

## LETTER TO THE EDITOR

(*J Bangladesh Coll Phys Surg 2010; 28: 203-205*)

**Cost Effective Preoperative Evaluation:** The editorial of the Journal of Bangladesh College of Physicians and Surgeons, May 2010, Vol. 28, No. 2

1. To the Editor-in-Chief: We have gone through the time-demanding editorial on 'Cost Effective Preoperative Evaluation' with keen interest. We would like to supplement few relevant data of study performed in our centre. Assessing and optimising a patient before surgery is an essential for planning and administering a successful peri-operative management with the best possible outcome. Peri-operative morbidity, mortality and thereby cost increase with the severity of pre-existing diseases.' We studied a total of 2,086 patients in CMH Dhaka, who were scheduled for routine surgery. During pre-anaesthetic assessment we tried to detect the pre-existing systemic diseases which were not diagnosed earlier. The incidental findings of diseases were: conduction heart block 18.75%, COPD 15%, anaemia 11.62%, IHD 5.55%, bronchial asthma 1.61%, hypertension 1.3% and some other conditions like drug allergy, CRF, and peptic ulcer disease.<sup>2</sup>

This report depicts that the patients with incidental findings were fortunate enough to come across a functioning anaesthesia OPD setup and they got the scopes to be optimised for the planned procedures before hand. But this is the scenario of quite a thin section of in vogue anaesthesia practice in our country. The author has very correctly mentioned that 'the practice of seeing patients preoperatively by an anaesthesiologist *just* before surgery still exists in this part of the world and yet a fair number make their way to OR without being seeing at all'. This custom is mainly prevailing in private practice and requires improvement particularly for the patients with co-morbidity to have desired safety and cost effectiveness. The advised investigations should also be rational and logical ones following the guidelines to reduce the procedural expenditures.<sup>3</sup> This can be achieved by integrated and concerted efforts of the health care continuum of family practitioners, internists, residents, surgeons, pathologists and anaesthesiologists.

### References:

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### Dr. (Lt Col) Md Rabiul Alam

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### 2. Sir

Thank You for publishing a well informed journal. I thoroughly gone through May 2010 Vo. 28, No. 2. About Editorial of this issue I want to mention that its a time honoured publication and it may be a guideline in all the institute where Anaesthesia is being practiced as an speciality. Its nice to see Anesthesia grade has been matched with Surgery grades and rewrite the importance of ASA score. I demand well circulation of this editorial among those who use anesthesia as an speciality.

With thanks

### DR. Abul Bashar Md. Jamal

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### Author's Reply for both letters

We do not have enough study backup in this country to say with some assurance about the incidence of incidental co-morbidity during preoperative assessment. Dr. Alam's series is quite a pioneer in this area. He is right that a great but unknown number of surgical patients do not meet the anaesthesiologist before the day of surgery albeit this responsibility lies with both the Surgeons and Anesthesiologists.

Regarding the correlation of comorbidity and increase in expenses as Dr. Alam mentioned, I think the guideline

laid down by various work groups can act as optimizer.

Dr. Jamal also mentions about an integral approach consisting of relevant disciplines. This, I believe ought to be a product of team work and the job to be done in phases. The first person to start the ball to roll is the surgeon and then with collaboration of the anesthesiologists other clinicians and investigative departments could get involved.

### **Kazi Mesbahuddin Iqbal**

**Images in medical practice: Short communication** of Journal of Bangladesh College of Physician and Surgeons, May 2010; 28(2): 128.

To the editor in chief: At first I thank to the editor for starting some new section like 'letter to the editor' and short communication. I have gone through the report and I would like to give some comments about Toxic encephalopathy. Toxic encephalopathy, also known as toxic-metabolic encephalopathy, is a degenerative neurologic disorder caused by exposure to toxic substances.<sup>1</sup> It can be an acute or chronic disorder. Toxic encephalopathy has a wide variety of symptoms, which can include memory loss, small personality changes, lack of concentration, involuntary movements, nausea, fatigue, seizures and depression.<sup>2,3</sup> Toxic encephalopathy may be caused by prolonged exposure to toxic elements including solvents, drugs, radiation, paints, industrial chemicals, and certain metals. In addition, chemicals, such as lead, that could instigate toxic encephalopathy are sometimes found in everyday products such as cleaning products, building materials, pesticides, air fresheners, and even perfumes.<sup>3,4</sup> Different kinds of lesions, which lack specificity for toxic injury, can be observe on radiological images, but deep grey matter lesions with symmetrical distribution through out basal ganglia are most often seen. However, such findings have also been reported after anoxic-ischemic insults or during severe metabolic disturbances. Lesions in the white matter may also be present in the case of acute exposure to toxic agents. The true prognostic value of toxic-induced brain changes in the acute phase in CT or MR studies is unclear, although serial MRI may add new

information or molecular imaging techniques such as the MR diffusion –weighted imaging or MR spectroscopy. MR imaging with diffusion and perfusion imaging provides information regarding brain lesions induced by the toxic agents (vasogenic edema, cytotoxic edema, infarction, hemorrhage, demyelination).<sup>5</sup> Treatment is mainly for the symptoms that toxic encephalopathy brings upon victims, varying depending on how severe the case is. To reduce or halt seizures, anticonvulsants may be prescribed. Dialysis or organ replacement surgery may be needed in some severe cases.<sup>5</sup> Toxic encephalopathy is often irreversible. If the source of the problem is treated, by removing the toxic chemical from the system, further damage can be prevented, but prolonged exposure to toxic chemicals can quickly destroy the brain. Research is being done by organizations such as NINDS (National Institute of Neurological Disorders and Stroke) on what substances can cause encephalopathy, why they do this, and eventually how to protect, treat, and cure the brain from this condition.<sup>6</sup> It is increasing day by day in our country due to ignorance, illiteracy, poverty & illegal practice of different substances by local traditional healer. I thank to author to highlight the case and image which will make awarness among medical practioner about toxic encephalopathy.

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**Author's Reply:**

We pleased to see the keen interest of Dr. Aparna Das regarding the article "Images in Medical Practice: Short Communication of JBCPS, May 2010;28(2):128".<sup>1</sup> We appreciate the opportunity to respond. In my short communication I wanted to highlight the changes that occur in the CT scan and MRI of brain of a toxic

encephalopathy patient. In the short communication, there were little scope of detailed discussion on various aspects of toxic encephalopathy but I must appreciate and thank you for your letter highlighting the etiology, clinical presentation, diagnostic approach and treatment of toxic encephalopathy.<sup>2</sup> I gladly accept the additional information you have provided. It was gratifying to read the response from the reader.

**References:**

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