

SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 337 To 338

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BALLOON DILATATION OF RENAL ARTERY STENOSIS. FIRST CASE REPORT IN PAKISTAN. Kundi A., Faruqui, A. Pakistan Heart Journal, 1985; 18 : 86-89.

A case of renal artery dilatation using a balloon catheter is presented. A 44 year old male having hypertension since 25 years was hospitalized for abdominal angiography. The blood pressure was poorly controlled despite a combination of antihypertensive drugs. On admission the reading was 240/140 mm Hg in the Right arm, peripheral pulses were not palpable in the right lower limb and an abdominal bruit was present. Laboratory investigations, Chest X-ray and ECG were unremarkable. Coronary angiogram showed severe disease of the left anterior descending and the right coronary arteries. An Aortogram revealed severe obstruction of the right renal artery with diseased terminal aorta and a pressure gradient of 100 mm Hg across the lesion. A selective renal angiogram showed 90 percent stenosis.

Balloon dilatation of the right renal artery was done with a 4 mm balloon using initial pressure of 5 bars and then 10 bars. The approach was percutaneous through the left Femoral artery. The pressure gradient fell to zero after the procedure and the renal angiogram showed a reduction in the stenosis to 30 percent.

Renal vascular hypertension is the most common type of secondary hypertension. The most common etiology in males is atherosclerosis and fibromuscular dysplasia in females. Trauma, embolization and coarctation of the abdominal Aorta are the less common causes. It is usually diagnosed when the patient presents with sudden onset drug resistant, malignant hypertension with deteriorating renal function and a renal bruit. Selective stimulated renal vein renin assays are useful and a fall in blood pressure with ACE inhibitors is a helpful screening test.

Surgery is not free of risks though the incidence of operative mortality and post-operative complications have reduced tremendously. Renal artery dilatation was first done in 1971.

Renal angioplasty has shown excellent results with no mortality and 5-6 percent post-procedure complications making it the safest and treatment of choice.

SURGICAL EXPERIENCE WITH PERIAMPULLARY CANCER; ANALYSIS OF 188 CASES IN THE ORIENT. Kim, S.S., Seel, D.J. Pak. J. Surg., 1986;2:1-8.

188 patients with periampullary cancer studied over a period of 14 years in Chonju, Korea are presented. The mean age was 55.9 years with male female ratio being 2:1 65 percent of the cases had cancer in the head of the pancreas, 21 percent in the distal common duct, 8 percent in the Ampulla of Vater and 6 percent in the second part of the duodenum.

The commonest symptom was abdominal pain followed by jaundice. Indigestion, weight loss, anorexia, nausea, vomiting weakness, fever with chills. and backache were also reported. On examination jaundice was found in 58 percent of the patients. Hepatomegaly, abdominal mass, palpable gall bladder and ascites were the other noted signs. Anaemia with elevated LFT values were had in all the cases and PTC was accurate in 95.5 percent of the 74 cases where employed. Ultrasonography also gave exact results in cases where performed. A large number of patients had a previous history of biliary calculi and clonorchis sinensis infestation was present in 9 patients thus suggesting that lithogenic or altered bile is carcinogenic.

35 cases could be resected and 110 patients had palliative surgery. 43 individuals underwent laparotomy with biopsy. The overall operative mortality rate was 10.1 percent. The techniques used for resection were Whipple Type procedure, child-Type operation and modified Child's operation with a

Braun Jejunojejunal anastomosis with the last one carrying the lowest risk. The complications encountered were wound sepsis, haemorrhage, pulmonary infections, urinary tract infections, anastomotic leakage and sub-phrenic abscess. The overall 5 year survival was 20 percent. Cancer of the ampulla and distal common duct had a more favourable prognosis than the others. The mean survival period in the cases undergoing resection was 24.5 months as compared to 8-9 months in the other group.

ENDOGENOUS HYPERINSULINISM FROM ISLET CELL ADENOMATOSIS. Moizuddin, Soomro, R., Jaffar, S. Pak. J. Surg., 1982; 216-20.

A 50 year old male attended the hospital with a dislocated elbow following a fall due to sudden loss of consciousness. He had regained consciousness in 3 hours spontaneously. General and systemic examination was unremarkable and the laboratory tests were all within normal limits. During hospitalization the episodes of unconsciousness accompanied with convulsions occurred daily and mostly in the early morning hours. He was diagnosed as post-traumatic epilepsy and antiepileptic drugs were initiated. The fits remained uncontrolled despite changing the combination of the anticonvulsants. A fasting blood sugar carried out during the early morning attack gave a reading of 24 mg%, and 20 ml of 25% glucose given intravenously showed a dramatic improvement. Further investigations revealed a high plasma insulin level, flat glucose tolerance curve and an abnormal glucose/Insulin ratio. These were all suggestive of pancreatic beta cell overactivity. A coeliac artery angiogram was inconclusive. Distal pancreatectomy was carried out and the histopathology gave a result of islet cell adenomatosis. The post-operative blood sugar was 196 mg% whereas the fasting blood sugar level did not fall below 70 mg%. The recovery was uneventful.

Hyperfunction of the pancreatic beta cells, a rare pathology, presents with symptoms of the familiar insulin reaction when the fall in blood sugar is rapid. Neurological sequelae as confusion, headache, diplopia, dysarthria and ataxia, are encountered when the blood sugar is lowered gradually. The diagnosis is confirmed by carrying out a fasting Insulin/Glucose test. Prolonged fasting tests upto 72 hours have also been recommended. Serum C-Peptide and Plasma Insulin concentrations may be disproportionately high in relation to blood glucose in such cases.

GAS IN A LIVER ABSCESS - A CASE REPORT. Drago, P., Ahmad, M. Pak. J. Surg., 1982;2:24-26.

A 55 year old lady underwent a cholecystectomy and pancreatico-duodenectomy, the indication being an obstruction at the common hepatic duct suspected to be due to malignancy. At operation a hard mass was found in the region of the common bile duct. The gall-bladder contained pus and stones.

Cholecystectomy and pancreatico duodenectomy was performed. Intramuscular gentamycin was continued in the postoperative period. 24 hours after surgery the Blood Pressure dropped, pulse and respiratory rate increased and fine basal crepitations developed in the lungs. I/V Ampicillin was added to the antibiotic regime. On the third post-operative day the patient got drowsy with a TLC of 22,700/cmm. Metronidazole 500 mg i/v 8 hourly was started. Gradual improvement was had till the seventh day when again fever with leucocytosis recurred. An ultrasound examination revealed fluid collection at the pancreatico jejunal anastomosis and a drain had to be introduced. She again developed fever on the fourteenth post-operative day. A plain film of the abdomen, ultrasound examination and CT Scan all confirmed gas in an abscess in the left lobe of the liver.

Re-exploration was done on the third post-operative day when the general condition did not improve with antibiotics. A 6 x 8 cm abscess containing necrotic tissue and thick pus was found in the medial segment of the left lobe of the liver. Culture showed a growth of *Enterobacter cloacae*, *Serratia liquefaciens* and *Clostridium perfringens*. Heavy doses of Benzyl Penicillin in addition to Metronidazole and Amikacin improved the status and the patient could be discharged after eleven weeks of admission. Histology confirmed adenocarcinoma of the gall bladder invading the common bile duct.

Gas containing pyogenic liver abscesses are rare. They can follow cholangitis, infected pancreatic fistulae or accidental ligation of the hepatic artery. Mottled gas in the epigastrium in plain Xrays should

arouse a suspicion and confirmation of the diagnosis can be had by ultrasound and CT scan.