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PAEDIATRIC NEUROLOGY: A TIMELY NEEDED SUB-SPECIALTY IN BANGLADESH

Wahed MA

Paediatric Neurology is a sub-specialty of Paediatrics which deals with diseases or effects of diseases or insults in the nervous system. Like Paediatrics the extent of this sub-specialty also extends from prenatal life to the late adolescent period. With the control of common infectious diseases, the relative incidence as well as prevalence of neurological problems is increasing day by day and occupying a large area among Paediatric diseases. The learning and caring procedure in neurology is different from other subjects. Because, the mode of presentation, clinical features and treatment modalities are different. The mortality rate is also high and neurological sequelae occur in as many as one third of survivors¹.

Acute bacterial meningitis takes a large share in neurological disease profile and a major cause of childhood morbidity and mortality. In an Indian study, among all the Paediatric admissions 1.5-5% were due to bacterial meningitis with a mean case fatality rate of $16\%^{2,3}$. In 2005, in a tertiary care hospital, almost 47.0% children were admitted with meningitis among neurological diseases in Paediatric ward with a case fatality rate of $7.0\%^4$. Many of these children were admitted very late and full recovery was impossible and ultimately became victims of various types of disability. Primary immunization

Professor of Paediatrics Prime Medical College, Rangpur against bacterial meningitis is yet not included in EPI programme. As a result, vaccination coverage is also very low.

Outbreak of encephalitis occurs a few years interval in our country. Epidemiological and laboratory studies have been conducted in these epidemics with the collaboration of some international organizations and these studies have shown evidence of infection by Nipah virus⁵. Moreover it occurs endemically throughout the year with a high case fatality (57.4%)⁶. Endemicity of this has also been documented by Acute Meningo-Encephalitis Surveillance (AMES) programme conducted in three Medical College Hospitals and laboratory evidence of Japanese Encephalitis (JE) has been shown in 6% cases with Nipah in 1% and Dengue in 8% cases⁷.

Epilepsy is the third common neurological disease in children. About 50 million people in the world suffer from epilepsy and one-third of them are children. The life-time prevalence rate varies from 2-5%⁸. Though around 70% of epilepsies are now curable, there is a belief in the general population that modern medicine are not suitable for epilepsy and the parents usually take treatment from indigenous or faith healers and ultimately many of the cases are died of various complications. Moreover, many of the drugs have become resistant and treating of these cases need special iudaement bv Paediatric neurologists⁹.

Treatment of cerebral palsy is a growing concern to Paediatricians. About 85% deliveries occur outside the hospitals and most of the cases are conducted by untrained birth attendants. The rate of antenatal care is also very low and risk factors are not always diagnosed or conveyed to the families. There is usually delay in decision making by the family members or delay in reaching the hospital^{10,11}. All these contribute to perinatal asphyxia. About 50% of the neonatal admissions in tertiary care hospitals suffer from perinatal asphyxia^{12,13}. Many of the children suffering from perinatal asphyxia develop cerebral palsy. It has been contributing about 7.2% causes of disability with another 20.5% from birth related complications¹⁴.

The above mentioned facts are only the tip of an ice-berg. There are many other neurological conditions in children remaining uncared in the community. Approximately 10% (13.9 million) of the total population in our country are disabled and among them 50% are children and 58% cases of disability have neurological origin¹⁵. Realizing the situation, Paediatricians have come forward to combat this reality. They have realized that Paediatric neurology is very essential component of learning as well as patient management. Child Neurology and Development Centers have been established in few number of large hospitals in limited scale. This is indeed a timely step in our country. Now it is necessary to expand the activities of the centers to all stakeholders and to develop public awareness. At the same time curriculum should be developed to incorporate it as a separate sub-specialty in medical education.

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INTESTINAL TUBERCULOSIS ASSOCIATED WITH CHRONIC ABDOMINAL PAIN

Sarker MAA¹, Akhter S², Hossain M¹

Abstract

Background: Intestinal tuberculosis (TB) is rarely encountered, but in Bangladesh specially in northern zone Intestinal TB is not uncommon. In most of the cases symptoms are mild and slight abdominal colic noted.

Method: During the last three (03) years period (August 2007 to July 2010) 196 patients having mild abdominal pain with weight loss have been evaluated in Prime Medical College Hospital, Rangpur. Fifteen patients in this group were unusual as no diagnosis could be made after complete history, physical examination, multiple imaging and by others laboratory studies. Each of 15 patients underwent a diagnostic laparoscopy.

Results: The age range of these patients were 15 to 47 years, among them 09 were female and 06 were male (Female: male =3:2). All patients in this series had band & adhesion, multiple stricture in small intestine and thicken gut wall specially near ileum with some enlarged lymph node in the adjacent mesentery. All patients had complete resolution of their chronic abdominal pain after appropriate surgical procedure & after taking anti-tubercular drugs.

Conclusion: A usual case of chronic mild abdominal pain can be the presence of intestinal TB. The clinical evaluations of these patients may be normal. Laparotomy should be the final evaluation for these types of patients and Laparoscopy should be considered for the final diagnostic and therapeutic test for chronic abdominal pain. *Prime Medical Journal 2011; 1 (1): 3-5*

Keywords: Chronic abdominal pain, Intestinal tuberculosis.

Introduction

According to the latest estimates from the World Health Organization (WHO) tuberculosis kills someone approximately in every 20 seconds, nearly 5000 people in every day and in the year 2008, 1.8 million people had died due to tuberculosis. TB is second only to HIV as the leading infectious killer of adults worldwide. It accounts for more deaths among women than all other causes of maternal mortality and is the leading infectious cause of death among people with HIV/AIDS. TB is global. The WHO also estimates that two billion people, one third of the world's population, are infected with Mycobacterium tuberculosis (M.tb), the bacillus that causes the disease. M.tb has unique cell wall, which has a waxy coating primarily composed of mycolic acids that allows the bacillus to lie dormant for

1. Professor of Surgery Prime Medical College, Rangpur.

2. Associate Prof. (Obs & Gynae) Prime Medical College, Rangpur. many years. The body's immune system may restrain the disease, but it does not destroy it. While some people with this latent infection will never develop active TB, 5 to 10 percent of carriers will become sick in their lifetime¹.

Intestinal tuberculosis is common in developing country like Bangladesh. Primary tuberculous infection of the intestine is caused by ingestion of the Bovine strain of Mycobacterium Tuberculosis, specially in low socioeconomic group & malnourished person. Secondary infection can also occur due to swallowing of the human tubercle bacillus. Among the patients with pulmonary TB 1% showed intestinal involvement. The distal ileum is the most common site of the disease. The bacillus localize in the mucosal glands and spreads to Payer's patches, where inflammation, sloughing of tissue and local attempts at walling off give rise to symptoms². Hypertrophic or ulcerative lesion occurs in case of intestinal TB. Hypertrophic tubercular enteritis results in stenosis and symptoms and signs are those of obstruction. The ulcerative form causes abdominal pain, alternative constipation and diarrhoea. Free perforation, fistula formation or haemorrhage may occur in severe untreated, malnutrated or immunosuppressed patients³. Diagnosis of intestinal TB can be difficult, but medical treatment should not be based on clinical suspicion alone, since carcinoma and Chron's disease causes similar symptoms & signs. So this study was conducted for Laparoscopic evaluation of the patients having suspicion of intestinal tuberculosis.

Materials & Methods:

During the last 03 years period (August 2007 to July 2010) 196 patients were evaluated for chronic abdominal pain in our hospital. All the patients were selected purposefully (non random sampling). Then complete history was recorded and full physical examinations were done for each patient. Among the 196 patients 15 patients had normal Ultrasonogram of abdomen, Endoscopy of G.I.T, Colonoscopy, Ba-enema, X-ray chest, Montaux test and other laboratory investigations. These patients had no history of BCG vaccination. They were unusual and included in this study. An abdominal exploratory laparotomy was performed in these patients as a final diagnostic evaluation. Necessary surgical procedure had done and tissue was taken for biopsy during the procedure. Each patient was evaluated by follow up physical examination every 03 months interval for 01 year. Fourteen patients were completely relieved by antitubercular drugs and one patient complained mild abdominal pain for 01 year. This patient is still under observation.

Results:

The age range of the 15 patients of this study was 15 to 47 years. Among them 09 were male and 06 patients were female. The duration of symptoms varied from 09 months to 02 years (Table-1). Terminal ileum was involved in most of the cases (Table- 2). Per-operative findings were multiple or single strictures in the terminal ileum and enlarged (mild) lymphnodes (Table-3). Histological findings showed Granulomatous lesion compatible with tuberculosis in 13 patients. In addition, two patients had histologically nonspecific chronic inflammatory lesion but these patients responded with antitubercular drugs (Table-4).
 Table-1: Demographic profile of patients (n=15)

Features	Value
Age	15-47 yrs
Mean age	30 yrs
Sex:	
Male	9
Female	6
Socioeconomic status:	
Ultra Poor	11 (no)
Poor	4 (no)

Table-2: Site of intestinal tuberculosis (n=15)

2	Location	Number	(%)	
	Terminal ileum	09	60.0	
	Jejunum	02	13.3	
	Ileocecal valve/Cecum	02	13.3	
	Sigmoid colon	01	6.66	
	Ascending colon	01	6.66	

Table-3: Histopathological findings (n=15)

Pathology	Number	(%)	
Granulomatous lesion compitable with Tuberculosis	13	86.66	
Nonspecific chronic inflammation	02	13.33	

Table-4: Peroperative clinical findings (n=15)

Findings	Number	(%)	
Bands & adhesion	06	40.00	
Narrowing of lumen	04	26.66	
Enlarged mesenteric lymph node	05	33.34	

Discussion:

Tuberculosis of the gastrointestinal tract is an ancient disease and has long been recognized far back 1643 by Virodt^{4,5}. It is often a disease of people of low socioeconomic conditions and non-vaccinated people. In this study 11 out of 15 patients were ultrapoor, which is consistent with the above statement. Again, all patients were from low socioeconomic group and they were not vaccinated.

Tuberculosis can involve any organ of the body and gastrointestinal tract is the second common site of involvement. Again ileo-caeal region is the common site of abdominal TB^{6-8} . In the study 60% cases had lesion in the terminal iteum which corresponds with the above statement.

Diagnostic laparotomy detected bands and adhesion in 06 (40%) patients and mild narrowing of lumen in 04 (26.66%) patients. Rest of the patients had inflamed mesenteric lymph nodes and slightly thickened inflamed terminal part of ileum. Different studies have also evaluated many patients where they found that around 10% of them had same types of changes⁹⁻¹⁴. The pathogenesis of Intestinal Tuberculosis is known. The inflammatory reaction results in formation of the bands & adhesion, subacute intestinal obstruction, stricture and enlarged lymph node.

In our study histological findings were positive in about 86.6% cases and all were gromlomutus lesions. In several studies on pathologic changes of intentional TB, gramulomelous lesion was present in 87% of cases and all were in lymphnodes¹⁵⁻¹⁹.

Conclusion:

Tuberculosis remains to be one of the most common health problems in the northern zone of Bangladesh. Intestinal tuberculosis sometimes becomes very difficult to diagnose by the Physician, Gastroenterologist, General surgeon and Gynaecologist. Laparoscopy has become important final diagnostic test & evaluation for these patients but it is not always possible in our country. Therefore, Laparotomy is considered for final diagnosis and treatment procedure for these patients after an extensive evaluation and investigations. Histopathological confirmation always needed after the procedure for Granulomatous lesion. More studies with large sample may be helpful for prevention or early diagnosis and treatment of intestinal tuberculosis. If early diagnosis is possible by laparoscopy, then it may be possible to reduce the morbidity and mortality of the patient by taking appropriate measures

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A PROSPECTIVE COMPARATIVE STUDY OF PROPHYLACTIC ANTIBIOTICS IN ELECTIVE UROLOGIC SURGERY

Mallik AU¹, Sarker MAA², Rahman SM³

Abstract

Introduction: Antibiotics are used in surgery to control postoperative infection. For prophylaxis, antibiotics may be used preoperative and peroperative period for control of infection. But it does not always necessary for prophylaxis postoperatively in elective surgery.

Method: A total of 49 patients were randomly selected from those who came for operation of diseases in Prime. Medical College Hospital, Rangpur. Patients were divided into 2 groups. Group A comprises of 22 patients who received antibiotics in preoperative, peroperative and postoperative periods. Group B comprises of 27 patients receiving same antibiotics in pre and peroperative period, but no antibiotics in postoperative period.

Results: Age of the patient's population ranged 2.5 yrs to 70 yrs, with mean 36.25 yrs ±47.73 in group A and 14 yrs to 75yrs in group B with mean 44.50 yrs ±43.13. In group A, 4.55% had postoperative wound infection and 18.18% had UTI. In group B, 8% developed fever which was relieved by NSAID only, and 5% developed dysuria.

Conclusion: This study indicates that prophylactic antibiotics did not have any significant role to play in prevention of postoperative wound infection in elective urologic surgery. *Prime Medical Journal 2011; 1 (1): 6-9*

Keywords: Prophylactic antibiotics, Elective surgery

Introduction

The use of prophylactic antibiotics in surgery is controversial¹. However, antibiotics are used to treat and prevent postoperative infections. Therefore, prophylactic antibiotics are now used in almost all surgical procedures. The most effective method is preoperative administration, because it can act at the time when the wound is potentially contaminated by organism^{2,3,4}. But in practice, prophylactic antibiotics are generally administered both preoperatively and postoperatively. Hence, the effects of this indiscriminate method and period of administration is unclear. There are reports showing no increase in the incidence of infection without the administration of postoperative prophylactic antibiotics^{5,6}. On the other hand, there are reports to suggest the necessity of continuous antibiotics use⁷.

Herein, we carried out a prospective study to define the

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role of prophylactic antibiotics in elective surgery to prevent postoperative infection and compared between patients population of two groups to see the needs of postoperative antibiotics.

Materials & Methods:

A total of 49 patients were randomly selected from those who came for operation of diseases in Prime Medical College Hospital, Rangpur, situated in Northern part of Bangladesh. Patients were divided into 2 groups. Group A comprises of 22 patients who received antibiotics in preoperative, peroperative and postoperative periods.

Group B comprises of 27 patients receiving same antibiotics in pre and peroperative period, but no antibiotics in postoperative period. Duration of the study period ranged from April 2007 to March 2010. This study was carried out after approval of the institutinal ethical committee. Consent was taken from patients/gurdians.

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^{2.} Prof. of General Surgery

Results:

Age of the patient's population ranged 2.5 yrs to 70 yrs, with mean 36.25 yrs \pm 47.73 in group A and 14 yrs to 75yrs in group B with mean 44.50 yrs \pm 43.13 (Table-1). There were 14 males and 8 females in group A and 22 males and 5 females in group B. In group A number of Benign Enlargement of the prostate (BPH) was 2, Pelviureteric junction obstruction (PUJO) 2, ureteric calculi 2, hypospadias 1, renal calculi 5, stricture urethra 5, suspected carcinoma prostate 1, vesicovaginal fistula (VVF) 2, bladder carcinoma 1 and ectopic ureter 1.

Ta	ble-	1:	Patient's	characteristics

Variables	Group A (post ope. antibiotics)	Group B (post ope. no antibiotic)
No. of patients	22	27
Age ranged (yrs)	2.5 to 70	14 to 75
mean (yrs)	36.25±47.73	44.5±43.13
Sex		
male	14	22
Female	8	5
		3

In group B, BPH was 4, PUJO 3, ureteric calculi 5, hypospadias 3, renal calculi 8, stricture urethra 2, testicular tumor 1 and vesical calculi 1 (Table-2).

Table-2:	Types of	urologic	diseases

Variables	Group A (with antibiotics)	Group B (without antibiotics)
ВРН	2	4
PUJO	2	3
Ureteral calculi	2	5
Hypospadias	1	3
Renal calculi	5	8
Stricture urethra	5	2
Testicular tumor	0	1
Vesical calculi	0	1
CaP	1	0
VVF	2	0
Ca Bladder	, 1	0
Ectopic ureter	1	0
Total	22	27

The types of surgery underwent in group A was TURP 2, Pyeloplasty 2, ureterolithotomy 2, hypospadias repair 1,nephrolithotomy/pyelolithotomy 5, visual internal

urethrotomy (VIU) 5, VVF repair 2, prostate biopsy 1, transurethral resection of bladder tumor (TURBT) 1 and ureteral reimplantation 1. In group B the types of surgery underwent was, TURP 3, pyeloplasty 3, ureterolithotomy 5. hypospadias repair 3. nephrolithotomy/pyelolithotomy 8 VIU 2, high orchiectomy 1, cystolithotomy 1 and open prostatectomy 1. Data are shown in Table-3. The protocol of antibiotic therapy is shown in table 4. In both groups preoperative and peroperative antibiotics were ciprofloxacin orally or intravenous (IV), or Gentamycine, or Cefradine or Ceftriaxone IV for 1 to 3 days. In postoperative periods same antibiotics were applied in Group A for 7 to 11 days, but no antibiotic in group B. The parameters recorded in both groups on admission were urine C/S (when suspected UTI), body temperature, wound condition, presence or absence of DM, complication during micturition, number of patients infected, length of hospital stay, days of antibiotics used. Patients having diabetis mellitus were excluded in this study. Complications encountered in postoperative period are shown in table⁶. In group A, 4.55% had postoperative wound infection and 18.18% had UTI. In group B, 8% developed fever which was relieved by NSAID only, and 5% developed dysuria. Antibiotic added in 11.11% patients at 7th, 8th, and 9th postoperative day.

Table-3:	Types of	surgery	und	lerwent
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Variables	Group A (with antibiotics)	Group B (without antibiotics)
TURP	2	3
Pyeloplasty	2	3
Ureterolithotomy	2	5
Hypospadias repair	1	3
Nephrolithotomy/		
pyelolithotomy	5	8
VIU	5	2
VVF repair	2	0
High orchiectomy	0	1
Cystolithotomy	0	1
Prostate biopsy	1	0
TURBT	1	0
Ureteral reimplantat	ion 1	0
Open prostatectomy	0	1
Total	22	27

A prospective comparative study of prophylactic antibiotics in elective urologic surgery

Table-4: Protocol of antibiotics therapy

	Group A	Group B
Preoperative	Ciprofloxacin orally or I/V or Cephradine I/V or Ceftriaxone I/V or Gentamycin I/V	Ciprofloxacin orally or I/V or Cephradine I/V or Ceftriaxone I/V or Gentamycine I/V
Duration	1 to 3 days	1 to 3 days
Peroperative	Same antibiotic	Same antibiotic
Postoperative	e Same antibiotic	No antibiotic
Duration	7 to 11 days	Not applicable

Table-5: Complications encountered (post. Ope.)

	Group A (%)	Group B (%)
UTI	18.18	7.41
Wound infection	4.55	3.70
Dysuria	nil	5.00
Fever	nil	7.41
Antibiotic added/change	nil	11.11

Discussion: Infections remain an important complication of surgical procedures despite increased knowledge about prevention and technological advances. Prophylactic antibiotics given before surgery have been shown to decrease the occurrence of infection after surgery. Due to rising treatment costs and concerns about antimicrobial resistance, surgeons have been trying to use fewer antibiotics. Most guidelines published in medical journals recommend using only one dose of antibiotic prior to surgery ; surgeons might not comply with this recommendation, sometimes giving patients more doses of antibiotics after surgery for longtime using broad-spectrum targeting many types of bacteria rather than narrow-spectrum drugs⁸.

Elective urologic surgery is mainly performed on patients without an underlying illness or comorbidity. Moreover, the number of factors affecting the development of postoperative infections decreases with the improvement of surgical procedure, materials and techniques. One study suggested that use of prophylactic antibiotics administration in some procedures should be performed if there is a strong probability of infection, with high dose for short period of time. They also reported that an incidence of an anticipated infection in some surgery could be reduced by using prophylactic antibiotics⁹. Another study suggested that the incidence of postoperative infections increased without the administration of prophylactic antibiotics. Another study suggested that the routine use of prophylactic antibiotics in some series is unnecessary⁵. Lindeboom et. Al also suggested that the use of postoperative prophylactic antibiotics is unnecessary in orthopedic surgery or dental surgery ^{9,10}.

Conclusion: In patients undergoing elective urologic surgery prophylaxis with antibiotics may be justified only in high risk patients. In all other patients prophylactic antibiotics do not seem to affect the incidence of postoperative infective complication. In low-risk patients, eliminating the unnecessary use of prophylactic antibiotics may result in a cost reduction.

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PREVALENCE OF DYSLIPIDAEMIA AT A RELATIVELY ISOLATED RURAL AREA (SHOAL AREA) IN NORTHERN PART OF BANGLADESH

Arefin MS¹, Rahman MA², Sharif MM³, Alam A⁴, Israt S⁵

Abstract

Introduction: During last few decades there is increased prevalence of dyslipidaemia in several folds.

Method: This descriptive cross sectional study was carried out on 304 subjects during the period of one year in the several places of rural areas of Northern Bangladesh with the objective to investigate the prevalence of dyslipidaemia among a relatively isolated rural area.

Results: It was revealed that prevalence of abnormal lipidaemic status was prevailed as cholesterol level about 5.7% in male and 3.1% female were within high risk group; 9.9% male and 21.5% female had border line high risk group. About 2.1% male and 0.6% female had very high level of TG. Seventeen (17%) male and 16.6% female were at border line high risk (200.01-500 mg/dl) group. High risk HDL level prevailed as 63.1% in male and 90.2% in female but only 36.9% of male and 9.8% of female had good HDL level. Regarding LDL level only 1.4% male and 6.1% female had very high risk of LDL and high risk LDL group included 12.1% male and 15.3% female. SBP and DBP as dependent variable separately found no significant relation with lipid profile in regression analysis and Logistic regression analysis of dyslipidaemia showed significant association only with sex (p=0.001).

Conclusion: The study revealed that although rural people are not sedentary and hardworking there is an increase prevalence of dyslipidaemia which should pay special attention.*Prime Medical Journal 2011; 1 (1): 10-13*

Keywords: Prevalence, Dyslipidaemia, Isolated rural Bangladesh.

Introduction

During last few decades there is increased prevalence of dyslipidaemia in several folds. A vast amount of evidence has confirmed the critical role played by the dyslipidemias in the pathogenesis of atherosclerosis¹. Multiple studies have shown that modification of the plasma lipid concentrations is a useful approach in decreasing cardiovascular mortality². Studies have shown that a significant proportion of the risk of stroke assumed to be related to hypertension and

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dyslipidaemia. In the general population, high blood pressure is one of the most important risk factors for stroke³. CVD and dyslipidaemia are raised two to threefold in South Asians, Caribbean and West Africans in Britain. Detection, management and control of hypertension and dyslipidaemia have improved, but there are still differences between various groups living in different areas. Bangladesh has been experiencing an epidemiological transition from communicable diseases to non-communicable diseases. Tertiary level hospital data indicate that cardiovascular diseases have already appeared as one of the leading causes of mortality. However, to explore the situation in the country several studies have been conducted. Dyslipidaemia and hypertension are new epidemic in South Asia and are the results of social influences and changing lifestyles. The study was conducted to see the prevalence of dyslipidaemia at a relatively isolated rural area of bangladesh.

Methods & Materials: This descriptive cross sectional study was carried out on a total number of 304 subjects during the period of January '09 to December '09 in the various places of rural areas (nine villages from three unions) of Northern Bangladesh (Shoal areas of Sirajganj district). Subjects were selected after taking brief history. Preliminary selection was done and the purpose of the study was explained in details to each subject. A data collection form was developed to obtain relevant information regarding demographic and socioeconomic status such as age, gender etc. The prevalence rate of dyslipidaemia was determined by simple percentages. Data are expressed as mean±SD for parametric values & median (range) for non-parametric values. Comparisons between groups were done using Independent t test to compare means. All tests were done in the Department of Biochemistry, BIRDEM, Dhaka. Multiple regression analysis was performed. All the statistical analysis was performed by the SPSS data (SPSS Inc, Chicago, IL, USA).

Results: Regarding cholesterol level about 5.7% and 3.1% female were within high risk group; 9.9% male and 21.5% female had border line high risk cholesterol level. About 2.1% male and 0.6% female had very high level of TG. Seventeen (17%) male and 16.6% female were at border line high risk (200.01-500 mg/dl) group. High risk HDL level prevailed as 63.1% in male and 90.2% in female but only 36.9% of male and 9.8% of female had good HDL level. Regarding LDL level only 1.4% male and 6.1% female had very high risk of LDL and high risk LDL group included 12.1% male and 15.3% female. In regression analysis of SBP and DBP as dependent variable separately found no significant relation with lipid profile (Cholesterol, Triglyceride, HDL and LDL). Logistic regression analysis of dyslipidaemia showed significant association only with sex (p=0.001).

	Variables	Mal	e	Female		
		Frequency	%	Frequency	%	
Chalastanl	<200 normal	119	84.4	123	75.5	
(mg/dl)	200.01 - 240 border line high risk	14	9.9	35	21.5	
	>240.01 high risk	8	5.7	5	3.1	
	<150 normal	91	64.5	112	68.7	
Triglyceride	150.01-200 border line high risk	23	16.3	23	14.1	
(mg/dl)	200.01-500 high risk	24	17.0	27	16.6	
	>500.01 very high risk	3	2.1	1	0.6	
HDL	normal >40 for male, >50 for female	52	36.9	16	9.8	
(mg/dl)	risk <40 for male, <50 for female	89	63.1	147	90.2	
	<100 normal	90	63.8	78	47.9	
LDL (mg/dl)	100.01-130 near optimal	32	22.7	50	30.7	
	130.01-190 high risk	17	12.1	25	15.3	
in prevaig in	>190.01 very high risk	2	1.4	10	6.1	

Table-1: I	Prevalence	of	lysli	pidaemia	among	the	study	populatic	on.
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Prevalence of dyslipidaemia at a relatively isolated rural area (shoal area) in northern part of Bangladesh.

	S	BP	DBP ·		
Variables	ß-value	p-value	ß-value	p-value	
Cholesterol (mg/dl)	0.354	0.117	0.397	0.079	
Triglyceride (mg/dl)	-0.106	0.425	-0.108	0.416	
HDL (mg/dl)	0.046	0.525	0.005	0.943	
LDL (mg/dl)	-0.117	0.539	-0.145	0.448	

Table-2: Multiple regression analysis of blood pressure level as a dependent variable with lipid profile of the study subjects

Multiple regression analysis was performed where SBP and DBP were taken as dependent variable separately with other independent variables. β was for standardized regression coefficient. p<0.05 was considered as statistically significant.

Table-3: Logistic regression analysis of dyslipidemia as a dependent variable with other variables of the study subjects

Variables	Dyslip	Dyslipidemia			
variables	ß-value	p-value			
Age (yrs)	0.105	0.070			
Sex	0.204	0.001			
Yearly family income (taka)	0.045	0.434			
BMI (kg/m2)	0.097	0.100			
WHR	0.033	0.575			
FBG (mmol/l)	0.103	0.275			
AG (mmol/l)	-0.0048	0.613			

Logistic regression analysis was performed where dyslipidemia was taken as dependent variable and others were independent variables. β was for standardized regression coefficient. p<0.05 was considered as statistically significant.

Discussion: The heterogenic nature of dyslipidaemia necessitates the conduction of epidemiological studies in various communities even within the same racial background. The environmental factors, particularly food habit and physical activity, play a great role in modulating the diabetogenic genes and thus exploration of these factors is a must for rational intervention against the disease both in terms of management and prevention. The 'char' areas in Bangladesh constitute very special locations with isolation, underdevelopment, relatively traditional lifestyle, and a challenging life against environmental odds like flood and cyclones. This present study was conducted in such a char area named as 'Shoal' under the Sirajganj district. Regarding cholesterol level about 5.7% and 3.1% female were within high risk group; 9.9% male and 21.5% female had border line high risk cholesterol level. About 2.1% male and 0.6% female had very high level of TG. Seventeen (17%) male and 16.6% female were at high risk group. In the study conducted by Salinas et al revealed that hypertriglyceridaemia was the second most prevalent abnormality (24.3%). High risk HDL level prevailed as 63.1% in male and 90.2% in female but only 36.9% of male and 9.8% of female had good HDL level. This is very much similar with the study conducted by Salinas et al where it was found that most prevalent abnormality was HDL cholesterol. Regarding LDL level only 1.4% male and 6.1% female had very high risk of LDL and high risk LDL group included 12.1% male and 15.3% female. But increased LDL cholesterol was observed in 11.2% of the total population⁴. Erem et al⁵ showed same study result that the prevalence of hypercholesterolemia, LDL, HDL and hypertriglyceridaemia were respectively 37.5, 44.5, 21.1, and 30.4%. In regression analysis of SBP and DBP as dependent variable separately found no significant relation with lipid profile but this result was dissimilar to the study (de Souza et al) where it was seen that dyslipidaemia had significant association with blood pressure (P<0.001). This dissimilarity may be due to hard working life style and environment of the shoal area. Logistic regression analysis of dyslipidaemia showed significant association only with sex (p=0.001). This is similar to the study conducted by de Souza et al where it was found that sex (P<0.001) has a positive correlation with dyslipidaemia. Erem et al also revealed

that dyslipidemia was significantly associated with the factors of age, gender, BMI by multiple logistic regression analysis. All the studies are similar to this present study because dyslipidaemia share common risk factors despite different sociodemographic background and rising prevalence of dyslipidemia in this population may again be reflection of lifestyle changes⁶.

Conclusion:

Genetic and environmental heterogeneity of dyslipidaemia suggests epidemiological studies to be conducted in various community settings. Community based epidemiological studies on dyslipidaemia in Bangladesh are only few in number and the rural data from those studies reflect dyslipidaemia was prevailed on those societies of transmission to semi urban demography. Due to this present study we explore high prevalence of dyslipidaemia in rural Bangladesh.

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SUCCESSFUL MANAGEMENT OF PRIAPISM SECONDARY TO LEUKEMIA - A CASE REPORT

Mallik AU¹, Sarker MAA²

Abstract

Priapism due to sickle cell disease is common but rare due to leukamia. Here in we report a case of priapism secondary to leukemia, which was managed by aspiration followed by glanulocavernous shunt. A 16-year-old male presented with prolonged involuntary painless erection of 24 hours duration. The physical examination and Doppler USG revealed low flow priapism. Blood parameter showed increase leukocyte count indicating leukemia. We treated the patient successfully by cavernous lavage with adrenaline, an alpha-1 adrenergic agonist, followed by glanulocavernous shunt. Complete detumescence was achieved after second time puncture lavage of the cavernous. We conclude that priapism due to leukemia can be best treated with adrenaline lavage until full detumescence achieved. *Prime Medical Journal 2011; 1 (1): 14-17*

Keywords: Priapism, detumescence, glanulocavernous shunt.

Introduction

Priapism is usually defined as an abnormal persistent erection of the penis unrelated to sexual stimulation and unrelieved by ejaculation. The penis is composed of 2 corpora cavernosa and the corpus spongiosum, which contains urethra. These corpora are capped distally by the glans penis. Each corpus is enclosed in a fascial sheath known as tunica albuginea and a thick fibrous envelope known as Buck's fascia which surrounds all. The tunica albuginea of the corpus cavernous is a bilayered structure with multiple sub layers. The inner circular bundles support and contain the cavernous tissue¹⁻². From this inner layer radiate intracavernousal pillars, which provides essential support to the erectile tissue. The outer layer bundles are oriented longitudinally. Emissary veins run between the inner and outer layers for a short distance, often piercing the outer bundles obliquely. Branches of the dorsal artery takes a more direct perpendicular route. The outer layer of tunica albuginea appears to play an additional role in compression of the vein during erection³⁻⁴. The paired

internal pudendal artery is the major carrier of the blood supply to the penis. The terminal part of this artery divides into 3 branches, supplies the corpora cavernosa⁵⁻⁸.

In the normal male, penile erection may last for several minutes to 1 hour or more under erotic stimulation. An erection lasting longer than 4-6 hours is considered to be priapic⁹. The urological condition priapism gets its name from Priapus. In Greek Mythology, Priapus was a minor rustic fertility God of purely phallic character, protector of livestock, fruit plants, gardens and male genitalia. Priapus was a son of Aphrodite. Aphrodite was the Greek Goddess of love and beauty, and podroness of physical love.

Priapism may be classified into 3 different types : 1st is low flow, ischaemic, anoxic or veno-occlusive priapism, second is high flow, arterial or non-ischaemic priapism, and third is recurrent or shuttering priapism. High flow priapism occurs due to trauma, which results in loss of penile blood flow regulation. The low-flow priapism usually presents with several hours of erection.

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The glans penis and corpus spongiosum are soft and uninvolved in the process. The low-flow type is more common and dangerous, as these patients are susceptable to greater complications and the long- term recovery of erectile function is dependent on prompt and urgent intervention. The mechanism of priapism remains in debate, but most authors believe the abnormality to be physiologic obstruction of the venous drainage. This obstruction causes highly viscous, poorly oxygeneted blood (low O_2 , high CO_2) within the corpora cavernosa^{9,10}. Penile erection occurs as a result of increased blood inflow to the penis, engorgement with blood, and decreased outflow of blood from the penis. Primarily the process is mediated by nitric oxide.

Many researchers investigated to know the mechanism of erection in normal condition. Sexual stimulation causes the release of nitric oxide (NO) via stimulation of nonadrenergic, non-cholinergic neurons. Nitric oxide causes vasodilatation^{7,9}. Herein, we report a case of priapism due to leukemia, which was treated successfully with adrenaline intracavernous injection followed by glanulocavernous shunt formation.

Case report

A 16 years old boy was referred to our hospital, for sustained erection of penis longer than 24 hours duration (Fig.-1).



Fig.-1: Priapic penis

He was not clinically anaemic. General examination revealed no abnormality. He had no history of trauma. The patient was initially diagnosed as a case of priapism and was treated with ice cool application around penis for 1 hour. The patient did not respond to this management, so complete blood count was requested. The white blood cell count was more than 100000/mm³ of blood. Doppler USG was done, which revealed low-flow of blood to the penis. In view of the patient's

clinical condition, he was admitted to the Urology ward for further management. After general anaestesia an 18G I/V cannula inserted through the glans penis to the corpora cavernous (Fig.-2).



Fig.-2: Diagrammatic representation of glanulocavernous shunt

Milking of the shaft of the penis was done in order to empty both the corpora cavernosa for quick detumescence. Cannula was kept in-site for more 24 hours. At the same time treatment of leukemia was started. Recurrence of priapism was occurred after 24h. For which same procedure was done under G/A. At this time intracavernous adrenaline injection (1/100000 strength) and milking of the shaft was done simultaneously. At the end of the procedure a true-cut biopsy needle was inserted through the cannula site to the cavernous muscles for glanulocavernous shunt. Postoperative period was uneventful.

Discussion

Priapism due to leukemia is an uncommon condition but a urology emergency, which require rapid detumescence to prevent erectile dysfunction. It causes impotence, a devastating condition for male, if not treated urgently. In most cases of priapism, treatment invites draining of the stagnant blood with prevention of further blood flow into the penis, with a cannula inserted into the corpus cavernous through glans penis. Medication that acts on the blood vessels can also be injected to help shrinkage of blood vessels and thus decreases blood flow into the penis.

Leukemia is a neoplastic disorder of blood, which requires medical attention. In Leukemia white cell count in blood increases to high level, subsequently blood viscosity increases. Leukocytes trapped inside sinusoids of corpora cavernous muscles of the penis, the sinusoid engorged as well as penis engorged and enlarged. But the venous return stop due to blockade of the emissary

Successful management of priapism secondary to leukemia - A case report

veins. These cause sustain erection of the penis. For treatment of priapism, leukemia should receive prompt chemotherapy. We diagnosed priapism and started chemotherapy immediately. The patient came to us in late. So, there is chance of development of impotence. Our described technique for treatment of priapism is based on knowledge of penile blood circulation during erection and detumescence condition as described by others¹¹⁻¹³. Adrenaline is an alpha-adrenoreceptor agonist that causes vasoconstriction. This agent has been extensively studied with regard to its efficacy in the control of priapism9,11. Numerous clinical trials using multiple doses format as injection inside corpora cavernous have demonstrated tremendous efficacy for detumescence of priapic penis^{11,12}. Xiao H. et al. also documented a sinificantly earlier return of detumescence, preventing impotence with adrenaline intracavernous injection¹¹⁻¹⁶. We have shown successful effect of intracavernous adrenaline injection followed by glanulocavernous shunt formation in our patient. Result from our treatment is in agreement with those of earlier report^{11-13,17}. The slugged blood was evacuated from the corpora through a large bore needle. The addition of adrenergic injection via intracavernous irrigation has proved helpful¹⁸. Multiple wedges of tissue can be removed via a true-cut biopsy needle to create a shunting fistula between the glans penis and corporacavernosa. This technique, which has been very successful, provides an internal fistula to keep the corpora decompressed. Our technique was similar to those techniques^{19,20}. The recurrence after first manipulation of priapism in our case corresponds to the inaccurate technique of detumescence. Therefore, we currently recommend exclusive use of adrenaline during detumescence of priapism. We feel that recurrence in our case was due to incomplete evacuation of the stagnant blood in first time, for which we performed milking second time, until phallus of the penis became completely soft. We also recommend glanulocavernous shunt with a true-cut biopsy needle after adrenaline injection and milking. We know that the pathological cause of priapism in our case was due to Leukemia ; therefore, it seems clear that despite the chance of ED, this minor surgical procedure for priapism treatment is of great value in this case.

Conclusion :

With the detumescence procedure for priapism in our case, we believe that our technique is of highly

effective. Therefore, we recommend adrenaline intracavernous injection for the treatment of priapism followed by shunt formation. Longtime follow-up is necessary to see ED for those who come in delay after onset of priapism.

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College News

List of Topics of Integrated Teaching Presented

SI.	Name of Topics	Name of Department	Date of Presentation
1	Thyriod function & its disorder	Physiology	28.04.10
2	Postoperative fluid therapy	Surgery	06.10.10
3	Childhood immunization update	Paediatrics	27.10.10
4	Antharx	Community medicine	03.11.10
5	Hypertension	Medicine	10.11.10
6	Rational use of drug	Pharmacology	17.11.10
7	Staphylococcal infection	Microbiology	08.12.10
8	Streptococcal infection	Microbiology	15.12.10
9	Granulomatous inflammation & Granuloma	Pathology	22.10.10
10	ТВ	Community Medicine	29.12.10
11	Cell Injury	Pathology	05.01.2011
12	Chromosome	Anatomy	09.02.2011
13	Childhood Cancer	Paediatrics	23.02.2011
14	Fate of RBC and Jaundice	Physiology	02.03.2011

New Arrival

The Following Personnel have joined in Prime Medical College within the previous six months

Professor Dr. Nawazesh Farid, MBBS, D-Card
Professor Dr. A E Md Abdul Wasey, MBBS, FCPS (Surgery)
Professor Dr. Ashraf Uddin Mallik, MBBS, PhD (Urology)
Professor Dr. Md. Abul Hossain Khan, MBBS, M-Phil (Micro.)
Dr. Quazi Abdullah Al Masum, MBBS, FCPS (Medicine)
Dr. Md. Shaiful Arefin, MBBS, M-Phil (Bio.)
Dr. K M Abul Ehsan, MBBS, DO
Dr. Masuma Jesmin, MBBS, MPH

9. Dr. Manosantosh Malick, MBBS, DTCD

10. Dr. Md. Ayub Ali, MBBS, DIH

Professor of Cardiology Professor of Surgery Professor of Urology Professor of Microbiology Associate Professor of Medicine Assistant Professor of Biochemistry Assistant Professor of Ophthalmology Assistant Professor of Community Medicine Assistant Professor of Respiratory Medicine Curator, Forensic Medicine

40th Victory Day observed

With great enthusiasm and spirit of Liberation war we have celebrated 40th glorious victory Day reimbursing immense respect to our heroic sons who had sacrificed their lives in 1971 for the motherland and we got victory. On the day our students participated in a colourful rally across the city. Then special prayer was conducted at our college premises.

Orientation Programme of 3rd Batch (PMC3) Held

By the grace of Almighty in this year we have got the permission for admission of 91 students. Our heartiest thanks to the of Ministry of Health and Family Welfare. Orientation of new students that is PMC-3 was held on 9th January 2011. On that day new students were delightedly received by the old students. Distinguished guests, present to grace the occasion, were Commissioner and Joint commissioner of Rangpur Division, respected members of current parliament and Superintendent of Police of Rangpur district.

Training period for 6 months

We are happy to announce that on 11th January 2011 Bangladesh College and Physicians and Surgeons (BCPS) visited our hospital and kindly approved training for 6 months on Medicine, Surgery, Gynae & Obs and Paediatrics.

Meeting of Governing body held on 16.9.10

A meeting of Governing body was held on 16th September 2010 and Chaired by the Honorable Chairman of the Company, where several issues were discussed. Some decisions were taken for the betterment of the Prime Medical College and Hospital as well as the students.

Positions available

The Following positions are available for the competent doctors for the following Department:

1. Professor of Pathology

2. Associate Professor of Cardiology

3. Assistant Professor of Cardiology.

4. Assistant Professor of Paediatrics.

5. Assistant Professor of Surgery

6. Assistant Professor of Anatomy

7. Assistant Professor of Microbiology

8. Assistant Professor of Pharmacology

9. Assistant Professor of ENT

10. Assistant Professor of Gynae & Obs.

Information for the Contributors

Manuscripts prepared following the "Uniform Requirements for Manuscripts to Biomedical Journals" is acceptable to this journal for publication.

Editorial scope:

- The Prime Medical Journal (PMJ) is intended to promote prompt publication of concise scientific article based on the study in all fields of medical and health sciences.
- Submitted manuscripts should not be previously published or being considered for publication elsewhere.
- All submitted articles will undergo double blind peer review as per recommendations by subject specific experts selected by editors.
- * Reviewed manuscripts will be sent to the corresponding author for appropriate response if it is indicated.
- Acceptance is based on significance, originality clarity and fulfillment of the criteria of the publication policy of this journal.
- * The Editor- in- Chief will make all final decisions regarding acceptance.
- Selection of the reviewed and accepted manuscripts intended for publication in a particular issue will be decided by Editorial Board.
- * Rejected manuscript will be returned if accompanied by stamped or self- addressed envelop.
- Upon acceptance for publication the copy right of the paper automatically transfers to the PMJ and will not be published elsewhere either in part or whole without written permission of the copyright holder.
- * Review article should be written by a subject expert.

Ethical aspects:

- Manuscripts based on the study should have been conducted according to the ethical standards laid down in the 1994 Declaration of Helsinki revised 2000.
- Manuscript must contain a statement in the method section that all human subjects involved in studies have been approved by appropriate ethical committee after careful examination of the ethical aspects.
- Permission of the patients or their families to reproduce photographs of the patients where identity is not disguised.
- Author should obtain written permission to reproduce any table, illustration from any other source.

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The authors are requested to strictly follow the guide lines below for submission of manuscript to PMJ for publication. The following documents with manuscripts are to be submitted for publication.

- A covering letter addressed to the Editor-in-Chief of the journal (Sample given at the end).
- Abstract and key words in the first page followed by the text
- Authors must submit 2 hard copies of all documents and one copy in electronic form preferably written in a CD with adequate labeling.
- In special case, submission through E-mail with file attachment of all documents is acceptable.

Covering letter:

- * All authors must sign after seeing the manuscript with the Statement that they only
- ✤ authors they are the only authors.
- * The corresponding author should mention the contribution of each author to the work.
- It should contain a declaration that this manuscript has not been submitted else where or not under consideration in any journal.
- ✤ It should clearly indicate the publication type (Original/Review/Case report/Letter etc).
- * It should be also mention the expected benefit of the medical science from publishing of this article.

Authors are requested to submit new and revised manuscript to:

Editor-in Chief Prime Medical Journal Prime Medical College Pirjabad, Badargonj Road, Rangpur. Tele:+0521-53902 E-mail: pmcrang@gmail.com

Manuscript Organization:

Typing

* Double spaced throughout with Justified and 2.5 cm margins in the left and top.

- ♦ Font type is Times New Roman with size 12.
- Printed on a good quality A4 80 gm on one side of paper.

Manuscript should have uniform style, correct journal format, carefully proofread for grammar, spelling and punctuation.

Manuscript format

In general, original article should be divided into following sections: Title page, Abstract Text, Tables with titles and foot notes, alternatively Graph with title and Illustrations with legends. Each of the sections is to start on a separate page. Pages should be numbered consecutively beginning from the abstract.

Title page:

- * Title of the article (Not exceeding 60 characters).
- Names of all authors with their designation and institutional affiliations Name of the department and institute where the study was undertaken
- * Name of the corresponding author with contact address, telephone number, Email address.
- Disclosure of conflict of interest (if any).
- v Disclosure of sources of funding or sponsor

Abstract:

- * Structured with headings (Background, Objectives, Methods with statistical analysis, Result & Conclusion).
- * Authors name should not be given.
- Preferably within 250 words.
- Avoid abbreviations in the title and abstract except standard abbreviation.
- A non structured abstract is suggested for review article and case report.

Text:

Text should be arranged into Introduction, Materials & Methods, Results, Discussions, Acknowledgement & References (IMRDAR).

Introduction:

- Statement of the problem with a short discussion of its importance and significance.
- Review of the literature related to the problem with pertinent reference.
- * Objectives/ hypothesis/ benefits expected stated in 1-2 paragraph.

Materials & Methods:

- Study type, place and time.
- Description of study variables.
- * Description of study subjects and grouping.
- Selection criteria
- Approval of the study involving human subjects by ethical review committee and description of the ethical aspects in such study
- * Description of procedure, methods, apparatus, drugs or chemicals as applicable.
- Description of statistical procedure with enough detail to enable a knowledge able reader with access to the original data to verify the reported results

Results:

- * Present result in logical sequence in text, table and illustration with most important finding first.
- Describe without comment.
- * Restrict number of table and figure needed to support assessment of paper.
- Do not duplicate data in table and figure.

Table:

- * Simple self explanatory with brief title, not duplicate in text.
- * Each table should be numbered in Romans and printed in separate page.
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Illustration:

- * All illustrations must be numbered consecutively in English numerals as they appear in the text.
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- * All drugs should be mentioned in their generic form. The commercial name may be used in parenthesis

Acknowledgement:

v Individuals, Institutions, Sponsors, Organizations of bodies can be acknowledged in the article for their contribution or financial or any form of assistance to the work.

References:

- For reference, use author number style (Vancouver) which is based on an ANSI standard adapted by the National Library of medicine (NLM).
- * References should be numbered consecutively in the order on which they are first mentioned in the text.
- Identify references in the text, tables and legends by English numerals in superscript.
- All citations to electronic references should be presented in numbered references following the text.

The titles of the journals should be abbreviated as

- * Coding to the style used in Index Medicus.
- Write names of 6 authors followed by et al, if authors number is more than six.
- The reference list is also checked by the editorial staff or reviewer. So, it is the responsibility of author to provide accurate information.

Standard journal article:

Example:

Khalil M, Chowdhury MAI, Rahman H, Mannan S, Sultana SZ, Rahman MM, etal Splenic Mass and its relation to age, sex and height of the individual in Bangladeshi People. J Bangladesh Soc Physiol 2008;3(1):71-78.

Journal article with organization as author:

American diabetes Association. Diabetes Update. Nursing, 2003 Nov; Suppl: 19-20.

Journal article with multiple organization as author:

American Dietetic association; Dietitians of Canada; Position of Dietetic association and Dietitians of Canada Nutrition and Women's health. J Am Deet Assoc 2004 Jun; 104(6): 948-1001.

Journal article with Governmental body as author:

National Institute on Drug Abuse (US); Caribbean Epidemiology Centre; Pan American Health Organization; World Health Organization. Building a collaborative research agenda: drug abuse and HIV/AIDS in the Caribbean 2002-2004. West Indian Med J. 2004 Nov; 53 suppl 4: 1-78.

Standard book with initials for authors:

Eyre HJ, Lange DP, Morris LB. Informed decisions: the complete book of cancer diagnosis, treatment and recovery 2nd ed. Atlanta: American Cancer Society; 2002.768p.

Contributed chapter of a book:

Rojko JL, Hardy WD. Feline lukemia virus and other retroviruses. In: Sherding RG, editor. The cat: diseases and clinical management. New York: Churchill Livingstone; 1989. p 229-332

Conference Proceedings:

Pacak K, Aguilera G, Sabban, E, Kvetnansky R, editors. Stress: current neuroendocrine and genetic approaches. 8th symposium on Catecholamines and Other Neurotransmitters in stress: 2003 Jun 28-July 3; Smolenice Castle (place of conference), Slovakia. New york (place of publication): new York Academy of Sciences (publisher); 2004 Jun. 590 p.

Scientific and Technical Reports:

Page E, Harney JM. Health hazard evaluation report. Cincinnati (OH) (Place of publication: National Institute for Occupational Satety and Health)(US)(Publisher); 2001 Feb.24p (Total number of pages). Report No: HETA2000-0139-2824.

Dissertation & Thesis:

Entire Reference

Kempner JL. Aching heads. making medicine gender and legitimacyin headache (title) [dissertation] [Philadelphia] University of Pennsy lvania;2004.271p.

Alam M. Study of Heart Rate Variability in Adolescent Athletes [m Phil thesis]. [Dhaka]: Bangabandhu Sheikh Mujib Medical University; 2008. 178p.

Part of Dissertation & Thesis:

Mackowski MP. Human factors: aerospace medicine and the origins of manned space flight in the United States [dissertation]. [Tempe (AZ)]: Arizona State University;2002 May. Part 2, Space medicine; p. 188-377.

Alam M. heart Tate Variability in Adolescent Athletes[M Phil thesis].[Dhaka(Bangladesh)]: Bangabandhu Mddical University;2008 July. Appendix (Name of the part 4(Number of the part),Classification of Physical Activity Intensity (Title of the part).p.7 (Location of the part).

Standard journal article on the Internet:

Kaul S, Diamond GA. Good enough: a primer on the analysis and interpretation of noninferiority trials. Ann Intern Med [Internet]. 2006 July 4 [cited 2007 Jan 4];145(1):662-9. Available from:http://www.annals.org/cgi/reprint/145/1/62.pdf

Journal article on the Internet with organization (s) as author:

National Osteoporosis Foundation of South Africa. Use of generic alendronate in treatment of osteroporosis. S Afr MedJ[Internet].2006Aug[cited 2007 Jan 9];9(8):696-7.Available from:http://blues.sabinet.co.za/WebZ/Authorize?

Journal article on the Internet with governmental body as author

Centers for Disease Control and Prevention (US), National center for HIV/AIDS, Hepatitis, STD, and detention and control of tuberculosis in correctional and detention facilities: recommendations from CDC. Endorsed by the Advisory Council for the elimination of tuberculosis, the national Commission of Correctional Health Care and the American correctional Association. MMWR R Rep[Internet].2006 July 7[cited2007Jan9];55(RR-9):1-44. Available from:http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509al.htm

Journal article on the Internet with no author:

Prevention strategies for asthma-secondary prevention.CMAJ [Internet]2005 Sept[cited2007Jan5];173(6Suppl):S25-7.Available from:http//www.cmaj.ca/cgi/content/full/173'6_suppl/S25

Journal article on the Internet without standard volume, issue or article number:

Jacobs JL, Lee MT, Lindberg M, Kamin C. Problem based learning, multimedia paucity of behavioral issue learning Med Educ. Online [Interner].2005[cited2005]: [5p]. Available from:http://www.med-ed-online.org/pdf/10000006.pdf

FOR WARDING LETTER FOR SUBMISSION TO PMJ

	Date
То	
The Editor-In-Chief	
Prime Medical Journal	
Prime Medical College, Rangpur	
Sub: Submission of manuscript	
Dear Sir,	
We are submitting our manuscript entitled,	hv
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for publication in your journal. This article has not been published or submitte	ed for publication elsewhere.
for publication in your journal. This article has not been published or submitte	ed for publication elsewhere.

We, therefore, hope that you would be kind enough to consider our manuscript for publication in your journal as Original/Review article/Case Report.

Thanks and best regards

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*Corresponding author



হাসপাতালের বিভাগ সমূহ

- মিডিসিন বিভাগ
- 🚸 সার্জারী বিভাগ
- 🛠 স্ত্রীরোগ ও প্রসৃতি বিভাগ
- ጵ শিশু ও নবজাতক বিভাগ
- 🗞 অর্থোপেডিক্স বিভাগ
- 🔹 চক্ষ বিভাগ
- নাক,কান ও গলা বিভাগ
- 🚸 ইউরোলজি বিভাগ
- শিশুসার্জারী বিভাগ ♦ রিহ্যাবিলিটেশন সেন্টার

ক্ষেন্যাগ বিভাগ

🚸 ক্যান্সার বিভাগ ৬ ডায়াবেটিক সেন্টার

🚸 নিউরোলজি বিভাগ

- ♦ ফিজিওথেরাপী সেন্টার

🚸 দন্ত বিভাগ

প্রাইম ডায়ালাইসিস সেন্টার

সম্পূর্ণ নতুন ৬ টি জাপানী টরে মেশিনের সমন্বয়ে ডায়ালাইসিস সেন্টারে ২৪ ঘন্টা ডায়ালাইসিস করার সু-ব্যবস্থা

প্রাইম সিসিইউ

হৃদরোগীদের সু-চিকিৎসার জন্য অত্যাধুনিক যন্ত্রপাতি ও বিশেষজ্ঞ চিকিৎসকবৃন্দের সমন্বয়ে "প্রাইম সিসিইউ" সিসিইউ এর সার্বিক তত্ত্বাবধানে রয়েছেন অধ্যাপক ডাঃ নওয়াজেস ফরিদ, বিভাগীয় প্রধান, হৃদরোগ বিভাগ, প্রাইম মেডিকেল কলেজ ও হাসপাতাল, রংপুর।

প্রাইম আইসিইউ

উত্তরবঙ্গে এই প্রথম আইসিইউ। মুমূর্ষ রোগী, জটিল অপারেশন পরবর্তী নিবিড় পরিচর্যা ও সু-চিকিৎসার জন্য অত্যাধুনিক যন্ত্রপাতি ও বিশেষজ্ঞ চিকিৎসকবন্দের সমন্বয়ে "প্রাইম আইসিইউ"

প্রাইম স্টোনক্রাশ সেন্টার

উত্তরবঙ্গে এই প্রথম কোনপ্রকার অপারেশন ও কাটা-ছেঁড়া ছাড়া ব্যথামুক্তভাবে কিডনীর পাথর অপসারনের সু-ব্যবস্থা।

নবজাতক নিবিড পরিচর্যা কেন্দ্র

নবজাতক শিশুদের নিবিড় পরিচর্যা ও জন্ম পরবর্তী জটিলতার চিকিৎসার জন্য সার্বক্ষণিক নিওনেটাল আইসিইউ।

২৪ ঘন্টা সকল এ্যম্বলেন্স ও প্রকার পরীক্ষা-নিরীক্ষার সু-ব্যবস্থা



াইম মেডিকেল কলেজ হাসপাতাল, রংপুর

পীরজাবাদ, বদরগঞ্জ রোড, রংপুর (কেন্দ্রীয় বাস টার্মিনালের অর্ধ কিলোমিটার পশ্চিম) ফোন ঃ ০৫২১-৬১২৯০, ৬১২৯১, মোবাইল ঃ ০১৭৩০০৩৩১১০, ০১৭১৮৫৩২৪৩৮, ০১৭১৯২০৮৭৪৭





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সর্বাধুনিক প্রযুক্তির সেবাসমূহ

- 🐟 সিটি স্ক্যান
- ৬ ভিডিও এডোক্ষোপ
- � ডিজিটাল 4-D কালার ডপলার
- ৬ ডিজিটাল ইকোকার্ডিওগ্রাম
- ৬ ডিজিটাল আল্ট্রাসনোগ্রাম
- 🐟 ডিজিটাল এক্স-রে
- ☆ স্পেশালাইজড প্যাথলজি
- 🐟 সাইটোলজি ও বায়োপসি





ভিডিও এন্ডোহ্ব

22

প্রাইম মেডিকেল কলেজ হাসপাতাল, রংপুর (৫০০ শয্যা বিশিষ্ট পূৰ্ণাঙ্গ বেসরকারী মেডিকেল কলেজ হাসপাতাল)

স্টোনক্রাশ



ডায়ালাইসিস সেন্টার