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CONTENTS

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2. Kilpatrick RM, Aseron CA : Radioisotope detection of Meckel's diverticulum causing instestinal bleeding. Z. Kinderchis 13 : 210-217, 1973.

Journal article, more than 3 authors :

3. Filler RM, Erablis AJ, Das JB, et al : Total intravenous nutrition. AM J Surg 121 : 454-458, 1971.
4. Coran AG. The hyperalimentation of infants. Biol Neonat (in press).

Complete Book :

5. Gallagher JR. Medical care of the Adolescent (ed. 2). New York, Appleton, 1966, p. 208-216.

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CONTENTS

THE PATTERN OF ABDOMINAL SKIN FLORA, EFFECT OF ANTISEPTIC SKIN PREPARATION ON THEM AND THEIR ROLE IN SURGICAL WOUND INFECTION.

Mujibur Rahman [1]
Golam Rasul [2]
Mashiur Rahman [3]

Key-words : *Skin flora, Antiseptic pre-operative skin preparation, Surgical wound infection, role of antibiotic in prophylaxis of surgical wound infection.*

Summary : *Swabs for culture were taken from the abdominal skin of 70 patients, before skin preparation, after skin preparation and after closure of the wound, and also from all infected wounds of the same patients post-operatively.*

81% of the skin contain Staph aureus, 10% contain E. coli and 5·8% contain Ps. pyocyaneus. Antiseptic skin preparation with Tn. iodine followed by surgical spirit or savlon eliminates all skin flora. However, the skin gets contaminated in about 10% of cases with Gram-negative organisms during operation when bowel or bile ducts are opened, and a similar percentage develop wound infection.

Inspite of routine antibiotic use in post-operative cases, the rate of wound infection remains the same. So, the routine use of antibiotics is discouraged.

Introduction : "Strict enforcement of the antiseptic principle had been accompained by a most striking change in the salubrity of the wards under my care, which had been converted from some of the most unhealthy in the Kingdom into models of healthiness"—with these few words Lord Lister ushered in the era of modern surgery, and paved the way for rapid development of it. He continued —"Considering the circumstances of those wards, it seems hardly too much to expect that the same beneficent change which passed over them will take place in all surgical hospitals, when the principle shall be similarly recognised and acted on by the profession generally (Lord Lister, 1870)." We all know, his wishes had been full-filled ; so much so that we tend to take things for granted as far as those principles are concerned. It is not easy to find publications in modern literature on patterns of skin flora at operation sites, the value of antiseptic skin preparations on them, and the role they play in causing surgical wound infections.

To find an answer to these questions, the present work was undertaken at the Institute of Post-Graduate Medicine and Research and P. G. Hospital, Dhaka.

Methods and Materials : Swabs were collected from the patient's abdominal skin at the site of operation. Patients were unselected ; whenever the collector was free, he did so without knowing previously who was the patient, and what type of operation was going to be done ; sterile cotton in a swab stick, moistened with sterile normal saline was used to collect specimens by rubbing it on the skin. Three swabs were taken in all

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cases and numbered as Swab No. 1, Swab No. 2 and Swab No. 3. The first swab was taken from the proposed site of incision after the patient had been anæsthetised, but before the antiseptic skin preparation. The second swab was taken from the same place after the skin preparation and towelling up the patient. Antiseptic skin preparation was done by using Tn. iodine followed by surgical spirit or savlon lotion alone. The third swab was taken from around the skin stitches after the operation was over, before the dressing was applied. A fourth swab (Swab No. 4) was taken only in those cases where significant wound infection was present, and pus was available for collection.

All these swabs were inoculated into blood agar plates and McConkes's media and cultured aerobically. No attempt was made for anaerobic culture. The culture plates were read 24 and 48 hours after inoculation.

Result : The results are shown in the table along with the age and sex of the patient and the nature of the operation done.

A total of 70 patients were examined. 57 out of these 70 Swab No. 1 yielded positive growth. Staph. aureus was present in all positive cultures. In addition, seven of them yielded E. coli and another four yielded Ps. pyocyaneous. All Swabs No. 2 were sterile. Five cases of Swab No. 3 yielded growth of E. coli, and one case each yielded growth of Staph. aureus and Ps. pyocyaneus.

Eight patients developed significant post-operative wound infection, and pus was collected for culture (Swab No. 4). One of them did not yield any organism on culture. Staph. aureus alone was grown from one case, Staph. aureus with E. coli in two cases, E. coli alone in one case, Staph. aureus with Streptococcus beta-hæmolyticus in one case, Ps. pyocyaneus in one case, and Ps. pyocyaneus with Streptococcus beta-hæmolyticus in one case.

Discussion : About 25% of people harbour Staph. aureus in the skin, particularly on the hands, face and perineum (Walter and Israil, '79), 10% of patients were found to carry hospital staphylococci on their skin (Shepherd and Kinmonth, '62). In our study, 81% of the patients abdominal skin harbour Staph. aureus. In addition 10% of them harbour E. coli, and another 5·8% harbour Ps. pyocyaneus, which normally should not be present in the skin of the abdominal wall. These abnormal findings may be due to the facts that on an average, our patients stay in hospitals for two weeks before they are operated upon ; mattresses, blankets and pillows used by the patients are never sterilised ; bed covers, bed sheets and pillow cases are laundered from time to time, but never sterilised.

Swab No. 2 was uniformly sterile, which is a good thing considering the fact that high percentage of skin contained Staph aureus and some of them also contained E. coli and Ps. pyocyaneus, which are all potentially pathogenic. This finding is contrary to the opinion expressed that resident skin flora are rarely pathogenic, and may indeed be a direct asset to their host (Forfar et al, '68). This also shows the effectiveness of Tn. iodine and savlon in the antiseptic skin preparation.

Only one case of Swab No. 3 yielded Staph. aureus, whereas five yielded Esch. coli and one more yielded Ps. pyocyaneus. This preponderance of gram negative becteria in Swab No. 3 is probably related to the nature of the operation performed viz. opening of the bowel or bile ducts. This calls for stricter control at handling organs once bowel or ducts have been opened, so as to prevent wound contamination.

Wound infection with gram-negative bacteria occured in those cases where stomach, jejunum, bile ducts or appendix were opened ; and in none of those cases, they were isolated in Swab No. 1. Staph. aureus was isolated from two cases of Swab No. 4, Streptococci beta-hæmolyticus in another two cases, none of the patients who grew Esch. coli or Ps. pyocyaneus in Swab No. 1 developed wound infection with the same organisms. This also suggests the benefit of antiseptic skin preparation.

We do not know where from the Streptococcus beta-hæmolyticus came, but the nasophasynx of the surgical and nursing staff are the obvious suspects. Immediate vicinity of the operative wound is exposed to large number of bacteria when the

personnel of the surgical team talk, sneeze or cough, even though the accepted methods of wearing masks, caps and gloves are enforced all the time (Calbertson et al, '61).

All of these patients received ampicillin as a routine in the post operative period. Inspite of that there was 11·5% rate of wound infection, which is more or less the same when no antibiotic is used at all. This confirms our earlier finding that routine antibiotic use in the prophyllaxis of surgical wound infection is not warranted (Rasul and Ali, '79).

Table Showing the Results in Details.

No.	Age	Sex	Nature of operation	Swab 1	Swab 2	Swab 3	Swab 4
1	65	M	Partial gastrectomy	Staph ++	Neg.	E. coli ++	X
2	25	F	Vagotomy+Gastro-jejuno-stomy.	,,	,,	Neg.	Pseudo++beta-hæmo.
3	50	M	,,	Neg.	,,	,,	X
4	20	M	,,	,,	,,	,,	X
5	45	M	,,	Staph ++	,,	,,	X
6	55	M	Gastro-jejunostomy for ca-stomach.	,,	,,	,,	X
7	50	M	Vagotomy & Gastro-jejuno-stomy.	,,	,,	,,	X
8	32	M	,,	,,	,,	,,	X
9	35	F	,,	,,	,,	,,	X
10	28	F	,,	,,	,,	E. coli +	X
11	45	M	,,	,,	,,	Neg.	X
12	45	M	,,	,,	,,	,,	X
13	40	M	,,	,,	,,	,,	X
14	41	M	,,	,,	,,	E. coli + Staph +	X
15	42	M	,,	,,	,,	Neg.	E. coli ++ Staph +
16	25	F	,,	,,	,,	Pseudo +	Pseudo ++
17	60	M	Gastro-jejunostomy for ca-stomach.	Staph + E. coli ++	,,	,,	Neg.
18	36	M	Vagotomy & Gastro-jejunostomy & appen-dicectomy.	Staph +	,,	E. coli +	E. coli + Staph +
19	67	M	Cholecystectomy	Neg.	Neg.	Neg.	X
20	42	F	,,	Staph +	,,	,,	X
21	30	F	,,	,,	,,	,,	X
22	44	M	,,	,,	,,	,,	X
23	30	F	,,	Neg.	,,	,,	X
24	31	F	,,	,,	,,	,,	X
25	25	F	,,	,,	,,	,,	X

No.	Age	Sex	Nature of operation	Swab 1	Swab 2	Swab 3	Swab 4
26	50	F	Cholecystectomy	Staph +	Neg.	Neg.	X
27	35	F	,,	Neg.	,,	,,	X
28	39	F	,,	Staph + E. coli +	,,	,,	X
29	33	M	,,	Neg.	,,	,,	X
30	70	M	,,	,,	,,	,,	X
31	50	M	,,	Staph ++	,,	,,	X
32	29	F	,,	Staph + Pseudo +	,,	,,	X
33	26	F	,,	Staph +++	,,	,,	E. coli + Staph +
34	34	M	,,	,,	,,	,,	X
35	60	M	,,	,,	,,	,,	X
36	30	F	,,	,,	,,	,,	E. coli +
37	40	E	,,	Neg.	,,	,,	X
38	42	M	,,	Staph ++ E. coli +	,,	,,	X
39	30	E	,,	Staph ++ E. coli ++	,,	,,	X
40	50	M	,,	Staph ++	,,	E. coli	X
41	30	E	,,	,,	,,	Neg.	X
42	40	F	,,	,,	,,	,,	X
43	48	M	,,	,,	,,	,,	X
44	45	M	,,	,,	,,	,,	X
45	50	F	Cholecystectomy + Choledocholithotomy	,,	,,	,,	Staph + Beta hæmo +
46	55	E	,,	,,	,,	,,	X
47	40	M	,,	Staph +	,,	,,	X
48	40	F	,,	Staph + E. coli +	,,	,,	X
49	40	F	,,	Staph +	,,	,,	X
50	30	F	,,	Staph + Pseudo +	,,	,,	X
51	36	F	Cholecysto-jejunostomy	Staph +	,,	,,	X
52	35	M	,,	Staph + Pseudo +	,,	,,	X
53	25	M	,,	Staph +	,,	,,	X
54	32	F	Cholecystectomy & Appendicectomy.	,,	,,	,,	X
55	21	F	,,	,,	,,	,,	X
56	10	F	Appendicectomy	,,	,,	,,	X
57	17	F	,,	Staph + Pseudo +	,,	,,	X

No.	Age	Sex	Nature of operation	Swab 1	Swab 2	Swab 3	Swab 4
58	45	M	Appendicectomy	Staph +	Neg.	Neg.	X
59	20	M	,,	Neg.	,,	,,	X
60	25	M	,,	Staph ++	,,	,,	X
61	10	F	Laparotomy	Staph + E. coli +	,,	,,	X
62	30	F	,,	Neg.	,,	,,	X
63	45	M	,,	Staph + E. coli +	,,	,,	X
64	24	M	,,	Neg.	,,	,,	X
65	28	F	,,	Staph +	,,	,,	X
66	45	M	,,	,,	,,	,,	X
67	20	M	Herinorrhaphy	Staph ++	,,	,,	X
68	34	F	,,	,,	,,	,,	X
69	32	M	,,	,,	,,	,,	X
70	45	M	,,	,,	,,	,,	Staph +

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PREVALENCE OF URINARY TRACT INFECTION IN PREGNANCY

Dr. Asia Akther Khatun [1]
Dr. Harunur Rashid [2]
Prof. T. A. Chowdhury [3]

Key-words: *Urinary tract infection in pregnancy : Asymptomatic bacteriurea.*

Summary: *Asymptomatic bacteriurea is a common problem in pregnancy. If untreated this may lead to complications.*

We therefore, screened 50 pregnant women to see the prevalance of U. T. I. The mean age was 28 years. Mean duration of pregnancy was 38 weeks. They were multipara. Only eight of the 50 subjects had past history of U. T. I. Sixteen of the subjects revealed evidence of U. T. I. E. coli grow from the urine of 15 subjects ; only one case showed growth of proteus. All culture positive cases had more than 5-7 pus cells per high power field of urine under the microscope.

As we found no correlation between history of U. T. I. and asymptomatic bacteriurea, U. T. I. in pregnancy cannot be predicted on the basis of history. We suggest that all pregnant women should be screened for U. T. I.

Introduction: Recurrent urinary tract infection is commonly encountered in private practice. Symptomatic urinary tract infection poses no problem because of easy in diagnosis and treatment. However asymptomatic significant bacteriurea is a major problem in diagnosis. Asymptomatic bacteriurea is more commonly seen in pregnant women, compared to non-pregnant women. The prevalence of U. T. I. varies from 4—7% by different authors (Kass 1960 ; Turner 1961 ; Kincaid-Smith & Bullen 1965 ; Little 1966 ; Dixon & Brant 1967). This prevalence is no higher than that observed in sexually active non-pregnant women (Sleigh et al, 1964 ; Baily 1972).

Routine antinatal screening procedure has remained useful for the diagnosis of U. T. I. A significant number of women with bacteriurea develop overt features usually associated with urinary tract infection. Williams et al, 1973 reported that 30% of their untreated pregnant women with bateriurea developed acute pyelonephritis.

In the long term structural and functional abnormalities including chronic pyelonephritis was also detected (Gower et al, 1968 ; Houston 1969 ; Leigh et al, 1968 ; Whalley 1967).

The third more controversial reason is that asymptomatic bacteriurea may be associated with pregnancy complications. Kass (1973) reviewed this recently and found support from Gruneberg et al (1969) for this view that the incidence of prematurity was greater in these patients. Kincaid Smith (1968) reviewed the information available on the effects of bacteriurea on the incidence of abortion, pre-eclamptic toxaemia, hypertension and anæmia.

Materials and Methods: Fifty pregnant women were screened for evidence of urinary tract infection in their pregnancy. The patients were studied in the obstetrics and gynæcological unit of the Institute of Post-Graduate Medicine and Research between June 1983 to November 1983. The

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mean age of the patients was 26 years and the mean duration of pregnancy was 38 weeks; eight of the fifty patients had history of previous attacks of urinary tract infection. All patients were clinically normal and had normal blood pressure at the time of examination. Mid-stream specimen of urine was collected and they were sent immediately to the laboratory for culture.

Laboratory Materials : Fresh specimen of mid stream urine was collected and placed in McConkey's media in aerobic condition. Colony count was done after 48 hours of incubation. If the growth was greater than 10^5 sensitivity to standard antibacterials including ampicillin, cloxacillin, trimethoprim-sulpha methoxazol combination, nitrofuran and cephaloridine and gentrimicine was studied.

Result ; Of the fifty patients, sixteen showed evidence of urinary tract infection. Specimen from fifteen patients had growth of E coli and in only one case proteus was isolated.

Of the culture positive patients, all showed presence of pus cells (Greater than 5 to 7 per high power field). In only two patients morning specimen of urine showed proteinuria of moderate degree by heat test.

Microscopic examination of urine, showed presence of pus cell in 28, 16 of whom were excreting 10 pus cells H.P.F. in their urine. None had any granular or cellular cast. M.S.U. culture grew organism in 16 patients, all of whom had pus cells in their urine. Of the 16 patients E. coli grew in 15, proteus in one.

Discussion : The result of the present study shows a significant number or patients had asymptomatic bacteriurea. It is interesting to see that the patients with bacteriurea were also excreting pus cells in urine. The prevalence of asymptomatic urinary tract infection was 30%. Changes in sexual behaviour in pregnancy can account for this difference as an effect of sexual activities on the prevelence of asymptomatic bacteriurea has been reported (Baily 1972). The prevalence of asymptomatic bacteriurea in pregnancy is higher than the symptomatic infection. [About 10% of those with asymptomatic bacteriurea develop symptomatic U.T.I. during pregnancy.]

Kass 1978 estimated that 15 to 20% of all adult women would at some time experience a U.T.I. in their life.

Our findings suggest that asymptomatic bacteriurea and a previous history are virtually independent of each other. It is, therefore, difficult to predict urinary tract infection in pregnancy. The history suggestive of previous U. T. I. does not always indicate the diagnosis. We therefore, suggest that all pregnant women should be screened properly to evaluate the U. T. I. of pregnancy.

Acknoledgement : We are greatful to Professor Shahla Khatun and Professor Kazi Moshiur Rahman for their kind advice and co-operation to prepare this paper.

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BACTERIAL STUDY OF CHRONIC SUPPURATIVE OTITIS MEDIA AND THEIR SENSITIVITY TO ANTIBIOTICS.

Professor M. N. Amin [1]
Wazir Ahmed Chowdhury [2]

Key-words : *Chronic suppurative otitis media : common organism : role of sensitive antibiotics.*

Summary : *Total 147 cases C.S.O.M. had studied of which Pseudomonas pyocynea 51·02%, 38·78% contains 38·78% and fungus infection was 08·84%. No growth in 1·36%. The sensitivity pattern of the organisms isolated were tested against different antibiotics available in this country.*

Introduction : It is important to know the type of organism in any infection to plan a scientific and economical treatment. If the organism and their sensitivity is generally known then the misuse of antibiotic will be minimised and the period of treatment will also be shortened. This is much more true in a country like ours, where available antibiotics are costly and the people in general are poor.

C.S.O.M. (Chronic suppurative otitis media) is a frequent finding in E.N.T. practice. But there is not much of studies being done about the organismal pattern and their sensitivity to antibiotic in this country. This led us lo make a survey over the subject.

Methods and Materials : Aural swabs were taken from the ears of the patients suffering from C.S.O.M., irrespective of age, sex, previous treatment, or duration of treatment, attending the E.N.T.O.P.D. of Dhaka Medical College Hospital, during the period March—September '84. In all the cases the ear swabs were taken from the ears after ensuring no antibiotic therapy to the ears for at least 7 days. The swabs were sent to the pathology department of Dhaka Medical College for culture and sensitivity test. The organismal pattern and their sensitivity to antibiotics were tabled on the basis of the culture and sensitivity reports. The cases of C.S.O.M. with cholesteatoma or other complications were not included in the study.

Result :

Total cases	Male	Female
Studied ... 147	82	65

Organism isolated :

Pseudomonas pyocyanea	... 75 (51·02%)
Staphylococcus aureus	... 57 (38·78%)
Fungus	... 13 (08·84%)
No growth	... 02 (01·36%)

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Table showing the sensitivity pattern of the organisms.

	Ampi-cillin	Cloxa-cillin	Amoxi-cillin	Cepha-losporin	Doxicy-cline	Tetra-cycline	Co-tri-moxazole	Genta-micin	Kena-micin
Pseudomonas pyocyanea.	15/75 (20%)	05/55 (9·09%)	07/22 (31·81%)	09/20 (45%)	21/67 (31·37%)	38/73 (52·06%)	07/68 (10·30%)	58/67 (89·23%)	29/67
Staphylococcus aureus.	26/57 (45.16%)	7/47 (14·89%)	15/26 (57·69%)	19/26 (73·07%)	50/57 (87·72%)	39/57 (68·42%)	11/57 (19·30%)	38/44 (86·36%)	37/57 (64·9%)

The sensitivity pattern of the organisms isolated were tested against different antibiotics available in this country. It is seen that 89·23% of pseudomonas pyocyanea are sensitive to gentamicin, similar observation was seen in Mandonca's study. Whereas Staphylococcus aureus are sensitive to Cephalosporin in 45%. The next antibiotic is tetracyclin where Staphylococcus aureus showed 63·36% and Pseudomonas pyocyanea showed 52·05% sensitivity. The sensitivity to tetracycline is in contradiction to the findings of Rao et al, '80, where they found 100% of the Pseudomonas were resistant and only 34·01% of staphylococcus were resistant to tetracycline. The reason for this contradictory result could be attributed to the fact that the tetracycline—a least used antibiotic by systemic and local route for E. N. T. infection in this country in the recent years.

Discussion : In this series the organisms isolated are Pseudomonas pyocyanea (51·02%) and Staphylococcus aureus (38·78%). This finding collaborates with the findings of Mandonca '69, studied in South—East Kent Group of Hospital, which showed Pseudomonas pyocyanea (50%) and Staphylococcus aureus (6·25%). Proteus and Pseudomonas do not normally inhabit the upper respiratory tract and their emergence in chronic middle ear infection can not be ascribed to a primary derivation from the Eustachian tube. These organisms are considered mostly as secondary invaders from the external auditory canal gaining access the middle via a defective tympanic membrane, resulting from an acute episode of otitis media (Mawson '63). The possible reason for high incidence of Pseudomonas pyocyanea in our series may be attributed to the socio-economic condition of the people of this country. Our people take their bath in stagnant pond water and polluted river water. And also they have not habit of cleaning the ears with dirty materials.

The next organism isolated is Staphylococcus aureus. Many authors reported Staphylococcus aureus is the most common aetiological agent in C. S. O. M. (Karim '83, Friedman '57 cited from 'Disease of the ear' 2nd ed. by S. R. Mawson).

The variation between the studies may be environmental and geographical condition of different countries. It is also possible that the use of antibiotic has changed the picture, eliminating the more susceptable organism like beta hæmolytic streptococci, pneumococci and alpha hæmolotic streptococci, due to treament in acute stage and gradual replacement by hardier and antibiotic resistant organism like coagulase positive staphylococci, Pseudomonas pyocyanea, proteus, coliform etc. is chronic infection (Rao et al, '80).

Acknowledgements : We are thankful to the Director, Dhaka Medical College Hospital for allowing us to publish this paper. We are also indebted to the Professor of Pathology, Dhaka Medical College for his sincere help. Thanks are also due to the Medical Officers of E.N.T.O.P.D. of this institution for their sincere co-operation.

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VDRL REACTION AMONG BANGLADESHI MALE

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Key-words : *VDRL reaction.*

Summary : *47,986 subjects were examined for VDRL test of which 1020 (2·15%) sera gave positive result and were reported reactive. Doubtful results were checked by repeating the test and equivocal results were reported as non-reactive. 636 individuals were female. This result includes only the male subjects.*

Till recently Wassermann reaction (W. R.) and Kahn test (K. T.) were common investigations in routine clinical pathology laboratory for the diagnosis of syphilis. But now-a-days VDRL (Venereal Disease Research Laboratory) reaction is used all over the world. Though VDRL test is also based on heterogenous antigen as in W. R. & K. T. It is preferred for its simplicity and reliability. The improved tests like TPI (Triponema pallidum immobilieation) test and Fluorescent antibody technique etc. are much time consuming, complicated and costly in comparison to VDRL test.

Though syphilis is said to be on increase no reliable data is still available for Bangladesh. Among the patients referred by the clinicians 10% positive results for syphilis (W. R. & K. T.) were found in Bangladesh (erstwhile East Pakistan) (Muazzam 1967), but this does not reflect the incidence in the country.

In recent years, we in the Ibn Sina Laboratory got an opportunity to do VDRL test for a large number of adult Bangladeshi male subjects who were going out of the country for job. Since these subjects were all apparently healthy young people and came from all walks of life throughout Bangladesh and each of them were tested for syphilis, we think our finding will be very near the incidence in the country.

Materials and Methods : 47,986 subjects came for examination of which 636 were fen ales and children. The total number of adult males were 47,350. Since the number of females are very small and children were not tested for syphilis, we record here the results of the male subjects only.

Blood was collected in the morning in clean dry test tube, allowed to clot and serum separated. The serum was then inactivated at 36°c water bath

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for half an hour and test was done on the same day. The test was done with standard VDRL antitien available from reliable manufacturer.

Only quantitative tests were done as the tests were for routine check up. The working antigen was prepared daily at the time of test.

Results : A total of 1020 (2·15%) sera gave positive result and were reported reactive. Doubtful results were cheked by repeating the test and equivocal results were reported as non-reactive.

Discussion : Though our findings do not represent true incidence of syphilis in Bangladesh it indicates a fairly reliable picture as, the subjects were normal adults and came from all over the country.

Syphilis is a disease of the modern world and is now spreading in alarming proportion every where (WHO, 1978). Wigfield (1971) estimated that about 50 million cases of syphilis in early infective stage is present in the world. This figure is mostly based on figures of Western world and no reliable figure is available in many developing countries. No such study was ever carried out in Bangladesh.

Our finding of 2·15% incidence of syphilis among the unsuspected population is not high in comparison to the neighbouring India. In a truly Muslim society the incidence of venereal disease should be very low, as such this figure is no doubt high. But it compares favourably with 10% found among the patients in Bangladesh, who were referred for investigation (Muazzam, 1967).

Syphilis is said to be found in 5% population of sub-Himalyan region, Himachal Pradesh and big cities, ports and industrial areas of India (Tampi, 1962). Similiar studies in big ports of Bangladesh may show higher incidence. Noronha (1962) reports an incidence of 30-40% syphilis in some parts of India. This suggests endemic nature of the disease. A survey in Himachal Pradesh, Kulu velly, Indian held area of Jammu and Kashmir and Jaunser area-Bawar area of Uttar Pradesh of India revealed the alarming figure (Noronha, 1962). Incidentally all these are torist centres.

However the probable figure around two percent incidence of syphilis in our country is also very high. Due to lack of proper education, mass illitracy, sense of guilt and shame associated with V. D. (as those are usually results of adultery) and consequence avoidence of treatment, lack of facility for proper treatment and absence of proper machinery to detect contacts and treat them are responsible for the spread. Health authorities should carry a survey, detect the sources, treat the infective cases and help prevent further spread. Educationist, political and religious leaders and social welfare departments should join together to stop further spread of venereal disease. The theory' 'prevention is better than cure' should be put in real practice.

Acknoledgement : We are grateful to the Members of Ibn Sina Trust for providing us this opportunity to carry on the study and our laboratory technicians for their technical help

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H_2-RECEPTOR ANTAGONISTS

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Key-words : *H 2-receptors, cimetidine, ranitidine.*

Summary : *Cemetidine H_2 receptor antagonist. inhibits basal and nocturnal gastric secretion and that induced by food and other stimuli. The parietal cells have specific recetors for histamine, gastrin and acetylcholine. H_2 receptor antagonists block the effects on the receptors and eliminate the potentiating effect of histamine on gastrin and acetylcholine.*

Ranitidine also a H_2-receptor antagonist. Both cimetidine and ranitidine accelerate the healing of duodenal and gastric ulcer.

Introduction : For many years the role of histamin in gastric physiology was controversial but appears to have been solved by the discovery that there are at least two kinds of receptors for histamine, which have been designated H_1 and H_2. In 1964, the research workers began to synthesize chemical compounds which would block the action of histamine on gastric secretion. Burimamide was the first H_2-receptor antagonist to be tested in man. It was poorly absorbed from the gut and was soon discarded in favour of metiamide which was well absorbed. Metiamide was highly effective in reducing acid secretion but 1 percent of patients developed granulocytopenia. Agranulocytosis was not due to H_2-receptor blockade as such but was an effect of the thio-urea group in the molecule. The successor to metiamide was synthesized by replacing the thio-urea group with a cyano-guanidine group. Cimetidine is now widely used in Bangladesh. Another H_2-receptor antagonist-ranitidine has also been marketed but not widely available in our country.

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H_2-receptor :

H_2-receptor are present in the stomach, heart, blood vessels, uterus, bronchial musculature, adipocytes and T-suppressor cells (Feely and Wormsely, 1983). Effect of stimulation of H_2-receptors of stomach is increased gastric secretion.

H_2-receptor antagonists :

Two H_2-receptor antagonists currently used for therapeutic purpose are cimetidine and ranitidine.

Cimetidine—Cimetidine is a derivative of histamine molecule in which imidazole ring has been retained but side-chain has been modified. Cimetidine is rapidly and almost completely absorbed and peak concentration occurs in 30 to 90 minutes after ingestion in fasting state but delayed to 1 hour when taken with food. Most of the drug is excreted through kidney unchanged although a sulpoxide metabolite is produced in the liver, requiring dose reduction in renal failure patients. The elimanation half life is 2 hours.

Cimetidine inhibits basal nocturnal gastric secretion and that induced by food or other stimuli. The mechanism of action is unknown but there are conflicting theories. The parietal cells have specific receptors for histamin, gastrin snd acetylcholine. H_2-receptor antagonists block the effects on the re .eptors and eliminates the potentiating effect of histamin on gastrin and acetylcholine (Freston, 1982a).

Pepsin production is also reduced.

Cimetidine can be given by mouth, intramuscular or intravenous injection. Intravenous route is restricted to emergencies. Since hypotension can occur, very slow injection lasting for 5 to 10 minutes is recommended (Feely and Wormsley, 1983).

The usual dose for healing ulcer is 1 gm per day as 200 mg thrice daily after meals and 400 mg before sleep. Recent studies have shown that twice daily dose may also be effective (Bardhan et al, 1979 : Bourne et al, 1984).

Headache, nausea, diaziness, dry mouth, rashes and transient rise of transaminases are minor adverse effects. Concentration of serum prolactin increases after intravenous dose. In vitro cimetidine competes for androgen binding sites. Gynaecomastia, often tender has been seen when used for prolonged period but is reversible after withdrawal of the drug (Jensen et al, 1983) Cimetidine binds cytochrome P450 in hepatic microsomes and thus reduces the clearance of drugs—warfarin, diazepam, phenytoin (Feely & Wormsley, 1983. The clearance of drugs (propranolol, lignocaine) is reduced as cimetidine reduces hepatic blood flow (Feely et al, 1980). Cimetidine crosses the blood-brain barrier and placenta. Mental confusion, drowsiness and disorientation sometimes occur in the elderly and in patients with renal and hepatic failure necessiating dose reduction. It seems unlikely that cimetidine significantly stimulates immunologic reactivity in healthy subjects but can enhance immunoresponse in immunodepressed patients (Freston, 1982a).

Out of 1280 patients receiving cimetidine 1·3 percent were withdrawn because of side-effects. The frequency of side-effects are low, below 5 percent with cimetidine (Freston, 1982b).

Ranitidine—Ranitidine is chemically distinct having a furan ring instead of imidazole ring. The drug is well-absorbed with no influence by food ingestion. Peak plasma concentration is obtained in 1-3 hours and duration of action lasts for 8-12 hours. About 30 percent is metabolised in the liver and 70 percent excreted by kidneys unchanged. Serum half life is about 3 hours but the plasma concentration that produce 50 percent inhibition of gastric acid secretion exceeds or is maintained for at least 6 hours after ingestion of 150 mg of ranitidine (Feely and Wormsley, 1983). In elderly and in renal failure half life is prolonged and reduction of dose is necessary but probably no reduction is needed in liver disease (Zeldis et al, 1983).

Ranitidine does not appear to bind androgen receptors, nor-inhibit hepatic oxidase system so fewer side effects are seen (Zeldis et al, 1983).

Ranitidine can be given by mouth or intravenous route. It is safe but may produce minor side-effects. Amongst minor effects are headache, malaise, constipation, nausea, skin rash, transient rise of transaminases and rarely hepatitis occur. Gynaecomastia is less common. Dose dependent confusion and mentat depression are rare events. Experience with the drug is short and long term effects are not yet known.

Most of the studies to date recommend the dose of ranitidine for healing of ulcers as 150 mg twice daily.

Clinical use : Duodenal ulcer—Both cimetidine and ranitidine accelerate healing of duodenal ulcer. There is usually relief of pain in 1 week, often in 48 hours. Healing rate of duodenal ulcer by cimetidine is above 76 to 87 percent (Frestone, 1982a ; Gray et al, 1976), in 6 weeks and with ranitidine the rate is 70 percent in 4 weeks and 95 percent in 8 weeks (Zeldis et al, 1983). Duodenal ulcer patients have a recurrence rate of 45-70 percent in 3 months and 74-90 percen in 1 year. A nocturnal dose 400 mg cimetidine (Burland et al, 1980) as compared with 150 mg ranitidine reduces ulcer recurrance rate to 12-15 percent in a year as compaired with 54 percent of those maintained on placebo (Frestone, 1982a).

Gastric ulcer—Both drugs are effective in healing of gastric ulcer and their prevention of recurrance. Healing rate is 57 and 58 percent after 4 weeks but raised to 67 and 76 percent after 8 weeks with cimetidine and ranitidine respectively, whereas with placebo it is only 48 percent

after 8 weeks (Freston, 1982a ; Zeldis et al, 1983). Recurrence is reduced te 6·7 percent from 44 percent after a nocturnal dose of 150 mg of ranitidine for 1 year. Cimetidine is found equally effective with a night dose of 400 mg daily.

Prepyloric ulcers are more resistant to treatment. Careful diagnosis is needed for malignant lesion as H 2-receptor antagonists can partially heal and re-endoscopy is advocated after treatment.

Gastro-intestinal hæmorrhage—Both drugs are used in upper gastro-intestinal hæmorrhage but to date no evidence of effectiveness in controlling the bleeding. No active drug regimen is superior to placebo (Welch et al, 1979). These agents are more effective in preventing stress ulcers. More promising results are obtained in the prophylaxis of acute bleeding from upper gastro-intestinal tract (Freston, 1982a).

Reflux oesophagitis—There is alleviation of symptoms but no improvement on endoscopic appearance by the use of these drugs (Ferguson et al, 1979). Often there is improvement of endoscopic appearance but no histological change (Behar et al, 1978).

Zollinger-Ellison syndrom—There is satisfactory control of symptoms and suppression of grastric secretion with high dose of cimetidine or ranitidine. Ranitidine appears three fold more potent than cimetidine in controlling the gastric hypersecretion (Collen et al, 1984). The usual dose of ranitidine is 600-1200 mg daily but low dose has been found effective in some cases Intial dose of cimetidine is 1·2 gm which is increased to 2·4 gm daily and can be continued for longer period.

Which drug : Although H 2-receptor antagonists are capable of relieving pain rapidly and accelerating healing of ulcers but it cannot cure ulcer disease and may not even change its long-term course. While prescribing a drug physicians should consider the efficacy, cost, safety and compliance. The H 2-receptor antagonists are well accepted by the patients. Short course treatment is not recommended because healing not only depends on dose but also on duration and on average 6-8 weeks are needed for healing (Mc Carthy, 1983). Some patients are benefitted by switching from cimetidine to ranitidine and vice-versa (Feely & Wormsley, 1983).

Currently there is no evidence that these drugs are carcinogenic. But with reduction of gastric acidity, bacterial colonisation of stomach produce nitrites from dietary nitrates which with amines in foods produce nitroso compounds which is carcinogenic in animals but not proved in man (Feely & Wormsley, 1983).

At present cost per day of H 2-receptor antagonists slightly exceeds that of alternate therapies such as antacids, sucralfate but the compliance is better.

Cimetidine has been in use for over 8 years and has an excellent safety and tolerance. However there are reservations in use and there may be clinical situations where ranitidine would be preferred drug (Lee et al, 1983).

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CONGENITAL MALARIA—A CASE REPORT

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Key-words : *Malaria, Congenital malaria, Neonatal malaria.*

Summary : *Though malaria is a cause of ill-health in children in the tropics, congenital malaria is very rare. So far about 150 cases have been reported in the world literature. This may be due to transplacental acquisition of humoral immunity from the mother. Here we report a case of congenital malaria, first ever report from Bangladesh.*

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Case report : A 36 days old male baby was admitted to Dhaka Shishu Hospital on the 14th of August, 1983 with a history of irregular fever, jaundice and high coloured urine of one day's duration. Mother suffered from proven malaria during the 8th week of pregnancy while she was visiting Bandarban, an endemic area for malaria situated in the South-east corner of Bangladesh adjacent to Burma, within a tropical rain forest. This was a full-term normal delivery.

At the age of 4 days the baby was earlier admitted to Dhaka Shishu Hospital with jaundice and suspected urinary tract infection. Urine examination during that admission showed presence

of pus cells, R. B. C. and proteinuria ; but culture yielded no growth. It was treated with Gentamicin and discharged home symptom free.

Physical examination at second admission showed an anaemic baby with hepato-splenomegaly, both organs enlarged two centimetres below costal margin. Other systems were within normal limits. Investigations on admission—Hb-50%. Total W. B. C.-12,000 c.m., Neutrophils-34%, Lymphocytes-51%, Eosinophils-2%, Monocytes-3%, Reticulocytes-10%, M. P.-present, Plasmodium vivax (figure 1). V.D.R.L.-non-reactive, Routine urine and stool examination—Normal, Serum bilirubin-8 mg%.

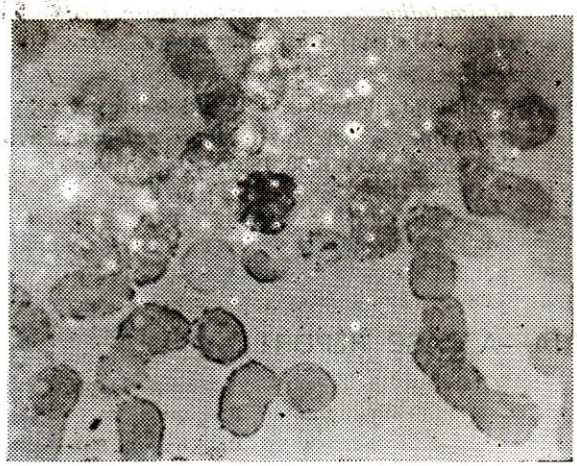

Fig. 1. Showing Plasmodium Vivax.

The baby was on oral ampicillin before admission. As M.P. was found in the peripheral blood, chlorquine was started, 75 mg loading dose, followed by a second dose of 75 mg loading dose 6 hours later, and 37 mg daily for the next 4 days (Forfar and Arneil, 1973). The baby responded satisfactorily, temperature subsided, and serum bilirubin came down to normal. Anaemia was corrected with compatible blood transfusion. It was discharged from the hospital after 8 days and was found thriving well at follow-up.

Discussion : Congenital malaria is extremely rare, so far about 150 cases have been reported in the literature (Hindi et al, 1980). In congenital malaria, infection is acquired from the mother either before or at delivery (Sanyal, 1981). In untreated or partialy treated mother sinusoids in the placenta may be packed with malarial parasites, very rarely, they can cross the intact placental barrier. Usually, infection occurs during parturition when the sinusoids are broken (Lal, 1981). It may therefore be called co-natal rather than congenital infection.

The onset of clinical manifestations are variable from the 1st to the 50th day of life. In plasmodium vivax malaria, incubation period usually varies from 10-15 days, but may be weeks and relapses are common. Acquired malaria under the 6th month of age in the endemic areas are extremely rare because of transplacental passive immunity by Ig G from the mother to the foetus. Incubation period in infants born to mother with malaria might have been prolonged because of incomplete suppressant therapy and/or passive immunity.

Acknowledgement : I am grateful to Dr. S. Hoq, Ph. D. and Dr. W. Khan, M. Phil, of the Department of Pathology, Dhaka Shishu Hospital for making the diagnosis of congenital malaria from an examination of peripheral blood film and for supplying the slide for publication.

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PERITONITIS FOLLOWING ASCARIDEAL PERFORATION OF MECKEL'S DIVERTICULUM.

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Key-words : *Peritonitis, Ascarideal perforation, Meckel's diverticulum.*

Summary : *Round-worm infestation is quite common in our country but round-worm perforation of the bowel with peritonitis is not so common. The current diagnosis of round-worm perforation of the small bowel is always made at operation or autospy.*

Introduction : Peritonitis following ascarideal perforation of Meckel's diverticulum is a rarity. Only six cases have been reported so far in the English literature (Camejo, 1942 ; Masella T., Paul, Pujari, Schul J.).

Case report : S. B., a 22-years-old female was admitted to hospital on 13-9-83 with a 4-day history of continuous pain in the abdomen, vomiting and loose motions. She also passed one round-worm in the vomitus. She was given piperizine citrate on the first day of pain. The long-standing history of a peptic ulcer or an attack of enteric fever preceding the catastrophe was absent. She was also having vague abdominal pain since her childhood and passed round-worms in her stool on several occasions.

On examination, the patient looked anxious and was restless ; pulse was 124/minute and temperature 99°F. The abdomen showed moderate distension with tenderness and rigidity in the lower half. Liver dullness was obliterated along the right midaxillary line. Peristalsis was absent. Rectal examination elicited tenderness on the anterior rectal wall. Laboratory investigations showed only moderate leukocytosis with polymorphonuclear preponderance. The widal reaction was negative. The plain X-ray of the abdomen demonstrated free gas beneath the diaphragm and gas and fluid levels at the same level of the film (Fig 1). The provisional diagnosis was peritonitis following perforation of acute oppendicitis.

Fig. 1. Plain X-ray of the abdomen.

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An emergency laparotomy was performed through a lower right paramedian incision and on exploration, there was moderate collection of milky exudate with flakes of lymph and three round-worm in the peritoniel cavity. The small bowel was congested and a round-worm protruded through the tip of Meckel's diverticulum with about one fourth of its body outside. The anterior end of the worm was protruding first (Fig. 2). The

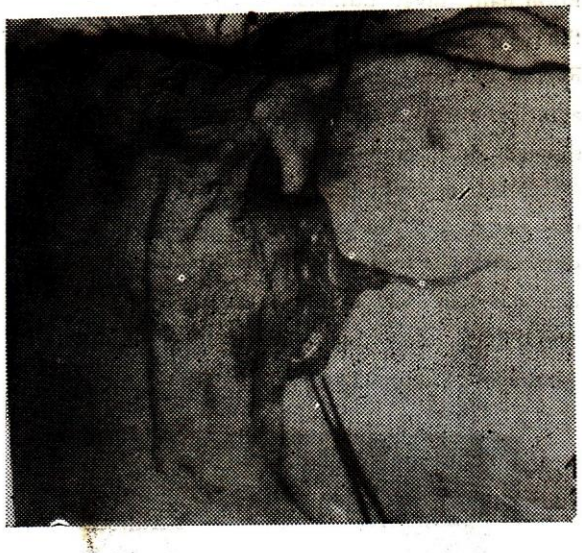

Fig. 2. The round-worm is coming out of the tip of Meckel's diverticulum.

worm was recovered and immediately the opening in the diverticulum closed due to contraction of the muscle coat. The diverticulum was excised and the abdomen was closed as usual. Post-operative recovery was smooth and uneventful. Multiple sections of the diverticulum were examined histologically. No abnormal tissue was seen. The subserosa was oedematous with infiltration by lymphocytes, plasma cells and eosinophils. Evidence of early organisation was also present. The findings were suggestive of peritonitis (Fig. 3).

Fig. 3. Histopathology of Meckel's diverticulum (H & E×26).

Discussion : Round-worm infestation is quite common in the tropics ; but round-worm perforation of the bowel with peritonitis is not so common. Perforation of the intestine due to round-worm is considered primary when there is no preexisting disease in the bowel and secondary when there is a previous pathological lesion at the site or in the vicinity of the perforation (De Sa AE, 1966). The factors which help round-worm penetrate the intestinal wall are poorly understood. It has four suckers and a row of hooklets with which it can adhere to the mucosa of the bowel. It is known to produce some lytic enzymes. It penetrates gradually the bowel wall and the opening virtually closes after expulsion of the worm. Thus there is minimal leakage of intestinal contents and inflammatory reaction in the peritonial cavity is also relatively mild in primary round-worm perforation.

In the present case there was no associated disease in Meckel's diverticulum. Similarly there was no pressure necrosis of the diverticulum due to clumping of worms. The worm has a "wanderlust" and tends to explore ducts and cavities. The wandering worm entered the lumen of the diverticulum and when it came across the blunt end, it

started making its way through its tip by nibbling the wall. Once the anterior end comes out, expulsion mainly depends upon the intraintestinal pressure and the peristaltic aciton of the segment of the bowel. This can explain the duration of symptoms for two or three days. If the operation had been delayed for some time, it might have been very difficult to find the site of penetration (Schul J, 1940).

The surgical complications of ascariasis are still diagostic problems for the surgeons working in the tropics. Intestinal obstruction due to worms can be diagnosed in some cases. The perforative complications may not be diagnosed preoperatively because of its rarity and the non-specificity of both clinical features and the results of laboratory and radiological investigations. The toxæmia is mistaken many times for enteric toxaemia. The correct diagnosis of round-worm perforation of the small bowel is always made at operation or autopsy.

Acknoledgements : Thanks are due to the Medical Superintendent, Dhaka Medical Callege and Hospital, Dhaka, Bangladesh for allowing us to use hospital records and publish this case report.

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RUPTURED PYOGENIC LIVER ABSCESS WITH FATAL HAEMORRHAGE—A CASE REPORT

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Tareak-Al-Nasir [3]
Md. Mizanur Rahman [4]
Md. Saiful Quddus [5]

Summary : *A case of pyogenic liver abscess which developed following an attack of 'dysentery' and subsequently ruptured and proved fatal is described. The case is of particular interest since ruptured pyogenic liver abscess, to our knowledge has not been described till this report.*

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Introduction : The incidence of pyogenic liver abscess is remarkably rare and their rupture rarer. In one series it was found to be 0·0077%. and at autopsy 0·2 to 0·9% in a number of other series (Bockus et al, 1976). In contrast, the incidence of amœbic liver abscess is about 2-10% (Chatterjee, 1980) and rupture of such abscesses especially if large (Manson-Behr and Apted, 1982) is well-recognised though not common. On the contrary, the rupture of a pyogenic abscess is such an unlikely eventually that it is not referred to in the standard literature. Traumatic rupture of the liver following blunt injury is unusual but can prove fatal due to severe intrahepatic hæmorrhage (Soni and Persaud, 1972). We describe a case of pyogenic liver abscess which ruptured leading to fatal sub-diaphragmatic bleeding.

Case report : A 70-year-old male (M H.) (Fig. 1) who had been running low-grade pyrexia for the

Fig. 1. Showing moribund patient after second laparotomy.

previous 2 weeks following an attack of 'dysentery' experienced sudden sharp right upper abdominal and chest pain while digging in the paddy field. This was followed by dizziness and then 'unconsciousness''. He regained consciousness on being brought home and the sharp pain was replaced by a dull ache while he was placed under the care of a village quack. He remained fairly mobile for the next 4-5 days before taking to bed for incressing lethergy progressing to stupor for which he was rushed to P. G. Hospital. He was not a known hypertensive or diabetic and there was no history suggestive of peptic ulcer. On examination : the patient was of average built and nutrition, markedly pale, apathetic and afebrile. There was no visible icterus, no hepatic or diabetic foetor and no neck stiffness. Pulse : 96 min., B.P. 100/60 mm. Hg. ; there was faint erythema over the right upper abdomen upto the lower part of the right chest with restriction of the movement with respiration and mild tenderness but no muscle guarding. The liver was not palpable but the upper border of hepatic dullness was at the 4th i.c.s. in the mid-clavicular line. The spleen was not palpable. Breath sound was diminished at the right lung base. Portable X-ray of the chest and abdomen revealed elevated right dome of the diaphagm. There was no abnormal gas or fluid levels. In the light of the clinical history, physical and radiological signs a tentative diagnosis of a ruptured liver abscess (? amœbic) was made but poor general condition of the patient forced to defer surgical intervention while conservative management with blood transfusions, parenteral Metronidazole and Gentamicin was continued in the mean time a wide-bore needle was inserted into the liver through the anterior axillary line. The needle went in as through a hollow viscus drawing torrent of fresh blood with only initial trace of yellowish-white pus-like material thus confirming the suspicion of a rutured liver abscess with hæmatoma formation. On the 2nd post-admission day in view of persistent signs of internal bleeding and worsening condition of the patient a laparotomy was considered unavoidable despite the hazard involved and was carried out by one of us (Anmar) in a desperate bid to repair the liver to check the bleeding. A right sub-costal incision revealed a large hæmatoma on the superior and lateral surface of the right lobe which was removed. There was an area of shallow

excavation on the superior surface with friable liver substance underlying the hæmatoma, The Glission's capsule was torn at places. No fresh bleeding was noticed. Biopsy specimens were taken from the liver and the abdomen closed with a drainage tube in situ. The condition of the patient seemed to stabilise following the laparotomy but bleeding resumed on the 4th post-operative day proving unresponsive to treatment and a 2nd laparotomy. Patient died 5 weeks after hospitalisation in terminal coma.

Investigation : Hb. 30%, total WBC count 38000/cmm., Poly. 84%, Lympho. 15%, Platelets 225000/cmm., B.T. 3·30 min., C.T. 4 30 min., Prothrombin time—not available, Serum Bilirubin 34·2 umol/L, Alk. Phos. 16 K.A. units, SGPT 52 units/L, SGOT 21 units/L, Random blood sugar 5·0 mmol/L, Serum Electrolytes within normal range. Blood culture was sterile. Discharged from the site of surgical incision on culture showed heavy growth of E. coli sensative to Gentamicin, Kanamycin and Carbenicillin, X-ray chest revealed a raised right dome of the diaphragm and obliteration of the right costophrenic angle due to a small effusion. X-ray of the abdomen showed no abnormal gas or fluid levels.

Histopathology of the liver biopsy :

Slide A (Fig. 2). Section shown fibrino-purulent exudate, haemorrhage, necrosis and granulation tissue.

Fig. 2. Section of the liver showing centre of the abscess with necrotic cellular debris. H. & E. X 200

Slide B (Fig. 3). Shows wall of an abscess composed of dense granulation tissue covered by a layer of fibrino-purulent exudate. Neutrophils are the predominant cells. Hæmorrhage is also seen.

Fig. 3. Section of liver showing wall of the abscess with granulation tissue, H. & E. X 20.

Slide C (Fig. 4). Reveals wall of a medium sized artery with easily descernible elastic lamina. The vessel wall is infiltrated with acute inflammatory cells and covered by fibrino-purulent exudate on top of a layer of granulation tissue. No E. histolytica (vegetative form) in seen. Conclusion : The sections are consistent with pyogenic liver abscess.

Fig. 4. Section of liver showing wall of an artery with its internal elastic lamina. It has been involved by the abscess. Granulation tissue enclosing the artery. H. & E. X 200.

Discussion : It is virtually certain that the initial period of 'unconsciousness' was in fact state of shock cause by sudden massive hæmorrhage due to rupture of the superficial abscess cavity tearing the vascular liver tissue. It is uncertain, however, whether the rupture was due to the sheer superficial location of the abscess bursting under its own tension for lack of support or to pull on the Glisson's capsule overlying the abscess wall tearing the latter off by the jolt of the digging at work. On the other hand, inflammatory erosion of a branch of the medium sized artery involved by the same inflammatory process (see figure) could well have led to bleeding and rupture of the abscess. This seems more plausible since it would explain the profuse and persistent bleeding better than the other two possibilities. Spontaneous hæmorrhage in an abscess cavity is highly improbable unless post-aspirational (Adams and Maegraith, 1976).

For reasons not explained pyogenic liver abscesses seem to rupture seldom in contrast to amœbic abscesses. It is possible that since pyogenic abscesses are more frequently multiple than solitary (Bockus et al, 1976) they are usually too small to rupture and perhaps the patient comes under medical attention earlier for being acutely ill and febrile. Solitary abscesses, on the other hand, are less dramatic and are characterised by low-grade pyrexia and chronicity and the patient is usually elderly (Butler and McCarthy, 1966). Our patient was elderly, had a solitary pyogenic abscess and his pyrexia subsequent to and preceding hospitalisation was a low-grade,

Amœbic infection of the liver and abscess formation is far more frequent in the tropics and the abscesses are more commonly single than multiple in great majority of cases. History of preceding colitis may be lacking altogether in some and in others there may not be active amœbic colitis at the time of the complication (LeMont and Isselbacher, 1977). In the series of (Harinasuta et al, 1968) 87% of the abscesses were located in the right lobe, and overall 27% of all abscesses ruptured. The rupture rate in this series appears rather exceedingly high since ruptured liver abscess seems to be so rare in this part of the world that the present case in fact is the first of its kind in our collective experience. Nevertheless, with the over present risk of such an eventuality in an area where dysenteric colitis is all too common due to poor sanitation and personal hygiene the importance of prompt and correct treatment of every attack of 'dysentery' can hardly be overemphasised. Alertness with the history of sudden severe right upper abdominal and chest pain followed by shock in a febrile patient with a preceding history of 'dysentery' should, as in the present case, enable an early and crucial diagnosis of a ruptured liver abscess to be made and appropriate measures taken.

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COLLEGE NEWS

Continuing Medical Education Programme :

The following lectures were delivered in the College Auditorium.

Oct. '84—Dr. Moslem Uddin Khan, Scientist, ICDDR., B., Dhaka delivered a lecture on "Epidemiology of Diarrhoeal Disease and its control".

Nov. '84—Dr. M. Kabiruddin Ahmed, Prof. of Surgery, SSMC., Dhaka delivered a lecture on "Buerger's Disease in Bangladesh".

Dec. '84—A 3-weeks Orientation course for FCPS, Part I Examination was held from 1-12-84 to 22-12-84.

Dr. M. Mustafizur Rahman, Ophthalmic Surgeon and Eye Specialist, Addl. Chief Consultant, Islamia Eye Hospital, Dhaka delivered a lecture on "Corneal Ulcer in Bangladesh".

Jan. '85—Dr. J. B. McFarland, MD., ChM., FRCS., FRCSE, Senior Lecturer in Surgery, University of Liverpool, U. K., delivered a lecture on "Benign Breast Diseases". He was also a Examiner in FCPS, Part II (Surgery).

Feb. '85—Prof. C. R. Whifield, Deptt. of Obstetrics and Gynaecology, Queen Mothers Hospital, Glasgow, U. K., visited the College as a SIMS-Black visiting Professor from the Royal College of Obstetricians and Gynaecologists of England and delivered a lecture on "Higher training in Obstetrics and Gynaecology".

Examination News :

New regulations are coming into force for dissertation for FCPS, Part II with effect from January, 1986. They are as follows :—

1. A candidate intending to appear at the FCPS, Part II examination will have to submit a dissertation at least six months before the date of the theoretical examination.

2. Acceptance of the dissertation is a pre-requisite for eligibility to appear at the Part II examination. The acceptance or otherwise will be communicated to the candidate three months before the said examination.

3. The dissertation will be examined by two examiners appointed by the examination Committee of the College. If the examiners are unanimous in their decisions this will be treated as final. If they differ the Examination Committee will appoint a third examiner whose dicision will be final. The third examiner may call for the candidate in person for an interview.

4. The dissertation will be candidate's own work. It could be an original research work or a critical review of a subject carried out any time after qualifying MBBS. The title of the dissertation and the name of the guide are to be communicated to the College at least six months before its submission. Within 15 days of its receipt the College will inform the canidate of its acceptance or otherwise about his proposal. Any change of title of the dissertation shall not be allowed after 3 months of the 1st communication by the candidate.

5. Any change in title or guide will have to be communicated to the College with justifications. In this event the date of submission will be calculated from the date of acceptance of the change.

6. The dissertation must be of good literary presentation in English. Three typed copies shall have to be submitted, properly bound, should not normally exceed more than 150 pages in text.

In writing the dissertation the candidates are advised to follow the instructions to the authors as published in the Journal of the Bangladesh College of Physicians and Surgeons.

To be put on effect from January, 1986.

Results of FCPS, Part I/Part II and MCPS Examinations held in January, 1985.

122 candidates appeared in FCPS, Part I Examination in different subjects. Only 27 candidates came out successful. Subjectwise results are as follows :—

	Number appeared	Number passed.
Medicine	28	10
Surgery	34	4
Obst. and Gynaecology	14	2
Paediatrics	23	5
Ophthalmology	11	1
Psychiatry	3	2
ENT	3	0
Anaesthesiology	4	1
Radiology	1	1
Clinical Pathology	1	1

List of candidates who passed FCPS, Part II are as follows :—

Roll No.	Name	Subject.
18	Dr. Md. Matiur Rahman	Surgery
19	Dr. S. M. Safiruddin Ahmed	Surgery
22	Dr. Abdul Haque	Surgery
25	Dr. (Maj.) A. K. M. Zafrullah Siddiq	Surgery
26	Dr. Md. Shahid Hossain	Surgery
27	Dr. Anjan Kumar Deb	Surgery
36	Dr. Laila Arjumand Banu	Obst. & Gynæ.
38	Dr. Dilruba Begum	Obst. & Gynæ.
39	Dr. Masuda Khatun	Obst. & Gynæ.
40	Dr. Md. Nurul Absar	Paediatrics
41	Dr. Mainuddin Ahmad	Paediatrics
43	Dr. A. S. M. Kamal Uddin	Ophthalmology
44	Dr. Ava Banik	Ophthalmology
45	Dr. Jamal Nizamuddin Ahmed	Ophthalmology
47	Dr Md. Mofakharul Islam	Ophthalmology
49	Dr. Nilakanta Bhattacharjee	ENT
51	Dr. Chowdhury Abdul Gaffar	Radiology

List of candidates who passed MCPS are as follows :—

Roll No.	Name	Subject
14	Dr. Rajat Kanti Roy	Obst. & Gynæ.
16	Dr. Sharifun Nessa	Obst. & Ganæ.
17	Dr. Dilip Kumar Das	Paediatrics
30	Dr. Mohammed Abu Zaffar	Anaesthesiology

Annual General Meeting and Election News :

The Annual General Meeting was held on 14-2-85 in the College auditorium. Important decisions are as follows :

1. Postal ballot for those Fellows only who are residing outside Bangladesh.
2. A Fellow can pay a lumpsum subscription Tk. 5,000/- only at a time to the College in place of the Annual subscription of Tk. 200/- only.

Eight new Councillors were elected by the Fellows for a term of four years. The are—

1. Dr. A. H. M. Ahsanullah
2. Dr. Md. Abdul Hadi
3. Dr. A. K. M. Anowarul Azim
4. Dr. Waliullah
5. Dr. Mazhar Ali Quaderi
6. Dr. A. S. M. Fazlul Karim
7. Dr. K. M. H. S. Sirajul Haque
8. Dr. Md. Nurul Amin

The Government nominated four Councillors for a term of four years. They are—

1. Dr. Mohammad Ibrahim
2. Dr. Mashiur Rahman
3. Brig. Abdul Malik
4. Dr. R. K. Khandaker

Election of the Office-bearers of the Executive Committee of the College Council was held on 27-2-85. They are—

President	Dr. S. A. Ashraf
Sr. Vice-President	Dr. Mazhar Ali Quaderi
Vice-President	Dr. A. H. M. Ahsanullah
Treasurer	Dr. Md. Ruhul Amin
Members	1) Dr. A. H. M. Towhidul Anowar Chowdhury
	2) Dr. Nazmun Nahar

[*Continued from front inside cover.*]

Chapter of book :

6. **Nixon HH :** Intestinal obstruction in the newborn. in Rob C, Smith R (eds). Clinical Surgery, chap 16, London, Butterworth, 1966, p. 168-172.

Chapter of book that is part of published meeting :

7. **Natvig JB., Kunkel HG.,** Gedde-Dahl T Jr. : **Chain sub-groups** of G Globulin, in Killander J (ed) : **Gamma** Globulins proceedings of the **Third Nobel Symposium,** New York, Wiley, 1967, pp. **37-54.**
8. Okamatsu **T, Takayama H,** Nakata K, et al : Omphalocela **surgery,** presented at the meeting of **the Pacific Association** of Pediatric Surgeons, San **Diego, April,** 1973.

Proofreading :

Contributors may be asked to proofread the galley proofs for typesetting errors. Important changes in data are allowed, but authors will be changed for excessive alterations in proof. Galley proofs should be returned within 24 hours.

Reprints :

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