patients were presented primarily with no previous surgery, 2 patients had a previous surgery and one patient (8 years) had previous 2 surgeries.

All patients were assessed preoperatively with CT scan paranasal sinuses and nasal endoscopy, except the pediatric patients where endoscopic examination was done at the time of surgery under general aneasthetic.

Operative procedure

All patients had the surgery done under general anaesthesia. The steps taken in the surgery were:

- Polypectomy, which was done endoscopically and transnasaly in all patients except one case in which the polyp was removed transorally.
- Removal of the lower part of the uncinate process and keeping the upper part untouched.
- Middle meatal antrostomy and connecting the natural with the accessory ostium if present. Enlarging the maxillary ostium was done both posteriorly and anteriorly with the aid of backbiter.
- Removal of the hypertrophied maxillary sinus mucosa.
- Exploration of the bulla ethmoidalis was done in 10 patients.
- Three patients had septoplasty done for concomitant septal deviation. The septoplasty was done in the traditional method.

During the procedure the ipsilateral eye was left uncovered with regular check by gentle pressure over it every now and then.

Hemostasis was achieved by using patties soaked in 1:10000 adrenalin applied topically. No injection was used in the procedure. All patients had simple nasal packing at the end of surgery which was removed the next day. All patients were given broad spectrum antibiotics for 2 weeks and they had postoperative care with endoscopic debridement which was done weekly for 4-6 weeks.

RESULTS

Seventeen patients underwent endoscopic sinus surgery for antrochoanal polyps. Fourteen patients had the procedure for the first time, 2 patients had the procedure after a previous surgery and one had the surgery done after previous 2 surgeries. Patients were followed up for one year to detect complications or recurrent disease.

All patients, except two, had improvement of symptoms, and frequent follow ups with endoscopic examination showed patent maxillary ostium.

One patient, 8 year old child, had recurrent polyp after 6 months and this patient was subjected to another surgery. Postoperatively, she developed temporary epiphora of the ipsilateral side which resolved completely in 2 weeks. Follow up in this child for one year showed no recurrence.

One patient, 17 year old female patient, had adhesion of the middle turbinate to the lateral nasal which was opened in the outpatient clinic under local aneasthetic.

The success rate of endoscopic sinus surgery (ESS)

No.	Age (years)	Sex	Type of Surgery	Complications/Recurrence
1	8	Female	Revision	Recurrence
2	12	male	Primary	None
3	13	Female	Revision	None
4	16	male	Primary	None
5	17	Female	Primary	None
6	17	male	Primary	None
7	18	Female	Primary	Adhesions
8	18	Female	Primary	None
9	18	Female	Primary	None
10	19	Female	Primary	None
11	20	Female	Primary	None
12	23	Male	Primary+Septoplasty	None
13	25	Female	Primary	None
14	28	Female	Primary+Septoplasty	None
15	32	Female	Primary	None
16	33	Male	Revision	None
17	35	Female	Primary+Septoplasty	None

Table 1. Clinical summary, operative, procedure and outcome.

in this study is 94%. No major complications were reported in any patient, (Table 1).

STUDY OF THREE CASES

Case I: Eight year old female child had 2 previous simple polypectomies with recurrence within 2 months of each surgery. She underwent the first endoscopic removal of the polyp without uncinectomy, and developed recurrence after 6 months of surgery. She was subjected to another endoscopic session in which the polyp was big to be removed per nose.

The polyp was removed per oral and endoscopic surgery was done in which the lower part of the uncinate was removed and meticulous attempt to remove hypertrophied mucosa of the sinus and widening of the maxillary ostium with backbiter. Postoperatively she developed epiphora which resolved completely in 2 weeks. One year follow up revealed no recurrence. Figure 1 shows the polyp removed.

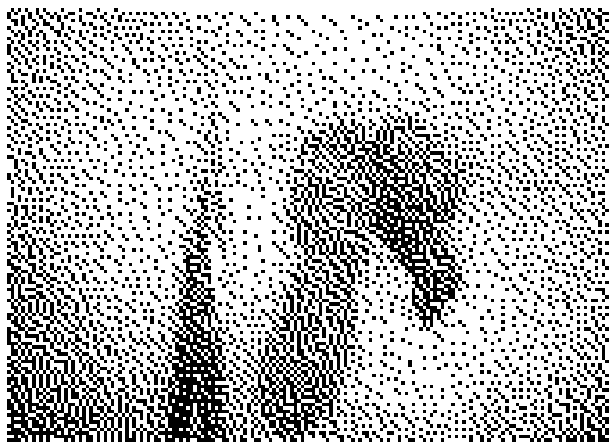

Figure 1. Antrochoanal polyp with both antral and choanal parts.

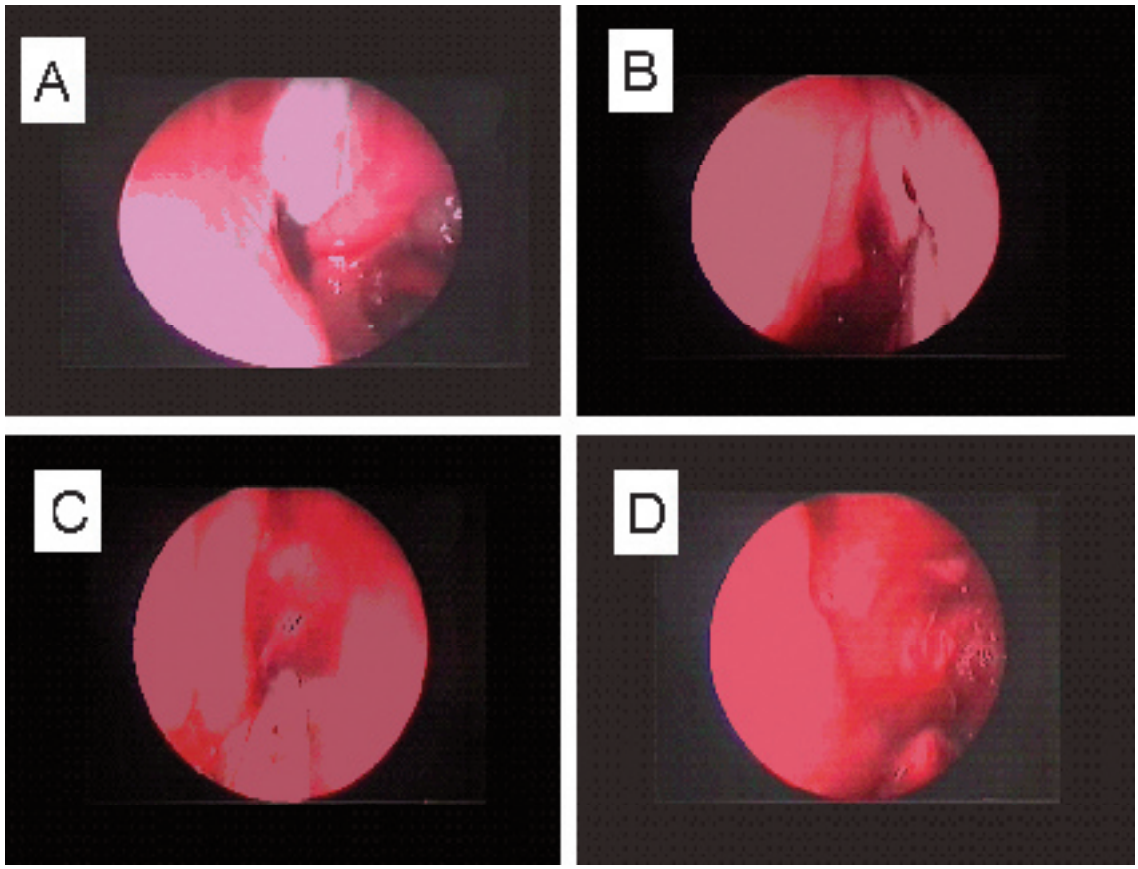

Figure 2. Antrochoanal polyp exits from inferior antrostomy (A). Uncinectomy (B), Enlarging the middle meatal antrostomy (C) and (D).

Case II: Twelve year old female patient who had single previous polypectomy for antrochoanal polyp, and developed recurrence of symptoms of nasal block and facial pain within 6 months after surgery. She had endoscopic surgery with complete resolution of symptoms and no recurrence after one year.

Case III: Thirty-three year old male patient who had polypectomy and inferior antrostomy for ACP since 7 years. On endoscopic examination, the polyp was extruding from the inferior antrostomy. He underwent uncinectomy, middle meatal antrostomy with removal of the hypertrophied sinus mucosa from both the inferior and the middle antrostomies. He had additional exploration of the bulla ethmoidalis which was found not diseased. Again, there was no recurrence after one year follow up. Figure 2 shows the operative procedure in this case.

DISCUSSION

Antrochoanal polyp, a benign solitary polypoid lesion, arises from the maxillary antrum and passes through the ostium of the sinus into the nasopharynx. Treatment is essentially surgical, by means of a wide antrostomy.[6] Because of recurrence after simple avulsion of the nasal part, maxillary sinus exploration and removal of the antral part of the polyp is recommended.[7] Caldwell-Luc procedure which includes sublabial incision and removal of the anterior wall of the maxillary sinus is associated with damage of the maxillary and dental growth centers.[8]

Recently, endoscopic technique became the popular approach to remove ACP. [2] Complications after endoscopic sinus surgery include severe hemorrhage, intracranial injury, and optic nerve injury. Minor complications, which are not life threatening, include periorbital hematoma, subcutaneous orbital emphysema, epiphora, synechiae and recurrence. Reported complication rates vary among investigators, however, there appears to be a correlation between complication rates and surgical experience.[9,10]

In our study in which follow up was done for one year, only one recurrence in pediatric patient was seen, and this child had previously rapidly recurrent disease after 2 simple polypectomies done by others.

This result agree with several studies reviewed in the literature that show higher recurrence in the pediatric group. [3,6] Some proposed additional transcanine approach to complete extirpating the polypoid mucosa.[3,7,11,12]

In our study we adopted transnasal approach which is less traumatic and with similar success rate.

No major complication was reported, because of the minimal and conservative nature of the procedure done. This is because the surgery is limited to removal of the lower portion of the uncinate process and avoiding dissection upwards or posterioly, which puts the skull base, ethmoidal vessels, optic nerve and the orbit into risk of injury.

CONCLUSIONS

The endoscopic transnasal surgery of antrochoanal polyp is a minimally invasive technique which is both effective and safe. It is effective because it follows the normal anatomy to enlarge the natural ostium and removes the diseased sinus mucosa allowing the regeneration of normal mucosa with normal mucociliary clearance. It is safe because the surgery is limited inferiorly and anteriorly to the lower part of the uncinate process and maxillary ostium, thus avoiding important structures of the skull base and orbit.

REFERENCES

1. *Drake-Lee AB. Antrochoanal polyps. In: Mackay IS, Bull TR, (eds). Scott-Brown's Otolaryngology. 6th ed. UK: Reed Educational and Professional Publishing Ltd; 1997. p. 4,10,14.*
2. *Facon F, Paris J, Dessi P. Antrochoanal polyps: diagnosis and management. Ann Otolaryngol Chir Cervicofac 2004;121(6):315-21.*
3. *Lee TJ, Huang SF. Endoscopic sinus surgery for antrochoanal polyps in children. Otolaryngol Head Neck Surg 2006;135(5):688-92.*
4. *Anand VK, Glasgold MJ. Functional Endoscopic Sinus Surgery. In: Bleach N, Milford C, Hasselt AV, (eds). Operative Otorhinolaryngology. UK: Black Science Ltd;1997. p.193.*
5. *Lee KJ. Essential Otolaryngology. 8th ed. USA: McGraw-Hill Companies Inc; 2003. p.398.*
6. *Bozzo C, Garrel R, Meloni F, et al. Endoscopic treatment of antrochoanal polyps. Eur Arch Otorhinolaryngol 2007;264(2):145-50.*
7. *Kwon SH, Kim KM, Kim W. The role of endoscopic sinus surgery with transcanine approach in antrochoanal polyps. Korean J Otolaryngol Head Neck Surg 2000; 43(9):956-60.*
8. *Maldonado M, Martinez A, Alobid I, et al. The antrochoanal polyp. Rhinology 2004;42(4):178-82.*
9. *Lund VJ, Wright A, Yiotakis J. Complications and medicolegal aspects of endoscopic sinus surgery. J R Soc Med 1997;90(8):422-8.*
10. *Hudgins PA. Complications of endoscopic sinus surgery. The role of radiologist in prevention. Radiol Clin North Am 1993; 31(1):21-32.*
11. *Basak S, Karaman CZ, Akdilli A, et al. Surgical approaches to antrochoanal polyps in children. Int J Pediatr Otorhinolaryngol 1998;46(3):197-205.*
12. *El-Guindy A, Mansour MH. The role of transcanine surgery in antrochoanal polyps. J Laryngol Otol 1994; 108(12):1055-7.*

Original Article موضوع أصيل

EFFECT OF TIGHT SWADDLING ON PULMONARY FUNCTIONS IN INFANTS UNDER MECHANICAL VENTILATION

[illegible]

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ABSTRACT

Objective: *Swaddling is a common baby care practice, there are some benefits and some complications. The aim of this study is to see the effect of tight swaddling on pulmonary functions in infants under mechanical ventilation.*

Methods: *Pulmonary functions were studied before and after tight swaddling in fifteen patients in the intensive care unit at Babylon Maternity and Children Hospital while they were on ventilator from January 2006 till January 2007 and the results were checked statistically by Paired t-test.*

Results: *The commonest diseases linked to the study were apnoea and birth asphyxia. Expiratory minute volume and expiratory tidal volume were the most commonly affected pulmonary functions by tight swaddling. The statistical difference was highly significant, ($p<0.001$). Oxygen saturation was not significantly affected, ($p>0.05$).*

Conclusions: *Tight swaddling has its deleterious effects on pulmonary functions.*

INTRODUCTION

Mothers have swaddled their babies throughout history since the ancient Greek and Romans and it is a well known practice in many areas of the world. Tight

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swaddling is an important baby care practice in our country. The technique of swaddling involves wrapping the baby with sheets followed by more tight wrapping with a rope like bandage with an average length of two meters and a half. The legs are straightened with force and kept in adduction. The procedure is usually demonstrated by the grandmother in front of the young mother who will take the job thereafter.

The local belief behind swaddling is that it gives better sleep and straight legs. There are different ways of swaddling, the baby may be wrapped with a piece of clothes without wrapping him with a bandage or by using the same procedure while the arms are left free.

The most commonly practiced type in our country is the tight wrapping with a bandage, the legs are kept straight and adducted and the head is left free (Figure 1).

Figure 1. Tight swaddling, the head is left free.

There are some benefits of light swaddling where the baby is wrapped lightly with a piece of clothes without a bandage, it has been found to reduce sudden infant death syndrome, if the baby is kept supine on a firm mattress,[1] help the baby to sleep,[2] it is more effective in reducing crying in infants with cerebral injuries than massage,[3] reduce the feeling of pain during blood testing,[4] light swaddling may control temperature in cold weather,[5] and it enhances neurodevelopment of premature babies,[6] however there are some complications especially if the baby is wrapped tightly, like increase incidence of DDH (developmental dysplasia of the hips),[7,8,9] hyperthermia in hot weather[10,11] and increase in respiratory infections.[12,13]

Effects of swaddling on pulmonary functions have not been studied well on usual infants because of the difficulties of doing the tests due to lack of cooperation by the infant.

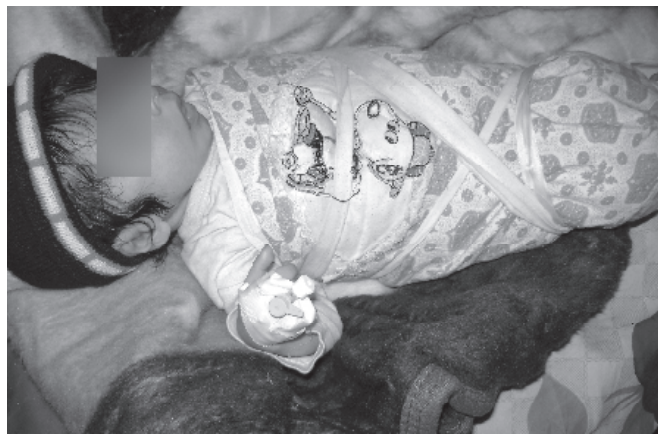

Figure 2. Modified swaddling, one of the arms is left free.

METHODS

Fifteen patients with respiratory failure in the intensive care unit in Babylon Maternity and Children Hospital were studied, age ranges from few days to one year. All patients were under mechanical ventilation and an uncuffed indotracheal tube was used. Expiratory tidal volume and expiratory minute volume were calculated by the machine, type Servo 900c (Siemens). Just before weaning of infants from ventilator, expiratory tidal volume, expiratory minute volume and oxygen saturation were recorded before swaddling. The baby now is wrapped by his mother who usually accompanies him in the ICU and does his swaddling as she used to do every day. In the absence of the mother, an experienced nurse can do the procedure and the measurements were recorded again after swaddling. All the results on the ventilator are recorded by a consultant anesthetist. The

respiratory rate is fixed at 50/minute. To get the optimum expiratory tidal volume a pressure controlled method is used by starting an air pressure of 15 cm water for all patients and increase or decrease pressure until a tidal volume is reached according to an average normal of 8-10 ml/kg. PEEP is left at zero level. Paired t-test is used for statistical analysis.

RESULTS

Fifteen patients (10 males and 5 females) (12 neonates and 3 babies under 3 years of age) are referred from other wards of the hospital and from nearby governorate hospitals. The most important types of referral in collection are due to central nervous system disorders as shown in Table 1.

Diagnosis	No.	%
Perinatal asphyxia	4	26.7
Septic shock	1	6.7
Leukodystrophy	1	6.7
Apnea	4	26.7
Congenital heart disease	1	6.7
Coma	1	6.7
Encephalitis	1	6.7
Lung collapse	1	6.7
Myelomeningocele and laryngomalacia	1	6.7

Table 1. Diagnosis as mentioned on the referral paper.

Expiratory tidal volume and expiratory minute volume were recorded before and after tight swaddling by using a pressure controlled method. The results of difference of volumes were obvious and were statistically highly significant. The p-value was less than 0.001 for both measurements by using paired t-test. Oxygen saturation was not affected by swaddling significantly, ($p>0.05$). The results are shown in Table 2.

DISCUSSION

Swaddling of infants if applied lightly and properly may have the following benefits: 1- It enhances sleep. 2- It reduces pain during laboratory tests. 3- It improves neuromuscular development in premature babies as mentioned in other studies.

There are on the other hand some complications especially if swaddling is applied tightly like: 1- Developmental dysplasia of the hip. 2- Increase incidence of SIDS if the baby is left to sleep prone on a soft mattress. 3- Hyperthermia in hot weather. 4- Respiratory infections.

In our study we found that the decrease in expiratory tidal volume and expiratory minute volume after swaddling is highly significant, ($p<0.001$) for both items. Decrease in oxygen saturation was not significant, ($p>0.05$), since it takes time for oxygen saturation to drop in addition to other deciding factors and also depends on the sensitivity of the oxymetry machine. Decrease in inspiratory tidal volume, measured as expiratory tidal volume means less oxygen delivered to the tissue and this limited movement of the lungs may be the cause of increase respiratory infections found in other studies.[12] To get the benefit of swaddling and reduce the deleterious effects like SIDS, the infant can be wrapped lightly and kept supine on a firm mattress.

Pulmonary function and SpO2	Mean±SD Before Swaddling	Mean±SD After Swaddling	p-value
Expiratory tidal volume	27.767±10.030	22.400±10.183	<0.001
Expiratory minute volume	1355.333±480.221	1065.333±465.063	<0.001
Oxygen saturation	95.200±5.088	93.400±4.997	>0.05

Table 2. Mean pulmonary functions before and after swaddling.

We think that our procedure is simple and applicable way to measure lung functions, but more ideal methods need to develop, which do not need cooperation of the child, these machines are still far from our hands. To our knowledge we couldn't find a study using this method in the intensive care unit to compare our results with. It is difficult to check pulmonary functions in healthy children since the procedure needs cooperation of the infants or we should wait until new machines develop which do not need such cooperation, these machines are on their way of application and they are not too far from clinical use.

CONCLUSIONS

Light swaddling is a helpful procedure but tight swaddling has it's deleterious effects on lung functions.

REFERENCES

1. *Wilson CA, Taylor BJ, Laing RM, et al. Clothing and bedding and its relevance to Sudden Infant Death Syndrome. J Paediatr Child Health 1994;30:506-12.*
2. *Franco P, Seret N, Van Hees JN, et al. Influence of swaddling on sleep and arousal characteristic of healthy infants. Pediatrics 2005;115(5):1307-11.*
3. *Ohgi S, Akiyama T, Arisawa K, et al. Randomized controlled trial of swaddling versus massage in the management of excessive crying in infants with cerebral injuries. Arch Dis Child 2004;89:212-6.*
4. *Campos RG. Soothing pain elicited distress in infants with swaddling and pacifiers. Child Development 1989;60:781-92.*
5. *Tsogt B, Mariseki-Holand S, Pallock J, et al. Can traditional care influence thermoregulation? A prospective controlled study of the effects of swaddling on infants thermal balance in a Mongolian winter, 9th sudden infant death conference, June 1-4, 2006, Yokohama, Japan.*
6. *Short MA, Brooks-Brun JA, Reeves DS, et al. The effects of swaddling versus standard positioning on neurodevelopment in very low birth weight infants. Neonatal Netw 1996;15(4):25-31.*
7. *Kutlu A, Memik R, Mutlu M, et al. Congenital dislocation of the hip and its relation to swaddling used in Turkey. Pediatr Ortho 1992;12(5):596-602.*
8. *Mamoun K, Alshahid KH, Khalid I, et al. The pattern of developmental dysplasia of the hip. Saudi Med J 2003;24(10):1118-20.*
9. *Shaheen MA. The Saudi tradition of infant wrapping as a possible etiological factor in congenital dislocation of the hip. J R Coll Edin 1989;34:85-7.*
10. *Plotz FB, L'Hoir MP, ten Berge M. Risks of ancient practices in modern times. Pediatrics 2002;110(6):78.*
11. *Guntheroth WG, Spiers PS. Thermal stress in sudden death: is there an ambiguity with the rebreathing hypothesis?. Pediatrics 2001;107:693-8.*
12. *Yardakok K, Yavus CE. Swaddling and acute respiratory infections. Am J Public Health 1990;80(7):873-5.*
13. *Van Sleuwen BE, Engelberts AC, Boere-Boonekamp MM, et al. Swaddling: a systematic review. Pediatrics 2007;120(4):1097-1106.*

Original Article

موضوع أصيل

EFFECT OF PASSIVE SMOKING AND THE USE OF HARM REDUCTION STRATEGIES BY PARENTS ON THE HEALTH OF THEIR ASTHMATIC AND NON-ASTHMATIC CHILDREN

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ABSTRACT

Objective: *This study was design to assess the effort taken by parents of both asthmatic and non asthmatic children to reduce the adverse effects of smoking at home through the use of harm reduction strategies.*

Methods: *A case-control study was conducted covering 2 hospitals in Mosil city. A total of 304 children (age 6-11.99 years) were included (110 asthmatic children, and 194 controls). Data was collected from the parents, and lung function tests were done to all the children in the sample.*

Results: *Eighty percent of parents of cases did certain measures to protect their children from environmental tobacco smoke compared to 93.3% of parents in control group with significant difference between them, the number of measures used by parents in both groups significantly differ, but when the number of measures used by parents in both groups were compared with results of lung function tests of children there were no significant differences between them.*

Conclusions: *Majority of parents agreed that tobacco smoke harm a great deal or quite a lot; yet, only 1% of parents in the control group and non of parents in the asthmatic children group agreed to stop smoking*

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at home as a measure to reduce the adverse effects of tobacco smoke. Lung function tests of the included children show no significant difference when studied with the numbers of harm reduction measures used by their parents.

INTRODUCTION

Environmental tobacco smoke (ETS), is a mixture of the smoke given off by the burning end of cigarette, pipe, or cigar and the smoke exhaled by the smokes, also known as second hand smoke (SHS), and some time called involuntary passive smoking.[1] Environmental tobacco smoke contaminates the air and it returned in clothing, curtains, and furniture, over 4000 different chemicals has been identified in ETS, among them carbon monoxide which is known to interfere with oxygen transport and utilization.[2,3] Smoking deepens the effects of poverty on families and children, parents smoked, spending about 15 per cent of their disposable income on cigarettes. Children in these families were more likely to lack basic amenities such as food, shoes, and coats;[4] in Egypt, more than 10 per cent of household expenditure is on tobacco; in Morocco, household spend nearly as much as they do on education.[5] Second hand smoke is especially harmful to people who already have asthma, when a person with asthma is exposed to second hand smoke; he or she is more likely to experience the wheezing, coughing and shortness of breath associated with asthma.[6,7]

WHO estimates that around 700 million or almost half of the world's children breath air polluted by tobacco smoke, particularly at home. The large number of exposed children, coupled with the evidence that ETS causes illness in children, constitutes a substantial public health threat.[8] Both asthma and respiratory illness (wheeze, cough, phlegm) are increased among children whose parents smoke on the basis of over 60 studies of school-aged children, among children with established asthma, parental smoking is associated with more severe disease.[9]

Smoking parents of children with asthma frequently report modifying their smoking behavior to reduce their child's exposure. Research has not analyzed the association between parental efforts and the child's smoke exposure.

Parents who smoke should be aware that their children might become ill as a result of breathing in airborne tobacco smoke.[10] Evidence shows that only a completely smoke-free home offers effective protection from the health effects of secondary hand smoking (SHS).[11-13] Some studies have suggested that "harm reduction" measures such as opening windows, smoking fewer cigarettes or avoiding smoking in the same room as children reduce levels of exposure to SHS. These studies also demonstrate that such measures still leave children exposed to levels of SHS that are far higher than those found in children who live in smoke-free homes, and in some cases are as those where there are no restrictions on smoking at all.[14,15] Other studies indicate that parental report of their own smoking as a source of children's exposure correlates well with biological measures of smoke exposure, suggesting that providers can obtain important and accurate information about the harmful exposure of children.[16-18] For this reason this study was design to assess parents knowledge about the effect of tobacco smoke on the health of their asthmatic children and the different modification methods used by them to reduce the adverse effect of tobacco smokes on their children in the home and its relation to different socioeconomic characteristics of the family.

METHODS

Mosil is a big city, its population around 1.125 million, and presenting different socioeconomic levels and ethnic groups. Because of these reasons and because of convenience purpose, data was collected from Mosil city. A case-control study was conducted covering 2 hospitals in Mosil, those where Ibn-Sina Teaching Hospital and Al-Khansa'a Maternity and Pediatric Surgery Hospital. A total of 304 children (age 6-11.99 years attending out patient, inpatient, and emergency clinic) were included in the study, among them 110 were asthmatic children, and 194 control children.

Inclusion criteria: Because the desire of this study was to perform lung function tests to all the children (cases and controls), children less than 6 years of age were not included in the study. As for cases, asthmatic children of both sexes who were diagnosed previously and presented with typical history of asthma were

included in the study. Control children were taken from children (of both sexes) attending surgical ward in the above hospital with similar age group (6-11.99 years), and with no history of asthma.

All the children were included in the study through well-structured questionnaire form; the information was taken directly from the parents of the child only. Data was collected on knowledge and use of harm reduction strategies by the parents, in addition to some socioeconomic characteristics of the included families in the study, lung function tests were performed to every child in the sample, and the researcher recorded the result on separate sheet for each child.

Analysis was done using SPSS program version 10.0 to calculate frequencies, percentages and odd ratios. Test of significant was done using chi-square, p-value ≤ 0.05 was considered as significant.

Variables		Cases (110)		Controls (194)		OR	95% CI	p-value
		Frequency	%	Frequency	%			
Age\years	6-7 8-9 10-11	42 21 47	38.2 19.1 42.7	50 59 85	25.8 30.4 43.8	1.52 0.64	0.88-2.62 0.35-1.19	0.13 0.16
Sex	Male Female	75 35	68.2 31.8	118 76	60.8 39.2	1.38	0.84-2.62	0.20
Birth weight	<2500 g ≥2500 g	14 96	12.7 87.3	6 188	3.1 96.9	4.57	1.70-12.27	0.001*
Mother education	Illiterate Primary Secondary	17 31 61	15.6 28.4 56.0	33 36 125	17.0 18.6 64.4	1.06 1.77	0.55-2.04 1.00-3.12 -----	0.87 0.05*
Mother occupation	Housewife Employed	99 11	90.0 10.0	163 31	84.0 16.0	1.71	0.82-3.56	0.15
Father education	Illiterate Primary Secondary College	6 16 75 12	5.5 14.7 68.8 11.0	19 4 159 12	9.8 2.1 82.0 6.2	0.32 4.0 0.47 ----	0.09-1.07 3.03-52.89 0.20-1.10 -----	0.06 0.04* 0.08 ------
Father occupation	Non-employed Employed	20 90	18.2 81.8	22 172	11.3 88.7	1.74	0.90-3.35	0.097
Residency	Urban Rural	103 7	93.6 6.4	184 10	94.8 5.2	0.80	0.30-2.16	0.27
Ethnicity	Arab Kurd Turkmen	97 7 6	88.2 6.4 5.5	187 3 4	96.4 1.5 2.1	----	----	0.019*
Family type	Extended Nuclear	20 90	18.2 81.8	10 184	5.2 94.8	4.09	1.84-9.10	0.0003*
Family size	<4 5-7 >7	8 49 52	7.3 45.0 47.7	21 89 84	10.8 45.9 43.3	---- 1.63 1.45	---- 0.67-3.94 0.60-3.51	---- 0.41 0.28
Crowding index	<2 2-4 >4 Mean±SD	12 68 29 3.41±1.56	11.0 62.4 26.6	39 122 33 2.95±1.43	20.1 62.9 17.0	---- 2.86 1.81	---- 1.26-6.47 0.89-3.69	---- 0.099 0.011*

*Significant association using chi-square test.

Table 1. Some socioeconomic characteristics of chidren's families of children (cases and controls).

RESULTS

Distribution of the children in the sample showed that highest proportion of children (cases and controls) were among the age group 10-11 years, among cases the proportion of males (68.2%) was higher than females (31.8%). Secondary education was the highest among parents of both cases and control groups, primary education was higher among parent of cases than control group, majority of children were from nuclear type of families and with bigger family size (Table 1).

Table 2 showed that 82.7% of parents of asthmatic children agreed that tobacco smoke harm a great deal or quite a lot compared to 95.9% of parent of control children with a significant difference between the two groups (OR=0.20 and 0.24, p-value=0.002 and 0.006 respectively). Eighty percent of parents of cases did certain measures to protect their children from ETS compared to 93.3% of parents of control group with significant relation between the two groups (OR=3.48, p-value=0.0005) (Table 3).

Table 4 showed that 86.4% of parents of children could recall measures to protect their children against ETS compared to 93.8% of parents in the control group with significant difference between the two groups (OR=2.40, p=0.029). Non of the parents of asthmatic children and only 1% of those in the control group would stop smoking, a small proportion of parents (2.7% of asthmatic children and 2.6% of control children would smoke fewer cigarette, Table 5). The number of measures used by parents in both groups significantly differ (p=0.04), Table 6; there were significant differences between cases and controls regarding different lung function tests except for PEFR, but when the number of measures used by parents was compared with results of lung function tests among children in the study there were no significant differences between them (Table 7 and 8).

Harm from exposure to tobacco smoke	Cases (110)		Controls (194)		OR	95% CI	p-value
	Frequency	%	Frequency	%			
A great deal	60	54.5	124	63.9	0.20	0.08-0.49	0.0002*
Quite a lot	31	28.2	62	32.0	0.21	0.08-0.54	0.0006*
A little or not at all	19	17.3	8	4.1	---	-----	------
Total	110	100	194	100			

*Significant association using chi-square test.

Table 2. Harm effect of tobacco smoke on health of children according to parents.

Are there practical things people can do to protect children from environmental tobacco smoke?	Cases (110)		Controls (194)		OR	95% CI	p-value
	Frequency	%	Frequency	%			
No	22	20.0	13	6.7	3.48	1.68-7.23	0.0005*
Yes	88	80.0	181	93.3			
Total	110	100.0	194	100.0			

*Significant association using chi-square test.

Table 3. Distribution of cases and controls according to protection practice to environmental tobacco smoke environmental tobacco smoke.

Able to recall measures to protect children from environmental tobacco smoke?	Cases (110)		Controls (194)		OR	95% CI	p-value
	Frequency	%	Frequency	%			
No	15	13.6	12	6.2	2.40	1.08-5.32	0.029*
Yes	95	86.4	182	93.8			
Total	110	100.0	194	100.0			

*Significant association using chi-square test.

Table 4. Distribution of cases and controls according to ability to recall measures to protect children from environmental tobacco smoke environmental tobacco smoke.

No. of measures	Cases (110)		Controls (194)		Total (304)		p-value
	Frequency	%	Frequency	%	Frequency	%	
0	15	13.8	12	6.2	27	8.9	0.041*
1	22	20.2	29	14.9	51	16.8	
2	43	39.4	94	48.5	138	45.2	
3	23	21.1	55	28.4	78	25.7	
4	6	5.5	4	2.1	10	3.3	
Total	109	100	194	100	303	100	

*Significant association using chi-square test.

Table 6. Distribution of cases and controls according to number of measures used by the parents.

Parameters	Mean±SD		Level of significance
	Cases	Controls	
FVCm	1.94±0.54	2.36±0.56	0.001*
FVCp	82.46±17.49	99.53±10.16	<0.001*
FEV1m	1.54±0.51	2.04±0.49	<0.001*
FEV1p	74.96±19.22	98.48±13.32	<0.001*
FEV1%m	78.65±10.89	87.66±5.36	<0.001*
PEFR	3.22±4.67	3.23±1.23	0.994
MMFERm	1.4±0.72	2.28±0.76	<0.001*
MMEFRp	53.76±24.91	92.6±18.6	<0.001*
PEF	0.17±0.08	0.24±0.14	0.006*
MVV	1.06±0.39	1.44±0.61	0.001*
FEV1%p	90.17±9.12	97.58±7.35	<0.001*
FEV1/FVC	65.06±17.23	89.14±11.53	0.01*

*Significant association using chi-square test.

Table 7. Results of lung function tests among cases and controls.

Variables		Cases (110)		Controls (194)		OR	95% CI	p-value
		Frequency	%	Frequency	%			
M1=do not smoke, or allow smoking in the house	No Yes	81 29	73.6 26.4	145 49	74.7 25.3	0.94	0.55-1.61	0.83
M2=stop smoking	No Yes	110 0	100 0.0	192 2	99.0 1.0	----	----	0.41
M3=avoid smoking places	No Yes	90 20	81.8 18.2	142 52	73.2 26.8	1.65	0.92-2.94	0.09
M4=smoke fewer cigarettes	No Yes	107 3	97.3 2.7	189 5	97.4 2.6	0.94	0.22-4.03	0.94
M5=do not smoke in the same room of the child	No Yes	59 51	53.6 46.4	91 103	46.9 53.1	1.31	0.82-2.09	0.26
M6=do not smoke or allow smoking in the living room	No Yes	101 9	91.8 8.2	151 43	77.8 22.2	3.20	1.49-6.84	0.02*
M7=do not smoke or allow smoking where child is sleeping	No Yes	108 2	98.2 1.8	145 49	74.7 25.3	18.25	4.34-76.69	0.0001*
M8=air room where smoking or someone else is smoking	No Yes	60 50	54.5 45.5	129 65	66.5 33.5	0.61	0.37-0.98	0.039*
M9=air room after smoking or someone else is smoking	No Yes	78 32	70.9 29.1	162 32	83.5 16.0	0.48	0.28-0.84	0.009*

*Significant association using chi-square test.

Table 5. Distribution of cases and controls according to measures performed to modify the effect of environmental tabacco smoke.

No. of measures and pulmonary tests	Mean					p-value
	0	1	2	3	4	
FVCm	1.84	1.91	1.89	2.2	1.67	0.436
FVCp	78.93	79.7	85.58	85.97	75	0.709
FEV1m	1.44	1.59	1.47	1.78	1.3	0.399
FEV1p	71.36	75.03	76.46	78.63	66.13	0.852
FEV1 %m	79.52	82	75.06	81.16	76.5	0.412
PEFR	2.45	2.65	2.5	5.78	2.31	0.356
MMEFRm	1.26	1.52	1.32	1.64	1.02	0.579
MMEFRp	49	56.02	53.45	60.28	41.03	0.757
PEF	0.14	0.16	0.19	0.17	0.08	0.150
MVV	0.99	1	1.13	1.14	0.91	0.780
FEV1%p	91.47	92.9	88.95	89.92	87.23	0.777
FEV1/FVC	56.94	62.54	68.78	67.83	67.33	0.728

Table 8. Effect of number of measures made to protect children from environmental tobacco smoke on pulmonary function test results among cases.

DISCUSSION

Children in both groups were mainly in the age group of 10-11 years, males were more affected by asthma than females, which is in agreement with the results of other studies,[19,20] while it disagree with the results obtained by Al-Thamiri et al 2005.[21] The finding that parental low education (primary education) and increase crowding index were significantly differ between cases and control groups (similar finding in other studies).[22] A research study from 2005 has warned that policies aiming to reduce chidren's exposure to SHS may not be sufficient without parallel action to improve maternal education, and reduce material hardship,[23] this indicate that the impact of socioeconomic status on asthma in children is major and significant one, and reflecting the association between tobacco use and social disadvantage.[24] In low income families, parents addiction to tobacco can divert scarce funds away from meeting basic needs, interviews with smokers who are in low socioeconomic groups support the idea that the majority will find the money for tobacco, or use other strategies to obtain cigarettes, even when circumstances are difficult.[25] The birth weight of asthmatic children were significantly lower from control children, one of the reasons for that could be cases are expose more to tobacco smoke at home than non asthmatic one. Cigarette smoking is the most important factor affecting birth-weight,[26] SHS exposure is also associated with low birth-weight. On average, babies of mothers who smoke during pregnancy are 200 to 250 g lighter than those of non-smoker.[27] Majority of children in both groups were among Arab ethnicity, this possibly might reflect the population proportion of the different ethnic groups in Mosil city but there was a significant difference in percentage of children with asthma among Kurd than non-Kurd children, this point might indicate ethnic susceptibility for asthma, though the number of cases were small, a point that need to be clarify using larger sample size in future studies. The study showed that parents of children with asthma are less knowledgeable regarding: first the harm imposes on their children from tobacco exposure (82.7% compared to 95.9%). One study of families who smoke found that 85% of parents believed that SHS affected children a great deal or quite a lot, but that awareness of effective measures to protect babies from SHS was much lower,[12] second point is whether their children can be protected from it at home (80% compared to 93.3%). In one study from USA, only half (51%) of children with asthma whose parents smoked lived in smoke-free home,[21] these finding suggest that health promotion messages urging parents to protect their children from tobacco smoke may have had some success. Non of parents of asthmatic children and only 1% of parents of control group agreed on banning smoking, while around one quarter of parents in both groups agreed on stop smoking at home, the fact that the two groups differ significantly in the use of measures by parents to reduce exposure of their children in the home, and significant difference was also found when the number of measures used was discussed, reflect the importance of changing practice of smoking at home in the presence of young children as a means of reducing exposure to tobacco smoke when cessation is not possible. Most studies examine harm reduction strategies by parents in the home report on children with specific conditions such as asthma, where parent's knowledge and use of measures to reduce exposure to tobacco smoke is likely to be higher than in general population.[14]

The finding that number of measures used by parents was not significantly related to results of lung function tests among children in the study in spite of the fact that both groups differ significantly in most of the test used in the lung function tests could be due to the fact that parents frequently used a combination of measures that they might not equally adhere to them, making it difficult to determine the extend to which individual practices affect exposure, or because they know these interventions were valued by physicians, in addition, the study questionnaires did not specify a specific point in time at which parents made modifications, overlapping of responses could occurred if parents had tried both smoking outside and also smoking in another room. Study done by Blackburn et al 2003[14] found that only banning of smoking in the home was associated with a small but significant reduction in urinary cotinine to creatinine ratio in infants, whereas less strict measures compared with no measures to reduce tobacco smoke in the home had no effect on exposure of infants, other studies[28,29] reported a significant reductions in cotinine levels associated with less strict measures. Published

observational studies have studied older children and adolescent (1-19 years) in hospital outpatient population reported a decreased cotinine concentration associated with harm reduction strategies.[30-32]

Further studies should investigate the benefit of providing smoking cessation programs targeted to the specific needs of smoking parents of children with asthma, in addition, because many of those parents reported using modifications to reduce their smoke exposure, physicians serving children should also improve their performance in the areas of tobacco control. Efforts should focus on determining how the child health care system can be best screen and counsel for parental smoking in a consistent and effective manner.

CONCLUSIONS

Majority of parents agreed that tobacco smoke harm a great deal or quite a lot; yet, only 1% of parents in the control group and non of parents in the asthmatic children group agreed to stop smoking at home as a measure to reduce the adverse effects of tobacco smoke. Lung function tests of the included children show no significant difference when studied with the numbers of harm reduction measures used by their parents.

REFERENCES

1. *U.S Environmental Protection Agency. Indoor air-smoke-free home program. Health effect of exposure to second hand smoke, 2001.*
2. *Smoking and health: Report of the Advisory Committee to Surgeon General of the Public Health Service. Washington D.C, U.S.DHHEW. U.S. Department of Health Education and Welfare U.S. DHEW,1964.*
3. *Holbrook JH. Nicotine addiction. In: Braunwald E, (ed). Harrison's principles of internal medicine. 14th Ed. New York: McGraw-Hill;1998. p. 2516.*
4. *Taylor AJ, Langdon M, Campion P. Smuggled tobacco, deprivation and addiction. Eur J Pub Health 2006:7:333-43.*
5. *WHO. World No Tobacco Day Materials. 2004.*
6. *Liou A, Grubb JR, Schechtman KB, et al. Causative and contributive factors to asthma severity and patterns of medication use in patients seeking specialized asthma care. Chest 2004;124(5):1781-8.*
7. *Carlsen KH, Lodrup Carlsen KC. Parental smoking and childhood asthma: Clinical implications. Treat Respir Med 2005;4(5):337-46.*
8. *Willers S, Skarping G, Dalene M, et al. Urinary cotinine in children and adult during and after semi experimental exposure to environmental tobacco smoke. Arch Environ Health 1995;50:130-8.*
9. *Cook D, Stachan DP. Health effects of passive smoking: Summary of effects of parental smoking on the respiratory health of children and implications for research. Thorax 1999;54:357-66.*
10. *Leiss W. Risk perception and communication: Environmental tobacco smoke and child health. Background paper for WHO's Consultation Report 1999.*
11. *Johansson AK, Hemansson G, Ludvigsson J. How should parents protect their children from environmental tobacco –smoke exposure in the home?. Pediatrics 2004; 13:291-5.*
12. *Spencer N, Blackburn C, Bonas S, et al. Parents reported home smoking bans and toddler (12-30 months) smokeexposure: a cross-sectional survey. Arch Dis Child 2005;90:670-4.*
13. *U.S. Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General Atlanta, GA: U.S. Deopartment of Health of Health and Human Services, Center for disease Control and Prevention, Office on Smoking and Health 2006.*
14. *Blackbum C, Spencer N, Bonas S, et al. Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: cross sectional survey. BMJ 2003;327:257.*
15. *Matt GE, Quintana PJE, Hovell MF, et al. Households contaminated by environmental tobacco smoke sources of infant exposures. Tob Control 2004;13:29-37.*
16. *Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence. Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services, Public Health Services; June 2000.*
17. *Hovell MF, Zakarian JM, Wahlgren DR, et al. Reported measures of environmental tobacco smoke exposure: trials and tribulations. Tob Control 2000; 9 (suppl 3): III22-III28.*

18. *Matt GE, Hovell MF, Zakarian JM, et al. Measuring secondhand smoke exposure in babies: the reliability and validity of mother reports in a sample of low-income families. Health Psychol 2000;19:232-41.*
19. *Luyt DK, Burton P, Simpson H. An epidemiological study of wheeze, doctor diagnosed asthma and cough in preschool children in Leicestershire. BMJ 1993;306: 1386-90.*
20. *Bassili A, Zaki A, El-Sawy IH, et al. Current health care of childhood bronchial asthma in Alexandria, Egypt. EMHJ 1998;4(3):575-84.*
21. *Al-Thamiri D, Al-Kubaisy W, Ali SH. Asthma prevalence and severity among primary school children in Baghdad. EMHJ 2005;11(1/2):79-86.*
22. *Strachen DP. A national survey of asthma prevalence, severity, and treatment in Great Britain. Arch Dis Child 1994;70:174-8.*
23. *Spencer N. Maternal education, lone parenthood, material hardship, maternal smoking and longstanding respiratory problems in childhood: testing a hierarchical conceptual framework. Eur J Epidemiol Community Health 2005;59:842-6.*
24. *Wakefield M, Banham D, Martin J, et al. Restrictions on smoking at home and urinary continine levels among children with asthma. AM J Prev Med 2000;19:188-92.*
25. *Wiltshire S, Bancroft A, Amos A, et al. They're doing people a service- quantitative study of smoking smuggling and social deprivation. BMJ 2001;323:203-7.*
26. *Di Franza JR, Aligre CA, Weitzman M. Prenatal and postnatal environmental tobacco smoke exposure and children's health. Pediatrics 2004;113(suppl 4):1007-15.*
27. *US Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, Center for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Office of Smoking and Health 2004.*
28. *Bakoula C, Kafritsa Y, Kavadias G, et al. Factors modifying exposure to environmental tobacco smoke in children. Cancer Causes Control 1997;8:73-6.*
29. *Winkelstein ML, Tarzian A, Wood RA. Parental smoking behavior and passive smoke exposure in children with asthma. Ann Allergy Asthma Immunol 1997;78: 419-23.*
30. *Huss K, Rand CS, Butz AM, et al. Home environmental risk factors in urban minority asthmatic children. Ann Allergy 1994;72:173-7.*
31. *Halteman IS, Fagnano M, Conn KM, et al. Do parents of urban children with persistent asthma bansmoking in their homes and cars?. Ambulatory Pediatrics 2006;6: 115-9.*
32. *Ogborn CJ, Duggan AK, DeAngelis C. Urinary cotinine as a measure of passive smoke exposure in asthmatic children. Clin Pediatr 1994;33:220-6.*

Original Article

موضوع أصيل

IL-10 LEVELS DETERMINATION IN SYRIAN PATIENTS WITH NEWLY DIAGNOSED LYMPHOMA AND THEIR RELATION WITH DISEASE PROGRESSION

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د. رنوة السيد، د. غادة الأخرس، د. محمد عامر الشيخ يوسف

ABSTRACT

Objective: *Interleukin 10 is an immune regulatory and immunomodulating cytokine, in this study serum IL-10 levels were measured in 44 Syrian patients with newly diagnosed lymphoma (Hodgkin's disease, non Hodgkin's lymphoma) to determine the significance of pre-treatment IL-10 levels. In our attempting to further elucidate the immunological state of lymphoma patients, serum interferon gamma (IFN-γ) (the immune stimulating cytokine) levels were determined.*

Methods: *Pre treatment serum IL-10 were measured and patients were followed-up for at least one year, at the end of the study, the significance of basal serum IL-10 levels, and its independence from other prognostic factors were determined. Pre treatment serum IFN-γ were calibrated, and the correlation between IL-10 levels and IFN-γ levels was examined.*

Results: *Serum IL-10 levels were significantly higher in patients compared with healthy controls (p=0.002), basal IL-10 values were found significantly higher in non responders compared with responders in retrospective analysis (univariate analysis) p=0.008 in both Hodgkin's disease patients (p=0.013), non Hodgkin's lymphoma patients (p=0.004). Moreover this prognostic value was found to be independent from other prognostic factors, tumour stage (p=0.13), clinical symptoms (p=0.49), (multivariate analysis MANOVA test). The correlation between IL-10 and IFN-γ in pre treatment lymphoma patients was (r=0.54), and it was stronger in Hodgkin's patients (r=0.93), than non Hodgkin's lymphoma patients group (r=0.53).*

Conclusions: *The results of the current study show that measurement of pre treatment serum IL-10 levels is of independent prognostic utility in patients with Hodgkin's disease, and some non Hodgkin's lymphoma types.*

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*Mohammed Amer Yousif, MD, Nuclear Medicine Center, Damascus, Syria.

METHODS

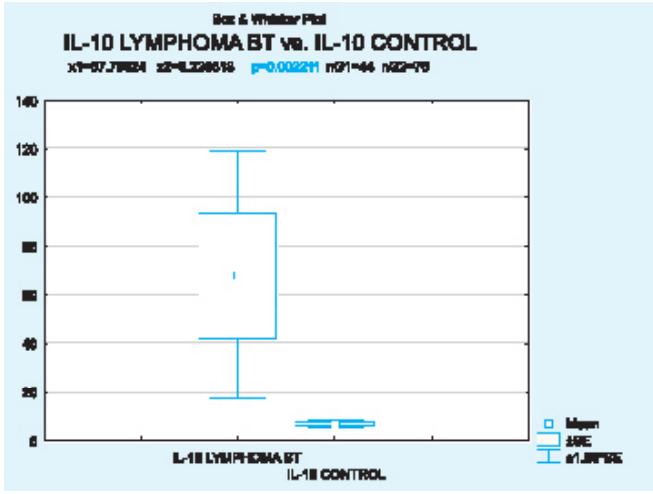
INTRODUCTION

.ĠnjĻjŏhu Ġdžŏõ5 łŏưƨdž!ƒ KĠƵĂdžŋdž!ƒ LJŏhuĂ IþNjĆT!ƒ .INFù!ƒ DžŏpĂ IL-10 ù!ƒ DžŏpLJŏhu ƱĠhwkƨŮƒ łpŭƵ łĻƒƨþ - ýŏŽŏơk!ƒĂ ÜUnivariate Analysis þŏơĂ!ƒ ƨŏʒkdž!ƒ ýŏŽŏơk łĻƒƨþ - KƒR łĻĂƨþdž!ƒ ýdžƒĂzŽ! Multivariate Analysis Kƒƨŏʒkdž!ƒ þþƶkdž .ƨƒRĻÚĠhu łŽŢ!ƒ

RESULTS Ăəƒ₩ƌ℔

ýdž/Ɛ‡hu 6.22 łƵĂdžŋdž!ƒ IjRNj ăþ! IL-10ù!ƒ DžŏpƱĻĂkdž Ɛ℔hu ĭƨSNjĂŋ Ƨƨ5 ℍĠĻNj LJ‡ŏ Dž! Ü(ýdž/Ɛ‡hu 24.37Ă 0 LJŏhu DžŏIl!ƒ KơĂƒƨk) NJŏŽƵ ĠĻŽŢơ ĭR!ƒ ýĠŋdž!ƒ łĻƨĠldž LJdž LJ‡džkĻ Dž!Ă LJŏĻĻŋ!ƒ LJŏhu DžŏI!ƒ Ŏ5 ăþ! IL-10ù!! Ŏzŋƨdž!ƒ ýĠŋdž!ƒ þŏþơ'k þƶhu DžkŏDž! Rg Ŏzŋƨdž ýĠŋdž yƵƶ .LJŏŏƨĂĻ!ƒ

DžƒƨĂŮƒ łƵĂdžŋdžĂ IþNjĆT!ƒ łƵĂdžŋdž!ƒ LJŏhu DžŏIl!ƒ ƱĻĂkdž łĻƨĠldž ăþ! łŏFĆŢơg ł!ŮþĭR ĭƨSNjĂŋ Ƨƨ5 þĂŋĂ Uơ'A! ƒ ŏPTk!ƒ łλŏþơ łŏĂĆsdžŽ!ƒ ¡(1) ý‡T!ƒ (p=0.002) LJŏkƵĂdžŋdž!ƒ LJŏkĠNj Ŏ5 DžŏIl!ƒ ƱĻĂkdž LJŏhu LJŏkŏƑƨŋ!ƒ LJŏkƵĂdžŋdž!ƒ Ŏ5 NJk!ŮþĂ IjþĂŋĂ ĬŽŽ Ƨƨ5s!ƒ ƒRNj U5ơ'ơ þþĂ Džŏp ƱĻĂkdž yƵƶ ƒ ŏPTk!ƒ łλŏþơ łŏĂĆsdžŽ!ƒ DžƒƨĂŮƒ łƵĂdžŋdž! LJŏkŽ‡Tdž!ƒ .(3-2 LJŭ‡T!ƒ) łŏĂĆsdžŽ!ƒ łŏŽP!ƒ ĠdžĂsdž! łƵĂdžŋdž Ŏ5 WƵĆsk2ƒ ƨλ‡D



BT: Before treatment

DžƒƨĂŮƒ łƵĂdžŋdž بين IL-10ال Džŏp ƱĻĂkdž łĻƨĠldž ƱƱP dž .1 ý‡T!ı łƵĂdžŋdž!ƒ þþƵ Ɛ℔hu .IþNjĆT!ƒ łƵĂdžŋdž!ƒĂ ƒ ŏPTk!ƒ łλŏþơ łŏĂĆsdžŽ!ƒ LJŏơ Ŏ5 ýdž/Ɛ‡hu 67.79 Ġnjŏþ! DžŏIl!ƒ ƱĻĂkdž LJĆ‡Ă WưŏƨdŽ 44 ĬĭĂŮƒ Ġnjŏþ! DžŏIl!ƒ ƱĻĂkdž LJĆ‡Ă WŢPT 76 łŏĻĠĂ!ƒ łƵĂdžŋdž!ƒ Ŏ5 þþƶ!ƒ LJĆ‡ .ýdž/Ɛ‡hu 6.22

ƨĂnjU IþĂƶhu þþơ5 Σ‡Ļ!ƒ ĠdžD ÜWĆĂĻ NJk!Ġơþŏõþeƒ ĂD ljƨĠTkĻjĂ Ư'ƨdž!ƒ Iþdž! IƨdžkĻdž łhĆŋkĻƒ þƶhu WŏƨhPdžĂ WŏƨŏƨĻ Ư'ƨdž!ƒ Kƒƨĝdž D Ăd Ư'ƒƨƵ .ýpŮƒ ĬŽŽ ƨnjT

Ƶəɛþư℔ℓ

LJdž Džþ!ƒ KĠĻjŏƵ ℞PD Džk :ŎŽŢdž!ƒ 10 LJŏ‡Ă!ƨkĻŮƒ ăĂkĻdž þŏþơ'k ÜƱŭƶ!Ġhu Cfhu!ƒ ýhpĂ f ŏPTk!ƒ KĠhλq þƶhu Ĭ!ĂŮƒ łƶŋƒƨdž!ƒ þĻƵ Ĭư'ƨdž!ƒ ýŏsλkhu ýŢdž!ƒ ýŢơ'kĻƒĂ ł5ĠŋYŏhĠĻp ĬŽŽ ĭþŏƨĂ!ƒ Džþ!ƒ łĻŏƵ Yơ'Ļ Džk ýŢdž!ƒ Usơ þþĂ ŬŞƑĝþþ 10 Iþdž! łlŏpþ/IƨĂþ 3000 ĠnjkƵƨĻ łlŏsλdžhu Džþ!ƒ þþĂ ÜNJ!ĠdžƶkĻƒ LJŏơ! łŏĂFdž łŋƨþ 80- Iƨƒƨơ łŋƨþ Ŏ5 ll!R ƨλg .YĂŭĻŮƒ Σsŀjhu IþNjĆT!ƒ łƵĂdžŋdž!ƒ KĠĻjŏƵ KŭdžĂƵ

:IL-10ù!ƒ ăĂkĻdž łĻĝĠldž

LJdž ƨNjĠŋ ĭƨĠŋk DžpĝŬ ýĠdžƶkĻĠhu IL-10 ù!ƒ KĠŏĂkĻdž Iƨŏ€ƶdž Kdžk - łƱhkƨdž!ƒ łŏƨƒƨkdžŮƒ łŏƵĆĻjdž!ƒ łĻĝĠldž!ƒ łlŏƨƱ þdžkƶŏ Milenia łǂƨT .ELISA DžŏƨĻjŮĠhu

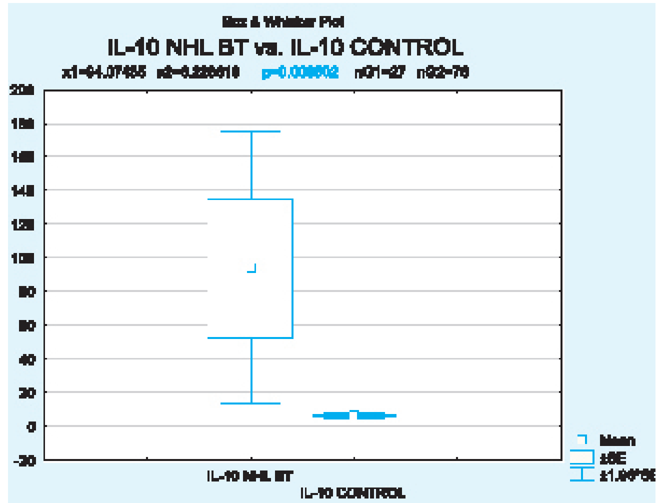
Üljþƒþư'DĂ IL-10 ù!ƒ LJŏhu ŎƵĆĻjdž!ƒ ýƵĠsk!ƒ ĬŽŽ łlŏƨƱ!ƒ Dphwdž þdžkƶŏ - ýŏŽʒk Ĭ!g þdžƵ Ŏk!ƒ łŽŏĻj!ƒ Iþŏơ'Ă ljþƒþư'D yƵƶ IL-10 Ʊhkƨŏ łŏơ DžŏƨĻjhu DžĂĻĂdž!ƒ ŎljĠλ!ƒ þư'!ƒ ƨĠư'ŏ DžĂ ÜĬ!ĂD LJư'ơ Iƨk5 ýŭP ƨĠhuŮƒ Ʊhkƨdž!ƒ IL-10 ù!ƒ ƨĠnjUg DžkŏłŏLjĠλ!ƒ LJư'ơ'!ƒ Iƨk5 þƶhĂ Üƨƒþŏ'ĻǂĂƨŏhu!ƒ ù!ƒ łŏdž‡ yƵƶ Whu'ĻĠLjkdž WĻjĂ! ŎƱƶk ŎkƒƒĂ LJĂŭ! Iþ!Ădƶƒƒ Iƨĝ‡ƨ!ƒ łƵĠư'Ehu DžƒþPk'ĻĠhu yƬĠLj ýhĠldž f ĠƬkdžŮƒ D2IŏĂ KĠĻjŏƶ!ƒ Ŏ5 IþĂŋĂdž!ƒ IL-10 3 łlŏƨƱ!ƒ łŏ'ĻĠ'Ļơ Kʒ℔hu .ƨkdžĂĻjĝLj 450 łŋĂdž ýĂƱhu ELISA Əƨĝp .ýdž/Ɛ‡hu

IFN-γ ăĂkĻdž łĻĝĠldž

ĠdžĝƐ LJĂƨŏƵƨkĻjŮƒ łĻĝĠldž! łƬƬPdž!ƒ Ĭưƨdž!ƒ KĠĻjŏƶ łŭdžĠƶdž Kdžk :ĠnjơƨT Ƨhu'Ļ Ŏk!ƒ łlŏƨƱ!ƒ Σsŀjhu þdžkƶŏ Diaclone łǂƨT LJdž ĭƨĠŋk DžpĝŬ łƱĻƒĂhu Iƨŏ€ƶdž!ƒ Kdžk - .ELISA DžŏƨĻjŮĠhu łƱhkƨdž!ƒ łŏƨƒƨkdžŮƒ łŏƨĠĻjdž!ƒ łĻĝĠldž!ƒ łlŏƨƱ IFN-γ LJŏhu ŎƨĠĻjdž!ƒ ýƨĠsk!ƒ ĬŽŽ łlŏƨƱ!ƒ þdžkƶk :łlŏƨƱ!ƒ Dphwdž - Ĭ!g þdžƵ Ŏk!ƒ łŽŏĻj!ƒ Iþŏơ'Ă ljþƒþư'D yƵƶ IFN-γ ýƨĠskŏ Rg ljþƒþư'DĂ Ŏ5 LJŏkĂŏhu!Ghu łdžĂĻĂdž!ƒ łŏLjĠλ!ƒ ljþƒþư'D yƵƶĂ Ġnjhu Yŭ'Ļ!ƒ ƨĂƱ!ƒ ýŏŽʒk Üƨƒþŏ'ĻǂĂƨŏhu!Ghu DžĂĻĂdž!ƒ LJŏþŏ5ĠkhuƨŏkĻ!ƒ ƨĠư'ŏ DžĂ ÜlþơƒĂ łŭơ'ƨdž ŊkGLj!ƒ LJĂŭ!ƒ IþT YĻĠLjkk ÜLJĂŭdž!ƒ ýƨĠsk!ƒ WĠkLjÚ Iƨĝ‡ƨ!ƒ ƨĠư'k WƨŏPD ƏƨĝpDžƒþPk'ĻĠhu LJĂŭ!ƒ D2IŏĂ KĠĻjŏƶ!ƒ Ŏ5 IFN-γƨŏ‡ƨk yƵƶ ƨTĠhdž ý‡Thu .ƨkdžĂĻjĝLj 450 łŋĂdž ýĂƱhu ELISA

STATISTICAL ANALYSIS Ĭəƒ₩ƟÜ℄ üŭ‡Ə₩℔

łƵĂdžŋdž!ƒĂ łŏưƨdž!ƒ KĠƵĂdžŋdž!ƒ LJŏhu IL-10 ù!ƒ DžŏpƱĻĂkdž łĻƨĠldž -



NHL: non Hodgkin's lymphoma, BT: Before treatment

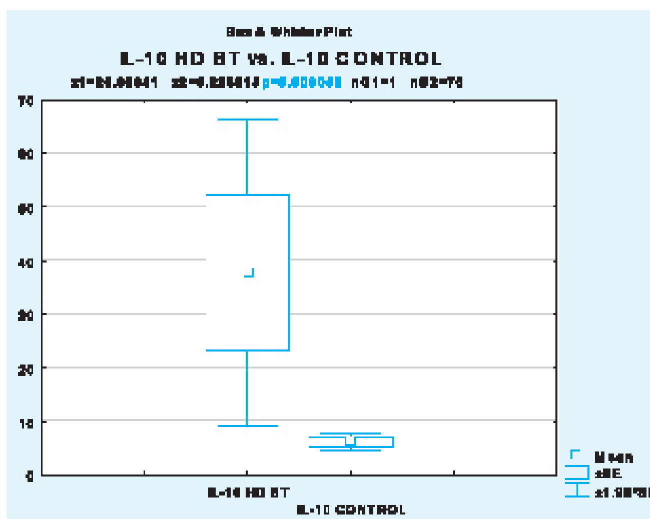
ýǂT!ƒ .2 ƱƱPdž ǂǇƧǀdž ƱǏĂkdž Džǿþ IL-10ù!ƒ LJǿù ǂƵĂdžηdž

.ǀþNjƓT!ƒ ǂƵĂdžηdž!ƒĂ ƭ ǒPTk!ƒ ǑλǒþƠ ǂǒĂǤsdžǚ!ƒ ǂǒǚP!ƒ ǤdžĂsdž! Ĭ ư Ƨdž

ǈǚǀ ƮǂǙ ǂƵĂdžηdž!ƒ Ǒ5 Ĭ ư Ƨdž!ƒ þþƵ Ĭ!ĂŰƒ 27 ǕưǒƧdž LJǤǂĂ ƱǏĂkdž Dždžl!ƒ

ǕƮPT 76 ǂùǒǀĞλ!ƒ ǂùƵĂdžηdž!ƒ þƒƧ5 þþƵ ƮǚǕ Ǖýdž/Ʃǂǖ 94.07 Ǥnjǒþ!

.ýdž/Ʃǂǖ 6.22 Ǥnjǒþ! Dždžl!ƒ ƱǏĂkdž LJǤǂĂ



HD: Hodgkin disease, BT: Before treatment

ýǂT!ƒ .3 ƱƱPdž ǂǇƧǀdž ƱǏĂkdž Džǿþ IL-10ù!ƒ LJǿù ǂƵĂdžηdž

þþƵ ƮǚǕ .ǀþNjƓT!ƒ ǂƵĂdžηdž!ƒĂ ƭ ǒPTk!ƒ ǑλǒþƠ LJǂηþĂNj Ƈƒþ Ĭ ư Ƨdž

Ǥnjǒþ! Dždžl!ƒ ƱǏĂkdž LJǤǂĂ ǕưǒƧdž 17 Ĭ!ĂŰƒ ǂƵĂdžηdž!ƒ Ǒ5 Ĭ ư Ƨdž!ƒ

LJǤǂĂ ǕƮPT 76 ǂǒĞλ!ƒ ǂƵĂdžηdž!ƒ þƒƧ5 þþƵ ƮǚǕ Ǖýdž/Ʃǂǖ 26.06

.ýdž/Ʃǂǖ 6.22 Ǥnjǒþ! Dždžl!ƒ ƱǏĂkdž

ǂþŭƵ þĂηĂ LJǿùk ǂǇĂƧþdž!ƒ Džǚ!Ǥƶdž!ƒ LJǿù ƱǤùkƧŬƒ ǂþŭƵ ǂǇƒƧþ ăþ!Ă

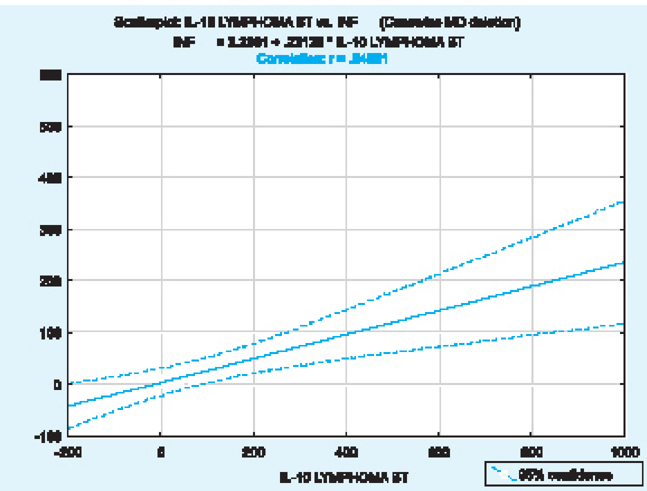
Ĭ ư Ƨdž ăþ! IFN-γù!ƒ ăĂkǇdžĂ IL-10ù!ƒ ăĂkǇdž LJǿù ƱǏĂkdž ƱǤùkƧƒ

ǑƵĂǀ ŭǂ Ǒ5 ǂþŭƵ!ƒ ǁǚk ƘƧnjƱ þþĂ Ǖ(r=0.54) Ɯŭƶ!ƒ ýǂþ ǤdžĂsdžǚ!ƒ

Ǒ5 ƻŭkPƒ ƴdž ƭ ǒPTk!ƒ ǂλǒþƠ ǤdžĂsdžǚ!ƒ ǂƵĂdžηdž! LJǿǚǂTdž!ƒ ǤdžĂsdžǚ!ƒ

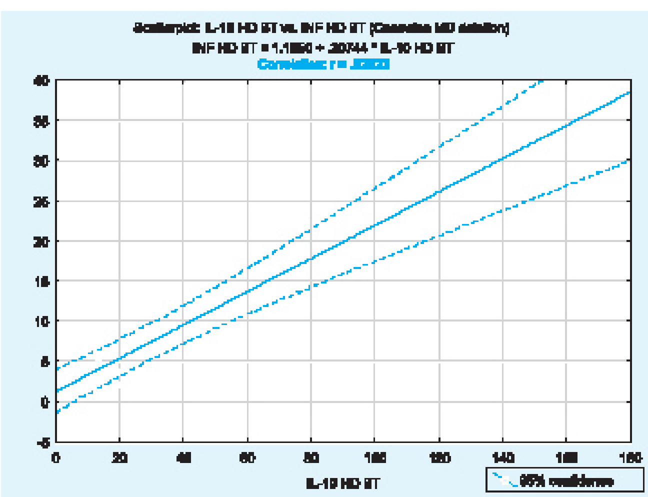
ǂǒĂǤsdžǚ!ƒ ǂǒǚP!ƒ ǤdžĂsdž! ǂƵĂdžηdž Ǒ5 ǕƱǏĂkdž LJǤǂ ĬŖ!ƒ ƱǤùkƧŬƒ ǂηƧþ

.(r=0.93) LJǂηþĂNj ǤdžĂsdž! Ǒ5 ǕþǒþTĂ Ǖ(r=0.53)



ù!ƒĂ IL-10ù!ƒ ăĂkǇdž LJǿù ƱǤùkƧŬƒ ǂþŭƵ ƱƱPdž .4 ýǂT!ƒ

.Ɯŭƶ!ƒ ýǂþ ǂǒĂǤsdžǚ!ƒ DžƒƧĂŰƒ Ĭ ư Ƨdž ăþ! IFN-γ



ù!ƒĂ IL-10ù!ƒ ăĂkǇdž LJǿù ƱǤùkƧŬƒ ǂþŭƵ ƱƱPdž .5 ýǂT!ƒ

.Ɯŭƶ!ƒ ýǂþ LJǂηþĂNj Ƈƒþ Ĭ ư Ƨdž ăþ! IFN-γ

ƚöƧƒȐǉŰƒ ýďžƒĂž!ƒ ǈƵ ǘlkƪďž ɎƓƽkƧŰƒ ll!Ʀ ǈƓǂ ƥpĂ ¡(p=0.13) ƚùŏưƧďž!ƒ ƚùǚơƧďž!ƒ :ýďžƬk Ŏk!ƒĂ ăƧƤŰƒ ƚùƪĂƧƥďž!ƒ ƥƥžkďž ǈŏƓǃk!ƒ ýŏǚơk ƚȠŏkǉǃ (p=0.49) ƚùŏƧŏƪ!ƒ Ưƒƨùƶ Űƒ ǈŏkŏƑƨȠ!ƒ ǈŏkƵĂďžȠďž!ƒ Ŏ5 ƚǚĂƓďžďž ƚȠŏkǉ Ĭǚƶ ƓǉǚƬơ ƥpĂ Ǩƒƨŏʓkďž!ƒ .(ǈǂȠƥĂǋ Ŭ ƓďžĂƨďž! ŬǈǂȠƥĂǋ Ƈƒƥ Ĭưƨďž)

DISCUSSION ƚʋƪƽƑďžǅlƨ

ăƥ! ƚǚƬďž!ƒ IL-10 ù!ƒ Ďžŏp Ŏ5 Ʊơǚďž!ƒ ƨŏʋ‡!ƒ ɎƓƽkƧŰƒ ƧŏƬŏ Ɯǚžǚ! ǈŏʋŏȠkƪďž!ƒ ƨŏƹ Ĭưƨďž!ƒ ăƥ!Ă Ɯǚž!ƒ ýʋp Ĭưƨďž!ƒ Ưƶʋ ƜƓkǉŰƒ ĎƱžďž ǈĂ‡ Ĭ!ǫ Ɯǚžǚ! ǈŏʋŏȠkƪďž!ƒ Ĭưƨďž!ƒĂ ƇƓĂƪŰƓʋ ƚǉƧƓlďž ƚŏƵƓǉďž!ƒ ƓŏǚƤ!ƒ ǈďž ƨƒƧ5ǫ ƥĂȠĂ ǳďž lƧ5ƓƱ!ƒ ƓŏǚƤǚ! ƥƑƓƵ Ʊơǚďž!ƒ Ĭ!ǫ ƚǌʋƓƬďž!ƒ ǨƓƪƒƧƥ!ƒ Ɣǚƺǫ ǨƧƓƬǫ ƥpĂ [14].ĎžƧĂ!ƒ Ʊŏơďž Ŏ5 ăƧƤŰƒ ǈŏ‡Ăŏƪ!ƒ ƒȐǋ! ŎďžƧĂ!ƒ ƜƓkǉŰƒ ƚŏưƧ5 .

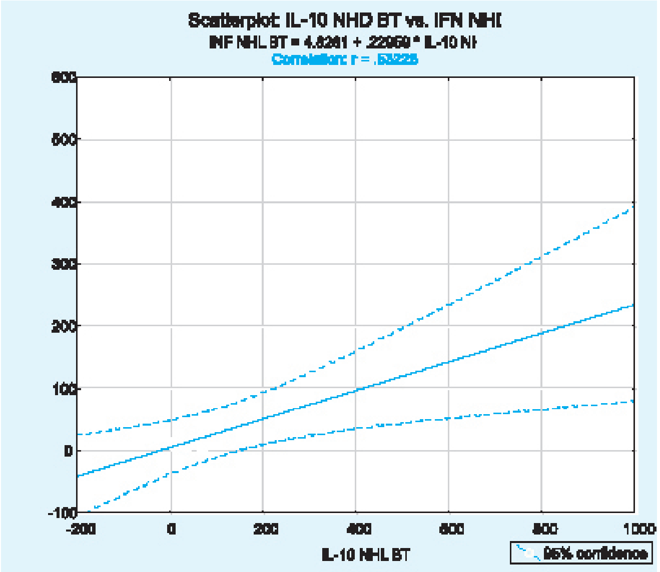
ŰƓǋƌƬǉďž ǈƓǂ ǜŏƉ ƚŏďžƧĂ!ƒ ƚǚƤǚ! ƚďžƓƵ ƚďžƪ‡ IL-10ù!ƒ ƨƒƧ5ǫ Ăƥʋŏ ǈďžƒƨkďž!ƒ ƨƒƧ5Űƒ ɎƶǚƧ ƓďžʋƨĂ .ŎƵƓǉďž!ƒ ƻŏưƧďž!ƒ ƥƨ ýŏƱžk ǈďž Ɠǋǉ‡ďžk ƚŏƬĂŏƵĂ ĂďžǉǇ ýďžƒƓƵ ǇǉǇĂ‡! ƓďžĂƨďžǚ!ƒ ƚ!Ɠơ Ŏ5 ǜƥȠ ǜŏʋǚƪ ǜƨĂƥ IFN-γ ù!! ƚŏƑƓʋ!ƒ ǨƓĂƓƨďžǚ!ƒ ǈďž lƧ5ƓƱ!ƒ ƓŏǚƤ!ƒ ƓǉǋǇ ŎǋĂ ǇǃǃǃǃǃƓƨďž!ƒ ƓŏǚƤǚ! ƨǆǂ‡ǫĂ ǈǅ ƥlƶŏĂ ƚŏƑƓʋ!ƒ ƓŏǚƤ!ƒ Ŏ5 ǨƒƦĂƦƬ! ƥƑƓƵ ǈǂȠƥĂǋŬ ƓďžĂƨďž! ǈďž %80) ƨƒƦǃǫ ýƶȠŏ ƓďžǃƒƦǋĂ .(ǜưƨŏǅ ŎƑƓʋ ĬĂƓƨďž! ƌƬǉďž ǈďž ȜƨʋǉƨkƬ ƥŏƨ ƚŏǚƤ .ĎĂƪǅ ǈŏǉŏ‡Ăŏƪ!ƒ ǈŏƦǋ ǈďž ƚƶƨkƨďž!ƒ ƚŏƑƥʋ!ƒ ǨƓĂkƪďž!ƒ ĬĂƦ Ĭưƨďž!ƒ

ĎžƒƨĂŬƒĂ ƚŏƵƓǉďž!ƒ ƚ!Ɠơ!ƒ ƨƓƱǫ Ŏ5 IL-10ù! ƚƬƓƤ!ƒ ƚŏďžǋǚ!Ă ƥŏƥž!ƒ ǈŬƒ ƚơʋk ŎʋƓǋk!Űƒ ƥƨǚ! ƱʋƓưƒ ĂǅĎžƱǈďž!ƒ ǈŏ‡ĂŏƪǨƒ ǉƨƓʋkƵƓʋ Ǩǉǂ‡ ƒƦ ƓďžƵĂ ƨƒƧ5Űƒ ƒƦǋ ýǅďž ƇƒƨĂ ƚŏǉŏŏ!ƒ ƚŏƑƓʋƓ!ƒ ǈƵ ǨƓƪƒƨƥ! ǈďž 10 ǈŏ‡Ă!ƨkǉŰƒ ǈŏǉ! Ưƨơďž!ƒ ƚlƱǉďž ǨƓ!ƓǩkǤ! ƚžŏʋƱ!ƒ ǨƓǚkƤƤŰƒ ƚʋǋŰƒ Ŏ5 Ŏ!ƓkǂʋĂ ƥƒƨ5Űƒ ǈŏʋ ǈǉǈƵ ƨŏʋžk!ƒ ƵƬǩƤƒ Ŏ5 ǜƨĂƥ Ɣžǚk [18-15].Ĭưƨďž!ƒ ăƥ! ĎĂƪǅ ƨƒƦǃǫ ǳďž ƽ5ƒƨk!ƒ Ŏ5Ă ƚǉƓƱƪ!ƒ ƚʋƓƬǚ!

ǈŏƓǃk!ƒ ýŏǚơk) ƚŏƑƥʋ!ƒ IL-10 ù!ƒ Ďžŏlʋ Ɯǚž!ƒ ýŏƬơ ƧƑƓk ǈǅ ƓďžǂǋƓ ǈďž ƚƑ!ƒ ǉȐǋ ăƥ! ĬƧƒƦǃǫ ýďžƓž‡ ǇǉƧƥ Ĭ!ǫ ƧŏƬŏ (ƥŏơĂ!ƒ ƨŏʓkďž!ǫ Ŏ5 ƚŏƧŏƪ!ƒ ƯƒƧƶŰƒ ƥĂȠĂĂ ƯƧďž!ƒ ƚǚơƧďž ǈƵ ýlkƪďž Ĭưƨďž!ƒ .(Ǩƒƨŏʓkďž!ƒ ƥƥžkďž ǈŏƓǃk!ƒ ýŏǚơk) ǈǂȠƥĂǋ ƓďžĂƨďž! Ĭưƨďž ƚ!ƓƓơ

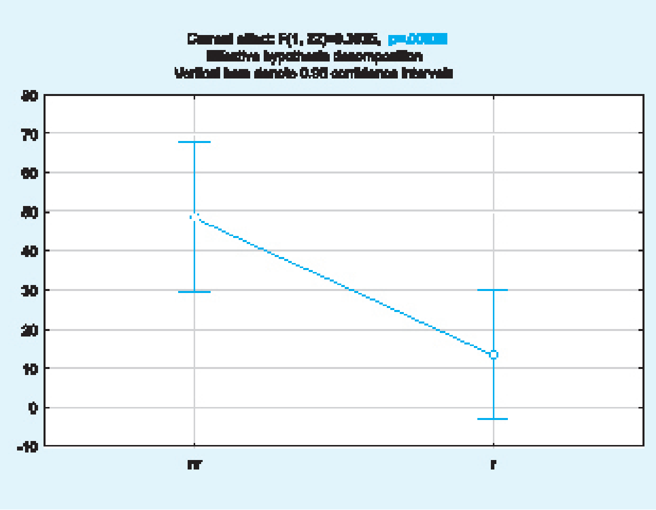
ƓďžĂƨďž! ɎƒĂǉŬ ƥƥƬ!ƒ ƨŏƓǃk!ƒ Ĭǚƶ ƥŏ‡ƥk!ƒ ƓǉǋǇ ĬƨƧĂƨưƒ ǈďž ŬƱƓďžǉŰƒ ll ǚk ǈďž ý‡ ǈďž lƨŏʋ‡ ƥƒƥƶŬ ƚƪƒƨƥ!ƒ ýĂďžƬ ĎžƥƶĂ ŬǈǂȠƥĂǋŬ Ĭǚƶ ƚơʋ!ƒ ƨ‡ƨk ƚƪƒƨƥ ƇƒƨȠǫ lƨĂƨư ƨǋǉƹĂ ƓǉȠƑƓǉ ƥŏlŏ ĬƦ!ƒ ƨďžŬƒ .Ďžƒƨ ĂŬƒ ǈďž ƚƶĂďžȠďž!ƒ ǇǉǋǇ

Ĭưƨďž ăƥ! IL-10ù!ƒ Ďžŏp ɎƓƽkƧƓǋ ƽǚžkŏ ƓďžŏƽƓ ƓǉƓƪƥƥƨƓ ǈƓǉƓǋ ƽƽƒĂ



ù!ƒĂ IL-10ù!ƒ ăĂkƪďž ǈŏʋ ƱƓǋƧŰƒ ƚpǚƵ Ʊ ƱƤďž .6 ý‡T!ƒ .Ɯǚž!ƒ ýʋp ƚŏĂƓƽǚ!ƒ ƚǚƤ!ƒ ƓďžĂƨďž! Ĭưƨďž ăƥ! IFN-γ

Ĭǚƶ ǋƑƒƧƥǫ ăƥ! ǉƓȠkŰƒ ƥŏơĂ ƥŏơĂ!ƒ Ƨŏʓkďžǚ! ǈŏƓǃk!ƒ ýŏǚơk ƧǋƱǅ Ǩǉǂ‡ Ɯǚž!ƒ ýʋp IL-10ù!ƒ Ďžŏp ǈĂ‡ ƚžʋƓkďž!ƒ ƚƵĂƥȠďž Ĭưƨďž ǋƑƓkǉ Ɯǚžǚ! ƒĂŏȠkǉŏ Ďž! ǈŏƦ!ƒ Ĭưƨďž!ƒ ăƥ! ƚ!Űƥ ĂƦ ý‡Tʋ ǜƵƓƽƧƒ ƧȜ‡ƌ ýĂƬơ!ƒ Ďžk ƥpĂ ǋ! ƒĂƓʋƓkǉ ǈŏƦ!ƒ Ĭưƨďž!ƒ ăƥ! ǉǂǉƓǋ ƚǚǂƓkǉ lƥďž ýŰƥ p=0.008 ƓďžĂƨďžǚ!ƒ Ĭưƨďž) : ƚŭƒ! Ǩƒƨǎďžǉďž!ƒ Ŏ5 ƚȠŏkǉ ǉƧǋ Ĭǚƶ ƚǚƤ!ƒ ƓďžĂƨďž! Ĭưƨďž Ŭp=0.01 ǈǂȠƥĂǋ Ƈƒƥ Ĭưƨďž Ŭ(7ý‡T!ƒ) .(p=0.0048 ƚŏĂƓƽǚ!ƒ



NR: non responders, r: responders

ýʋp IL-10ù!ƒ Ďžŏl! ǉƓȠkŰƒ ƥŏơĂ ǈŏƓǃk!ƒ ýŏǚơk ƱƤďž .7 ý‡T!ƒ .ƓďžĂƨďžǚ!ƒ Ĭưƨďž ăƥ! Ɯǚžǚ! ƚǋƓȠkŰƓǋ ƓǉƥŭƶĂ Ɯǚž!ƒ

Ɨ ƭ ʹ ƴ Axdorph U[19] ƭ ƭ ƴ ƳƙƆƸ ƜƸǀƱƴ ǁǂƦƶƱƴ Ɛƴ Vassilakopoulos et al ƭ ƭ ƴ ƳƙƆƸƴ [20] ƭƵƸƍǂƱ Bohlen et al [22]. ƭƵƴƳƍƘ Viviani et al ƭ ƭ ƴ ƳƙƆƸƴ [21] ƭƵƸƍƸƴ

ƊƮƴ ƸƗƫƵ ƭƍƹƴ ƪƵƵƮ ƠƵƹ ƭƵƍƵƲƴ ƘƆƭƴ ƳƙƆƸ ǁƆƸǀƱƴ Blay ƭ ƭ ƴ ƳƸƧ ƪƵƧ Ƶƙ ǁǂƦƶƱƴ ƠƵƹƭƶ ƳƸ ƳƴƸ ƴ ƶƴ IL-10ƴƵ ƪƵ ƱƍƘƸƵ ƴƧƸ ƱƵƸƭƴ ƭƧƸƴƳƸ ƴƶƴ ƭƵƴƸƘƸƱ ƮƗƴƸ ƶƴƵƱ [23] ƭƵƴƸƧƴƱ et al ƶƴƸ ƭƵƳƸƘ Cortes et al[24] ƭ ƭ ƴ ƳƸƧ ƵƮƸ ǁǂƦƶƱƴ ƠƵƹƭ ƪƵƵƮ ƴƧƭƵƧƘƴ ƶƸƵ ƪƵƵƮ ƪƘƸƴ ƶƴƸ ƠƵƹƭƴ ƸƸ ƴƸƍ ƭƵƵƮ ƭƵƵƮƪƶƸƴ ƱƱƪ ƸƸƴƸ .Diffuse Large Cell Lymphoma ƱƧƗƸƴ

CLINICAL CASES ƴƸƳƸƶ ƱƘƭ

ƶƴ ƲƘƸƴ ƸƸƴ ƵƱƧƭƴ IL-10ƴƵ ƭƵƧƸƘ ƱƧƶ ƪƶƧƗ ƪƘƵƴ ƭƵƍƴ ƴƸƸ ƶƴ ƮƆƴƸ ƊƵƴƆƭ ƭƸƴƸƴƴ ƮƗƴƸƘƸƴ ǁǂƦƶƱƴ Ɛƴ ƮƲƧƸ .ƮƲƧƸƴ ƪƸƴ

ƪƵƵƮ ƲƸ ƮƲƧƸ ƶƴ IL-10ƴƵ ƭƵƧƸƘ ƱƧƶ ƪƶƧƗ ƪƘƵƴ ƭƵƍƴ ƴƸƸ ƶƴ ƮƆƴƸ ƊƵƴƆƭ ƭƸƴƸƴƴ ƮƗƴƸƘƸƴ ƭƵƴƸƴƸ ƭƵƳƸƴ ƪƵƵƮ .ƮƲƧƸƴ ƪƸƴ

ƭƵƍƴƴ ƭƵƍƱƴ:

- ƱƧƗƸƴ ƭƵƍƴ ƳƙƸƴ ƪƵƵƮ ƭƵƸƴ ƭƵƵƴ ƭƵƸ 33 ƭƴƸƴ ƪƵƵ ƪƵƴƴ ƸƸƸ ƭƵƧƸƘ - ƭƵƧƸƘ ƲƸƸ ƶƸƸ ƸƸ ƳƗƸƴƸ ƪƵƵƮƴ ƳƸ ƭƵƍƴ ƪƵƴ ǁǂƦƶƱƴ ƪƵƵ ƳƳƶƸƴ ƲƘƸƴ ƸƳƸ ƸƸƴ ƱƵƧƸƴ IL-10ƴƵ ƶƸƸƴ ƭ ƵƸƴ ƱƸƸ ƳƸ .ƸƸƴ/ƪƭ 38.5 ƪƵƸ ƭƵƴ ƸƸƵƸƸ
- ƪƵƸƴ ƸƸƴ ƭƸƸƸ ƸƸƸ ƪƸƸƸƴ ƭƸƴ ƭƵƧƸƘƸƴ ƭƸƸƸƘ ƳƵƸ . ƪƵƸƴ - ƶƸƸƸ ƶƸƸ ƶƸƸƴ ƪƵƸƴ ƶƸƸ ƱƵƧƸƴ IL-10ƴƵ ƶƸƸƴ ƭ ƵƸƴ ƱƸƸ - .ƸƸƴ/ƪƭ 68.06 ƪƵƸ ƭƵƴ ƸƸƵƸƸ

ƭƵƍƸƴ ƭƵƍƱƴ:

- ǁǂƦƶƱƴ ƪƵƵƮƴƵƸ ƪƵƸƴ ƭƵƴ ƸƸƸ 50 ƭƴƸƴ ƪƵƵ ƪƵƸƸ ƭƵƧƸƘ - ƭ ƵƸƴ ƱƸƸ ƭƵƧƸƘ ƲƸƸ ƶƸƸ ƸƸ STIV ƸƸƸƸ ƳƸƸ ƪƵƴƴ ƭƵƵ ƸƸƴƸ 66.3 ƪƵƸ ƭƵƴ ƸƸƵƸƸ ƪƵƵ ƲƘƸƴ ƸƳƸ ƸƸƴ ƱƵƧƸƴ IL-10ƴƵ ƶƸƸƴ .ƸƸƴ/ƪƭ
- ƸƸƸƸƴ ƲƘƸƴ ƭƵƧƸƘ ƸƸƸƸ ƴƸ. .ƳƳƱƸƴ
- ƪƵƵƴ ƸƱƸ ƭƵƵƸƴ ƸƸƸ ƶƸƸ ƱƵƧƸƴ IL-10ƴƵ ƶƸƸƴ ƭ ƵƸƴ ƱƸƸ - 165.9 ƱƸƸ ƭƵƴ ƸƸƵƸƸ ƱƸƸƸ ƶƸƸ ƱƸƸƸ ƳƳƱƸƴ ƲƘƸƴ .ƸƸƴ/ƪƭ ƭƸƴ ƭƵƧƸƘ ƳƸƸ ƪƵƵ ƸƸƸ ƸƸƸ ƳƸƸ ƭƸ ƭƸƸ ƭƵƧƸƘ ƸƸƸ ƸƸƸ.

CONCLUSIONS ƱƧƭƭƸƸƴ

ƮƲƧƸ ƶƴ ƲƘƸƴ ƸƳƸ 10 ƪƵƸƸƸƴƸ ƶƸƸƴ ƭ ƵƸƴ ƪƵƸƸ ƮƲƧƸ ƶƴ ƭƸƸƴ ƭƵƧƸƘƸ ƱƸƸƸ ƶƸ ƸƵƵƸ ƸƸƵƸ ƸƸƸƵƸƸ ƳƸƸƸƴ ƳƸƸ ƶƸƸƸ ǁǂƦƶƱƴ ƪƵƵƮ ƲƘƸ ƮƲƧƸƴ ;ǁǂƦƶƱƴ Ɛƴ ƪƸƸƸƴ ƮƸƸ ƪƸƸƸƸƸ ƮƲƧƸ ƭƸƸƸƴ ƪƵƸƸƴ ƳƸƸƸ ƸƵ ƱƸƸƸƸ ƱƸƸƸ ;ƱƸƸƸ ƭƸƸƸƸ ƭƸƸƸ ƱƸƸƸƸ ƮƲƧƸƴ ƳƸƸƸ ƮƲƧƸ ƶƴ ƭƸƸƴ ƱƸƸƸ ƱƸƸƸ ƱƸƸƸ ƭƸƸƸ ƸƸƸƸ ƸƸƸƸƸ IL-10 .ƱƸƸƸƴ ƪƵ ƸƸƸƸ ƸƸ

REFERENCES ƳƸƸƸƸ

1. *Costello RT, Gastaut JA, Olive D. Tumor escape from immune surveillance. Arch Immunol Ther Exp (Warsz) 1999;47(2):83-8.*
2. *Houghton AN. Cancer antigens: immune recognition of self & altered self. J Exp Med 1994;180:1.*
3. *Poggi A, Zocchi MR. Mechanisms of tumor escape: role*

ƭƵƍƴƴ ƭƵƍƱƴ:

ƸƸƸƸƴ ƳƸƸ ƪƵƸ ƳƵƵƮ ƭƸƸ ƭƵƳƸƴ ƭƸƸ 12 ƭƴƸƴ ƪƵƵ ƪƵƸƸ ƸƸƸ - ƶƸƸƸ ƸƸƸ ƭƵƧƸƘ ƸƸƸƸƸƸ ƸƸ STIII ƸƸƸƸƴ ƸƸƸƸƸ ƸƸƸƸƸ ƸƸƸƸƴ ƲƘƸƴ ƳƸƸ ƸƸƴ ƶƸƸ IL-10ƴƵ ƶƸƸƴ ƭ ƵƸƴ ƱƸƸ ƱƭƵƧƸƘ ƲƸƸ .ƸƸƴ/ƪƭ 168.82 ƪƵƸ ƭƵƴ ƱƸƸ ƸƸƵƸƸ ƪƵƵ ƳƳƱƸƴ

- ƱƸƸƸƸ ƸƸƸ ƭƸ ƱƸƸ ƭƸƸƸ ƸƸƸƸ ƳƳƱƸƴ ƲƘƸƴ ƸƸƸƴ ƸƸƸƸ - ƸƸƸ ƵƵ ƶƸƸ IL-10ƴƵ ƶƸƸƴ ƭ ƵƸƴ ƱƸƸ ƭƵƧƸƘ ƲƸƸƸƴ ƶƸƸ ƳƸƸƸ ƸƸƸƸ ƲƸƸƸƸƸ ƸƸ ƪƵƵ (ƭƸƸƸƸ ƭƸƸƸƴ ƸƸƸ ƸƸƸ) ƭƸƸƸƸ ƭƸƸƸƸ ƵƵ ƭƵƍƱƴ ƪƵƸ .ƳƸƸƸƸƸƸ ƱƸƸƸƸƴ ƸƸƵƸƸ ƵƸƸ ƸƸƸƸ ƸƸƸ/ƪƭ 22.6 ƭƵƧƸƘ ƶƸƸ ƸƸƸ ƸƸƸ ƸƸƸ ƸƸƸ ƸƸƸ ƸƸƸ ƪƵƸƴ ƸƸƸƸ ƸƸƸƸ .ƸƸƸƸ ƸƸƸƸƸ

ƭƵƍƴƴ ƭƵƍƱƴ:

- ǁǂƦƶƱƴ ƳƸƸ ƭƵƵƮ ƶƸƸ ƭƵƸƴ ƸƸƸ 57 ƭƴƸƴ ƪƵƵ ƪƵƸƸ ƭƵƧƸƘ - ;ƲƘƸƴ ƸƸƸƸƸ ƭƵƧƸƘƸƴ ƭƸƸƸƸ ƱƸƸ 1999 ƸƸƸ ƪƵƸƸ ƵƵ STII ƲƸƸ ƳƸƸƸ ƸƸ ƸƸƸ ƪƵƵ ƳƸƸƸ ƭƸƸƸ ƸƸƸ ƶƸƸ ƭƵƧƸƘ ƪƵƸ .ƭƵƧƸƘƸ
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of tumor microenvironment in inducing apoptosis of cytolytic effector cells. Arch Immunol Ther Exp (Warsz) 2006 Sep-Oct;54(5):323-33.

4. *deWaal Malefyt R, Abrams J, Bennett B, et al. IL-10 inhibits cytokine synthesis by human monocytes:an autoregulatory role of IL-10 produced by monocytes. J Exp Med 1991;174:1209–20.*
5. *Fiorentino DF, Bond MW, Mosmann TR. Two types of mouse helper T cell.IV. Th2 clones secrete a factor that inhibits cytokine production by Th1 clones. J Exp Med 1989;170:2081–95.*
6. *Fiorentino DF, Zlotnik A, Mosmann TR, et al. IL-10 inhibits cytokine production by activated macrophages. J Immunol 1991;147:3815–22.*
7. *deWaal Malefyt R, Haanen J, Spits H, et al. IL-10 and viral IL-10 strongly reduce antigen-specific human T cell proliferation by diminishing the antigen-presenting capacity of monocytes via downregulation of class II MHC expression. J Exp Med 1991;174:915–24.*
8. *De Vita F, Orditura M, Galizia G, et al. Interleukin-10 is an independent prognostic factor in advanced solid tumors. Oncol Rep 2000 Mar-Apr;7(2):357-61.*
9. *De Vita F, Orditura M, Galiziai G, et al. Serum interleukin-10 levels as a prognostic factor in advanced non-small cell lung cancer patients. Chest 2000 Feb;117(2):365-73.*
10. *Inagaki A, Ishida T, Ishii T, et al. Clinical significance of serum Th1-, Th2- and regulatory T cells-associated cytokines in adult T-cell leukemia/lymphoma: high interleukin-5 and -10 levels are significant unfavorable prognostic factors. Int J Cancer 2006 Jun 15;118(12):3054-61.*
11. *Sakamoto T, Saito T, Tatebe S, et al. Interleukin-10 expression significantly correlates with minor CD8+ T-cell infiltration and high microvessel density in patients with gastric cancer. Int J Cancer 2006 Apr 15;118(8):1909-14.*
12. *Kurzrock R. Cytokine deregulation in cancer. Biomed pharmacother 2001 Nov;55(9-10):543-7.*
13. *Sheik youssef A. Epidemiology of cancer in syria, first conference of cancer in syria,1997.*
14. *Zeni E, Mazzetti L, Miotto D, et al. Macrophage expression of interleukin-10 is a prognostic factor in nonsmall cell lung cancer. Eur Respir J 2007 Oct;30(4):627-32.*
15. *Howell WM, Rose-Zerilli MJ. Interleukin-10 polymorphisms, cancer susceptibility and prognosis. Fam Cancer 2006;5(2):143-9.*
16. *Howell WM, Rose-Zerilli MJ. Cytokine gene polymorphisms, cancer susceptibility, and prognosis. Proc Nutr Soc 2002 Nov;61(4):447-56.*
17. *Howell WM, Calder PC, Grimble RF. Gene polymorphisms, inflammatory diseases and cancer. Breast Cancer Res Treat 2005 Mar;90(2):113-5.*
18. *Langsenlehner U, Krippl P, Renner W, et al. Interleukin-10 promoter polymorphism is associated with decreased breast cancer risk. Breast Cancer Res Treat 2005 Mar;90(2):113-5.*
19. *Axdorph U, Sjöberg J, Grimfors G, et al. Biological markers may add to prediction of outcome achieved by the international prognostic score in HD. Ann Oncol 2000;11(11):1405–11.*
20. *Bohlen H, Kessler M, Sextro M, et al. Poor clinical outcome of patients with HD and elevated IL-10 levels. Ann Hematol 2000;97(3):110-3.*
21. *Vassilakopoulos TP, Nadali G, Angelopoulou MK, et al. Serum IL-10 levels are an independent prognostic factor for patients with lymphoma. Hematologica 2001;86(3):274-81.*
22. *Viviani S, Notti P, Bonfante V, et al. Pretreatment serum levels of IL-10 are associated with a poor prognosis HD. The milan cancer institute experience. Med Oncol 2000;17(1):59-63.*
23. *Blay JY, Burdin N, Rousset F, et al. Serum Il-10 in non hodgkin's lymphoma: a prognostic factor. Blood 1993;82:2169-74.*
24. *Cortes JE, Talpaz M, Cabanillas F, et al. Serum levels of IL-10 in patients with diffuse large cell lymphoma: lack of correlation with prognosis. Blood 1995;1:85(9):2516.*

Original Article

موضوع أصيل

CONTINENT BLADDER AUGMENTATION IN CHILDREN

[illegible]

Abdo Khir Chamssuddin, *MD*

د. عبدو خير شمس الدين

ABSTRACT

Objective: *Cutaneous continent bladder reconstruction is a challenging operation for the pediatric urologist. The aim of this study is to review the different procedures of bladder augmentation and to present our experience.*

Methods: *Thirty one children (21 boys and 10 girls) with a mean age of 10 years (3-16 years) underwent this procedure between June 2004 and March 2007. Neurogenic bladder dysfunction represented the main indication. Bladder sphincter dyssenergia was present in another 7 cases.*

Results: *The ileum was used for the augmentation in 21 children, the ileocecal segment in 8 and the ureter in another 2 cases. The cutaneous continent mechanism was reconstructed from the appendix in 28 children and from the ileum (Monti procedure) in 3 children. The results of the majority of cases were encouraging and children could empty the bladder by self catheterization.*

Conclusions: *In case of failure of all conservative measures, bladder augmentation represents the final solution for the management of advanced dysfunction of the lower urinary tract in order to preserve renal function and to improve quality of life.*

[illegible] 31 [illegible] 10 [illegible] 16 [illegible] 3 [illegible] 2004 [illegible] .2007 [illegible] (%57) [illegible] 18 [illegible] (%22) [illegible] 7 [illegible] 21 [illegible] 8 [illegible] 28 [illegible] 3 [illegible]

INTRODUCTION

[illegible] Neurogenic. [illegible]

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Urinary incontinence [3,2] Chronic renal insufficiency

(CIC) Self clean intermittent catheterization [4] [6,5] Detubularization [7]

Compliance Urinary reservoir Monti [8] Mitrofanoff

Conservative management

(PUV) Bladder extrophy Posterior urethral valve Sphincteric lesions Contraction

Ileocecal segment[9] B12 Intractable diarrhea [10]

Sigmoid

[11] 1988 Metabolic alkalosis [12] Severe Heamaturia-Dysuria Syndrome [13] Dewan 100/2 50 (GFR) Glomerular filtration rate

15 20 15

[illegible] Autoaugmentation [illegible] 14.

[illegible] 15.

METHODS [illegible]

[illegible] 1 [illegible] 31 [illegible] 10 [illegible] (3 [illegible] 16 [illegible] 2004 [illegible] 2007. [illegible] 21 [illegible] 10 [illegible] 12 [illegible] (%38.6) [illegible] 10 [illegible] (%28.5). [illegible] Meningomyelocele [illegible] 14 [illegible] (%45) [illegible] 5 [illegible] (%16) [illegible] Ureterohydronephrosis [illegible] 6 [illegible] (%19) [illegible] 18 [illegible] (%58) [illegible] 21 [illegible] (%67.7) [illegible] (1 [illegible] Hyperreflexia [illegible] 18 [illegible] (%57) [illegible] 7 [illegible] (%22) [illegible] Bladder sphincter dyssenergia (BSD) [illegible] Isotope nephrogram [illegible] 26 [illegible] (%84) [illegible] (GFR) 50-80 [illegible].

RESULTS [illegible]

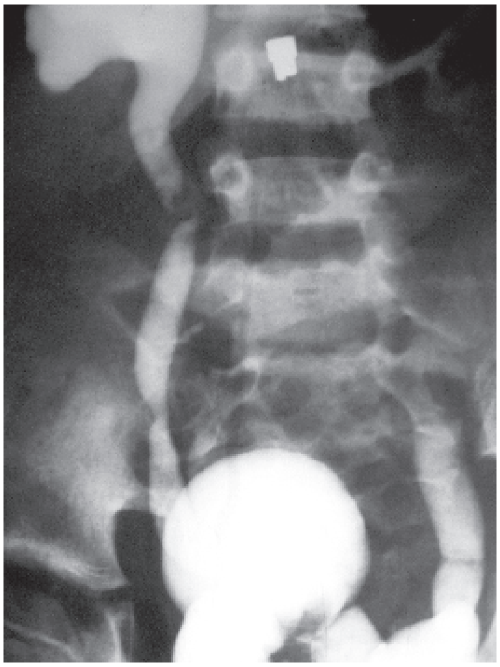
[illegible] 21 [illegible] 8 [illegible] (2 [illegible] (2 [illegible] 28 [illegible] 3 [illegible] 10 [illegible] (%32.8) [illegible] 7 [illegible] (%2.22) [illegible] Reconstruction neck bladder [illegible] 3 [illegible] Yang-Dees (Y-D) [illegible] (%9.6) [illegible] 3 [illegible] (%9.6).

الجنس	العدد	%
ذكور	21	66.4
إناث	10	33.6
الأعراض	العدد	%
سلس بولي	12	38.6
زحير بولي	5	16
إنتان بولي	5	16
آلام قطنية	2	6.4
قصور كلوي	4	13
عمليات جراحية سابقة	العدد	%
إعادة زرع حالب وحيد	3	9.6
إعادة زرع حالب مزدوج	2	6.4
عمليات قيلات سحائية	14	45
أهم الموجودات الصدوية	العدد	%
سبيل بولي علوي طبيعي	7	23
توسع حالبي كلوي معتدل	18	58
توسع حالبي كلوي شديد	6	19.3
انكماش المثانة	21	67.7

[illegible] .1 [illegible].

[illegible]	العدد	%
[illegible]	21	67.7
[illegible]	8	26
[illegible]	2	6.4
[illegible]	العدد	%
[illegible]	7	22.2
[illegible]	10	32.8
Y-D [illegible]	3	9.6
[illegible]	3	9.6

[illegible] .2 [illegible].



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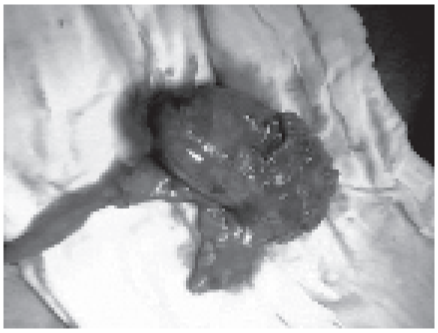
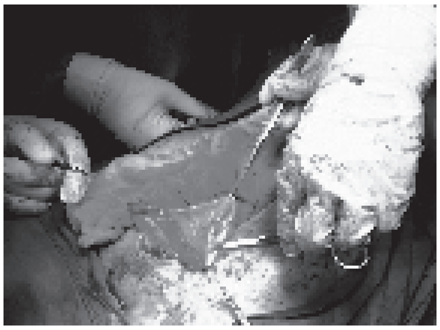
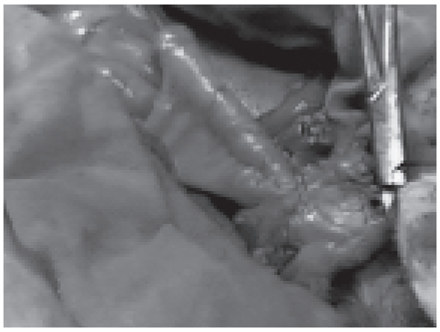
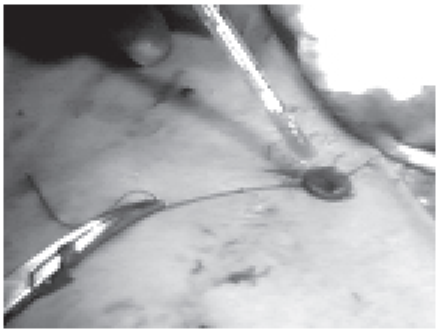








.ƚdžĂƥƶdž ƚƽǒƱĂ ƙƒƦ ƚǒǅǂ ƔǃƓơ Ǉdž ƚǉƓƛdžǃƒ ƧǒưǂƘ ýơƒƧdž .2 ǀƧĂƮǃƒ

ƨRɳ!ƒ ĠdžD .Uretero vesical junction ŎĿĵĠλdž!ƒ Ŏh!Ġơ!ƒ ýƮĂ!ƒ ƱI5 ǰƨƱ 14 þŭƵ f PT5 Vesico-ureteral reflux Ŏh!Ġơ!ƒ ŎĿĵĠλdž!ƒ Ŏ5 ŧ5þ'Ƭdž!ƒ ýŏïI!ƒ ¡ŧɳƨþ!ƒ Ŏ!Ġz!ƒ YĂĿ!ƒ LJdž ĸŰĠơ!ƒ ljRNj ý‡ KĿĵ‡Ă [20].ɯŭz!ƒĂ f ŏPTk!ƒ ƨĂƱk ɣh!ƫh ŧŏZĠĿjƬ!ƒ þŭh!ƒ

ƨɳơ Urodynamic studies ŧŏ‡ƨơ!ƒ ŧŏ‡ŏdžĠĿjŏþ!ƒ ŧ]ƒƨþ!ƒ ƨhkzk þŭƵ KŏƨɳD þI5 ĠĿjĵưƨdž! ŧh]Ŀj!ĠhĂ ÜĸŰĠơ!ƒ ljRNj f ŏPTk Ŏ5 ŧŏĂƒƨ!ƒ Ŏ5 Ŵơưƒ Ă ŴZĠsksƨƒ (Ŵưŏƨdž 18) DžnjdžUzdž ăþ! LJD LJŏhk Ŵưŏƨdž 21 ŧưsPĿjdž ŧŏĿjĠλdž!ƒ ŧZĂĠƱdž!ƒ KĿĵ‡Ă Ŏh]Ƭ Z ƫTĿjdž LJdž ŧŏĿjĠλdž!ƒ ƱĂʒưƒ DžþIk ɣh]ƫh ŧŏIh!ƒ þŭƵ ŧ]ƒƨþ!ƒ ƨɳk Dž!Ă ¡ŧĿjĠλdž!ƒ Džnơ ƨʒƬ ɣh]ƫh IþTh ŎĿjĠλdž!ƒ ƨUĠĿjk!ƒ DžþƵ ĠdžD .yŏ]ĂĸĊ! ƨ‡hdž!ƒ ɣĠhƱĸ]Ůƒ yưĂĂ ŧ!Ġơ!ƒ ŧĿjĠλdž Džnơ LJĠ‡Ă (%22) ĸŰĠơ 7 Ŏ5 f PT5 (BSD) ĭƨƬzdž!ƒ .(%9.6) ƱI5 ýĠsƱD ŧλŭλ ăþ! ŴŏzŏhƱ

YĠskƨĠh Ŵŏ‡ŏdžĠĿjŏþ KƨNjĠUk Ŏk!ƒĂ KŰĠơ!ƒ ljRNj DžUzdž DžþIk ɣh]ƫhĂ ŎĿjĠλdž!ƒ ɣŏƨ]k!ƒ ŧƱIlj Ʊʒư YĠskƨƒ ŧƬĠPĂ ŧŏĿjĠλdž!ƒ ƱĂʒư!ƒ Ŏ5 þŏþT ĠNjƨŏλăk [1]McGuire ƨnjUD Ŏk!ƒĂ Detrusor leak point pressure ¡ĊĠdž Dž] 40 KƨĂĠɳk ƒRǫ ŧƬĠP ĭĂŭz!ƒ Ŏ!Ăh!ƒ ýŏh]!ƒ ĬŭZ ŎλƨĠ‡!ƒ IþĠŏƨ! GnjkŏhŭĂhŭD ŧ!ƒƨǫ þzh ĊĠzdžŨƒ LJdž ŧĿjĠλdž!ƒ yŏ]Ăk Ċƒƨɳǫ LJdž þhŨ LJĠ‡ ŧŏ5Ġưǫ KŭPƒþdžh ŧŏŭdžz!ƒ ljRNj KI5ƒƨk .Gnjŭjdžư ƱĂʒư!ƒ Ư ŏsPkĂ ŧz]!ƒ Ŏ5 ll!ŖĂ ŧI5ƒƨdž!ƒ Ư ƒƨdžŨƒĂ KĠƱŭkPŨƒ ĂD KĠNjĂTk!ƒ ŧŏIh ŧɳ!Ġzdž! Yƨƨ IþĠZǫ KŭPƒþdž!ƒ ljRNj DžNjD LJdž LJĠ‡Ă .KŰĠơ!ƒ Ŏλŭλ LJdž ƨλ‡D ƽĿjZ ƽŭɛǫ LJdž þh Ů LJĠ‡ Ġdž‡ LJŏ5ƨƱ ĬŭZ ĂD þơƒĂ ƨƨƱ ĬŭZ Ɣ!Ġơ!ƒ Ɣh]ƫh (%9.6) KŰĠơ 3 Ŏ5 Closure of bladder neck ŧĿjĠλdž!ƒ Ŵưŏ̈́Ă ¡External sphincter ŧɳɳĠP!ƒ I2ƬzdžI!ƒ Ŏ5 þŏþT!ƒ ƨĂƬI!ƒ (%9.6) D-Y ŧIŏƨƱ Ɣ]oh KŰĠơ 3 Ŏ5 ŧĿjĠλdž!ƒ ƽĿjZ yŏĿjƬk GĿjŏƨɳD ljRNj KŏƨɳD ll!Ŗ‡ .ýpŨƒ ĬŭZ Ɣŏ2I!ƒ ăþdž!ƒ ĬŭZ ŧ!ĂIzdž ŃFĠKĿj KƱƵD Dznj! KŏƨɳDĂ ƽh]ƫ ŎIŭP ŧĿjĠλdž Ɣŭlljƒ LJdž ƒĂĿjĠZ ýĠsƱD 3 þŭƵ ŧŏŭdžz!ƒ KŭT5 (ŧŏŭdžZ 17-5) KĠŏŭdžZ 9 ŴŏƱ]Ă Kʒžhŭ IþþzkdžŧŏzŏĿj Ƭk KĠŏŭdžZ .Ġnjzŏdžɳ

ŧŏĿjĂ!Ă‡!ƒ ŧŏpĠpþ!ƒ ŧzƱI!ƒ LJdž ŧĿjĠλdž!ƒ yŏ]Ăk ĭƨɳD GĿjkhƨɳk ŧŏƒþh Ŏ5 ŧIŏpþ!ƒ CĠzdžŨƒ Ĭ!ǫ I2ŏPŨƒ KŰĠơ!ƒ Ŏ5 GĿjąɳ! GĿjŭ‡!Ă ŰKŰĠơ 8 Ŏ5 Dž]ƒ ƨI5Ă ɯŭz!ƒ ĬŭZ þŭzdž!ƒ ýĠnj]Ůƒ ƨĂnjU þzh ll!ŖĂ (ŧ!Ġơ 23) ll!R ý‡Ă Ĭ!ĂŰƒ ŧZĂdžnɳdž!ƒ LJdž ýĠsƱD ŧλŭλ ăþ! B12 LJŏdžĠkŏs!ƒ ƨĂzh ƒRNj f ĠƬkdžĠh ŧùŏĿjzdž!ƒ ƽĠpþ!ƒ LJùdž I2ùŏPŨƒ ŧzƱI!ƒ YĠƱkpƒ Ɣh]ƫh ƽĠpþ!ƒ KĠŏĂkơdž ƨĂƨdž DžŏULjk Ŏ5 LJNjĂh DžĠ]þ ƨĂþ CĠʒ!ǫĂ ¡LJùŏdžĠkŏs!ƒ ŧ Ăþơ ýĠdžkơƒ ƒĂþ‡D Steiner et al LJD DžŭZ!ƒ yƫ ¡LJĂ!Ă‡!ƒĂ ƨĂZŨƒ Ĭ!ƒ ŧùŏĿjĂ!Ă‡!ƒ ŧŏpĠpþ!ƒ ŧzƱI!ƒ Kŭdžzkƒ ýĠơ Ŏ5 KĠùƱŭkPŨƒ ljRNj ýλdž ŧ ŏơ Ʊl5 LJŏk!Ġơ Ŏ5 Ɣ!Ġơ!ƒ LJdž ŧĿjĠλdž!ƒ yŏ]Ăk ĭƨɳD [10].yùŏ]Ăk!ƒ Ŏ5 Ôŏƒþɳ!ƒ ĬŭZ ll]džk]dž!ƒ DžĠ]þ!ƒ ŧNjĂ5 ŧŏưk KĿĵ‡ KĠƱŭkPŨƒ DžNjD ĬŭZ þŭzdž ýĠnj]ǫnjU Gdž‡ ¡ŧŏþĂþ!ƒ IþFƒƨ!ƒ LJdž Gnjŭ‡ (%9.6) KŰĠơ 3 ŧŏpĠpþ!ƒ ŧzƱI!Ghu yŏ]Ăk!ƒ ŧZĂdžnɳdž LJdž (%9.6) ýĠsƱD 3 þŭƵ ɯŭz!ƒ ýĠsƱŨƒ ŧŏIh GdžD .(%6.4) LJŏŭŏsƱ þŭƵ þŏþT Ŏ!Ăh LJĠkĿjǫ ŧ þơĂ ŧŏƨĂZŨƒ ýĂh!ƒ Ʒƒ25ǫ LJdž DžnjdžUzdž LJ‡džkĂ Iþŏɳ Džnjŏþ! Ŏơƒƨɳ!ƒ ýdžz!ƒ NFĠKĿj KĿĵ‡5 .ll]džk]dž!ƒ DžĠ]þ!ƒ ƨhƵ ŎkƒR ý‡Th

DISCUSSION h]sFdDŽlc

LJ‡džŏ Gdž ƨPc ýĠsƱŨƒ þŭƵ þŭɳ!ƒ ĭĬŭZ ll]džk]dž!ƒ ŧĿjĠλdž!ƒ yŏ]Ăk ƨhkzŏ ýơƒƨdž!ƒ Ŏs5 ¡ŧŏĿjĠλdž!ƒ ŧZĂĠƱdž!ƒ DžƒþzLjƒ ĂD f Ilj KŰĠơ Ŏ5 Dznjŏ!ǫ DžþIŏ LJD KĠɳ!Ġzdž!ƒ Gnjŏ5 Gdžu ŧU5Ġơdž!ƒ ýFĠ]Ă!ƒ ý‡ Ĭ!ǫ CĂɳŭ!ƒ Ɣnŏ I2‡hdž!ƒ I2ƱλI!ƒ Cƒƨɳǫ ĭĬŭZ ýĠsƱŨƒ DžŏŭzkĂ [16]Ŭŧ0ƒFĠŏƨeŏs!ƒ KĠɳ!Ġzdž!ƒĂ ŧŏƒĂþ!ƒ [18,17].ŧsŏU]!ƒ ŧŏkƒR!ƒ ŧzƱIkdž!ƒ

ĠLjþŭh Ŏ5 ŧdžþIkdž!ƒ KŰĠơ!ƒ LJdž ŵƨŏλ‡ NJɳƒĂLj Gl!ƨ Gdž GLjŭ5 ƽ]ū!Ă ýŏh]!ƒ LJĂ‡ŏĂ ŧU5Ġơdž!ƒ KĠɳ!Ġzdž!ƒ LJdž YĂLj ĭŰ Ɣŏɳk]k Ů Ŏk!ƒĂ þɳLj GLjŭ5 KŰĠơ!ƒ ljRNj ýλdž Ŏ5Ă .ƨƱP!ƒ ŧ5Ġơ ĬŭZ Gnjŏ5 ĭĂŭz!ƒ Ŏ!Ăh!ƒ LJ‡džK!ƒ LJĂþ ŎFĠnjLj ýơ‡ ll]džk]dž!ƒ yŏ]Ăk!ƒ Cƒƨɳǫ ĬŭZ LJŏdžƐƨdž GLj]sLjD .ŧU5Ġơdž!ƒ KĠɳ!Ġzdž!ƒ ŧƬ25 ýsƱ!ƒ CĠƱZǫ LJdž

ýNjŨƒ þŭƵ ŎZĂ!ƒ f Ilj Ĭ!ǫ Ŵh!ĠƐ þĂzŏ f ŏPTk!ƒ yưĂ ƨPăk LJǫ GdžŏŏŧŏhƱ!ƒ KĠdžŏŭzkĊ! DžNjRŏsLjk DžþZ ŴLjĠŏơDĂ Ü Ư ƨƨƱdž!ƒ Ư ƒƨZD ýĠdžNjƒĂ .ŧLjĠλdž!! yƱIkdž!ƒ ŎkƒR!ƒ Ʒƒ25Ůƒ Gnjŭjdž Gdžŏ]Ů ŧU5Ġơdž!ƒ KĠɳ!Ġzdž!Ghu sŭzkŏ ŧ oh!Ghu LJŏ!ĂdžTdž!ƒ ýĠsƱŨƒ þŭƵ Ư ƒƨZŨƒ ƨĂnjU LJdžƨ ŎƱ]Ă ƩŭhD þpĂ DžNjD LJdž LJĠ‡Ă (ŵƨnjT 32 Ĭ!ǫ ƨnjTD 6 LJdž) ŵƨnjT 25 Ɣ̈́hƱŨ!! CĂɳŭ!ƒ ýhp Ĭ!ǫ ŧ5ĠưŨGhu Džnjŭjdž %28 LJdž ƨλ‡D þŭƵ Ŏ!Ăh!ƒ ΣŭĬ!ƒ Ư ƒƨZŨƒ ljRNj Ŏ5 Gdž‡Ă .Ɣh]ƫ ýĂnjɳdž!ƒ I2ƒƨơ!ƒ YĠskƨƒĂ Dysuria Ŏ!Ăh!ƒ ƨŏơƨ!ƒ GnjdžNjDĂ Ŏh]Ƭz!ƒ ƨĠnjɳ!ƒ Ŏ5 ŧŭlŭP!ƒ KĠNjĂTk!ƒ KĿĵ‡ ŧŏdž!Ġz!ƒ KĠŏFĠ]ƬơŨƒ LJĠ‡ Gdž‡ .KŰĠơ!ƒ ljRNj DžUzdž Ŏ5 Ŏ]ŏF2!ƒ Ɣh]ƫ!ƒ ŎNj ŧŏFĠơ]!ƒ KŭŏI!ƒ Ɣŭlljƒ ýλdž ăƨPŨƒ ŧŭlŭP!ƒ KĠNjĂTk!ƒ Ư zh! Ŏơƒƨɳ!ƒ ɯŭz!ƒ ýT5 Ŏ5 ţ Gdž‡Ljƒ LJdž ýTs!ƒ ƒRNj NJsŭP GdžĂ Ü‡ŏsŭP!ƒ ýŏŭoŨƒ KĠdžĠ]þĂ ŧLjĠλdž!ƒ yƱĂkh ljRNj ŧLjĠλdž!ƒ KĠŏRD KI5ƒƨk þpĂ [19].ŧŏŭdžz!ƒ ljRnj! CĂɳŭ!ƒ Ŵhh]ƫ ŧLjĠλdž!ƒ (ŧŏ]ŏƋ‡!ƒ ŧŏưŏĂơ!ƒ ŧZĂdžnɳdž!ƒĂ Ɣ!Ġơ!ƒ) ĭĂŭz!ƒ Ŏ!Ăh!ƒ ýŏh]!ƒ Ŏ5 7 þŭƵ ŵŏzŏhƱ ĭĂŭz!ƒ Ŏ!Ăh!ƒ ƨĠnjɳ!ƒ LJĠ‡Ă ¡(%77) Ŵưŏƨdž 24 þŭƵ Ĭ!ǫ ýĂƬĂ!ƒ Ŏ5 ƨPăk!ƒ ăþdž ŵdžĠdžk Σ‡zŏ Gdž ĂNjĂ (%23) ƱI5 Ĭưƨdž .Ɣ]GLjdž!ƒ f ŏPTk!ƒ

ƫTLjdž LJdž (%67.7) ǰƨƱ 21 þŭƵ ĭĂŭ‡!ƒ CĠI]k]Ůƒ Ɣh]ƫ LJĠ‡ ƩŏưkĂ Gnjŏ5 ƱĂʒư!ƒ YĠskƨƒ Ŏ!Ġk!ĠhĂ ŧLjĠλdž!ƒ ƫ Gdž‡Ljƒ Ɣh]ƫh ĭþƒþ]Ljƒ

[illegible]

[illegible] 27 [illegible] 4 [illegible]

[illegible] [7]Metcalfe [illegible] 1978 [illegible] 500 [illegible] 2006 [illegible] 2003 Laparotomy [illegible]

CONCLUSIONS [illegible]

[illegible]

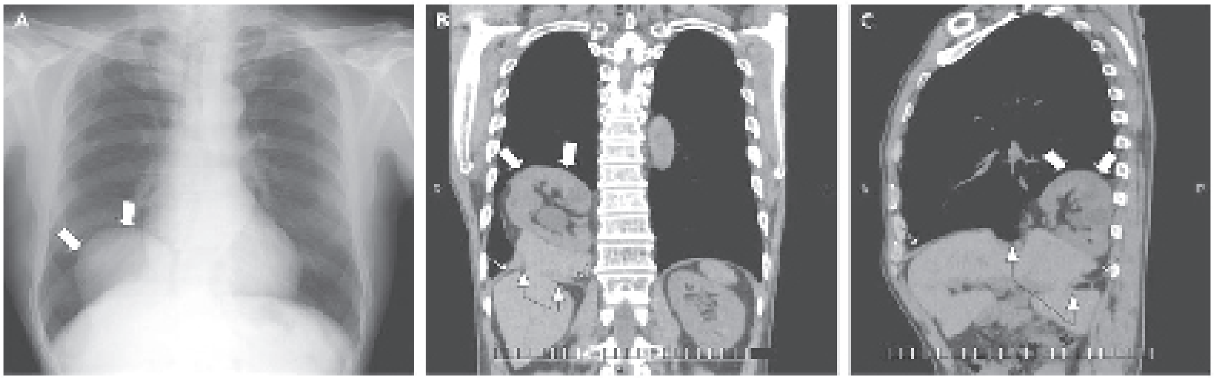
REFERENCES [illegible]

1. Brown S, Arshall D, Patterson D, et al. Chronic pyelonephritis is associated with neuropathic bladder. Eur J Pediatr Surg 1999;9:29-30.
2. Van Good JD. Vesicoureteral reflux in children with spina bifida and detrusor-sphincter dyssenergia . Contrib Nephrol 1984;44:319-21.
3. Glott T, Stanghelle JK, Thyberg M, et al. Follow-up of urinary tract problems in adults with myelomeningocele. Tidsskr Nor Laegeforen 2001;121:1247-51.
4. Lapides J, Diokono AC, Silber SJ, et al. Clean intermittent self catheterization in the treatment of urinary tract disease. J Urol 1972;107:458-61.
5. Kassabian NG, Bauer SB, Dyro FM, et al. The prophylactic value of clean intermittent catheterization and anticholinergic medication in new born and infants with myelodysplasia at risk of developing urinary tract deterioration. Am J Dis Child 1992;146:840-3.
6. Lin-Dyken DC, Wolraich ML, Hawtrey CE, et al. Follow-up of clean intermittent catheterization of children with neurogenic bladders. Urology 1992;40:525-9.
7. Metcalfe PD, Clain MP, Kaefer M, et al. What is the need for additional bladder surgery after bladder augmentation in childhood?. J Urol 2006;176:1801-5.
8. Liard A, Seguier-Lipszyc E, Mathiot T, et al. The Mitrofanoff procedure: 20 years later. J Urol 2001;165:2394-98.
9. Goodwin WE, Winter CC, Baker WF. "Cup patch" technique of ileocystoplasty for bladder enlargement or partial substitution. Surg Gyn Obs 1959;108:240-4.
10. Steiner MS, Morton RA, Marshall FF. Vitamin B12 deficiency in patients with ileocolic neobladder. J Urol 1993;149:255-7.
11. Adams Mc, Mitchell ME, Rink RC. Gastrocystoplasty: an alternative solution to the problem of urological reconstruction in severely compromised patients. J Urol 1988;140:1152.
12. Plowker MC, Rabiniwits SS, Etwaru DJ, et al. Hyper-gastrinemia,dysuria-haematuriaand metabolic acidosis: complications associated with gastrocystoplasty. J Urol

1995;154:546-9.

13. *Dewan PA, Stefanek W, Lorenz C, et al. Autoaugmentation gastrocystoplasty and demucosalized gastrocystoplasty in a sheep model. Urology 1995;45:291-5.*
14. *Marte A, Di Meglio D, Cotrufo AM, et al. A long term follow-up of autoaugmentation in myelodysplastic children. BJUI 2002;89:928-31.*
15. *Moon D, Anderson PD, Dewan PA. Ureterocystoplasty. New options. Aust NZ J Surg 2001;71:189-92.*
16. *Yamanishi T, Yasuda K, Murayama N, et al. Biofeedback training for detrusor overactivity in children. J Urol 2000;164:1686-90.*
17. *Opsomer RJ, Aad AA, Van Cangh PJ, et al. Clean intermittent catheterization in congenital neurogenic bladder. Acta Urol Belg 1989;57:537-43.*
18. *Pohl HG, Bauer SB, Borer JG, et al. The outcome of voiding dysfunction managed with clean intermittent catheterization in neurologically and anatomically normal children. BJUI 2002;89:923-7.*
19. *Kaefer M, Handren WH, Tobin MS, et al. Continent urinary diversion: the Children's Hospital experience. J Urol 1997;157:1394-99.*
20. *Sillen U, Hjalmas K, Aili M, et al. Pronounced detrusor hypercontractility in infants with gross bilateral reflux. J Urol 1992;148:598-9.*
21. *McGuire EJ, Woodside JR, Borden TA, et al. Prognostic value of urodynamic testing in myelodysplastic patients. J Urol 1981;135:94.*

Medical Case



THORACIC KIDNEY

كلية صدرية

A 74-year-old man with diabetes and hypertension was referred to our hospital for evaluation of a mass in the right side of the chest, identified on a radiograph (Panel A, arrows). He reported no pulmonary problems and no history of chest trauma. Physical examination was unremarkable. Reformatted coronal (Panel B) and sagittal (Panel C) computed tomographic scans show the right kidney (large arrows) and part of the liver protruding above the diaphragm (small arrows) and into the posteromedial aspect of the right hemithorax through the foramen of Bochdalek (arrowheads indicate the defective fusion of the diaphragm). Thoracic kidney is a rare congenital anomaly. Because of the location of the liver, thoracic kidney on the right side is much less common than thoracic kidney on the left side. Thoracic kidney is twice as common in men as in women. Typically, the presence of a thoracic kidney is asymptomatic and requires no intervention, as in this case.

[illegible]

Yoshitaka Doi, MD, PhD; Akihiko Sakamoto, MD, PhD. Chikugogawa Onsen Hospital, Ukiha, Japan
N Eng J Med 2009 October;361(17):e35. Images in Clinical Medicine
Translated by Samir Aldalati, MD

Case Report

تقرير حالة طبية

KLEINE-LEVIN SYNDROME

ǈĴŏƨŏ! ǈĴŏǕ‡ ƚďžƨǕƙďž

Youssef Latifeh, *MD*

د. يوسف لطيفة

ABSTRACT

Kleine–levin syndrome is a rare disorder with symptoms that include periodic, sudden-onset episodes of hypersomnia, cognitive and behavioral disturbances (96%), changes and eating disturbances (80%), hypersexuality (43%). This syndrome happened mostly in men (68%) and occurred sporadically worldwide. The median age of onset is adolescent. It was precipitated most frequently by infections (38.2%). The prognosis is generally benign, with almost complete remission with normal cognitive and social functions after the episodes.

The aim of this case report is to present a typical case of Kleine–Levin, and to illustrate problems in differential diagnosis, history, course, and therapeutic, neuropsychological sequela after the episode of the illness. Further research in the natural history of kleine-levin syndrome is needed.

Lithium and carbamazepine or other antiepileptics had a higher reported response rate (41%) for stopping relapses. It is important that the diagnosis is suspected early, especially in adolescent males who present with recurrent episodes of somnolence, increased appetite, and abnormal behavior.

ƕưǀƑƟǀƸ ƫ ƣǀ‡ƊƸ

ƚŏƒþƕĂ ƚŏƧĂþ ǜưƒƧƵ ǈĴžưƙŏ ƨþƓǈ ƔƒƧƱưƒ ǈĴŏƨŏ! ǈĴŏǕ‡ ƚďžƨǕƙďž ǁĂǓƪ!ƒ Ŏ5 ƔƒƧƱưƒ Ü(%100) ƉĂǈ!ƒ Ŏ5 ƖþƓŏƨ ǈĴďž ƨƒĂƱǕ ƚƑƞƓƨďž ƖþƓŏƨĂ Ü(%80) ƉƓƵƱ!ƒ Ŏ5 ƔƒƧƱưƒĂ ƘǕþƕƙ Ü(%96) ƺƒƧƵƙǁǕƒĂ (%68) ƧĂ‡Ʀ!ƒ þǈƵ ƔƒƧƱưǕƒ ƒƦǋ Ƨƛ‡ŏ .(%34) ƚŏǁǈƞ!ƒ ƚŏƠƓǈ!ƒ Ŏ5 ƚǀǋƒƧďž!ƒ Ŏ5 ƚŏƒþƕǈ!ƒ ŎƱǁĂ!ƒ Ƨďžƶ!ƒ .ƉƓƶ!ƒ ƇƓƠǈþ Ŏ5 ƾƧƺƙďž ý‡Ƭƕ ƚ þƠŏĂ ƉƓƙ ƳĂƞǋ ƴďž ƉƓƵ ý‡Ƭƕ ƉŏǕǁ ƧƒƦǈǕƒ .(%38.2) Ŏ5 ǋďžƤƕ ƉþƕŏþþĂ .ƚƕĂǈ!ƒ þƶƕ ƚŏĂǁ ƚŏƵƓďžƙƞǕƒĂ ƚŏ5ƒƧƵƙǁǕƒ ƺƑƓǓĂ!! ƖþĂƵĂ

ƚďžƨǕƙďž ǋŏþ! ƔƓƬ! ƚŏ5ƬĂ ƚ!ƓƠ ƯƧƵ ǏƠ!ƥ ƧŏƧƖƙ!ƒ ƒƦǋ ƺþǈƺŏ ƧĂƱƙ!ƒĂ ŎƖŏƧ5ƙ!ƒ ƚ ŏƬƬƙ!ƒĂ ƚŏƧŏƧǁ!ƒ ƚƬƖ!ƒ ƯƧƵĂ ÜǈĴŏƨŏ! ǈĴŏǕ‡ ƉĂŏĂŏƒ!ƓƕŏƠ ƜǕƵ!ƒ ŎƱƵŏ .ƚƕĂǈ!ƒ þƶƕ ƚŏƕƬƵ!ƒĂ ƚŏǁƨǈ!ƒ ƔþĂƵ!ƒĂ ƜǕƵ!ƒĂ

ƴǈďž Ŏ5 ƚŏ!ƓƵ ƚƕƓƞǁǁ!ƒ ăƧƤǕƒ ƜǕƙƤǕƒ ƘƒþƓưďžĂ ǈĴŏƕƓǈƓƓƧƓ‡!ƒĂ ƽƞƒƦďž þǈƵ ƚ ƬƓƤ ƒƘǁƙ!ƓƕƒƧƕ ƬƚƬǀƧƚ! ǈĴďž .(%41) Ʃ‡ǈ!ƒ Ŏ5 ƔƒƧƱưƒĂ ƚŏǁƙ!ƒ ƖþƓŏƨĂ ƩƓǈ!ƒ ǈĴďž ƖƧƧ‡ƙďž ƔĂǈ ƞŏþ! Ƨ‡Ʀ .ƉĂǈƚ!ƒ

INTRODUCTION ƕƛƤƢƪƛƤƨƸ

Üƨþƒǈ Ʊƨďž Kleine-Levin syndrome ǈĴŏƨŏ! ǈĴŏǕ‡ ƚďžƨǕƙďž ǈĴǫ Ɖďžƙ 2004-1962 ƉƓƵ ǈĴďž systematic review ƚŏƞǈǈďž ƚƵƞƒƧďž Ŏ55 ƔƒƧƱưǕƒ ƒƦǋ ƨŏďžƙŏ [1].ŎƕƱ!ƒ ƔþǕƓƕ ƖƧĂƬǈďž ƚ!ƓƠ 186 ǏƵƒ ƧĂǈƵ!ƒ ƚ5ǁƤďž ƘƓƞƧþĂ ¡hypersomnia ƉĂǈ!ƒ Ŏ5 ƱƧ5 ǈĴďž ƖƧƧ‡ƙďž ƔĂǈƕ cognitive ƺƒƧƵƙǁǕƒĂ ‹behavioral ƉĂǈ!ƒ ƘƓƕƒƧƱưƒ ǈĴďž ƖþƓŏƨĂ ¡compulsive eating behavior ŎƵƓ5ǁƒ ŎƪƓƵƱ ƉĂǈƚĂ

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CASE PRESENTATION [illegible]

[illegible] 1995 [illegible] 15 [illegible] hypersomnia [illegible]

[illegible] retardation.

[illegible] arousable [illegible] disorientated [illegible] hallucinations [illegible] (delusions) [illegible]

[illegible]

[illegible]

[illegible]

[illegible] CSF [illegible] hypersexuality [illegible]

[2]. American Academy of Sleep Medicine 2005

[illegible] Confusion [illegible] delusions [illegible] amnesia [illegible] visual hallucinations [3].

[illegible] irritability [1,3,4].

[illegible] 68.4% [illegible] [1] [illegible] [2,7] [illegible] [1,5] [illegible] 21-10 [illegible] [2].

[illegible] DR and DQ [8] [illegible] HLA-DQB1 [illegible] Autoimmune [9].

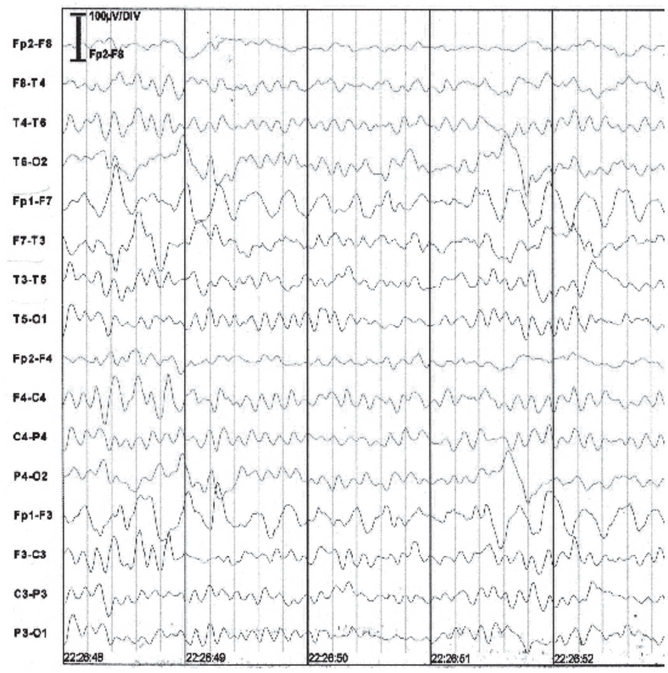
[illegible] lower striatal dopamine transporter [10] [illegible] cortical hypoperfusion [illegible] thalamus [11,12] [illegible] Dauvilliers [illegible] (hypocretin-1) [illegible] [13,14].

[illegible] [15] [illegible] short-term memory dysfunction [14].

[illegible] [3].

[illegible] MRI [illegible] CT [illegible]

[illegible] EEG [illegible] (1-[illegible]).



[illegible] 1. [illegible]

[illegible] Carbamazepine [illegible] [16] [illegible] Carbamazepine [illegible] 2008 [illegible] 2008 [illegible] (2009.

DISCUSSION [illegible]

[illegible] Narcolepsy [illegible]

[illegible] [17] [illegible]

[illegible] (2004 Dale, et al) [illegible]

[illegible]

[illegible] stimulants [illegible] [18] (methylphenidate) [illegible] (Smolik and Roth, 1988; Poppe et al, 2003) [illegible] %93 [illegible] %19 [17,19,20] [illegible] [21,1] [illegible] risperidone [illegible] [18].

CONCLUSIONS [illegible]

[illegible]

REFERENCES [illegible]

1. *Arnulf I, Zeitzer JM, File JN, et al. Kleine–Levin syndrome: a systematic review of 186 cases in the literature. Brain 2005;128(12):2763-76.*
2. *Sadock BJ, Sadock VA. Sleep disorders. In: Grebb JC, Pataki C, (eds). Kaplan and Sadock's Synopsis of Psychiatry. 10th ed. Philadelphia: USA: Lippincott Williams & Wilkins press; 2007. p. 765.*
3. *Billard M. Les troubles de l`éveil. In: Billard M, sommeil et éveil. (ed). 2éme. Paris: Masson press; 1997. p. 144-8.*
4. *Saha A. Case of Kleine-Levin Syndrome. German J Psychiatry 2008;11:73-5.*

5. *Salter MS, White PD. A varient of Kleine-Levin syndrome precipitated by both Epstein-Barr and varicella-zoster virus infections. Biol Psychiatry 1993;33:388-90.*
6. *Merriam AE. Kleine-Levin syndrome following acute viral encephalitis. Biol Psychiatry 1986;21:1301-4.*
7. *Masi G, Favilla L, Millepiedi S. The Kleine-Levin syndrome as a neuropsychiatric disorder: a case report. Psychiatry 2000 spring;63(1):101-3.*
8. *Arnulf I, Lin L, Gadoth N, et al. kline-Levin syndrome: a systematic study of 108 patients. Ann Neurol 2008 Apr; 63(4):482-93.*
9. *Dauvilliers Y, Mayer G, Lecendreux M, et al. Kleine-Levin syndrome: an autoimmune hypothesis based on clinical and genetic analyses. Arch Neurol 2002 Dec; 59(12):1959-61.*
10. *Hoexter M Q , Shih M, Mendes D, et al. Lower dopamine transporter density in an asymptomatic patient with Kleine-Levin syndrome. Acta Neurol Scand 2008 May;117(5):370-3.*
11. *Landtblom AM, Dige N, Schwerdt K,et al. A case of Kleine-Levin syndrome examined with SPECT and n europsychological testing. Acta Neurol Scand 2003 Apr;107(4):304-5.*
12. *Huang YS, Guilleminault C, Kao PF, et al. SPECT findings in the Kleine-Levin syndrome. Sleep 2005 Aug;28(8):915-6.*
13. *Dauvilliers Y, Baumann CR, Carlander B, et al. CSF hypocretin-1 levels in narcolepsy, Kleine-Levin syndrome, and other hypersomnias and neurological conditions. J Neur Nerusurg Psych 2003 Dec;74(12):1667-73.*
14. *Landtblom AM, Dige N, Schwerdt K, et al. Short-term memory dysfunction in Kleine–Levin syndrome. Acta Neurol Scand 2003;108(5):363-7.*
15. *Huang Yu-Shu, Lin YH, Guilleminault C, et al. Polysomnography in Kleine-Levin syndrome. Neurology 2008;70:795-801.*
16. *Mukaddes NM, Kora ME, Bilge S. Carbamazepine for Kleine-Levin syndrome. J Am Acad Child Adolesc Psychiatry 1999 Jul;38(7):791-2.*
17. *Poppe M, Friebel D, Reuner U, et al. The Kleine-Levin Syndrome: effect of treatment with lithium. Neuropediatrics 2003;34:113-9.*
18. *Justo LP, Calil HM, Prado-Bolognani SA, et al. The pharmacologic treatment included lithium, methylphenidate and risperidone. Arq Neuropsiquiatr 2007 Mar;65(1):150-2.*
19. *Muratori F, Bertini N, Masi G. Efficacy of lithium treatment in Kleine-Levin syndrome. Eur Psychiatry 2002 Jul;17(4):232-3.*
20. *Mapari UU, Khealani BA, Ali S, et al. Kleine-Levin syndrome. J Coll Physicians Surg Pak 2005 Jan;15(1):46-7.*
21. *Minvielle S. Klein-Levin syndrome: a neurological disease with psychiatric symptoms, Encephale 2000 Jul-Aug;26(4):71-4.*

Historical Reading

مطالعة تاريخية

HISTORICAL HIGHLIGHTS ON LEGISLATION OF MEDICAL CONDUCT IN IRAQ

[illegible]

Maha .S. Younis, *MD*

د. مها سليمان يونس

ABSTRACT

This paper aims to enlighten the establishment of medical legislations and regulation of medical conduct in Iraq, starting from the Abbasid era around 7-8 century to the beginning of modern medical associations around the 20th century and focusing on the role of Iraqi doctors who pioneered the Arab experience in establishing medical association, that set the standards of practice which are applied and reputed in the Arab world until now.

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عصر الخلافة الإسلامية في بغداد

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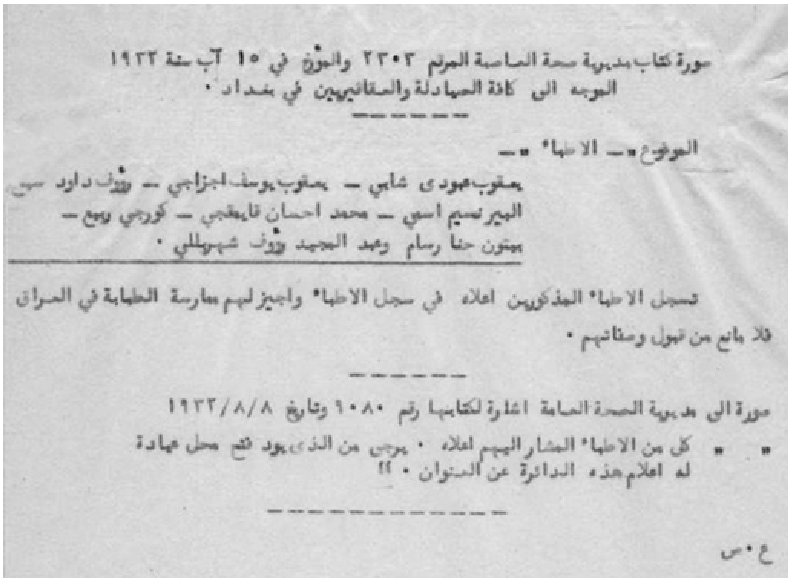
*Maha S. Younis, MD, Assistant Professor in Psychiatry, College of Medicine, Baghdad University, Iraq. E-mail: maha.younis@gmail.com.



صورة كتاب مديرية صحة العاصمة المرقم ٢٣٠٣ والمؤرخ في ١٥ آب سنة ١٩٣٢
الموجه الى كافة الصيادلة والمختبريين في بغداد .

الموضوع :- الاطباء :-

يعقوب عودى شابي - يعقوب يوسف ابزاجي - يوسف داود سمي
البير نسيم اسي - محمد احسان قايمقجي - كورجي ويح -
يعقوب حنا رسام وعبد المجيد رؤوف شهربللي .

تسجل الاطباء المذكورين اعلاه في سجل الاطباء واجيز لهم ممارسة الطبابة في العراق
فلا مانع من قبول وصفاتهم .

صورة الى مديرية الصحة العامة اشارة لكتابها رقم ١٠٨٠ وتاريخ ١٩٣٢/٨/٨
" كل من الاطباء المشار اليهم اعلاه . يرجى من الذي يود فتح محل عيادة
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Selected Abstracts

Public Health

صحة عامة

Exposure To Low-Dose Ionizing Radiation From Medical Imaging Procedures

[illegible]

Fazel R, et al.

N Engl J Med 2009 Aug 27;361(9):849-57.

Background: The growing use of imaging procedures in the United States has raised concerns about exposure to low-dose ionizing radiation in the general population.

Methods: We identified 952,420 nonelderly adults (between 18 and 64 years of age) in five health care markets across the United States between January 1, 2005, and December 31, 2007. Utilization data were used to estimate cumulative effective doses of radiation from imaging procedures and to calculate population-based rates of exposure, with annual effective doses defined as low (< or = 3 mSv), moderate (> 3 to 20 mSv), high (> 20 to 50 mSv), or very high (> 50 mSv).

Results: During the study period, 655,613 enrollees (68.8%) underwent at least one imaging procedure associated with radiation exposure. The mean (+/-SD) cumulative effective dose from imaging procedures was 2.4+/-6.0 mSv per enrollee per year; however, a wide distribution was noted, with a median effective dose of 0.1 mSv per enrollee per year (interquartile range, 0.0 to 1.7). Overall, moderate effective doses of radiation were incurred in 193.8 enrollees per 1000 per year, whereas high and very high doses were incurred in 18.6 and 1.9 enrollees per 1000 per year, respectively. In general, cumulative effective doses of radiation from imaging procedures increased with advancing age and were higher in women than in men. Computed tomographic and nuclear imaging accounted for 75.4% of the cumulative effective dose, with 81.8% of the total administered in outpatient settings.

Conclusions: Imaging procedures are an important source of exposure to ionizing radiation in the United States and can result in high cumulative effective doses of radiation.

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Pediatrics

طب الأطفال

Invasive Methods of Accurately Diagnosing in Children Anomalous Origin of The Left Coronary Artery From The Pulmonary Trunk

Chien KJ, et al.
Cardiol Young 2009 Aug 13:1-8.

Background: Anomalous origin of the left coronary artery from the pulmonary trunk is a rare congenital heart defect. Cardiac catheterization remains the standard means of diagnosis. Our purpose in this study is to emphasize the importance of assessing the electrocardiogram when making the diagnosis, in addition to taking note of transthoracic echocardiographic findings. We also analyzed the sensitivity of each parameter under investigation.

Methods and Results: Between June, 1999, and March, 2007, we studied 9 patients, 6 males and 3 females, with a mean age of 3.02 years, in whom anomalous origin of the left coronary artery from the pulmonary trunk was suspected subsequent to transthoracic echocardiographic examination. We examined their electrocardiograms, and undertook cardiac catheterization. In all patients, the transthoracic echocardiogram had shown retrograde flow into the pulmonary trunk, with the left coronary artery arising from pulmonary trunk, along with a dilated right coronary artery, or intercoronary collateral vessels. In 8 patients, the electrocardiogram showed deep Q wave in leads I and aVL, with depression of the ST segments over lead V4 through 6, or inversion of the T waves in leads I, II, and aVL. In the remaining patient, the electrocardiogram showed incomplete right bundle branch block. Later, cardiac catheterization confirmed the diagnosis in 8 patients, but the other patient was shown to have the right coronary artery arising from the pulmonary trunk.

Conclusions: By combining transthoracic echocardiography with study of the electrocardiogram, it is possible to provide accurate evaluation of anomalous origin of the left coronary artery from the pulmonary trunk.

Clinical Characteristics of Respiratory Syncytial Virus Infection-Associated Acute Otitis Media

Tomochika K, et al.
Pediatr Int 2009 Aug;51(4):484-7.

Background: It is known that children with respiratory syncytial virus (RSV) infection frequently have complications of acute otitis media (AOM).
Methods: The hospital records of 148 inpatients aged 6-35 months who had RSV infection between January 2004 and December 2007, were retrospectively investigated.
Results: Forty-six out of 148 children (31%) had AOM. There was a significantly greater number of children with fever who had AOM (P=0.005). The percentage of children with beta-lactamase-non-producing ampicillin-resistant (BLNAR) Haemophilus influenzae in nasopharyngeal culture who had AOM showed a tendency to be greater than that of those who did not have AOM, but this was not statistically significant (P=0.068). Moreover, BLNAR H. influenzae was positive in middle ear fluid specimens from four of five children with AOM who underwent tympanocentesis. There were no significant differences in the incidence of lower airway infection, leukocytes counts, or serum C-reactive protein levels between children with and without AOM.
Conclusions: Children who had RSV infection with AOM had a higher incidence of fever than those without AOM.

Neurological Symptoms in Children With Intussusception

Kleizen K, et al.
Acta Paediatr 2009 Aug 10.

Aim: The classical combination of abdominal pain, vomiting, rectal blood loss and a palpable abdominal mass is only present in a minority of children with intussusception. Neurological signs and symptoms have been described, but are not a well understood phenomenon. We performed a retrospective study to ascertain the frequency and nature

of these symptoms and to describe the characteristics of the patients presenting in this atypical way.
Methods: The records of 58 children presenting with intussusception from 2003 to 2008 were reviewed for abdominal and neurological signs and symptoms, duration of symptoms and effectiveness of treatment.
Results: In 10 out of 58 patients (17%), one or more neurological symptoms were recorded at presentation, with lethargy being the most frequent, followed by hypotonia and fluctuating consciousness. The patients with neurological abnormalities were significantly younger and presented with a shorter duration of symptoms. Therapy was more invasive, although not statistically significant, in this patient category.
Conclusion: Intussusception should be considered in the differential diagnosis in young children presenting with lethargy, hypotonia and/or sudden alterations of consciousness even in the absence of the classical symptoms of intussusception.

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Bronchiolitis-Associated Encephalopathy In Critically-Ill Infants: An Underestimated Complication?

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Antonucci R, et al.
J Matern Fetal Neonatal Med 2009 Aug 19:1-7.

Objective: To investigate the bronchiolitis-associated encephalopathy in critically ill infants.
Methods: The records of infants with severe bronchiolitis admitted to our intensive care unit between 1991 and 2003 were reviewed. Subjects with underlying neurological disorders were excluded. Encephalopathy was defined as occurrence of seizures or at least two nonconvulsive neurologic manifestations. A semistructured telephone interview investigated long-term neurodevelopmental outcome.
Results: Twenty-one infants (11 newborns) were enrolled. All patients required oxygen supplementation and 14 required mechanical ventilation. Encephalopathy occurred in 10 infants, six of whom developed seizures. Encephalopathic infants frequently (six of nine) showed transient EEG abnormalities, and occasionally (one of nine) cranial ultrasound abnormalities. A positive respiratory syncytial virus test was found in five of nine encephalopathic infants. One encephalopathic patient died, while 20 infants clinically normalised before discharge and showed a good neurodevelopmental outcome.
Conclusions: Acute encephalopathy was frequently observed in our patients with severe bronchiolitis. Long-term prognosis of encephalopathic infants was good.

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Obstetrics And Gynecology

التوليد والأمراض النسائية

Correlation of Anterior Vaginal Wall Pain With Endometriosis in Infertile Patients

[illegible]

Paulson JD.
J Reprod Med 2009 Mar;54(3):145-50.

Objective: To investigate whether anterior vaginal wall tenderness in a patient with unexplained infertility correlated to a high percentage of finding endometriosis on laparoscopy.

Method: Fifty-five consecutive patients with unexplained infertility had vaginal examinations with anterior wall palpation to determine whether there was tenderness (AVWT). As part of the infertility workup, laparoscopy, biopsies and cystoscopy with hydrodistention were performed.

Results: The prevalence of endometriosis in this study was 78%. The sensitivity of positive AVWT on palpation with patients who were found to have endometriosis was 84%, and the specificity was 75%. The positive predictive value was 86% and the negative predictive value was 69%.

Conclusion: Unexplained infertility may be amenable to treatment in finding problems such as endometriosis, adhesions or subtle other problems that can be corrected by use of laparoscopy instead of going directly to in vitro fertilization. AVWT is a test that may be able to aid physicians in choosing a management to treat a patient with a laparoscopy early in the workup.

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Amniotic Fluid Volume in Intra-Amniotic Inflammation With And Without Culture-Proven Amniotic Fluid Infection in Preterm Premature Rupture of Membranes

[illegible]

Lee SE, et al.
J Perinat Med 2009 Aug 27.

Objective: Previous studies reported that the clinical significance of intra-amniotic inflammation with a negative amniotic fluid (AF) culture is similar to that of intra-amniotic inflammation with microbiologically-proven AF infection. However, the magnitude of the fetal inflammatory response in these two conditions is different as gauged by umbilical cord C-reactive protein (CRP) concentrations. We undertook this study to determine if the frequency of oligohydramnios is different in these two conditions.

Methods: The amniotic fluid index (AFI) was measured in 205 patients with preterm premature rupture of membranes (PROM) (</=35 weeks). AF was cultured for aerobic and anaerobic bacteria and genital mycoplasmas. Intra-amniotic inflammation was defined as an elevated AF matrix metalloproteinase-8 (MMP-8) concentration (>23 ng/mL). Patients were divided into three groups according to the results of AF culture and the presence or absence of intra-amniotic inflammation: 1) without intra-amniotic inflammation and a negative culture (n=109); 2) with intra-amniotic inflammation and a negative culture (n=44); and 3) a positive culture (n=52).

Results: Patients with a positive culture had a higher frequency of oligohydramnios and a lower median AFI than those with a negative culture but with intra-amniotic inflammation (P<0.01). However, there was no significant difference in the median AFI or in the frequency of oligohydramnios according to the presence or absence of intra-amniotic inflammation among patients with a negative culture (P>0.1).

Conclusion: Oligohydramnios was more frequent in patients with culture-proven AF infection than in those with intra-amniotic inflammation and a negative AF culture.

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[illegible] AFI [illegible] ($p<0.01$) [illegible] ($p>0.1$).

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Choriocarcinoma in A Postmenopausal Woman

[illegible]

Chittenden B, et al.
Obstet Gynecol 2009 Aug;114(2 Pt 2):462-5.

Background: Choriocarcinoma typically occurs within 12 months of pregnancy but rarely may present many years after an antecedent pregnancy. This report describes choriocarcinoma in a postmenopausal woman.
Case: A 62-year-old woman presented with dyspnea, a history of postmenopausal vaginal spotting, and metastatic disease on chest X-ray. A transvaginal ultrasonogram revealed a thickened endometrium. Endometrial biopsy and an elevated beta-hCG confirmed the diagnosis of metastatic choriocarcinoma. Multiagent chemotherapy was initiated, and the patient developed fatal toxic epidermal necrolysis.
Conclusion: This case reminds practitioners that choriocarcinoma can occur in postmenopausal women, and although cure rates are high, deaths occasionally occur because of toxicity associated with treatment.

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Prevention of Gestational Diabetes Mellitus By Continuing Metformin Therapy Throughout Pregnancy in Women With Polycystic Ovary Syndrome

[illegible] metformin [illegible]

Begum MR, et al.
J Obstet Gynaecol Res 2009 Apr;35(2):282-6.

Aim: The aim of the present study was to assess whether continuation of metformin therapy throughout pregnancy can reduce the development of gestational diabetes in women with polycystic ovarian syndrome (PCOS).
Methods: This experimental study was conducted in a private tertiary level infertility care center between June 2002 and December 2006. Fifty-nine non-diabetic PCOS patients who conceived while taking metformin and different

ovulation-inducing agents comprised the sample group. Twenty-nine of them continued metformin throughout pregnancy and 30 did not. The main outcome measure was development of gestational diabetes in women with PCOS and their fetal outcome.

Results: Basic parameters such as age, body mass index, levels of follicle-stimulating hormone and luteinizing hormone, free testosterone, dihydroepiandrosterone sulfate, fasting sugar and fasting insulin did not differ between the two groups. Among 29 women who received metformin, gestational diabetes developed during one of 29 pregnancies (3.44%) versus nine of 30 pregnancies (30%) without metformin. The odds ratio for gestational diabetes in women without metformin versus with metformin was 12 (95% confidence interval: 6.20-18.08). All babies born in the metformin group had average birthweight and those in the control group 4 (13.33%) were large for date.

Conclusion: In PCOS use of metformin throughout pregnancy is associated with and might be responsible for a ninefold reduction (30-3.44%) of gestational diabetes.

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Prognostic Factor On Optimal Debulking Surgery By Maximum Effort For Stage IIIc Epithelial Ovarian Cancer

[illegible]

Terauchi F, et al.
J Obstet Gynaecol Res 2009 Apr;35(2):315-9.

Objectives: The aim of this study was to assess the prognostic factor of radical surgery in patients with stage IIIc ovarian cancer.

Study Design: Fifty-two patients were subjected to the study. The complete resection or optimal primary cytoreductive surgery (OPCS) was set as the maximum effort, and the accomplishment rate and prognosis were assessed. In addition, the poor prognosis cases among the OPCS-accomplished were evaluated with several factors based on univariate and multivariate analyses.

Results: The OPCS accomplishment rate was 84.6%. A worse prognosis was obtained in the more-than-4-weeks-delayed postoperative chemotherapy group, assessing poor-outcome cases in the OPCS group. A case that required more than three colon resections was the significant factor for the delay of postoperative chemotherapy.

Conclusions: OPCS should be performed with maximum effort to improve the prognosis of stage IIIc ovarian cancer. We should avoid any delay in starting postoperative chemotherapy. In cases that require more than three colon resections, it seems that <perioperative management> should be reconsidered and that priority should be given to postoperative management so that chemotherapy can be started soon after the operation.

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Surgery

الجراحة

Neoadjuvant Gonadotropin-Releasing Hormone Therapy Before Surgery And Effect on Fertility Index in Unilateral Undescended Testes

[illegible]

Jallouli M, et al.
Urology 2009 Apr 14.

Objectives: To investigate, in a prospectively randomized trial, whether preoperative gonadotropin-releasing hormone (GnRH) therapy improves the fertility index in primary cryptorchidism. Cryptorchidism is a common condition with a high risk of infertility. Treatment with GnRH appears to improve fertility later in life by inducing germ cell maturation.

Methods: A total of 24 boys, 12-123 months old (median 34.5), with 24 undescended testes were prospectively assigned to 2 groups during a 24-month period. The patients were randomized to receive either orchiopexy alone (n=12) or orchiopexy combined with neoadjuvant GnRH therapy (n=12) as a nasal spray for 4 weeks at 1.2 mg/d. In both groups, testicular biopsies were performed at orchiopexy, and the histopathologic fertility index was determined.

Results: The mean fertility index in the group treated with GnRH before surgery was significantly greater (0.88 +/- 0.31) than in the group without hormonal stimulation (0.49 +/- 0.52; P=0.02). No significant correlation was found between the fertility index in the GnRH group and the patient>s age.

Conclusions: The results of our study have shown that neoadjuvant GnRH treatment improves the fertility index in prepubertal cryptorchidism and, consequently, should improve fertility in adulthood.

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Ǥnjưǒƨoʞ ýŭƤ LJdž ɬIoŭ!ƒ ɬǒƨdžƶ!ƒ ýoƒƨdž!ƒ Ǒ5 ɬhĂŢƤ!ƒ ƨƶTdž LJǒǀoʞ Ǒ5 IþƑǤ5 GnRH ɬǒǐǀǤǰk!ƒ KǤƘǤoǔ! ƨƨoʠž!ƒ LJĂdžƨnj!Ghu ɬɳ!Ǥƶdž!ƒ KƨnjUD .ɬǒTǤkǰÚƒ GǒŭƤ!ƒ ǸuưLj!

ý‡Thu DǐnjƶǒƨĂk Dǐk ÜIƨɳǤnj!ƒ ǏŢƤ!ƒ LJdž 24 Dǐnjǒþ! (ẘƨnjT 34.5 ƱǒǀĂhu) ẘƨnjT 123-12 LJǒhu DǐNjƨǤdžƵD ẘǒhuŢ 24 ɬǀƒƨþ!ƒ KǐdžT **:KΘǤIIƐ ƷþƯ** Cƒƨɳ‡ orchiopexy ɬǒŢƤ!ƒ KǒhuÅk Cƒƨɳů (ẘưǒƨdž 12) ǏǃĂŬƒ ɬƵĂdžɳdž!ƒ Ǒ5 Ǐưƨdž!ƒ ýưƤ .ẘƨnjT 24 Iþdž ýŭƤ LJǒkƵĂdžɳdž ǏǐƵ ǑFƒĂTƵ ǏǐƵ þǒþɳ!ƒ ɬþoʞǀdž!ƒ GnRH LJĂdžƨnj!Ghu ɬɳ!Ǥƶdž!ƒ yǒž ɬ‡ƨǤTdž!Ghu ɬǒŢƤ!ƒ KǒhuÅK! (ẘưǒƨdž 12) ɬǒǀǤĂ!ƒ ɬƵĂdžɳdž!ƒ Ǒ5 Ǐưƨdž!ƒ ýưƤ GdžLjǒhu ÜþƨsdžKƒƨƵTdž!ƒ þǒþoʞ yǒž KǒhuÅk!ƒ ɬǒǐdžƵ ýŭƤ ɬǒŢƤ!ƒ LJdž KǤƵƨP Cƒƨɳǫ LJǒkƵĂdžɳdž!ƒ GKǐ‡ Ǒ5 Dǐk .ẘǒdžĂǒ ƐǐdžŁ 1.2 ɬƵƨɳhu yǒhǤǀD 4 Iþdž! ǑsLþ ǤǤPhu ý‡Ť .ɬ!Ǥo ý‡ Ǒ5 ɬhĂŢƤǐ! ɬǒưƨdž!ƒ ɬǒoǒƨTk!ƒ ɬǒɳǒǀLj!ƒ

ɬoƒƨɳ!ƒ ýhp GnRH LJĂdžƨnj!Ghu Gnjkɳ!Ǥƶdž Kdžk Ǒk!ƒ ɬǒLǤĂ!ƒ ɬƵĂdžɳdž!ƒ þLjƵ ẘǒƑǤŢoǫ DǤǴNj ý‡ThĂ ýưƷD LJǤ‡ ɬhĂŢƤ!ƒ ƨƶTdž ƱǀĂkdž LJD UoʞĂ! **:Ăǝ‡Kǐ̈IIƐ** ƨƶTdž LJǒhu ɬdžǴNj ɬpŭƵ þĂɳĂ Uoʞŭǒ Dž! .(p=0.02 ¡0.52±0.49) ɬǒLjĂdžƨnj!ƒ ɬɳ!Ǥƶdžƶǐ! yưƤk Dž! Ǒk!ƒ Ǐ!ĂŬƒ ɬƵĂdžɳdž!Ghu ɬLj‡ǤIdž (0.31±0.88) .ɬǒLjĂdžƨnj!ƒ ɬɳ!Ǥƶdž!ƒ ɬƵĂdžɳdž Ǒ5 Ưǒƨdž!ƒ ƨdžƵĂ ɬhĂŢƤ!ƒ

IƨkƷ Ǒ5 IƨɳǤnj!ƒ ɬǒŢƤ!ƒ KŬǤoʞ Ǒ5 ɬhĂŢƤ!ƒ ƨƶTdž LJǀoʞ þǒþɳ!ƒ ɬ þoʞǀdž!ƒ GnRH LJĂdžƨnj!Ghu ɬɳ!Ǥƶdž!ƒ LJD ɬǀƒƨþ!ƒ IjRNj ŅFǤkLj ƨnjUʞ **:ǏƑɯƑKǐ̈ɬƨŮƐ** .ƷĂǐhu!ƒ IƨkƷ Ǒ5 ɬhĂŢƤ!ƒ ƨƶTdž LJǒǀoʞ Ǒ5 ɬɳǒkLj!Ghu DǐNjǤǀk ƵĂǀĂ ÜƷĂǐhu!ƒ ýhp Gdž

Spontaneous Sutureless Closure of The Abdominal Wall Defect in Gastroschisis Using A Commercial Wound Retractor System

ǏŝɬǺIIƐ DžUưǤIIƐ þȼqɯ Ʒƒŝǀdž̈ ǏÚƑΘ Ǐʒ DžUưǤIIƐ þȼqɯ Ǐʒ ƒǐyɬǁ ăNjƵyIIƐ Ʒúƺ̈ŮƐ

hǐΘȼþɯ hUƤǐǺ DžNjqq qǐyǤHIƐNj hǔǐFÞŽΘIIƐ !ƒuʷž !ȼqǺɬƨƒǤ

Ogasawara Y, et al.
Pediatr Surg Int 2009 Aug 25.

Purpose: We report our experience of using a commercial wound protector and retractor system to allow spontaneous sutureless closure of the abdominal wall defect in gastroschisis.
Methods: Following birth, eviscerated bowel is wrapped with polyethylene wrap, the umbilical cord is deliberately left long and kept moist, and the patient stabilized and transferred to the operating room. Then the Applied Alexis((R)) wound protector and retractor system (Applied Medical Resources Corp, USA) was used for reducing eviscerated bowel. Once all organs have been reduced, the wound protector and retractor system (WPAR) is removed and the abdominal wall defect covered with the umbilical cord without suturing. Tegaderm((R)) (3M Health Care, USA) is used as a film dressing and is removed once the umbilical cord becomes adhered.
Results: We have used this technique to treat seven neonates with gastroschisis between April 2006 and March 2009. In three, WPAR was used as a silo initially, and removed after 3-4 days, and in four, WPAR was used only until primary reduction was achieved and removed. The abdominal defect closed spontaneously in all cases with excellent cosmesis. There were no complications attributed to our technique. At the time of discharge, all patients had insignificant umbilical hernias which have all resolved spontaneously.
Conclusion: The cosmetic appearance of the abdomen is improved using our technique compared with primary closure involving suturing and a conventional silo.

(ɬoƒƨɳ ɬƲǒƤ LJĂþ) ǏĂƹƶ!ƒ DǐǤoʞǔ! ýĂŢĂ!ƒ Ǒ5 (WPAR ؛ ƨĂƨƶdž!ƒ) þǒƶhk!ƒĂ ɬǒǤdžo!ƒ DǐǤULj DǐfþƤkǀƒ ýĂo ɬǒŢƤT!ƒ IƨhƤ!ƒ Ưƨƶ **:KΘǤIIƐ ȼqlj** .gastroschisis ǑIǐƤ!ƒ LJƲhu!ƒ ƨfþɳ ƹǤITLjƒ KŬǤo Ǒ5 LJƲhu!ƒ ƨfþɳ Ǒ5 Ɣǒƶǐ!

ƨǒhfþk Dǐk ÜtʰƲƨ ɬ!Ǥoʰu NǒǐƵ ɬU5Ǥoʞdž!ƒĂ ǔǒĂƲ Ǐǀǀǐƒ ýʰuo!ƒ ll8k þdƶƶk yǒž ÜLJǒǐǒkǒǫ Ǒ!Ău!ƒ LJdž ƨŭƹʰu ɬFkǤLj!ƒ CǤƶdžŮƒ ƨǒǐƹk IþŮĂ!ƒ þƶʰu Dǐk **:KΘǤIIƐ Ʒƒŝ** Applied Alexis (R), Applied Medical) þǒƶhk!ƒĂ ɬǒǤdžo!ƒ DǐǤULj ƹǒhuƲk Dǐk .KǤǒǐdžƶ!ƒ ɬ5ƨƐ Ǐ!ǫ ýILj Dǐƛ LJdžĂ ƨƨIkǀŭ! ǔĂŢĂ Ưǒƨdž!ƒ ɬ!Ǥo Ɣǒƶ!ƒ LJǤ‡dž ɬǒƲƹkĂ DǐǤULj!ƒ ƒRNj ɬ!ƒƨǫ Kdžk LJƲh!ƒ Ǐ!ǫ ɬFkǤLj!ƒ CǤưƵŮƒ ýdžɳdž IþĂƵ þƨɳdžhuĂ Ü‡FkǤLj!ƒ CǤƶdžŮƒ YǤɳƨÚ (Resources Corp, USA yǒž ƨǐƹdž þǤdžưɬ (Tegaderm (R), 3M Health Care, USA) þǤdžưǃ DǐfþƤkǀƒ Dǐk .ɬǒƨfþɳ ɬƲǒƤ Cƒƨɳǫ LJĂþ Ǐƨǀǐƒ ýʰuo!ʰu LJƲh!ƒ ƨfþɳ Ǒ5

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Diameter of the Infrarenal Aorta
As A Risk Factor for Abdominal Aortic Aneurysm

[illegible]

Solberg S, et al.
Eur J Vasc Endovasc Surg 2009 Nov 24.

Objectives: We aim to study whether the diameter of the non-aneurysmatic infrarenal aorta influences the risk for abdominal aortic aneurysm (AAA) and whether the larger diameter in men can explain the male predominance in AAA.

Design: This is a population-based follow-up study.

Materials & Methods: In 4265 men and women with a normal-sized aorta in 1994-1995, 116 incident cases of AAA were diagnosed 7 years later. The risk of an incident AAA was analysed in a multiple logistic regression model according to baseline maximal infrarenal aortic diameter, adjusted for known risk factors.

Results: Compared with subjects with aortic diameter in the 21-23 mm bracket, men and women with a diameter <18mm and >/=27mm had an adjusted odds ratio (OR) of 0.30 (95% confidence interval (CI): 0.10-0.88) and 4.22 (95% CI: 1.94-9.19), respectively, for an incident AAA. When adjusted for age and baseline aortic diameter, male sex was not statistically significantly associated with the incidence of AAA (OR=1.45, 95% CI: 0.93-2.30, P=0.10).

Conclusions: Increased baseline diameter of the infrarenal aorta was a highly significant, strong and independent risk factor for developing an AAA. The larger aortic diameter in men than in women may be the most important explanation for the higher AAA risk in men.

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Neoadjuvant Docetaxel, Capecitabine and Cisplatin (DXP) in Patients With Unresectable Locally Advanced or Metastatic Gastric Cancer

العلاج الكيميائي المساعد DXP (Docetaxel، Capecitabine وCisplatin) عند مرضى الحالات المتقدمة غير القابلة للاستئصال أو حالات النقائل الورمية من سرطان المعدة

Sym SJ, et al.
Ann Surg Oncol 2009 Nov 26.

Background: This phase II study was conducted to evaluate the efficacy of neoadjuvant chemotherapy with docetaxel, cisplatin and capecitabine (DXP) in patients with unresectable locally advanced and/or intra-abdominal metastatic gastric cancers.

Methods: Patients with advanced gastric cancer (AGC), clinically unresectable because of local invasion or limited intra-abdominal metastasis in para-aortic lymph nodes and/or the peritoneum based on multidetector row computed tomography, were enrolled. DXP consisted of docetaxel 60 mg/m(2) i.v. and cisplatin 60 mg/m(2) i.v. on day 1, and capecitabine 937.5 mg/m(2) twice daily p.o. on days 1-14 every 21 days. Surgery was performed after 4-6 cycles of DXP.

Results: Thirty-six (74%) of the 49 patients enrolled underwent surgery, and 31 (63%) had an R0 resection. R0 resection was possible in 15 of 21 patients (71%) with unresectable locally advanced lesions, 12 of 17 patients (70%) with para-aortic lymph node metastasis but only 4 of 11 patients (36%) with peritoneal metastasis. Grade 3/4 toxicities included neutropenia (69%), febrile neutropenia (4%) and hand-foot syndrome (8%).

Conclusions: Neoadjuvant DXP may offer a reasonable chance of curative surgery in AGC patients with unresectable locally advanced or para-aortic lymph node metastasis.

[illegible] (DXP [illegible]) capecitabine [illegible] cisplatin [illegible]docetaxel [illegible] DXP [illegible] 60 [illegible] DXP [illegible] 60 [illegible] cisplatin [illegible] 937.5 [illegible] capecitabine [illegible] 21 [illegible] 14-1 [illegible] 6-4 [illegible].

[illegible] 36 [illegible] 49 [illegible] (74% [illegible] R0 [illegible] 31 [illegible] (63%) [illegible] 15 [illegible] 21 [illegible] R0 [illegible] (71%) [illegible] 12 [illegible] 17 [illegible] (70%) [illegible] 4 [illegible] 11 [illegible] (36%) [illegible] 4/3 [illegible] (69%) [illegible] (4%) [illegible] (8%).

[illegible] DXP [illegible].

Preoperative Biliary Drainage for Distal Obstruction

[illegible]

Garcea G, et al.
Pancreas 2009 Nov 23.

Objectives: No conclusive evidence exists confirming the role of preoperative biliary drainage (PBD) in reversing the physiological disturbances resulting from biliary obstruction to improve outcome. This review examined the impact of PBD and the outcomes after surgery.

Methods: A PubMed literature search was undertaken using the keywords preoperative, biliary, and drainage. The primary end points were the effect of PBD on mortality, morbidity, and bile cultures. The secondary outcome measures were PBD and pancreatic leakage, intra-abdominal abscess, sepsis/infectious complications, wound infection, hemorrhage, and bile leak rates. The impact of bile cultures positive for bacteria and the outcomes after surgery were also examined.

Results: Preoperative biliary drainage significantly increases wound and bile infection rates on meta-analysis (P<0.0005) using a fixed and random effect model, but no adverse effect on mortality and morbidity was found. A bile culture positive for bacteria negatively impacts on both mortality and morbidity (P<0.005) after surgery.

Conclusions: Preoperative biliary drainage significantly increases the rates of bile culture positive for bacteria and the probability of wound infection. Bile cultures positive for bacteria adversely impact mortality and morbidity after surgery in jaundiced patients. Although no evidence has been found by this review that PBD directly increases mortality and morbidity, it is possible that in certain patients, PBD may deleteriously affect outcome by bacterial contamination of the bile.

هدف البحث: لا توجد حتى الآن أدلة نهائية تعزز دور النزح الصفراوي قبل الجراحة PBD في معاكسة الاضطرابات الفيزيولوجية الناتجة عن حالات الانسداد الصفراوي وتحسين النتائج السريرية الملاحظة. سيتم في هذه المراجعة البحثية استقصاء تأثير النزح الصفراوي قبل الجراحة على النتائج الملاحظة بعد الجراحة.

طرق البحث: تم البحث عبر PubMed باستخدام الكلمات المفتاحية التالية (قبل الجراحة، صفراوي، النزح). شملت النقاط النهائية الأساسية تأثير النزح الصفراوي قبل الجراحة على الوفيات، المراضة، والزروع المجراة من الصفراء. في حين شمل قياس النتائج الثانوية الترافق بين النزح الصفراوي قبل الجراحة PBD ومعدلات حدوث حدوث تسرب معثكلي، خراجات داخل البطن، الاختلاطات الإنتانية وإنتان الدم، إنتان الجرح، النزف، التسرب الصفراوي. من جهة أخرى تم استقصاء تأثير الزروع الصفراوية الجرثومية الإيجابية على النتائج الملاحظة بعد الجراحة.

النتائج: لوحظ أن النزح الصفراوي قبل الجراحة يزيد وبشكل هام من معدلات حدوث إنتانات الجرح والإنتانات الصفراوية (p<0.0005) وذلك من خلال التحليل النهائي باستخدام نماذج التأثير الثابتة والعشوائية، ولكن لم تلاحظ تأثيرات سلبية له على صعيدي الوفيات والمراضة. تؤثر الزروع الجرثومية الإيجابية للصفراء بشكل سلبي على كل من المراضة والوفيات بعد الجراحة (p<0.005).

الاستنتاجات: يزيد النزح الصفراوي قبل الجراحة من معدلات الزروع الجرثومية الإيجابية للصفراء ومن احتمال تطور إنتان الجرح. تؤثر الزروع الجرثومية الإيجابية بشكل سلبي على معدلات المراضة والوفيات بعد الجراحة عند مرضى اليرقان. وعلى الرغم من عدم وجود دلائل من خلال هذه المراجعة على دور مباشر للنزح الصفراوي قبل الجراحة في زيادة المراضة والوفيات، إلا أنه من الممكن أن يكون له تأثيرات سلبية على صعيد النتائج عند بعض المرضى من خلال حدوث تلوث جرثومي للصفراء.

Cardiovascular Diseases

الأمراض القلبية الوعائية

Impact Of Atrial Fibrillation On NT-proBNP Levels In A 75-Year-Old Population

NT-proBNP !NjĭqNjͲ‡ll þqDžlle Ĭ3FDžqlle qĭ‡GGlle I ƑĭNj‡ƨDž Ă‡Y ĬdžĭPŬε DžƑƶɯþlle þĭkƟ‡
ƕdžƨ 75 ƕƐllFGlle ƕĭþDžylle ƕYNjDžɯDžlle ĂƮþDž qdžY

Ulimoen SR, et al.
Scand J Clin Lab Invest 2009 Apr 24:1-6.

Objective: The objective of this study was to investigate the impact of atrial fibrillation (AF) on serum levels of N-terminal fragment of pro-brain natriuretic peptide (NT-proBNP) in a 75-year-old population.

Methods: All 75-year-old citizens in Asker and Baerum counties in Norway were invited to participate in a prevalence study of AF. Blood samples for measurement of NT-proBNP were collected at rest from 61 subjects with AF and a gender-matched control group of 126 subjects in sinus rhythm. NT-proBNP was measured in serum using the Elecsys proBNP sandwich immunoassay (Roche Diagnostics, Basel, Switzerland).
Results: Subjects with permanent AF had higher levels of NT-proBNP (median 1119 pg/mL (interquartile range 701, 1643)) than subjects with paroxysmal AF (257 pg/mL (169, 382)) and controls (95 pg/mL (60, 171)), p<0.001 for both. The presence of AF was still significantly associated with higher log NT-proBNP (B=0.61, p<0.001) after adjusting for the presence of heart failure, coronary heart disease and hypertension.
Conclusion: In this stable, out-of-hospital population of 75-year-old subjects, AF was independently associated with increased levels of NT-proBNP. Permanent AF was associated with higher NT-proBNP levels than paroxysmal AF.

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Prognostic Value of The Collagen Volume Fraction in Hypertrophic Cardiomyopathy

[illegible]

Arteaga E, et al,
Arq Bras Cardiol 2009 Mar;92(3):210-4, 222-6.

Background: In hypertrophic cardiomyopathy (HCM), interstitial myocardial fibrosis is an important histological modification that has been associated with sudden death and evolution toward myocardial dilation.
Objective: To prospectively evaluate the prognostic value of the collagen volume fraction in HCM.
Methods: An endomyocardial biopsy of the right ventricle was successfully performed in 21 symptomatic patients with HCM. The myocardial collagen volume fraction (CVF) was determined by histology. The CVF was also determined in fragments of nine normal hearts from subjects deceased from non-cardiac causes. The patients were divided into above-median CVF and below-median CVF groups, and their clinical and echocardiographic characteristics and survival curves were compared.
Results: Among the patients, the CVF ranged from 1.86% to 29.9%, median 6.19%; in normal hearts, from 0.13% to 1.46%, median 0.61% (p<0.0001 between HCM and control). There were no significant correlations between CVF and baseline echocardiographic measures. Patients with CVF < or =6.19% and CVF> 6.19% were compared and no baseline differences were observed. However, after an average follow-up period of 110 months, four deaths occurred

(two sudden, two due to heart failure) in the group with increased CVF, whereas the patients of the group with lower CVF were all alive at the end of the period (p=0.02).

Conclusion: For the first time, myocardial fibrosis was prospectively associated with a worse prognosis in patients with HCM. Efforts should be directed to the quantification of myocardial fibrosis in HCM, on the premise that its association with the prognosis can aid in the stratification of risk for defibrillator implantation, and in the prescription of drugs that potentially promote myocardial repair.

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Pulmonary Diseases

الأمراض الصدرية

Value of Fractional Exhaled Nitric Oxide FE(NO) for the Diagnosis of Pulmonary Involvement Due to Inflammatory Bowel Disease

[illegible]

Ozyilmaz E, et al.
Inflamm Bowel Dis 2009 Aug 24.

Background: Pulmonary involvement due to inflammatory bowel disease (IBD) is frequent when evaluating a patient with IBD and pulmonary involvement remains complicated. Most of the patients are asymptomatic and the methods used are mostly invasive or expensive procedures. The aim of this prospective study is to evaluate the value of the fractional exhaled nitric oxide (FE(NO)) level for the diagnosis of pulmonary involvement due to IBD and to investigate any correlation between FE(NO) level and disease activity.

Methods: Thirty-three nonsmoker patients with IBD (25 ulcerative colitis [UC] and 8 Crohn's Disease [CD]) who were free of corticosteroid treatment and 25 healthy subjects as a control group were enrolled in this study. All patients with IBD were investigated for pulmonary involvement with medical history, physical examination, chest roentgenogram, oxygen saturation, blood eosinophil levels, pulmonary function tests (PFTs), high-resolution computed tomography (HRCT), and FE(NO) level.

Results: Pulmonary involvement was established in 15 patients (45.5%) with IBD. The FE(NO) level was higher in patients with pulmonary involvement than without pulmonary involvement and healthy controls independent from the pulmonary symptoms, eosinophil count, duration of disease, activity of disease, and surgery history (FE(NO): 32±20; 24±8; 14±8 ppb, respectively) (P<0.05). In addition, diffusion capacity (DLCO) was found to be significantly lower in patients with CD compared with UC (P<0.05).

Conclusions: This study showed that an increased FE(NO) level may be used for identifying patients with IBD who need further pulmonary evaluation.

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Endocrinology, Metabolism, And Diabetes Mellitus

أمراض الغدد الصم والاستقلاب والداء السكري

Atypical Diabetes Mellitus Associated With Bone Marrow Transplantation

ǏǅǑƲǑǈ Ǐƽǅǈ ƱþǕ ǁƑǊǅǑǁ ƽƺƞǒǅǈ ǏǓPǋǅǈ þǑǋ ǎþǁƨǈ þǕǙǈ

Tor O, Grag R.
Endocr Pract 2009 Aug 24:1-12.

Objective: To introduce 3 cases of atypical diabetes mellitus following bone marrow transplantation (BMT).

Methods: We describe clinical presentation and relevant laboratory findings of 3 patients who presented with new onset diabetes mellitus after bone marrow transplantation and subsequently went into complete remission. We discuss

the possible mechanisms for this presentation.

Results: Onset of diabetes mellitus was acute, mimicking type 1 diabetes. Blood glucose levels were very high at onset but patients required only a small dose of insulin for glycemic control. Onset of diabetes appeared to be unrelated to immunosuppressive drug therapy because it happened several months after starting these drugs. C-peptide was detectable and glutamic acid decarboxylase antibodies were absent. Diabetes mellitus remitted spontaneously after a few months while the immunosuppressive drugs were still continued.

Conclusion: This is the first report of atypical diabetes mellitus in association with BMT. While we do not know the underlying mechanisms, cytokine changes after BMT may have led to temporary beta cell dysfunction.

[illegible] BMT.

[illegible] 3 [illegible]

[illegible] glutamic acid decarboxylase أضداد [illegible]

[illegible]

Gastroenterology

الأمراض الهضمية

The HomB Status of Helicobacter Pylori As A Novel Marker To Distinguish Gastric Cancer From Duodenal Ulcer

[illegible] homB [illegible]

Jung SW, et al.
J Clin Microbiol 2009 Aug 26.

Introduction: The hom family of Helicobacter pylori outer membrane proteins, especially homB gene, has been suggested as a novel virulence factor; however the clinical association and function of this gene is still unclear.

Methods: We evaluated the presence of the homA, homB and cagA genes in 286 strains isolated in the U.S. and Colombian populations (126 with gastritis, 96 with duodenal ulcer and 64 with gastric cancer) by a PCR. Results were compared with the clinical presentation and gastric injury.

Results: The prevalence of the homB gene was significantly higher in strains isolated from gastric cancer patients (71.9%) than those from duodenal ulcer patients (52.1%) (P=0.012). In multivariate analysis, the presence of the cagA gene significantly increased the risk for developing gastric cancer and duodenal ulcer with the presence of the homB gene acting as a factor that could distinguish gastric cancer from duodenal ulcer (adjusted odds ratio: 3.033, 95% confidence intervals: 1.37 approximately 6.73). The cagA status was correlated with the homB status (r=0.323, P<0.01). Histological analysis showed that the cagA status was associated with inflammation and atrophy both in the

antrum and the corpus, while the homB status was associated with those in the corpus.

Conclusions: The homB gene status might have possibility to be susceptibility to gastric cancer development such that the homB gene is used as a factor for discriminating the risk of gastric cancer from that of duodenal ulcer.

ŧλƨĂdž!ƒ ŧŢ'ĠPĂ hom ŧŻĂdžηdž!ƒ) Helicobacter pylori ŧðhƒĂh!ƒ ŧðĂïdž!ƒ Dïðλƒƨŋ! ÕηƨĠP!ƒ CĠTʒ!ƒ KĠljðkĂƨh! ƨĂþ þĂηĂ Θƨkpƒ þI! **:hυžϱqʂυž** .Ơuʳ∫Ă ƨðƐ ýƒƨð Ġüž ŧλƨĂdž!ƒ ljRnj! ÕsðUĂ!ƒ ƨĂþ!ƒĂ ĭ ƨðƨ2ļ!ƒ Ƽ5ƒƨk!ƒ LJD Ůϱ Ü↓ŻĂ5 ýdžĠƶ‡ (homB ŧ!Åƨƶdžƶ!ƒ ŧðdžĂλƨŋ!ƒ ĭ ƨƒƨR!ƒ LJdž 286 þljƵ homA، homB، cagA KĠλƨĂdž þĂηĂ DïðôIk PCR ƨƒƨðdžð!Ăh!ƒ ŧĭ'ļ'ļ ýƵĠśk ýŭ'P LJdž Dïk **:KΘĠllƐ ƽþU'** ŊFĠkĻ!ƒ ŧljƨĠIdž Kdïk .(Iþƶdž LJĠƠƨ2ļh 64Ă ŧðηsƵ ŧơƨIh LJðhĠ'Ţ dž 96 ÜIþƶdž ϒĠnjk!Ġh LJðhĠ'Ţ dž DïnjĻdž 126) ĠðhdžĂ!Ă‡Ă Iþơ'kdž!ƒ KĠðŮĂ!ƒ Õ5 Ĭ uʳƨdž LJdž .ŧUơŭdž!ƒ ŧðþƶdž!ƒ ŧðRŮ∫Ă ŧ!ĠơĭI! ĭ ƨðƨ2ļ!ƒ ƨNjĠUk!ƒ yïdž

ŧðηsƶ!ƒ ŧơƨII!ƒ KŮĠơh ŧljƨĠIdž (%71.9) Iþƶdž!ƒ LJĠƠƨ2ļ KŮĠơ LJdž ŧ!Ăƨƶdž!ƒ ŧðdžĂλƨŋ!ƒ ĭ ƨƒƨR!ƒ Õ5 homB ŧλƨĂdžïI! ĬïŻD ƨĠTkljƒ UơĂ! **:Ăϑ₣ĦïllƐ** Iþƶdž!ƒ LJĠƠƨ2ļ ƨĂƠk ƨƠP LJdž ƨðh‡ ý‡ThĂ þðƨð cagA ŧλƨĂdž!ƒ þĂηĂ LJD Kƒððʒkdžƒ þþƶkdž ýöïơk!ƒ ýŭ'P LJdž UơĂ! .(p=0.012) (%52.1) ŧ!þƶdž!ƒ IƨĂƠP!ƒ ŧhˈļLj) ŧðηsƶ!ƒ ŧơƨIl!ƒ LJŻ Iþƶdž!ƒ LJĠƠƨ2ļ Ƽðƨsk Õ5 þðsð ýdžĠƶ ƨĂþ Ygïk Ök!ƒ homB ŧλƨĂdž!ƒ þĂηĂ yïdž ŧðηsƶ!ƒ ŧơƨIl!ƒĂ ýöïơk!ƒ ƨnjUD .(p<0.01 ،0.323=r) homB ŧλƨĂdž!ƒ ŧ!Ġơh cagA ŧλƨĂdž!ƒ ŧ!Ġơ Ơhkƨĸ .(6.73-1.37 ¡%95 ŧlλ ýŢƒĂ5h ÜOR=3.033 þĂηĂ yïdž Ƽ5ƒƨkk GnjĻ35 homB ŧλƨĂdž!ƒ ŧ!Ġơ GdžD ÜIþƶdž!ƒ Dïļ ηĂ ƨĠʒ!ƒ ÖkIƠLjdž Õ5 ƨĂdžuʳĂ ϒĠnjk!ƒ þĂηĂ yïdž Ƽ5ƒƨkk cagA ŧλƨĂdž!ƒ ŧ!Ġơ LJD Õηŏļ!ƒ .ƠI5 Iþƶdž!ƒ Dïļη Õ5 KŮþhk!ƒ ljRNj

LJĠƠƨ2ļ KŮĠơ LJðh ƨððdžk!ƒ Õ5 ýdžĠƶ‡ DïþPkļk ŧλƨĂdž!ƒ ljRNj LJ35 ƒRnj!Ă ÜIþƶdž!ƒ LJĠƠƨ2ļ ƨĂƠk ŧðïhĠp Õ5 homB ŧλƨĂdž!ƒ ŧ!Ġơ DïNjĠļk þp **:IƑШFĦdžƨÚƐ** .ŧðηsƶ!ƒ ŧơƨI!ƒ KŮĠơĂ Iþƶdž!ƒ

Gastroesophageal Reflux May Cause Esophagitis Through A Cytokine-Mediated Mechanism, Not By Caustic (Acid) Injury

IƒdžĭINjĦƶllƐ ƒNJUʳƨ₵NjĦ hυĭĨlC DžY ĂdžĦĭ qs ĬəĭƤDžllƐ ăqyDžllƐ ƨ₹sllƐ IÚƒΘ Ĭʒ băƥDžllƐ ƒƒNJĦllƐ ƒ DžΘllƐ DžY hUШĦFdž ɣƥļFĠDž hυĭNjFI hυĭPΘI ƨĭllNj

Souza RF, et al.
Gastroenterology 2009 Aug 3.

Background And Aims: It is assumed that reflux esophagitis develops when esophageal epithelial cells succumb to the caustic effects of refluxed gastric acid. Caustic chemical injuries develop rapidly, but esophagitis may not appear for weeks after the induction of reflux in animal models. To explore this paradox, we studied early histological events in the development of reflux esophagitis in a rat model, and performed in vitro experiments to determine whether exposure to acidified bile salts causes esophageal epithelial cells to secrete chemokines that might contribute to inflammation.

Methods: At numerous time points following esophagoduodenostomy, histological evaluations of the rat esophagus were performed to assess inflammatory changes. Human, esophageal squamous cell lines were exposed to acidified bile salts to evaluate their effects on cytokine production and immune cell migration.

Results: Contrary to what would be expected for a caustic chemical injury, we found that reflux esophagitis started at postoperative day 3 as a lymphocytic infiltration in the submucosa that later progressed to the epithelial surface. Basal cell and papillary hyperplasia preceded the development of surface erosions. In the squamous cells, exposure to acidified bile salts caused significant increases in the secretion of IL-8 and IL-1beta, and the conditioned media from those cells caused significant increases in the migration rates of T cells and neutrophils.

Conclusions: These findings support, but do not prove, an alternative concept for the development of reflux esophagitis in which refluxed gastric juice does not damage the esophagus directly, but rather stimulates esophageal epithelial cells to secrete chemokines.

[illegible]

Hematology And Oncology

أمراض الدم والأورام

Molecular Defects in ITGA2B And ITGB3 Genes in Patients With Glanzmann's Thrombasthenia

Glanzmann [illegible] ITGB3 [illegible] ITGA2B [illegible]

Kannan M, et al.
J Thromb Haemost 2009 Aug 19.

Background: Glanzmann's thrombasthenia (GT) is an autosomal recessive inherited platelet function defect that is characterized by reduction in, or absence of, platelet aggregation in response to multiple physiologic agonists. The defect is caused by mutations in the genes encoding ITGA2B or that result in qualitative or quantitative abnormalities of the platelet receptor alphaIIb-beta3.

Objectives: The aim of the study was to identify the mutations in GT patients and to correlate with the phenotype.

Subjects and methods: Forty-five unrelated patients with GT were enrolled in the present study to identify the causative molecular defects and also to correlate the phenotype with the genotype. Platelet aggregation, flow cytometry, western blot, mutation screening by conformation sensitive gel electrophoresis (CSGE) followed by sequencing were performed in all the patients. Novel mutations were analyzed for penetrance into the individual families.

Results: A total of 22 novel mutations were identified in 45 unrelated GT patients. Missense mutations were seen in most of the GT patients (59%). The remaining mutations were heterogeneous and were distributed throughout the length of the gene. Molecular analysis in family members showed heterozygous mutations in all the families.

Conclusions: The type I GT, severe form, is the commonest subtype found in this study. Missense mutations were identified as the defects responsible for most of the GT patients. Carrier detection and genetic counseling in these families is an effective alternative for decreasing the burden of severe type of GT.

[illegible] Glanzmann [illegible] ITGB3 [illegible] ITGA2B [illegible] alphaIIb-beta3 [illegible].

[illegible] Glanzmann [illegible].

[illegible] 45 [illegible] Glanzmann [illegible] western blot [illegible] CSGE [illegible].

[illegible] 45 [illegible] 22 [illegible] Glanzmann [illegible] Missense [illegible] (%59 [illegible]).

[illegible] I [illegible] Glanzmann [illegible].

Expression of Tight-Junction-Associated Proteins in Human Gastric Cancer: Downregulation Of Claudin-4 Correlates With Tumor Aggressiveness And Survival

[illegible] claudin-4 [illegible]

Ohtani S, et al.
Gastric Cancer 2009;12(1):43-51.

Background: Claudin, occludin, and zonula occludens (ZO)-1 are known as tight-junction-associated proteins. The aim of this study was to examine the expression of these proteins in gastric carcinoma.

Methods: Gastric cancer tissues (n=124) were obtained from 124 patients who underwent gastrectomy at our hospital between January 2000 and December 2004. The expression of the above tight-junction-associated proteins in carcinoma, normal mucosa, and metaplastic epithelium was examined using immunohistochemistry. In addition, the expression of claudin-4 mRNA was examined in fresh frozen tissue obtained from 34 patients.

Results: Significant correlations were seen between the expression of claudin-4, occludin, and ZO-1. In regard to claudin-4, significant correlations were seen between the expression of claudin-4 evaluated by immunohistochemistry and the expression of claudin-4 mRNA. Claudin-4 expression was significantly decreased in tumors with undifferentiated-type adenocarcinoma, advanced T stage, lymph node metastasis, and peritoneal metastasis. Occludin and ZO-1 expression was significantly decreased in tumors with undifferentiated-type adenocarcinoma. Overall survival was significantly shorter in patients with low claudin-4 expression. Cox multivariate analysis revealed that low claudin-4 expression was independently associated with significantly decreased overall survival.

Conclusion: Tight-junction-associated proteins, particularly claudin-4, may play important roles in determining invasiveness, metastatic potential, and survival in gastric cancer.

[illegible] occludin [illegible] claudin [illegible] zonula occludens (ZO-1) [illegible] tight junction.

[illegible] 124 [illegible] 2000 [illegible] 2004 [illegible].

[illegible] claudin-4 [illegible] 34 [illegible].

[illegible] claudin-4 [illegible] ZO-1 [illegible] occludin [illegible] claudin-4 [illegible] claudin-4 [illegible] claudin-4 [illegible] claudin-4 [illegible] ZO-1 [illegible] occludin [illegible] Cox [illegible] claudin-4 [illegible] claudin-4 [illegible].

[illegible] claudin-4 [illegible].

Infectious Diseases

الأمراض الإنتانية

Abacavir-Lamivudine versus Tenofovir-Emtricitabine for Initial HIV-1 Therapy

Tenofovir-Emtricitabine [illegible] Abacavir-Lamivudine [illegible]

HIV-1 [illegible]

Sax PE, et al.

N Engl J Med 2009 Dec 1.

Background: The use of fixed-dose combination nucleoside reverse-transcriptase inhibitors (NRTIs) with a nonnucleoside reverse-transcriptase inhibitor or a ritonavir-boosted protease inhibitor is recommended as initial therapy in patients with human immunodeficiency virus type 1 (HIV-1) infection, but which NRTI combination has greater efficacy and safety is not known.

Methods: In a randomized, blinded equivalence study involving 1858 eligible patients, we compared four once-daily antiretroviral regimens as initial therapy for HIV-1 infection: abacavir-lamivudine or tenofovir disoproxil fumarate (DF)-emtricitabine plus efavirenz or ritonavir-boosted atazanavir. The primary efficacy end point was the time from randomization to virologic failure (defined as a confirmed HIV-1 RNA level >/=1000 copies per milliliter at or after 16 weeks and before 24 weeks, or >/=200 copies per milliliter at or after 24 weeks).

Results: A scheduled interim review by an independent data and safety monitoring board showed significant differences in virologic efficacy, according to the NRTI combination, among patients with screening HIV-1 RNA levels of 100,000 copies per milliliter or more. At a median follow-up of 60 weeks, among the 797 patients with screening HIV-1 RNA levels of 100,000 copies per milliliter or more, the time to virologic failure was significantly shorter in the abacavir-lamivudine group than in the tenofovir DF-emtricitabine group (hazard ratio, 2.33; 95% confidence interval, 1.46 to 3.72; P<0.001), with 57 virologic failures (14%) in the abacavir-lamivudine group versus 26 (7%) in the tenofovir DF-emtricitabine group. The time to the first adverse event was also shorter in the abacavir-lamivudine group (P<0.001). There was no significant difference between the study groups in the change from the baseline CD4 cell count at week 48.

Conclusions: In patients with screening HIV-1 RNA levels of 100,000 copies per milliliter or more, the times to virologic failure and the first adverse event were both significantly shorter in patients randomly assigned to abacavir-lamivudine than in those assigned to tenofovir DF-emtricitabine.

خلفية البحث: يمثل استخدام جرعة ثابتة بمشاركة مثبطات أنزيم الانتساخ العكسي النكليوزيدية (NRTIs) مع مثبطات أنزيم الانتساخ العكسي غير النكليوزيدية أو مع جرعة من مثبطات البروتياز معززة بـ ritonavir العلاج البدئي المفضل عند مرضى إنتان فيروس عوز المناعة البشري من النمط الأول HIV-1، ولكن من غير المعروف ما إذا كانت مشاركة مثبطات أنزيم الانتساخ العكسي النكليوزيدية (NRTIs) في العلاج تعطي فعالية وسلامة أكبر.

طرق البحث: في دراسة عشوائية معماة شملت 1858 من المرضى تمت فيها المقارنة بين أربعة من المعالجات البدئية للإنتان بفيروس HIV-1 باستخدام مضادات الفيروسات الارتجاعية (مرة يومياً) تضمنت: abacavir-lamivudine أو tenofovir disoproxil fumarate (DF)-emtricitabine مع efavirenz أو atazanavir المعزز بـ ritonavir. كانت النقطة النهائية للفعالية البدئية ممثلة بالزمن بين بدء العلاج وحدوث فشل فيروسي (معرف بمستوى HIV-1 RNA ≥1000 نسخة/مل بعد 16 أسبوعاً وقبل 24 أسبوعاً، أو كونه ≥200 نسخة/مل في الأسبوع 24 أو ما بعده).

النتائج: أظهرت نتائج المراجعة المنهجية للمعطيات ومراقبة السلامة وجود فروقات هامة في الفعالية الفيروسية –تبعاً للمشاركة العلاجية NRTI- عند المرضى ذوو مستويات HIV-1 RNA التي تعادل 100000 نسخة/مل أو أكثر. وضمن فترة متابعة امتدت 60 أسبوعاً كمدة وسطية عند 797 مريضاً بمستويات HIV-1 RNA تعادل 100000 نسخة على الأقل فقد لوحظ أن الزمن اللازم للوصول لمرحلة الفشل الفيروسي كان أقصر وبشكل هام لدى مجموعة abacavir-lamivudine مقارنةً بمجموعة tenofovir DF-emtricitabine (نسبة الخطورة 2.33، بفواصل ثقة 95%، 1.46-3.72، p<0.001)، حيث تطورت 57 حالة فشل فيروسي في المجموعة الأولى (بنسبة 14%) و26 حالة في المجموعة الثانية (بنسبة 7%). من جهة أخرى لوحظ أن الزمن الفاصل بين بدء المعالجة وظهور أول التأثيرات الجانبية كان أقصر وبشكل هام لدى مجموعة abacavir-lamivudine (p<0.001) مقارنةً بالمجموعة الثانية. لم يلاحظ وجود فوارق هامة بين المجموعتين السابقتين من حيث التغير في عدد الخلايا CD4 من المستوى القاعدي بعد 48 أسبوعاً.

الاستنتاجات: لوحظ لدى مرضى مستويات HIV-1 RNA التي تبلغ 100000 نسخة/مل على الأقل أن الزمن اللازم لحدوث الفشل الفيروسي والزمن الفاصل بين بدء العلاج وتطور أول التأثيرات الجانبية كانا أقصر لدى مجموعة المرضى الخاضعين للمعالجة باستخدام abacavir-lamivudine مقارنةً بالمرضى المعالجين باستخدام tenofovir DF-emtricitabine.

Neurology

الأمراض العصبية

NSAID Use and the Risk of Parkinson's Disease

Samii A, et al.
Drugs Aging 2009;26(9):769-79.

Background: Several studies have suggested that NSAID use may modify the risk of developing Parkinson's disease (PD).

Objective: Our aim was to conduct a meta-analysis of observational studies evaluating NSAID use and the risk of PD.

Methods: We systematically searched MEDLINE (1966-November 2008), EMBASE (1980-November 2008) and other databases. Data from 11 studies were included in the meta-analysis. We used the random effects model to calculate risk ratios (relative risks) and their corresponding 95% confidence intervals (CIs).

Results: The pooled risk ratio of PD with NSAID use was 0.95 (95% CI 0.80, 1.12). The pooled risk ratio of PD with high-dose or long-duration NSAID use was 0.91 (95% CI 0.78, 1.05). The pooled risk ratio of PD for aspirin (acetylsalicylic acid) users was 1.08 (95% CI 0.93, 1.26). The pooled risk ratio of PD among ibuprofen users was 0.76 (95% CI 0.65, 0.89). The pooled risk ratio of PD in men using NSAIDs was 0.79 (95% CI 0.69, 0.92), and in women using NSAIDs, it was 0.72 (95% CI 0.45, 1.15).

Conclusions: NSAIDs as a class do not seem to modify the risk of PD. However, ibuprofen may have a slight protective effect in lowering the risk of PD. Although the risk ratios of PD in male and female NSAID users were similar, the 95% CI for men was suggestive of a slight risk reduction

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Incidence of Venous System Disease in Pseudotumor Cerebri

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Santos-Lasaosa S, et al.
Neurologia 2009 Sep;24(7):462-464.

Objective: Pseudotumor cerebri (PC) is a complex syndrome characterized by increased intracranial pressure in the absence of any space occupying lesion, usually self-limiting, but often relapsing. In recent years, some authors had researched the relationship between venous sinus disease and PC and they have suggested that it must be ruled out by magnetic resonance venography (MRV) before diagnosing this condition as idiopathic. Our aim is to determine the frequency of venous sinus disease and the need for MRV in these patients.
Methods: We have studied 14 patients admitted between 1998 and 2005 in the Neurology Department of the University Clinical Hospital, Lozano Blesa (Zaragoza; Spain) who had been diagnosed of PC. We reviewed the epidemiological and clinical features. The MRVs were reviewed and their appearances rated for focal narrowing and signal gaps.
Results: Six patients had strong signal in both lateral and transverse sinus and their image was considered as normal. The other eight patients showed filling defects on the transverse sinus (focal unilateral narrowing in four cases, one or more signal gaps in four cases).
Conclusions: The presence of signal gaps in the venous sinus (stenosis/hypoplasia or absence of signal) is a frequent finding in patients with PC. That is why we have concluded that this test is important in patients with PC in order to search for a possible etiology and treatment option.

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ł7zůkdž!f IjRNjĂ ł0þö2Ă!f Y℞ŏŋ!f K¢5c LJöu ł7ůz!f ł]f2þu łIhG]!f KfĂLj]!f ýŭP LJöλσGu!f U·zu DiGp .Σ‡Lj]! þĂzk Gdž Wu!GƐ GnjLjD Ůo GnjkfR! IþþσdžŽ

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Urology And Nephrology

أمراض الكلية والجهاز البولي

Timing, Causes, Predictors And Prognosis of Switching From Peritoneal Dialysis To Hemodialysis

[illegible]

Jaar BG, et al,
BMC Nephrol 2009 Feb 6;10:3.

Background: The use of peritoneal dialysis (PD) has declined in the United States over the past decade and technique failure is also reportedly higher in PD compared to hemodialysis (HD), but there are little data in the United States addressing the factors and outcomes associated with switching modalities from PD to HD.

Methods: In a prospective cohort study of 262 PD patients enrolled from 28 peritoneal dialysis clinics in 13 U.S. states, we examined potential predictors of switching from PD to HD (including demographics, clinical factors, and laboratory values) and the association of switching with mortality. Cox proportional hazards regression was used to assess relative hazards (RH) of switching and of mortality in PD patients who switched to HD.

Results: Among 262 PD patients, 24.8% switched to HD; with more than 70% switching within the first 2 years. Infectious peritonitis was the leading cause of switching. Patients of black race and with higher body mass index were significantly more likely to switch from PD to HD, RH (95% CI) of 5.01 (1.15-21.8) for black versus white and 1.09 (1.03-1.16) per 1 kg/m2 increase in BMI, respectively. There was no difference in survival between switchers and non-switchers, RH (95% CI) of 0.89 (0.41-1.93).

Conclusion: Switching from PD to HD occurs early and the rate is high, threatening long-term viability of PD programs. Several patient characteristics were associated with the risk of switching. However, there was no survival difference between switchers and non-switchers, reassuring providers and patients that PD technique failure is not necessarily associated with poor prognosis.

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Diagnostic Radiology

التشخيص الشعاعي

Clinically Presenting Acute/Subacute Ischemic Stroke: Differential Diagnosis of the Non-Enhanced CT Hypodensity by Advanced Neuroimaging

[illegible]

Misra V, et al.
Neurol Res 2009 Oct;31(8):816-23.

Objectives: Patients presenting to the emergency room with an acute or subacute onset of focal neurological deficits are evaluated initially by non-contrast computed tomogram (CT) of the brain. This is primarily carried out to differentiate an ischemic from hemorrhagic stroke. However, other neurological conditions may have a similar clinical presentation as well as only hypodensities on CT scan, thus mimicking ischemic stroke. This review focuses on the advanced neuroimaging modalities that help differentiate these other conditions from a cerebral infarction.

Methods: The literature was reviewed in order to ascertain what conditions would clinically and by CT mimic an acute/subacute ischemic infarction, and what advanced neuroimaging techniques would be most useful in differentiating these conditions.

Results: Several infectious, inflammatory, metabolic and vascular diseases were found with clinical presentations identical to subacute/acute ischemic cerebral infarction, which also could demonstrate only hypodensities on a non-enhanced CT scan. However, advanced neuroimaging techniques could readily differentiate these conditions from ischemic infarction.

Conclusions: As presented in this review, although several diseases initially present a diagnostic dilemma upon presentation because of their clinical and non-enhanced CT similarities to cerebral infarction, advanced diagnostic neuroimaging readily establishes their unique pathologies.

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Psychiatry

الطب النفسي

Troponin and S100 Beta are Associated With Depression in Healthy Older Adults

[illegible] S100 beta [illegible]

Benitez A, et al.
Aging Ment Health 2009 Nov;13(6):894-8.

Objectives: Depression has a significant impact on the functioning of older adults and often precedes cognitive decline or dementia. The current study examines the association between biomarkers related to neurocognitive outcome and depression in this population.

Methods: Thirty-five older adults without significant neurological or psychiatric history underwent fasting blood draw and psychological testing. Self-reported measures of current and history of depression and assays for brain-derived neurotrophic factor, S100-beta, amyloid beta, and troponin were analyzed.

Results: Troponin levels were found to be inversely related to current depression (r = -0.35, p = 0.03), while individuals who reported having a past history of depression had significantly higher levels of S100 beta than those who did not report this (t (33) = -2.08, p < 0.05).

Conclusion: The current study shows some support for the association of neurocognitive biomarkers to depression, though the mechanisms for these relationships are unclear and warrant further investigation.

[illegible] 35 [illegible] S100-beta [illegible]

[illegible] (0.03=p ،0.35-=r) [illegible] S100 beta [illegible] (33)t= -2.08، [illegible] (0.05>p).

Dermatology

الأمراض الجلدية

Hypertension And Aldosterone Levels in Women With Early-Onset Androgenetic Alopecia

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Arias-Santiago S, et al.
Br J Dermatol 2009 Nov 10.

Background: Few studies have analyzed the relationship between androgenetic alopecia in women and cardiovascular disease. There is reported to be an elevated prevalence of hypertension among men with androgenetic alopecia (AGA), and it has been proposed that both phenomena may be explained by the presence of hyperaldosteronism. However, no data on blood pressure (BP) and aldosterone levels in women with AGA have been published to date.
Objective: The objective of this study was to evaluate aldosterone levels and the presence of systolic and diastolic hypertension in women with early-onset AGA and in healthy controls.
Methods: This case-control study included 40 women with AGA and 40 healthy controls from the Dermatology Department of San Cecilio Hospital, Granada (Spain).
Results: AGA patients showed significantly higher systolic BP values (139.43 vs. 107.80 mmHg P<0.0001), diastolic BP values (87.65 vs. 67.48 mmHg P<0.0001) and aldosterone levels (249.55 vs. 155.14 pg/ml; P=0.002) versus controls respectively. A positive correlation between aldosterone levels and systolic and diastolic BP values is described.
Conclusion: A higher prevalence of hypertension in women with androgenetic alopecia has been found. The elevated aldosterone values in these patients may contribute, alongside other mechanisms, to the development of AGA and may also explain the higher prevalence of hypertension. Blood pressure screening of women with AGA will permit earlier diagnosis of an unsuspected hypertension and initiation of appropriate treatment.

þĂηĂ WlhǴl þ2Ă0 þl! .ŧlöžöþ ýƒƨk Ǵdž ŧöƑǤƵĂ!ƒ ŧöhœIl!ƒ KǴ5ŮƒĂ CǴlǰ!ƒ þǰƵ ŧöǰöηĂƨƥǰŮƒ ŧŢǤơ!ƒ LJöu ƽ5ƒƨk!ƒ Ő5 Kλơu Ők!ƒ KǴlƒƨþ!ƒ LJǫ :ƘΘǴlle hŭž‡ɋ
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žlp Ő5 KđžkĂ þNjƒĂT!ƒ LJdž 40Ă ŧöǰöηĂƨƥǰŮƒ ŧŢǤơ!Gu KGhǴŢđž!ƒ CǴlǰ!ƒ LJdž 40 (þNjƒĂT!ƒĂ KŮǤơ!ƒ ŧlƒƨþ) ŧlƒƨþ!ƒ ljRNj Kǰdžuʻk :ƘΘǴlle ƽƥƱ
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Andrology

أمراض الذكورة

Recombinant FSH in the Treatment of Oligozoospermia

ƸƑƲǅƐ ǫǪƴŧ ƭ ƾdž ĪŰƟ ŀƜƜƑƴǅ

FSH ƒNjʅƊǅƐ ĪƑǦþƜŧƖ ǨƑƟƐ ǅNjǅþƝƐ !ǫƢŧƨƑǦ

Foresta C, et al.
Expert Opin Biol Ther 2009 Apr 21.

Background: FSH plays a crucial role in human reproduction. Treatment with gonadotrophins has been shown to be effective in males affected by hypogonadotrophic hypogonadism. The success of this treatment has brought about the utilization of the same therapy in infertile oligozoospermic subjects, aimed at obtaining increased sperm count. This physiological role in spermatogenesis has induced various attempts to treat idiopathic oligozoospermic men with FSH, often inducing the restoration of normal spermatogenesis and spontaneous pregnancy.

Objective: To evaluate clinical efficacy of recombinant FSH in male infertility.

Methods: Evaluation of pharmacokinetic, pharmacodynamic properties, efficacy and safety of this hormone preparation, on the basis of the data published in literature.

Conclusions: Recombinant FSH is effective, safe and well tolerated. Treatment with this hormone may represent a valid tool for infertile men. However it should be performed on selected patients utilizing some predictive parameters able to identify a priori responder subjects with high probability.

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.ĬƧŧŖ!ƒ ďžĪ!ƒ ǨŮǦơ Ŏ5 ƔĂƮdž!ƒ FSH ǈĂdžƧnj!Ǧŀ ŧη!Ǧždž! ŧŏƧŏʅ!ƒ ŧŏ!Ǧƶ5 ďžŏŏĪķ **:ǨƟǦƐ ƸǫŀǈNj**

ǨǦŏƱƷdž!ƒ ƴŮƤ ǈdž ǈĂdžƧnj!ƒ ƒŖnjǦ ŧη!Ǧždž!Ǧŀ ŧĪžķdž!ƒ ŧdžŮʅ!ƒĂ ŧŏ!Ǧƶ5 ŮŧŏƒƒĂþ!ƒ ŧŏŧŏdžǦŀþŏŀ!ƒ ƭ ƑǦƮƤ!ƒ ŮŧŏƒƒĂþ!ƒ ĪĪƒƧơ!ƒ ďžŏŏĪķ ďžķ **:ǨƟǦƐ ƾþƲ**

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ďžĪ!ƒ ĬƲƧdž þŀƷ ŧ!Ǧƶ5 ŧŏηŮƷ ĪþƊ ŧη!Ǧždž!ƒ ŀŖŊNj ƴȶdžķ þþĂ ŮþŏŋƊ ƴdžŏơĂ ŧdžŮʅĂ ŧŏ!Ǧƶ5 ƔĂƮdž!ƒ FSH ǈĂdžƧnj!Ǧŀ ŧη!Ǧždž!ƒ ǨƧnjƲƊ **:ĪƜƑŧŧƨŮ**

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ENT

أمراض الأذن والأنف والحنجرة

Otoneurologic Dysfunctions in Migraine Patients With or Without Vertigo

Casani AP, et al.
Otol Neurotol 2009 Aug 19.

Objective: To evaluate the neurotologic findings in patient suffering from migraine with and without vestibular symptoms.
Study Design: Comparative cross-sectional and observational study.
Setting: Tertiary referral center.
Background: Migraine headache is often associated with other symptoms, including dizziness, head motion intolerance, or rotational-type vertigo. The neuro-otologic examination in migrainous patients often gives unremarkable results. To date, it is not fully understood why some migraine patients complain of vestibular symptoms and some do not, and it is not yet clear whether neuro-otologic abnormalities among migraine patients are more common in patients complaining of vestibular symptoms or whether they can be considered a hallmark of migraine itself.
Materials And Methods: Forty-four migrainous patients were divided into 2 groups regarding the presence (22 patients, Group 1) or absence (22 patients, Group 2) of vestibular symptoms, and the results were compared with those obtained from a control group (22 normal subjects). All the patients underwent a complete neurotologic study to verify the presence of vestibular abnormalities.
Results: Neurotologic abnormalities were observed in only 34% of the total, and the incidence was very similar in the 2 groups (36.3 versus 31.8%). Central vestibular involvement was observed in 18% of Group 1 and in 18% of Group 2 patients. Peripheral vestibular involvement was demonstrated in 18% of Group 1 patients and in 16% of Group 2 patients.
Conclusion: Our data seem to confirm that migraine itself can affect vestibular pathways even if patients do not complain of vestibular symptoms. Vestibular examination alone does not provide enough information for a diagnosis of migrainous vertigo. A careful clinical history is fundamental for assessing the profile of patients with migrainous vertigo.

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The Benefits of Steroids Versus Steroids Plus Antivirals for Treatment of Bell's Palsy

l ƐǫĬǿNjþĭŧƨǁǁƐ hŀ þƑ ǂ ĎǤ hŀdžþƑƽĎ l ƐǫĬǿNjþĭŧƨǁǁƐ !ƐǫǪŧƨƐ ƔǫǿƑƷ
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Quant EC, et al.
BMJ 2009 Sep 7;339:b3354.

Objective: To determine whether steroids plus antivirals provide a better degree of facial muscle recovery in patients with Bell's palsy than steroids alone.

Design: Meta-analysis.

Data Sources: PubMed, Embase, Web of Science, and the Cochrane Central Register of Controlled Trials were searched for studies published in all languages from 1984 to January 2009. Additional studies were identified from cited references. Selection criteria Randomised controlled trials that compared steroids with the combination of steroids and antivirals for the treatment of Bell's palsy were included in this study. At least one month of follow-up and a primary end point of at least partial facial muscle recovery, as defined by a House-Brackmann grade of at least 2 (complete palsy is designated a grade of 6) or an equivalent score on an alternative recognised scoring system, were required.

Review methods: Two authors independently reviewed studies for methodological quality, treatment regimens, duration of symptoms before treatment, length of follow-up, and outcomes. Odds ratios with 95% confidence intervals were calculated and pooled using a random effects model.

Results: Six trials were included, a total of 1145 patients; 574 patients received steroids alone and 571 patients received steroids and antivirals. The pooled odds ratio for facial muscle recovery showed no benefit of steroids plus antivirals compared with steroids alone (odds ratio 1.50, 95% confidence interval 0.83 to 2.69; P=0.18). A one study removed analysis showed that the highest quality studies had the greatest effect on the lack of difference between study arms shown by the odds ratio. Subgroup analyses assessing causes of heterogeneity defined a priori (time from symptom onset to treatment, length of follow-up, and type of antiviral studied) showed no benefit of antivirals in addition to that provided by steroids.

Conclusions: Antivirals did not provide an added benefit in achieving at least partial facial muscle recovery compared with steroids alone in patients with Bell's palsy. This study does not, therefore, support the routine use of antivirals in Bell's palsy. Future studies should use improved herpes virus diagnostics and newer antivirals to assess whether combination therapy benefits patients with more severe facial paralysis at study entry.

ƘŰǤơ Ŏ5 NjηĂ!ƒ ƘǓ ư Ƶ ƇǤ5Ƭ ǈdž ý ư 5Đ ŧηƧþ ƾölơk Ŏ5 ŧö ǂ ĂƧös!ƒ Ƙƒ þǤ ư dž!ƒ ýdž ǈdžƒƨk!Ǥh Ƙƒ þöƑĂƧök ǂ !ƒ Ďƒ þƤk ǂ ƒ ŧdžNjǤ ǂ dž ăþdž þþơk :ƘǾǤǁǁƐ Ƹǫǁǰ
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Anaesthesia And Intensive Care Medicine

التخدير والعناية المركزة

Effects of Dexmedetomidine and Propofol on Lower Esophageal Sphincter and Gastroesophageal Pressure Gradient in Healthy Volunteers

[illegible] Dexmedetomidine [illegible] Propofol [illegible]

Turan A, et al.
Anesthesiology 2009 Nov 30.

Background: Many anesthetics reduce lower esophageal sphincter pressure (LESP). Reduced pressure and consequent reduction in the gastroesophageal pressure gradient (GEPG) thus promotes gastroesophageal reflux and may contribute to aspiration pneumonia and associated morbidity. Therefore, the authors compared LESP and GEPG during dexmedetomidine and propofol sedation.

Methods: Using a randomized, double-blind, crossover design, 11 healthy volunteers were sedated on 2 separate days. Baseline LESP and GEPG were recorded each day. Subsequently, on each day volunteers received three 40-min-long sedative infusions of increasing doses of 0.6, 1.2, and 2.4 ng/ml dexmedetomidine or 1, 2, and 4 mug/ml propofol. LESP and GEPG were recorded during inhalation and expiration at 20 and 40 min after starting each

infusion phase, and these measurements were averaged. Results are presented as mean (95% confidence interval).
Results: Two subjects did not return for the dexmedetomidine study day, and the dexmedetomidine results were unusable in another; propofol results in these volunteers were nonetheless retained for analysis. There were no significant differences in LESP and GEPG as a function of drug. However, there was a small but significant 7.4 (-1.6 to -13.2) mmHg (approximately 25%) dose-dependent decrease in LESP over the range of targeted low to high blood levels of each drug.
Conclusions: Both dexmedetomidine and propofol have similar effects on LESP and GEPG. Although both of the drugs cause some decrease in LESP at high concentrations, it is unlikely that this effect would promote gastroesophageal reflux during sedation.

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Ophthalmology

الأمراض العينية

Minimally Invasive Strabismus Surgery Technique in Horizontal Rectus Muscle Surgery for Esotropia

[illegible]

Pellanda N, et al.
Ophthalmologica 2009 Aug 26;224(2):67-71.

Purpose: To evaluate the minimally invasive strabismus surgery (MISS) technique in combined unilateral horizontal rectus muscle operations for esotropia.

Methods: This study included 61 patients operated by one surgeon with MISS medial rectus muscle recession and lateral rectus muscle plication. Alignment, binocular vision, conjunctival injection and swelling as well as complications during the first 6 postoperative months were recorded prospectively. Conjunctival swelling and injection on postoperative day 1 were scored retrospectively and compared to a study, which included patients operated with a limbal approach.

Results: Conjunctival swelling and injection were less pronounced than following surgery with limbal approach (comparison of swelling and injection: p<0.001 for MISS vs. limbal opening plication and p<0.001 for MISS vs. limbal opening resection). A conversion to a limbal opening was necessary in 2.4% of muscles. No scleral perforation or other serious complication was observed.

Conclusions: This study indicates that MISS induces less conjunctival swelling and injection compared to the usual limbal approach.

[illegible] MISS [illegible] (recession [illegible] 61 [illegible] (limbal approach) [illegible]

[illegible] MISS [illegible] p<0.001 [illegible] %2.4 [illegible]

[illegible] MISS [illegible]

دليل النشر في مجلة المجلس العربي للاختصاصات الصحية

تتبع المقالات المرسلة إلى مجلة المجلس العربي للاختصاصات الصحية الخطوط التالية المعتمدة من قبل الهيئة الدولية لمحرري المجلات الطبية URM، وإن النص الكامل لها موجود على الموقع الألكتروني www.icmje.org

1- المقالات التي تتضمن بحثاً أصيلاً يجب أن لا تكون قد نشرت سابقاً بشكل كامل مطبوعة أو بشكل نص الكتروني، ويمكن نشر الأبحاث التي سبق أن قدمت في لقاءات طبية.

2- تخضع كافة المقالات المرسلة إلى المجلة للتقييم من قبل لجنة تحكيم مؤلفة من عدد من الاختصاصيين، بشكل ثنائي التعمية، بالإضافة إلى تقييمها من قبل هيئة التحرير. يمكن للمقالات أن تقبل مباشرة بعد تحكيمها، أو تعاد إلى المؤلفين لإجراء التعديلات المطلوبة، أو ترفض.

3- تقبل المقالات باللغتين العربية أو الانكليزية. يجب أن ترسل صفحة العنوان باللغتين العربية والانكليزية، متضمنة عنوان المقال وأسماء الباحثين بالكامل باللغتين مع ذكر صفاتهم العلمية. يجب استخدام الأرقام العربية (1، 2، 3...) في كافة المقالات.

4- يجب أن تطابق المصطلحات الطبية الواردة باللغة العربية ما ورد في المعجم الطبي الموحد (موجود على الموقع الالكتروني www.emro.who.int/umd/ أو www.emro.who.int/ahsn)، مع ذكر الكلمة العلمية باللغة الانكليزية أو اللاتينية أيضاً (يمكن أيضاً إضافة المصطلح الطبي المستعمل محلياً بين قوسين).

5- يجب احترام حق المريض في الخصوصية مع حذف المعلومات التي تدل على هوية المريض إلا في حالات الضرورة التي توجب الحصول على موافقة المريض عند الكشف عن هويته بالصور أو غيرها.

6- تذكر أسماء الباحثين الذين شاركوا في البحث بصورة جدية، يجب تحديد باحث أو أثنين للتكفل بموضوع المراسلة حول الشؤون المتعلقة بالبحث مع ذكر عنوان المراسلة والبريد الالكتروني.

7- يجب أن تتبع طريقة كتابة المقال مايلي:

- يكتب المقال على وجه واحد من الورقة وبمسافة مضاعفة بين الأسطر (تنسيق الفقرة بتباعد أسطر مزدوج)، ويبدأ كل جزء بصفحة جديدة. ترقم الصفحات بشكل متسلسل ابتداء من صفحة العنوان، يليها الملخص، النص، ومن ثم الشكر والمراجع، يلي ذلك الجداول ثم التعليق على الصور والأشكال. يجب أن لا تتجاوز الأشكال الإيضاحية 203×254 ملم (8×10 بوصة)، مع هوامش لا تقل عن 25 ملم من كل جانب (1بوصة). ترسل كافة المقالات منسوخة على قرص مكتنز CD، مع إرسال الورقة الأصلية مع 3 نسخ. يمكن إرسال المقالات بالبريد الالكتروني على jabms@scs-net.org إذا أمكن من الناحية التقنية. يجب ان يحتفظ الكاتب بنسخ عن كافة الوثائق المرسلة.
- البحث الأصيل يجب أن يتضمن ملخصاً مفصلاً باللغتين العربية والانكليزية لا يتجاوز 250 كلمة يشمل أربع فقرات على الشكل التالي: هدف الدراسة، طريقة الدراسة، النتائج، والاستنتاجات.
- البحث الأصيل يجب ألا يتجاوز 4000 كلمة (عدا المراجع)، وأن يتضمن الأجزاء التالية: المقدمة، طرق البحث، النتائج، المناقشة، والاستنتاجات. يجب إيراد شرح وافي عن طريقة الدراسة مع تحديد مجموعة الدراسة وكيفية اختيارها، وذكر الأدوات والأجهزة المستعملة (نوعها واسم الشركة الصانعة) والإجراءات المتبعة في الدراسة بشكل واضح للسماح بإمكان تكرار الدراسة ذاتها. الطرق الإحصائية يجب أن تذكر بشكل واضح ومفصل للتمكن من التحقق من نتائج الدراسة. يجب ذكر الأسس العلمي لكافة الأدوية والمواد الكيميائية المستخدمة، مع تحديد الجرعات وطرق الإعطاء المعتمدة. يجب استخدام الجداول والصور والأشكال لدعم موضوع المقال، كما يمكن استخدام الأشكال كبديل عن الجداول مع مراعاة عدم تكرار نفس المعطيات في الجداول والأشكال. يجب أن يتناسب عدد الجداول والأشكال المستخدمة مع طول المقال، ومن المفضل عموماعدم استخدام أكثر من ستة جداول في المقال الواحد. يجب أن تتضمن المناقشة النقاط الهامة في الدراسة والاستنتاجات المستخلصة منها، مع ذكر تطبيقات وانعكاسات النتائج ومحدوديتها، مع مقارنة نتائج الدراسة بدراسات مماثلة، مع تجاوب دراسات غير مثبتة بالمعطيات. توصيات الدراسة تذكر حسب الضرورة.
- الدراسات في الأدب الطبي يفضل أن لا تتجاوز 6000 كلمة (عدا المراجع)، وبنية المقال تتبع الموضوع.
- تقبل تقارير الحالات الطبية حول الحالات الطبية السريرية النادرة. مع ضرورة إيراد ملخص موجز عن الحالة.
- تقبل اللوحات الطبية النادرة ذات القيمة التعليمية.
- يمكن استعمال الاختصارات المعروفة فقط، يجب ذكر التعبير الكامل للاختصار عند وروده الأول في النص باستثناء وحدات القياس المعروفة.
- يستعمل المقياس المتري (م، كغ، لتر) لقياسات الطول والارتفاع والوزن والحجم، والدرجة المئوية لقياس درجات الحرارة، والمليمترات الزئبقية لقياس ضغط الدم. كافة القياسات الدموية والكيماوية السريرية تذكر بالمقياس المتري تبعاً للقياسات العالمية SI.
- فقرة الشكر تتضمن الأشخاص الذين أدوا مساعدات تقنية، مع ضرورة ذكر الجهات الداعمة من حيث توفير المواد أو الدعم المالي.
- المراجع يجب أن ترقم بشكل تسلسلي حسب ورودها في النص، ترقم المراجع المذكورة في الجداول والأشكال حسب موقعها في النص. يجب أن تتضمن المراجع أحدث ما نشر من معلومات. تختصر أسماء المجلات حسب ورودها في Index Medicus ، يمكن الحصول على قائمة الاختصارات من الموقع الالكتروني www.nlm.nih.gov يجب أن تتضمن المراجع المكتوبة معطيات كافية تمكن من الوصول إلى المصدر الرئيسي، مثال: مرجع المجلة الطبية يتضمن اسم الكاتب (يتضمن جميع المشاركين)، عنوان المقال، اسم المجلة، سنة الإصدار، رقم المجلد ورقم الصفحة. أما مرجع الكتاب فيتضمن اسم الكاتب (جميع المشاركين)، المحرر، الناشر، مؤسسة النشر ومكانها، رقم الجزء ورقم الصفحة. للحصول على تفاصيل أوفى حول كيفية كتابة المراجع الأخرى يمكن زيارة الموقع الالكتروني www.icmje.org مع التأكيد على مسؤولية الكاتب عن دقة المراجع الواردة في المقال.

8- إن المقالات التي لا تحقق النقاط السابقة تعاد إلى الكاتب لتصحيحها قبل إرسالها إلى هيئة التحكيم.

هذه المجلة مفهرسة في سجل منظمة الصحة العالمية IMEMR Current Contents
http://www.emro.who.int/HIS/VHSL/Imemr.htm

مجلة المجلس العربي للاختصاصات الصحية

مجلة المجلس العربي للاختصاصات الصحية هي مجلة طبية محكمة تصدر كل ثلاثة أشهر، تعنى بكافة الاختصاصات الطبية، تهدف إلى نشر أبحاث الأطباء العرب لتقوية التبادل العلمي والطبي بين البلدان العربية، كما تقوم المجلة أيضاً بنشر ملخصات منتقاة من المقالات المهمة المنشورة في المجلات العلمية والطبية العالمية، مع ترجمة هذه الملخصات إلى اللغة العربية بهدف تسهيل إيصالها إلى الطبيب العربي، علاوة على ذلك تعمل المجلة على نشر أخبار وأنشطة المجلس العربي للاختصاصات الصحية .

ترسل كافة المراسلات إلى العنوان التالي:

مجلة المجلس العربي للاختصاصات الصحية

المجلس العربي للاختصاصات الصحية

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جامعة
الدول العربية

أخبار وأنشطة المجلس العربي للاختصاصات الصحية
خلال الفترة من 2009/9/1 لغاية 2009/12/31
أنشطة المجالس العلمية

اجتماع المكتب التنفيذي للهيئة العليا

عقد المكتب التنفيذي للهيئة العليا للمجلس العربي للاختصاصات الصحية اجتماعه في دمشق خلال الفترة 16-2009/12/17 حيث ناقش السادة الأعضاء المواضيع المدرجة على جدول الأعمال وأهمها توصيات المجلس العلمي الاستشاري وتوصيات اجتماع رؤساء الهيئات المحلية والنظام الداخلي للمجلس العربي للاختصاصات الصحية واتخذ السادة الأعضاء العديد من القرارات الهامة التي سيتم عرضها في اجتماع الهيئة العليا القادم.

اختصاص التشخيص الشعاعي

1- الامتحان الأولي لاختصاص التشخيص الشعاعي:

جرى الامتحان الأولي لاختصاص التشخيص الشعاعي الدورة الثانية لامتحان الجزء الأول بتاريخ 2009/10/19 في المراكز التالية: دمشق، وصنعاء، والدوحة، والرياض، وعمان، وبغداد. وقد تقدم لهذا الامتحان 79 طبيباً، نجح منهم 49 طبيباً، أي أن نسبة النجاح هي 62%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	5	4	%80
الدوحة	9	5	%55.5
صنعاء	15	7	%46.6
الرياض	15	4	%26.6
عمان	12	6	%50
بغداد	23	23	%100
المجموع	79	49	%62

2- الامتحان النهائي الكتابي لاختصاص التشخيص الشعاعي:

جرى الامتحان النهائي الكتابي لاختصاص التشخيص الشعاعي بتاريخ 2009/10/19 في المراكز التالية: دمشق، وصنعاء، والدوحة، والرياض، وعمان. وقد تقدم لهذا الامتحان 79 طبيباً، نجح منهم 35 طبيباً، أي أن نسبة النجاح هي 44.3%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	21	6	%28.5
الدوحة	16	9	%56.25
صنعاء	24	12	%50
الرياض	8	3	%37.5
عمان	10	5	%50
المجموع	79	35	%44.3

3- الامتحان النهائي السريري والشفوي لاختصاص التشخيص الشعاعي:

جرى الامتحان النهائي السريري والشفوي لاختصاص التشخيص الشعاعي خلال الفترة الواقعة 9-2009/12/10، في مقر الأمانة العامة للمجلس العربي للاختصاصات الصحية وقد تقدم لهذا الامتحان 40 طبيباً، نجح منهم 28 طبيباً، أي أن نسبة النجاح هي 70%.

اختصاص التخدير والعناية المركزة

1- الامتحان السريري لاختصاص التخدير والعناية المركزة:

جرى الامتحان السريري لاختصاص التخدير والعناية المركزة في مشفى الأسد الجامعي في دمشق خلال الفترة الواقعة 12-2009/12/15. وقد تقدم لهذا الامتحان 30 طبيباً، نجح منهم 18 طبيباً، أي أن نسبة النجاح هي60%.

2- اجتماع لجنة الامتحانات لاختصاص التخدير والعناية المركزة:

اجتمعت لجنة الامتحانات لاختصاص التخدير والعناية المركزة مع الأستاذ الدكتور أنيس بركة رئيس المجلس العلمي والأستاذ الدكتور عبد الحميد السعيد نائب رئيس المجلس العلمي والأستاذ الدكتور علي أرناؤوط مقرر المجلس العلمي والأستاذ الدكتور عبد الحميد الفلاح مقرر لجنة الامتحانات وبحضور أعضاء لجنة الامتحانات في دمشق مقر الأمانة العامة خلال الفترة الواقعة بين 12-2009/12/15.

اختصاص الأمراض الجلدية والتناسلية

1- الامتحان الأولي لاختصاص الأمراض الجلدية والتناسلية:

جرى الامتحان الأولي لاختصاص الأمراض الجلدية والتناسلية بتاريخ

2009/10/31 في المراكز التالية: دمشق، والرياض، والدوحة، وطرابلس، وصنعاء. وقد تقدم لهذا الامتحان 108 أطباء، نجح منهم 68 طبيباً، أي أن نسبة النجاح هي 62%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الرياض	22	14	%63
بغداد	23	20	%86
دبي	10	6	%60
دمشق	26	10	%38
صنعاء	10	7	%70
طرابلس	17	11	%64
المجموع	108	68	%62

2- الامتحان النهائي الكتابي لاختصاص الأمراض الجلدية والتناسلية:

جرى الامتحان النهائي الكتابي لاختصاص الأمراض الجلدية والتناسلية بتاريخ 2009/10/31 في مركز دمشق. وقد تقدم لهذا الامتحان 30 طبيباً، نجح منهم 20 طبيباً، أي أن نسبة النجاح هي 66%.

3- الامتحان السريري والشفوي الاستثنائي لاختصاص الأمراض الجلدية والتناسلية:

جرى الامتحان السريري والشفوي الاستثنائي لاختصاص الأمراض الجلدية والتناسلية في مركز دمشق خلال الفترة الواقعة 1-2/11/2009 في مركز دمشق. وقد تقدم لهذا الامتحان 29 طبيباً، نجح منهم 15 طبيباً، أي أن نسبة النجاح هي 51%.

4- اجتماع اللجنة التنفيذية لاختصاص الأمراض الجلدية والتناسلية:

اجتمعت اللجنة التنفيذية لاختصاص الأمراض الجلدية والتناسلية بتاريخ 2009/11/3.

اختصاص طب الأطفال

1- الامتحان السريري والشفوي لاختصاص طب الأطفال:

جرى الامتحان السريري والشفوي لاختصاص طب الأطفال بتاريخ 2009/10/18 في مركز دمشق. وقد تقدم لهذا الامتحان 18 طبيباً، نجح منهم 6 أطباء، أي أن نسبة النجاح هي 37%.

2- الامتحان الأولي لاختصاص طب الأطفال:

جرى الامتحان الأولي لاختصاص طب الأطفال بتاريخ 2009/11/8 في المراكز التالية: اربد، ودبي، والمنامة، والرياض، وبغداد، وصنعاء، وجدة، ومسقط، ودمشق، وطرابلس، وقطر، وبيروت. وقد تقدم لهذا الامتحان 474 طبيباً، نجح منهم 255 طبيباً، أي أن نسبة النجاح هي 53%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
اربد	17	9	%53
دبي	25	13	%52
المنامة	17	8	%47
الرياض	59	33	%56
بغداد	73	45	%61
صنعاء	60	37	%61
جدة	43	24	%56
مسقط	19	10	%52
دمشق	80	49	%61
طرابلس	58	20	%34
قطر	14	5	%36
بيروت	9	2	%22
المجموع	474	255	%53.7

3- الامتحان النهائي لاختصاص طب الأطفال:

جرى الامتحان النهائي لاختصاص طب الأطفال بتاريخ 2009/11/9 في المراكز التالية: اربد، ودبي، والمنامة، والرياض، وبغداد، وصنعاء، وجدة، ومسقط، ودمشق، وطرابلس، والدوحة. وقد تقدم لهذا الامتحان 289 طبيباً، نجح منهم 220 طبيباً، أي أن نسبة النجاح هي 76%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
اربد	14	11	%78
دبي	7	6	%86
المنامة	11	9	%81
الرياض	53	43	%81
صنعاء	40	26	%66
بغداد	32	29	%90
جدة	29	21	%72
مسقط	7	7	%100
الدوحة	16	14	%87
طرابلس	24	15	%62
دمشق	56	39	%70
المجموع	289	220	%76

اختصاص الجراحة

1- اجتماع لجنة الامتحانات لاختصاص الجراحة العامة:

اجتمعت لجنة الامتحانات لاختصاص الجراحة العامة خلال الفترة 30/9-2/10/2009 وذلك لوضع أسئلة امتحان الجزء الأول والجزء النهائي الكتابي لدورة تشرين الثاني/2009.

2- الامتحان الأولي لاختصاص الجراحة العامة:

جرى الامتحان الأولي لاختصاص الجراحة العامة بتاريخ 11/1/ 2009 في كل من المراكز التالية: دمشق، والرياض، واربد، وصنعاء، والخرطوم، والدوحة، وطرابلس، والقاهرة، وبغداد. وقد تقدم لهذا الامتحان 329 طبيباً، نجح منهم 136 طبيباً، أي أن نسبة النجاح هي 41%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الخرطوم	14	7	%50
الدوحة	23	6	%26
الرياض	27	7	%26
القاهرة	8	0	%0
اربد	39	19	%49
بغداد	107	69	%64
دمشق	55	7	%13
صنعاء	52	20	%38
طرابلس	4	1	%25
المجموع	329	136	%41

3- الامتحان النهائي الكتابي لاختصاص الجراحة العامة:

جرى الامتحان النهائي الكتابي لاختصاص الجراحة العامة بتاريخ 2009/11/1 في كل من المراكز التالية: دمشق، والرياض، واربد، والدوحة، وطرابلس، والقاهرة، وصنعاء، وبغداد. وقد تقدم لهذا الامتحان 144 طبيباً، نجح منهم 62 طبيباً، أي أن نسبة النجاح هي 43%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الدوحة	9	4	%44
الرياض	16	10	%63
القاهرة	1	0	%0
اربد	16	5	%31
بغداد	45	28	%62
دمشق	43	8	%19
صنعاء	13	7	%54
طرابلس	1	0	%0
المجموع	144	62	%43

4- الامتحان النهائي الكتابي لاختصاص الجراحة البولية:

جرى الامتحان النهائي الكتابي لاختصاص الجراحة البولية بتاريخ 2009/11/1 في كل من المراكز التالية: دمشق، والرياض، وصنعاء، والدوحة، واربد. وقد تقدم لهذا الامتحان 22 طبيباً، نجح منهم 13 طبيباً، أي أن نسبة النجاح هي 59%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الدوحة	3	1	%33
الرياض	1	1	%100
اربد	2	2	%100
دمشق	10	3	%30
صنعاء	6	6	%100
المجموع	22	13	%59

5- الامتحان النهائي الكتابي لاختصاص الجراحة العصبية:

جرى الامتحان النهائي الكتابي لاختصاص الجراحة العصبية بتاريخ 2009/11/1 في كل من المراكز التالية: دمشق، وصنعاء، والدوحة. وقد تقدم لهذا الامتحان 4 أطباء، نجح منهم 3 أطباء، أي أن نسبة النجاح هي 75%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الدوحة	1	1	%100
دمشق	1	0	%0
صنعاء	2	2	%100
المجموع	4	3	%75

6- الامتحان النهائي الكتابي لاختصاص الجراحة العظمية:

جرى الامتحان النهائي الكتابي لاختصاص الجراحة العظمية بتاريخ 2009/11/1 في كل من المراكز التالية: دمشق، وصنعاء، والدوحة، والرياض، واربد. وقد تقدم لهذا الامتحان 29 طبيباً، نجح منهم 16 طبيباً، أي أن نسبة النجاح هي 55%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الدوحة	4	1	%25
الرياض	2	2	%100
اربد	12	5	%42
دمشق	6	3	%50
صنعاء	5	5	%100
المجموع	29	16	%55

7- الامتحان النهائي الكتابي لاختصاص جراحة الأطفال:

جرى الامتحان النهائي الكتابي لاختصاص جراحة الأطفال بتاريخ 2009/11/1 في مركز دمشق. وقد تقدم لهذا الامتحان 5 أطباء، نجح منهم 5 أطباء، أي أن نسبة النجاح هي 100%.

8- الامتحان السريري لاختصاص الجراحة العامة:

جرى الامتحان السريري لاختصاص الجراحة العامة بتاريخ 15- 2009/12/16 في مركز دمشق. وقد تقدم لهذا الامتحان 63 طبيباً،

نجح منهم 16 طبيباً، أي أن نسبة النجاح هي 25%.

اختصاص جراحة الفم والوجه والفكين

1- الامتحان الأولي لاختصاص جراحة الفم والوجه والفكين:
جرى الامتحان الأولي لاختصاص جراحة الفم والوجه والفكين بتاريخ 2009/10/10 في مركزين امتحانيين: دمشق، وبغداد. وقد تقدم لهذا الامتحان 21 طبيباً، نجح منهم 13 طبيباً، أي أن نسبة النجاح هي 62%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
بغداد	5	5	%100
دمشق	16	8	%53
المجموع	21	13	%62

2- الامتحان النهائي الكتابي لاختصاص جراحة الفم والوجه والفكين:
جرى الامتحان النهائي الكتابي لاختصاص جراحة الفم والوجه والفكين بتاريخ 2009/10/10 في مركز دمشق. وقد تقدم لهذا الامتحان 20 طبيباً، نجح منهم 11 طبيباً، أي أن نسبة النجاح هي 55%.

3- الامتحان السريري والشفوي لاختصاص جراحة الفم والوجه والفكين:
جرى الامتحان السريري والشفوي لاختصاص جراحة الفم والوجه والفكين بتاريخ 2009/10/11 في دمشق في مشفى الجامعة- كلية طب الأسنان- جامعة دمشق. وقد تقدم لهذا الامتحان 11 طبيباً، نجح منهم 6 أطباء، أي أن نسبة النجاح هي 54%.

4- المجلس العلمي لاختصاص جراحة الفم والوجه والفكين:
اجتمع المجلس العلمي لاختصاص جراحة الفم والوجه والفكين بتاريخ 2009/10/13 في دمشق. وقد تم اعتماد نتائج الامتحانات للاختصاص لسنة 2009.

اختصاص الأمراض الباطنة

1- الامتحان السريري الاستثنائي لاختصاص الأمراض الباطنة:
جرى الامتحان السريري الاستثنائي لاختصاص الأمراض الباطنة بتاريخ 2009/10/1-9/28 في مركز دمشق- الجمهورية العربية السورية. وقد تقدم لهذا الامتحان 45 طبيباً، نجح منهم 13 طبيباً، أي أن نسبة النجاح هي 28%.

2- اجتماع لجنة الامتحانات لاختصاص الأمراض الباطنة:
اجتمعت لجنة الامتحانات لاختصاص الأمراض الباطنة بتاريخ 2009/10/7-3 وذلك لوضع أسئلة الامتحانات الأولي والنهائي.

3- اجتماع لجنة الامتحانات لاختصاص أمراض القلب والأوعية الدموية:
اجتمعت لجنة الامتحانات لاختصاص أمراض القلب والأوعية الدموية بتاريخ 2009/10/4-3 وذلك لوضع أسئلة الامتحان النهائي.

4- اجتماع اللجنة التنفيذية لاختصاص الأمراض الباطنة:
اجتمعت اللجنة التنفيذية لاختصاص الأمراض الباطنة بتاريخ 2009/10/7 وذلك لمناقشة الشؤون الإجرائية وشؤون الامتحان والتدريب.

5- الامتحان الأولي والنهائي الكتابي لاختصاص الأمراض الباطنة:
جرى الامتحان الأولي والنهائي الكتابي لاختصاص الأمراض الباطنة بتاريخ 2009/12/9-8.

6- الامتحان النهائي الكتابي لاختصاص أمراض القلب والأوعية الدموية:
جرى الامتحان النهائي الكتابي لاختصاص أمراض القلب والأوعية الدموية بتاريخ 2009/12/9-8.

اختصاص الأذن والأنف والحنجرة

1- الامتحان الأولي والنهائي الكتابي لاختصاص الأذن والأنف والحنجرة:
جرى الامتحان الأولي والنهائي الكتابي لاختصاص الأذن والأنف والحنجرة بتاريخ 2009/10/3 في المراكز التالية: دمشق، والرياض، وصنعاء، والعراق، ومسقط. وقد تقدم لهذا الامتحان 64 طبيباً، نجح منهم 33 طبيباً، أي أن نسبة النجاح هي 27%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	22	6	%27
الرياض	7	4	%57
صنعاء	3	3	%100
العراق	26	20	%76
مسقط	6	0	%0
المجموع	64	33	%27

2- الامتحان النهائي الكتابي لاختصاص الأذن والأنف والحنجرة:
جرى الامتحان النهائي الكتابي لاختصاص الأذن والأنف والحنجرة بتاريخ 2009/10/3 في المراكز التالية: دمشق، والرياض، وصنعاء، والعراق، ومسقط. وقد تقدم لهذا الامتحان 80 طبيباً، نجح منهم 42 طبيباً، أي أن نسبة النجاح هي 52%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	31	16	%51
الرياض	9	7	%57
صنعاء	6	1	%16
العراق	22	13	%59
مسقط	12	5	%41
المجموع	80	42	%52

3- الامتحان السريري والشفوي لاختصاص الأذن والأنف والحنجرة:

جرى الامتحان السريري والشفوي لاختصاص الأذن والأنف والحنجرة بتاريخ 14-2009/11/15 في مركز دمشق. وقد تقدم لهذا الامتحان 42 طبيباً، نجح منهم 20 طبيباً، أي أن نسبة النجاح هي 47.5%.

اختصاص النسائية والتوليد

1- الامتحان الأولي لاختصاص النسائية والتوليد:

جرى الامتحان الأولي لاختصاص النسائية والتوليد بتاريخ 2009/10/18 في المراكز التالية: الإمارات، وعمان، والبحرين، والرياض، ودمشق، وبغداد، والدوحة، وطرابلس، وبنغازي، وصنعاء. وقد تقدم لهذا الامتحان 185 طبيباً، نجح منهم 105 أطباء، أي أن نسبة النجاح هي 56%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
الإمارات	16	9	%56
عمان	12	7	%58
البحرين	2	1	%50
الرياض	11	7	%63
دمشق	17	10	%58
بغداد	43	37	%86
الدوحة	8	5	%62
طرابلس	23	6	%26
بنغازي	14	4	%28
صنعاء	39	19	%48
المجموع	185	105	%56

2- الامتحان النهائي الكتابي لاختصاص النسائية والتوليد:

جرى الامتحان النهائي الكتابي لاختصاص النسائية والتوليد بتاريخ 2009/10/18 في المراكز الامتحانية التالية: عمان، والبحرين، الرياض، ودمشق، وبغداد، الدوحة، وطرابلس، وبنغازي، وصنعاء، ودبي. وقد تقدم لهذا الامتحان 196 طبيباً، نجح منهم 114 طبيباً، أي أن نسبة النجاح 58%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
عمان	9	2	%22
البحرين	7	2	%28
الرياض	15	11	%73
دمشق	25	14	%56
بغداد	39	37	%94
الدوحة	6	4	%66
طرابلس	37	18	%48
بنغازي	17	4	%23
صنعاء	32	17	%53
دبي	9	5	%55
المجموع	196	114	%58

3- امتحان الأوسكي لاختصاص النسائية والتوليد:

عقد امتحان الأوسكي لاختصاص النسائية والتوليد بتاريخ 16-2009/12/17 في مركز الرياض- المملكة العربية السعودية. وقد تقدم لهذا الامتحان 14 طبيباً، نجح منهم 12 طبيباً، أي أن نسبة النجاح هي 85.7%.

اختصاص طب العيون وجراحتها

1- اجتماع لجنة التدريب والتوصيف وشؤون الاعتراف لاختصاص طب العيون وجراحتها:

اجتمعت لجنة التدريب والتوصيف وشؤون الاعتراف لاختصاص طب العيون وجراحتها بتاريخ 2009/10/3 وذلك لدراسة طلبات المتقدمين للامتحان الأولي والنهائي الكتابي لاختصاص طب العيون وجراحتها لدورة تشرين الثاني/2009.

2- اجتماع لجنة الامتحانات لاختصاص طب العيون وجراحتها:

اجتمعت لجنة الامتحانات في الفترة الواقعة 6-2009/10/8 لوضع أسئلة الامتحان الأولي والنهائي الكتابي لاختصاص طب العيون وجراحتها لدورة تشرين الثاني/2009.

3- الامتحان الأولي الكتابي لاختصاص طب العيون وجراحتها:

جرى الامتحان الأولي الكتابي لاختصاص طب العيون وجراحتها بتاريخ 2009/11/4 في المراكز الامتحانية التالية: دمشق، وبغداد، والدوحة، وصنعاء، وعمان. وقد تقدم لهذا الامتحان 52 طبيباً، نجح منهم 25 طبيباً، أي أن نسبة النجاح 48%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	8	1	%12.5
بغداد	17	12	%70
الدوحة	6	0	%0
صنعاء	13	10	%76
عمان	8	2	%25
المجموع	52	25	%48

4- الامتحان النهائي الكتابي لاختصاص طب العيون وجراحتها:
جرى الامتحان النهائي الكتابي لاختصاص طب العيون وجراحتها بتاريخ 2009/11/4 في المراكز الامتحانية التالية: دمشق، وبغداد، والدوحة، وصنعاء، وعمان. وقد تقدم لهذا الامتحان 43 طبيباً، نجح منهم 24 طبيباً، أي أن نسبة النجاح 55%. وفيما يلي نسب النجاح حسب المراكز الامتحانية التالية:

اسم المركز	عدد المتقدمين	عدد الناجحين	%
دمشق	12	8	%66
بغداد	15	8	%53
الدوحة	4	3	%75
صنعاء	10	3	%30
عمان	2	2	%100
المجموع	43	24	%55

4- الامتحان النهائي الشفوي والسريري لاختصاص طب العيون وجراحتها:
جرى الامتحان النهائي الشفوي والسريري لاختصاص طب العيون وجراحتها بتاريخ 19-2009/12/21. وقد تقدم لهذا الامتحان 43 طبيباً، نجح منهم 10 أطباء، أي أن نسبة النجاح 23%.

اختصاص طب الأسرة والمجتمع

1- اجتماع اللجنة التنفيذية لاختصاص طب الأسرة والمجتمع:
اجتمعت اللجنة التنفيذية التابعة للمجلس العلمي لاختصاص طب الأسرة والمجتمع بتاريخ 2009/9/29 في مقر الأمانة العامة بدمشق بحضور الأمين العام المكلف الأستاذ الدكتور محمد هشام السباعي ورئيس المجلس العلمي الأستاذ الدكتور فيصل الناصر ونائب الرئيس الأستاذ الدكتور عبد الله باحطاب ومقرر المجلس العلمي الأستاذ الدكتور غسان حمادة بالإضافة إلى الأستاذ الدكتور سليمان الشمري مقرر لجنة الامتحانات والأستاذ الدكتور عادل كاظم مقرر لجنة التدريب ونائب مقرر لجنة التدريب محسن جاد الله. تمت مناقشة قرارات المجلس العلمي الاستشاري الذي عقد خلال الفترة 28-2008/10/30 وقد تم رفع الكثير من التوصيات المتعلقة بشؤون التدريب والامتحانات.

2- الامتحان الأولي الكتابي لاختصاص طب الأسرة والمجتمع:
جرى الامتحان الأولي الكتابي لاختصاص طب الأسرة والمجتمع بتاريخ 2009/12/13 في المراكز الامتحانية التالية: صنعاء، والدوحة، وبغداد، ودمشق. وسيتم تصحيح أوراق الإجابة بتاريخ 2010/1/9.

3- الامتحان النهائي والشفوي لاختصاص طب الأسرة والمجتمع:
جرى الامتحان النهائي الشفوي (مناقشة رسائل بحث) لاختصاص طب الأسرة والمجتمع بتاريخ 2009/10/17 في مقر الأمانة العامة بدمشق وقد تقدم لهذا الامتحان 10 أطباء حسب الجدول التالي:

اسم المركز	عدد المتقدمين	عدد الناجحين
مؤسسة حمد الطبية	8	3 أطباء /نجاح/ 5 أطباء /نجاح مشروط/
وزارة الصحة- عمان	2	طبيب /نجاح مشروط/ طبيب واحد /إعادة الامتحان الشفوي/

اختصاص طب الطوارئ

1- الامتحان الأولي الكتابي لاختصاص طب الطوارئ:
جرى الامتحان الأولي الكتابي لاختصاص طب الطوارئ بتاريخ 2009/12/22 في كل من المراكز التالية: الرياض، والدوحة، والبحرين، وبغداد، ودمشق، وسلطنة عمان، وصنعاء.

2- الامتحان النهائي الكتابي لاختصاص طب الطوارئ:
جرى الامتحان النهائي الكتابي لاختصاص طب الطوارئ بتاريخ 2009/12/23 في كل من المراكز التالية: الرياض، والدوحة، والبحرين، ودمشق، وسلطنة عمان، وصنعاء. وسيتم تصحيح أوراق الإجابة بتاريخ 2010/2/3.

اختصاص الطب النفسي

1- الامتحان الأولي والنهائي الكتابي لاختصاص الطب النفسي:
جرى الامتحان الأولي والنهائي الكتابي لاختصاص الطب النفسي بتاريخ 2009/10/31 في المراكز الامتحانية التالية: دمشق، والمنامة، والرياض، والخبر، والخرطوم. حيث كان عدد المتقدمين للامتحان الأولي 39 طبيباً، نجح منهم 15 طبيباً، أي أن نسبة النجاح هي 38.4%. وكان عدد المتقدمين للامتحان النهائي الكتابي 40 طبيباً، نجح منهم 35 طبيباً، أي أن نسبة النجاح هي 87.5%.

2- الامتحان السريري والشفوي لاختصاص الطب النفسي:
جرى الامتحان السريري والشفوي لاختصاص الطب النفسي خلال الفترة الواقعة ما بين 11-2009/12/13 في مشفى الرشيد، عمان، في المملكة الأردنية الهاشمية. وكان عدد المتقدمين 57 طبيباً، نجح منهم 27 طبيباً، أي أن نسبة النجاح هي 47%.

خريجو المجلس العربي للاختصاصات الصحية
من 2009/9/1 لغاية 2009/12/31

اختصاص الأمراض الباطنة

اسم الطبيب	مركز التدريب
سالم أحمد ثانية	م. الحسين الطبية- عمان
محمد عبد الحسيب محمد اليافي	م. السلمانية الطبي- المنامة
حكم عبد الله الزعيم	م. المواساة الجامعي- دمشق
ضحى عبد الحميد جويحان	م. المواساة الجامعي- دمشق
فهمي سلطان أحمد عثمان	م. المواساة الجامعي- دمشق
نائل علي حسن	م. المواساة الجامعي- دمشق
نسرين خضر شيخ سليمان	م. المواساة الجامعي- دمشق
نصر موسى الحريري	م. المواساة الجامعي- دمشق
حسين علي مجيد يحيى	م. الموصل التعليمي- الموصل
ليلى ناصر ابراهيم الهيل	م. حمد الطبية- الدوحة
هشام عبد الله محمد	م. حمد الطبية- الدوحة
عبد المنعم عمران زقلوط التومي	م. طرابلس الطبي- طرابلس
وليد محمد سعيد عثمان الصلوي	م. الثورة العام- صنعاء

اختصاص الجراحة العامة

اسم الطبيب	مركز التدريب
فلاح كامل جبرائيل	مدينة الطب- بغداد
حسين عباس عبيد	مدينة الطب- بغداد
لؤي فؤاد حسين	مدينة الطب- بغداد
حسين صالح علي	م. الكاظمية التعليمي- بغداد
لينا زياد طارق طالب العزاوي	دائرة اليرموك الطبية- بغداد
فالح محسن علي	م. البصرة التعليمي- البصرة
منذر وجيه عيسى	م. المواساة الجامعي- دمشق
صلاح سرحان لايقة	م. المواساة الجامعي- دمشق
عبد العزيز رفعت غيبور	م. المواساة الجامعي- دمشق
وسيم عاطف حمد النجم	م. التخصصي- عمان
علي أحمد ضيف	م. السلمانية الطبي- المنامة
عصام سالم عمر باتياه	م. عسير المركزي- أبها
جميلة عبيد أحمد المعاري	م.فهد للحرس الوطني-الرياض
نائف عوض عبد الله الزهراني	م.فهد للحرس الوطني-الرياض
حسين ابراهيم صندقجي	م. فهد- المدينة المنورة
علي عبد المجيد رحيم ساير	م. الجمهوري- صنعاء

اختصاص التخدير والعناية المركزة

اسم الطبيب	مركز التدريب
مروان عبد الحليم الزلق	م. المواساة الجامعي- دمشق
حياة عبد الرحمن سحلول	م. المواساة الجامعي- دمشق
عبد الناصر فرحان الجراد	م. المواساة الجامعي- دمشق
نضال حجازي خلف	م. المواساة الجامعي- دمشق
سامر شومان القهواتي	م. المواساة الجامعي- دمشق
رامز محمد سعيد الطويل	م. المواساة الجامعي- دمشق
شادي أبو راس	م. المواساة الجامعي- دمشق
أميرة أحمد محمد فلمبان	ج. م. عبد العزيز- جدة
أحمد محمد سالم الشريف	م. م. خالد الجامعي- الرياض
منال سراج عمر مشاط	م.م. خالد للحرس الوطني- جدة
جيهان صالح عيسى آل درويش	م. القطيف المركزي- الرياض
منى عبد اللطيف الفرائضي	م. م.خالد للحرس الوطني- جدة
عبد الله سعد يعن لله الغامدي	م. القوات المسلحة- الرياض
أشرف فضل محمد محمد	م. الحسين الطبية- عمان
هشام محمد ابراهيم الزناتي	م. حمد العام- الدوحة
سعيد عبد الغفور محمود	م. حمد العام- الدوحة
صبا خالد مهدي البصام	م. حمد العام- الدوحة
مايا ابراهيم جلبوط	م. الجامعة الأميركية- بيروت

اختصاص الأمراض الجلدية والتناسلية

اسم الطبيب	مركز التدريب
فائزة أحمد عوض الراعي	م. النهضة- مسقط
مريم هاشم سيد شريف الهاشمي	م. المفرق- أبو ظبي
طيبه ابراهيم أحمد الكندي	م. النهضة- مسقط
أمل أحمد ناصر البورسعيدي	م. النهضة- مسقط
هبة عبد الوهاب محمد عبد الوهاب	م. السلمانية الطبي- المنامة
سوزان نبيل عبد الباقي الشربجي	ج. دمشق- دمشق
أسامة محمد محفوظ الشريف	م. عسير المركزي- أبها
علاء الدين خلف محمد الهويش	م. عسير المركزي- أبها
هناء الصغير محمد الدوكالي	م. طرابلس المركزي- طرابلس
مهلهل علي عيسى شاجري	م. عسير المركزي- أبها
فاطمة أحمد علي الكريري	م. عسير المركزي- أبها
نهلاء أحمد عبد الله فارس	م. المفرق- أبو ظبي
لمى غسان قسطنطين	ج. دمشق- دمشق
نوف محمد حسن الصديقي	م. حمد العام- الدوحة
عمران أحمد محمد أبو زريبة	م. طرابلس المركزي- طرابلس

اختصاص النسائية والتوليد

اسم الطبيب	مركز التدريب
شذى عبد الله وقاص	م. الملك خالد الجامعي-الرياض
مراد زاهي العكر	م. الجامعة الأردنية- الرياض
نوف بنت محمد علي الأسمري	م. قوى الأمن العام- الرياض
غادة سمير غراب	م. قوى الأمن- الرياض
عبير محمد الكومي	م. الملك خالد- الرياض
ميسون عبد العزيز المقبل	م.م. فيصل التخصصي- الرياض
هنادي عدنان محمد بخش	م. الملك فهد للحرس- الرياض
عائشة ناصر القحطاني	م. الولادة- الدمام
رضا سعد عبد الحليم شحاته	م.ج. الملك عبد العزيز- الرياض
ياسر صالح صديق صبر	م. م. فهد للحرس- الرياض
فاتن عادل محمد درويش	م. م. فهد للحرس- الرياض
نور محمد علي ابراهيم	م. الولادة- الدمام

خريجو المجلس العربي للاختصاصات الصحية
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صبيحة قمر جاويد	م. الرياض الطبي- الرياض
مريم سعد الدين	م. الجامعة الأردنية- عمان

اختصاص طب الأطفال

اسم الطبيب	مركز التدريب
أحمد ابراهيم كاظم	م. البصرة التعليمي- البصرة
السيد محمد أحمد السيد	م. م. فهد- الباحة
بهاء الدين حسن أحمد جمعة	م. حمد العام- الدوحة
راسم محمد خماس الجميلي	دائرة مدينة الطب- بغداد
منتصر المقداد	م. تشرين العسكري- دمشق
نوال ناصر خميس المسكري	م. السلطاني- عمان

اختصاص التشخيص الشعاعي

اسم الطبيب	مركز التدريب
درهم حسين صالح الفقيه	م. المواساة الجامعي- دمشق
سلام عبد الصاحب جدوع	م. المواساة الجامعي- دمشق
طارق علي علي	م. المواساة الجامعي- دمشق
علي عبد الله أحمد علي الكريمي	م. العسكري العام- صنعاء
زينة مهدي عبد علي الهنداوي	م. العسكري العام- صنعاء
آمال عبد الرحمن أحمد با فقيه	م. الثورة العام- صنعاء
سليم خضير مصلح	م. الثورة العام- صنعاء
كمال محسن العطوي	م. الجمهوري- صنعاء
مروان محمد سيف أحمد حيدر	م. الكويت الجامعي- صنعاء
عالم عبد الرحمن مقبل العريقي	م.الكويت الجامعي- صنعاء
رافد داخل هاشم الأسدي	م. الإسلامي- عمان
وسام أمجد عبد الرزاق أحمد	م. الملك عبد الله- اربد
وليد خلدون محمود الجنابي	م. الحسين الطبية- عمان
ريا جعفر الحيدري	م. الحسين الطبية- عمان
زياد طارق عبد الحسين	م. الحسين الطبية- عمان
فارس صالح حبتور	م. البشير- عمان
علي حسن البياتي	م. الملك عبد الله- اربد
فرح عصام عبد الواحد المهداوي	م. الحسين الطبية- عمان
أحمد محمد موسى المسلم	م. م. فهد للحرس الوطني-الرياض
سلمة عائد يتيم العنزي	م. م.فهد للحرس الوطني-الرياض
محمد وصل الله ابراهيم الثبيتي	م. م. خالد للحرس الوطني- جدة
تحية سالم صالح الكلدي	م. حمد الطبية- الدوحة
محمد أمين محمد مطر	م. حمد الطبية- الدوحة
هبة أحمد حسن يوسف	م. حمد الطبية- الدوحة
سلمان اسلم ميرزا	م. حمد الطبية- الدوحة
مي ابراهيم خليفة مطر	م. السلمانية الطبي- البحرين
نوال ابراهيم مبارك الحمر	م. السلمانية الطبي- البحرين
مروة محمد ابراهيم المسلماني	م. السلمانية الطبي- البحرين

اختصاص الطب النفسي

اسم الطبيب	مركز التدريب
جميلة سيف غميل سعيد الكتبي	م. العين الحكومي- دبي
انتصار أحمد علي بن حيدر	م. راشد- دبي
تهاني صالح سعيد عبد الله الكيومي	م. العين الحكومي- دبي
عبد الإله بن عبد المحسن الرويشد	م. الملك فهد للحرس- السعودية
خالد كليب مقبول العوفي	م. الأمل للصحة النفسية-السعودية
سعيد عبد الوهاب محمد زبره	الهيئة السعودية للتخصصات-السعودية
عبد الهادي عتيق عايض الهباد	م. الملك خالد- السعودية
محمد عبد الله محمد آل جعفر	الهيئة السعودية للتخصصات-السعودية
غادة جعفر أحمد الشماسي	م. الملك فهد- الخبر
ندى ابراهيم حسن القطان	م. الملك فهد- الخبر
محمد ياس محمد سالم الكرناوي	م. بغداد التعليمي- بغداد
سامي عادل عبد القادر البدري	م. بغداد التعليمي- بغداد
كريم ناصر حسين عبد العيساوي	م. الرشاد التعليمي- العراق
منصور علي منصر علي الشرجي	م. الأمراض النفسية والعصبية- اليمن
أصيلة بنت عبد الله الزعابي	م. ابن سينا- سلطنة عمان
ماجد علي يوسف العبد الله	م. حمد الطبية- الدوحة
إيمان سعيد أحمد سعيد	م. حمد الطبية- الدوحة
ماجد حامد جاسم المطر	م. الأمراض النفسية- ليبيا
نائل مصطفى حسن محمد	م. بهمان- مصر
شيرين محمد محمد علي	م. المعمورة للطب النفسي- مصر
أمجد أحمد عبد الغني العجرودي	م. الطب النفسي- مصر
حمدي محمد يوسف يوسف مرعي	م. الطب النفسي- مصر
وائل محمد ابراهيم عبد الله مرسي	م. المعمورة للطب النفسي- مصر
أحمد محمود عبد الفتاح أحمد	م. بهمان- مصر
عادل طه عمر النجار	م. المعمورة للطب النفسي- مصر
شريف نظير عزيز مسيحة	م. الطب النفسي- مصر
محمد عبد المنعم يوسف	م. الطب النفسي- مصر

اختصاص طب العيون

اسم الطبيب	مركز التدريب
عبد الحميد عمر زكريا	م. تشرين العسكري- دمشق
وليد الرحال العرابي	م. المواساة- دمشق
محمد نعيم محمد عظيم ناصر	م. السلمانية الطبي- المنامة
نبيل محمد عبد الخالق المطري	م. الكويت الجامعي- اليمن
ذاكرة أفغان	م. حمد الطبية- الدوحة
دلال أحمد محمد الماس	م. حمد الطبية- الدوحة
سناء محمد يونس محسن	م. الجامعة الأردنية- عمان
سمية جمعة عبيد جمعة	م. المفرق- دبي
سندس عبد الجبار عذاب ظاهر	م. الجراحات- العراق
علي نعمة أبو شنين	م. ابن النفيس- العراق