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BCPS Bhaban
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- Describe your selection of the observational or experimental participants (patients or laboratory animals, including controls) clearly, including eligibility and exclusion criteria and a description of the source population. Because the relevance of such variables as age and sex to the object of research is not always clear, authors should explain their use when they are included in a study report—for example, authors should explain why only participants of certain ages were included or why women were excluded. The guiding principle should be clarity about how and why a study was done in a particular way. When authors use such variables as race or ethnicity, they should define how they measured these variables and justify their relevance.

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  - Word limit 150 -200 words
  - Pertinent information only

- **Material and Methods**
  - Study Design
  - Duration and place of study
  - Ethical approval
  - Patient consent
  - Statistical analysis and software used.

- **Result**
  - Clearly present the data
  - Avoid data redundancy
  - Use table information at the end of the sentence before full stop between the small bracket

- **Discussion**
  - Avoid unnecessary explanation of someone else work unless it is very relevant to the study
  - Provide and discuss with the literatures to support the study
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- **Acknowledgement**
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Maternal Near Miss: An Indicator for Maternal Health and Maternal Care

The standard indicator used for the measurement of maternal health is the Maternal Mortality Ratio, defined as the ratio of the number of maternal deaths per 100,000 live births. The global maternal mortality ratio is 210/100,000 live births while it is about 240 in developing countries as compared to 14/100,000 in developed countries¹. Officially declared MMR in Bangladesh is 176/100,000 live births². Main causes of maternal deaths are Haemorrhage, Pregnancy Induced Hypertension, Sepsis, Obstructed labour, abortion, other direct & indirect causes and unclassified³,⁴.

The current main approaches to the reduction of maternal deaths are emergency obstetric care, skilled care by skilled birth attendants and unmet obstetric need. As the mortality rates are consistently decreasing, the focus is shifted on maternal near miss which describes severe maternal morbidity. Maternal mortality is the tip of the iceberg; there is a large base of the severe acute maternal morbidity (SAMM), which remains undescribed⁵.

A maternal near miss (MNM) is an event in which a pregnant woman who nearly died but survived by chance that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy. In practical terms, Women are considered near miss cases when they survive from life-threatening conditions (i.e. organ dysfunction) because of the hospital care she received. Recent review on articles between January 2004 and December 2010 the prevalence rates of maternal near miss varied between 0.6% and 14.98% for disease-specific criteria, between 0.04% and 4.54% for management-based criteria and between 0.14% and 0.92% for organ-based dysfunction based on Mantel criteria. The rates are higher in low-income and middle-income countries of Asia and Africa⁶,⁷.

Near miss is more common than maternal deaths⁵. For every woman who dies, many more will survive but often suffer from lifelong disabilities. Over the last decade, the identification of cases of severe maternal morbidity has emerged as a promising complement or alternative to the investigation of maternal deaths⁸. It has been suggested that with the observed decline in maternal mortality, analysis of well defined near-miss cases may be a more sensitive measure of the standard hospital based obstetric care and for assessing the incidence of life threatening complications.

Severe life threatening obstetric complications are ruptured uterus, pulmonary embolism, sepsis, eclampsia, obstetric haemorrhage, anemia related conditions, abortion, heart failure, ruptured ectopic, amniotic fluid embolism and anesthesia⁹,¹⁰. The causes of near miss vary in different geographical areas of the world and also there are variations within countries. Hemorrhage, hypertensive disorders, sepsis and obstructed labor are the most important causes in the developing countries. Causes of near miss are similar to causes of maternal deaths prevailing in the area. Hemorrhage was the leading cause of maternal deaths in Africa (33.9%) and in Asia (30.8%) while in Latin America and the Caribbean, hypertensive disorders were responsible for 25% deaths. Anemia was reported as an important cause in 12.8% deaths in Asia, 3.7% in Africa and none in the developed countries⁸,¹¹.

To understand the gaps in access to adequate management of obstetric emergencies leading to severe maternal complications and death three delays have been identified.

First delay is in deciding to seek care by the woman or her family, as they are unaware of the need for care. This occurs as the danger signs are not recognized or there is lack of support of the family.

The second delay is in reaching the adequate health care facility as the services may not exist or may be inaccessible for reasons such as distance, lack of transport, cost or socio economic barriers.

The third delay occurs in receiving adequate care at that facility resulting from errors in: diagnosis and clinical
decision making, lack of medical supplies and of staff proficiency in the management of obstetric emergencies\textsuperscript{12,13,14}.

In developing countries, about 75\% of the woman with severe obstetric morbidity is in a critical condition upon arrival, underscoring the significance of first two delays. Availability, accessibility, cost of health care and behavioral factors play an important role in the utilization of maternal health services.

Recently, a WHO Expert Group has suggested a uniform set of identification criteria for maternal near miss cases aiming to facilitate the reviews of these cases\textsuperscript{15,16,17}.

Disease-based: by clinical criteria related to a specific disease entity such as severe eclampsia or haemorrhage.

Management-based: a specific intervention such as admission to an intensive care unit or procedure such as a hysterectomy or massive blood transfusion.

Organ-dysfunction-based: a method whereby organ system dysfunction (circulatory, respiratory, cardiac, renal, hepatic, central nervous, metabolic and hematological) such as shock or respiratory distress is identified. The organ-system dysfunction based approach is considered the most promising frame for establishing a standard set of criteria.

The WHO near miss approach is a standardized method which is implemented in three steps in a cyclical manner: (1) base line assessment (or reassessment) (2) situation analysis and (3) interventions for improving health care.

A stepwise implementation of the maternal near miss concept can be done.

Step 1: Raising awareness and persuasion to conduct routine maternal near miss reporting (opinion leaders, educational meetings, printed materials, use of the surveillance tool).

Step 2: Confidential inquiries or Severe Maternal Outcome case review (audit and feedback).

Step 3: Addressing identified problems, prospective surveillance of life-threatening conditions and promotion of evidence-based practices (quality of care improvement).

In any setting, women who develop severe acute complications during pregnancy share many pathological and circumstantial factors. While some of these women die, a proportion of them narrowly escape death. Thus, there is a need for application of the maternal near-miss concept for assessment of maternal health and quality of maternal care. Beyond the conduct of the near-miss approach, multifaceted tailored approaches may be needed to improve the quality of care within the health system.

In selected areas and facilities, these approaches can include the implementation of evidence-based guidelines and the use of reminders, opinion leaders’ endorsement, and continued audit and feedback to achieve behavioral and process changes.

\textit{(J Bangladesh Coll Phys Surg 2018; 36: 1-3)}

**Professor Kohinoor Begum**

\textit{Councillor, BCPS and Professor & Head, Dept. of Obst. and Gynae}

\textit{Popular Medical College}

\textit{House No-25, Road No-02}

\textit{Dhanmondi R/A, Dhaka}

\textit{Bangladesh}

\section*{References:}


Morphological Pattern of Ovarian Tumour : Experience in a Tertiary Level Hospital

M AHMED a, N AFROZE b, M SABIHA c

Summary:
Background: Ovarian tumor is a common type of gynecological neoplasm and accounts for 15-25% of all gynecological malignancies. It is associated with high mortality and an accurate histological diagnosis is essential for management of patient.

Objective: The study was performed to find out the morphological pattern, nature and age distribution of ovarian tumour in our hospital.

Material and methods: It was a prospective study, conducted in the Department of Histopathology and Cytopathology, BIRDEM General Hospital, Dhaka for a period of two years from Jan 2014 to Dec 2015. This study included 186 cases of ovarian tumors sent in the Department of Pathology for histopathological evaluation. Non-neoplastic lesions and tumour-like conditions were excluded from the study. Histological diagnosis, age and laterality of ovary were recorded. Morphological pattern, nature and age distribution of ovarian neoplasms were calculated.

Result: 84.95% cases of ovarian tumour were benign, 1.61% cases were borderline and 13.44% cases were malignant.

Introduction:
Ovarian tumor is a common type of gynecological neoplasm in female. A wide variety of tumor arises in ovary from its different cell lineages and fall into benign, borderline or malignant categories. 1Ovarian cancer accounts for 15-25% of all gynecological malignancies, but is associated with the highest mortality rate (50%) in this group. The poor survival is due to the fact that they do not clinically manifest early and approximately 60-70% of the neoplasm present as either stage III or stage IV. 2,3 As there are no screening tests or tumor markers and low cytological accuracy in predominantly cystic neoplasm, histopathology plays a key role in detection of type and nature of ovarian tumour. 4 An accurate histological diagnosis is also crucial for management of patient.

Aim of the study was to find out the morphological pattern, nature and age distribution of ovarian tumour in our hospital.

Material and methods:
This was a prospective study, conducted in the Department of Histopathology and Cytopathology, BIRDEM General Hospital, Dhaka for a period of two years from Jan 2014 to Dec 2015. This study included
186 cases of ovarian tumors sent in the Department of Pathology for histopathological evaluation. Non-neoplastic lesion and tumour-like conditions were excluded from the study. Age and laterality of ovarian specimens were recorded. The nature of specimens were frozen section biopsy sample, simple oophorectomy, unilateral / bilateral salpingo-oophorectomy and hysterectomy with unilateral / bilateral salpingo-oophorectomy. Gross examinations were done following the guideline described by standard textbook of surgical pathology. Paraffin blocks were made; Hematoxylin and Eosin (H&E) stained histological slides were prepared and examined under microscope. The tumors were classified according to the World Health Organization classification of ovarian tumors. The study was approved by hospital ethical committee based on best practice of ethics in medicine and in concordance with the principals of Helsinki declaration and written consent was taken from every patient. Reported results and relevant data were recorded in SPSS data collection sheet and statistical analysis was carried out using SPSS version 17.

For descriptive purposes, patients were divided into three age groups, as follows: 0-19 years, 20-50 years and more than 50 years. Different morphological types of benign serous tumour such as serous cystadenoma, papillary serous cystadenoma, serous cystadenofibroma, papillary serous cystadenofibroma were grouped as benign serous tumour. Similarly different morphological variants of benign mucinous tumours were grouped as benign mucinous tumour. Thecomas, fibromas and thecofibromas were grouped altogether as fibromas/thecomas. Morphological pattern, nature and age distribution of ovarian tumours were calculated

Result:
A total 186 cases of ovarian tumours were found. Age ranges from 9 years to 70 years, median age was 50 years. Among these 158 cases (84.95%) were benign, 3 cases (1.61%) were borderline and 25 cases (13.44%) were malignant.

Surface epithelial tumour was the commonest type of tumour (61.83%) according to the histogenesis followed by germ cell tumour (table I and II).

Benign serous tumour was the most common type of benign tumor and seen in 60 (37.98%) cases, followed by mature cystic teratoma (table III).

Serous cystadenocarcinoma was the most common type of malignant tumour (36.0%) followed by endometrioid carcinoma. All malignant cases, that occurred below 20 years of age were germ cell in origin (table IV).

Both benign and malignant ovarian tumours were found in all age groups. Median ages for benign, borderline and malignant tumour were 44, 20.5 and 47.5 years respectively. Overall, ovarian tumour was most prevalent in 20-50 years age group (table II).

<table>
<thead>
<tr>
<th>Table-I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pattern of ovarian tumour according to histogenesis (n= 186)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Histogenesis of tumour</th>
<th>Benign</th>
<th>Borderline</th>
<th>Malignant</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surface epithelial Tumour</td>
<td>93</td>
<td>3</td>
<td>19</td>
<td>115</td>
<td>61.83</td>
</tr>
<tr>
<td>Germ cell tumour</td>
<td>53</td>
<td>-</td>
<td>4</td>
<td>57</td>
<td>30.64</td>
</tr>
<tr>
<td>Sex cord stromal Tumour</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>6.45</td>
</tr>
<tr>
<td>Metastatic</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>1.08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table-II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of ovarian neoplasm in different age group</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age(years)</th>
<th>Surface epithelial tumour</th>
<th>Germ cell tumour</th>
<th>Sex cord/stromal tumour</th>
<th>Metastatic tumour</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>4</td>
<td>10</td>
<td>-</td>
<td>-</td>
<td>14 (7.52%)</td>
</tr>
<tr>
<td>20-50</td>
<td>72</td>
<td>40</td>
<td>10</td>
<td>-</td>
<td>122 (65.60%)</td>
</tr>
<tr>
<td>&gt;50</td>
<td>39</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>50 (26.88%)</td>
</tr>
<tr>
<td>Total</td>
<td>115 (61.83%)</td>
<td>57 (31.64%)</td>
<td>12 (6.54%)</td>
<td>2 (1.08%)</td>
<td>186 (100%)</td>
</tr>
</tbody>
</table>
Incidence of malignant ovarian tumour increased with age and was most frequent in >50 years age group (table III). However, in all age groups benign tumours were more frequent than malignant neoplasm. Only three cases of borderline tumour were found. Two cases occurred in 20-50 years of age and one case occurred in 0-20 years of age.

Consistency of tumours was cystic in 145 cases (77.96%), solid in 18 cases (9.68%) and solid and cystic in 23 cases (12.36%). Consistency of benign tumours was commonly cystic whereas malignant tumours were commonly solid and cystic (table V).

Among 186 cases, information regarding laterality of tumours was found in 89 cases. Of these 10 (11.23%) cases were bilateral, 42 (47.19%) cases involved the right side and 37 (41.57%) cases involved the left side of ovary.

### Table-III

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-19 years</th>
<th>20-50 years</th>
<th>&gt;51 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign serous tumour</td>
<td>1</td>
<td>37</td>
<td>22</td>
<td>60</td>
</tr>
<tr>
<td>Mature cystic teratoma</td>
<td>7</td>
<td>39</td>
<td>7</td>
<td>53</td>
</tr>
<tr>
<td>Benign mucinous tumour</td>
<td>1</td>
<td>21</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Fibromas/thecomas</td>
<td>-</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Brenner tumour</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Mixed surface epithelial tumour</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>9 (5.70%)</td>
<td>111(70.25%)</td>
<td>38(24.05%)</td>
<td>158 (100%)</td>
</tr>
</tbody>
</table>

### Table-IV

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-19 years</th>
<th>20-50 years</th>
<th>&gt;51 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serous cystadenocarcinoma</td>
<td>-</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Endometrioid carcinoma</td>
<td>-</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Mucinous cystadenocarcinoma</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Immature teratoma</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Metastatic carcinoma</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>3 (12.0%)</td>
<td>10(40.0%)</td>
<td>12(48.0%)</td>
<td>25 (100%)</td>
</tr>
</tbody>
</table>

### Table-V

<table>
<thead>
<tr>
<th>Consistency</th>
<th>Benign</th>
<th>Borderline</th>
<th>Malignant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic</td>
<td>142</td>
<td>3</td>
<td>0</td>
<td>145(77.96%)</td>
</tr>
<tr>
<td>Solid</td>
<td>15</td>
<td>-</td>
<td>3</td>
<td>18(9.68%)</td>
</tr>
<tr>
<td>Solid and cystic</td>
<td>1</td>
<td>-</td>
<td>22</td>
<td>23(12.36%)</td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
<td>3</td>
<td>25</td>
<td>186(100%)</td>
</tr>
</tbody>
</table>
Discussion:
Ovarian tumour arises from different cell lineage. In Pakistan, a study conducted by Ahmed et al. found surface epithelial tumour were most common type of ovarian tumour (63.50%), followed by germ cell tumours (27.13%) and sex cord-stromal tumours (5.84%). In India, a study conducted by Sharma et al. found surface epithelial tumours comprised 60.78%, germ cell tumours 30.39% and sex cord-stromal tumours 5.88% of ovarian tumour. In Saudi Arabia, Abdullah found 61.0% of ovarian tumours were surface epithelial in origin, 28.0% were germ cell in origin, 7.6% were sex cord stromal tumour and 3.4% were metastatic. Whereas in Nepal, Vaidya found germ cell tumours were most common (51.52%), followed by surface epithelial tumour (43.53%) and sex cord–stromal tumour (3.30%). In Nigeria and Africa, germ cell tumours were the commonest ovarian neoplasm followed by surface epithelial tumours. In the western countries and in Japan, surface epithelial tumors were the most common tumour and account for 50 to 55% and 46 to 52% of ovarian tumour respectively. In present study, we found surface epithelial tumours were commonest tumour according to histogenesis (60.75%) followed by germ cell tumour (31.72%) and sex–cord stromal tumour (6.54%). Our findings were quite similar with the studies conducted in India, Pakistan and Saudi Arabia but differ from the studies conducted in Nepal and Africa, where germ cell tumours were most common.

The ovarian tumour is diagnosed as benign, borderline or malignant depending on the presence of predominant cell type, pattern of growth, amount of fibrous stroma and cellular atypia with invasiveness. In India, in a study it was found that 78.4% of ovarian tumours were benign, 20.6% were malignant and 0.98 % cases were.

Table-VI
Relative frequencies of five commonest benign ovarian tumour in our study with other studies.

<table>
<thead>
<tr>
<th>Name of tumour</th>
<th>Percentage (%) of cases in different studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Benign serous tumour</td>
<td>64.98</td>
</tr>
<tr>
<td>Mature cystic teratoma</td>
<td>21.66</td>
</tr>
<tr>
<td>Benign mucinous tumour</td>
<td>8.30</td>
</tr>
<tr>
<td>Fibroma</td>
<td>1.82</td>
</tr>
<tr>
<td>Brenner</td>
<td>0.92</td>
</tr>
</tbody>
</table>

Table-VII
Relative frequencies of five commonest malignant ovarian tumour in our study with other studies.

<table>
<thead>
<tr>
<th>Name of tumour</th>
<th>Percentage (%) of cases in different studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Serous cystadenocarcinoma</td>
<td>49.18</td>
</tr>
<tr>
<td>Endomertiotid carcinoma</td>
<td>3.28</td>
</tr>
<tr>
<td>Mucinous cystadenocarcinoma</td>
<td>21.30</td>
</tr>
<tr>
<td>Immature teratoma</td>
<td>1.64</td>
</tr>
<tr>
<td>Metastatic carcinoma</td>
<td>4.92</td>
</tr>
</tbody>
</table>
borderline. In the same country, Gupta et al. reported ovarian tumours were 72.9% benign, 4.1% borderline and 22.9% malignant. In Saudi Arabia, Abdullah found 61.0% of ovarian tumours were benign, 5.2% were borderline and 22% were malignant. In Nepal, Vaidya found 80.72% of ovarian tumour were benign, 3.58% were borderline while 15.70% were malignant. In Pakistan Ahmad et al. found 59.18% ovarian tumour were benign, 3.27% were borderline and 37.54% were malignant. However, in another study in Pakistan, Siddiqui et al. found 79% ovarian tumours were benign and 17.8% were malignant. In India, Mondol et al. found benign tumours were most common (63.1%), followed by malignant (29.6%) and borderline (7.3%). In Nigeria, 80.3% of the ovarian neoplasms were found benign while malignant ovarian tumours constituted 19.7% of cases. In present study, it was found that 84.95% of ovarian tumours were benign, 1.61% cases were borderline and 13.44% were malignant. Findings of our study were quite similar with study conducted in Nepal. Frequency of malignant ovarian neoplasm of our study was much lower than the some other studies. However, all studies found benign ovarian tumours were more frequent than malignant ones.

Like the studies in India and Pakistan, present study found benign serous tumour was most common type of benign ovarian neoplasm, followed by mature cystic teratoma and benign mucinous tumours (table 6). However, some studies conducted in Nepal, Nigeria and North America found mature cystic teratoma was the most common type of benign neoplasm. Serous cystadenocarcinoma was the most common type of malignant neoplasm. It was found as the most common malignant neoplasm in studies conducted in India, Pakistan and Saudi Arabia also. However, in Nepal, mucinous cystadenocarcinoma was found as the most common malignant tumour. Frequency of other common malignant neoplasms also varies slightly in different studies (table 7).

Similar to present study, other study also showed ovarian tumour had a wide range of age distributions. A study conducted in Indian subcontinent found overall median age for ovarian tumour was 33 years and the median age for benign, borderline and malignant tumour was 32, 47 and 40 years respectively. However, in our study overall median age for ovarian tumour was 50 years and median age of its different types also vary slightly. Similar to the findings of Abdullah et al. , our study also found that the frequency of malignant ovarian neoplasm increases with age, it was most prevalent in more than 50 years of age and all the malignant neoplasm that occurred below 20 years of age was germ cell in origin. Like other studies, our study also found benign tumors were more common than malignant tumours in all age groups.

Present study showed cystic ovarian neoplasm was commonest followed by solid and cystic than predominantly solid. Vaidya et al. found 45.09% ovarian tumors were cystic, 41.17% were solid and cystic and 13.74% were predominantly solid. Frequency of solid and cystic neoplasm was more than present study.

Bilaterality was found in 8.86% cases and 11.29% cases in studies conducted by Vaidya et al. and Sharma et al. respectively. Similar to these, present study also found 11.23 % tumours were bilateral. However, incidence of bilaterality was found much less in studies by Tejeswini et al. and Misra et al.. They found 5.40% and 4.52% of ovarian neoplasms were bilateral respectively.

**Conclusion:**
In this study it was found that benign ovarian neoplasms were more common than malignant ones. The most common type of benign ovarian neoplasm was benign serous tumour and the most common type of malignant neoplasm was serous cystadenocarcinoma. The pattern and age distribution of ovarian tumours of our study were quite similar with other studies with some variation. This study may be useful in future for further study of ovarian neoplasm in Bangladesh.

**References:**


Oral Azithromycin Pulse Therapy and Daily Topical Benzoyl Peroxide in the Treatment of Acne Vulgaris: An Open Clinical Trial Study

B AKTER

Summary:
Introduction: Combination therapy is an effective approach to simultaneously target multiple pathogenic factors of acne. A unique combination of oral azithromycin pulse therapy and daily topical benzoyl peroxide has been developed for treatment of acne.

Material & Methods: It was an open, controlled, clinical trial, conducted on 37 outpatients with acne vulgaris. Patients were clinically assessed at baseline & at week 0, 4, 8 and 12.

Evaluation included success rate (subjects clear or excellent improvement, good response), lesion count & percentage change in lesion count from baseline, cutaneous tolerability & adverse events.

Results: The combination of oral azithromycin pulse therapy & daily topical benzoyl peroxide was very safe & effective with significant differences in percentage of lesion count change observed as early as 1-4 weeks. Adverse events were more frequent with the combination therapy that occurred early in the study & were transient.

Conclusion: This study revealed that combination regimen of azithromycin & benzoyl peroxide (4%) is indeed very much efficacious & safe in the management of acne vulgaris.

Key words: “To evaluate the efficacy & safety of oral azithromycin pulse therapy & daily topical benzoyl peroxide (4%) combination in the treatment of acne vulgaris.”

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Benzoyl peroxide is safe & effective antimicrobial agent for the treatment of acne. It acts through oxidation and die formation of free radicals causing a reduction of Propionibacteria. The mechanism helps to prevent an induction of resistance of Propionibacterium acne often observed in long term acne treatment with antibiotic. Systemically absorbed benzoic acid so rapidly cleared by the kidneys that no systemic toxicity due to drug accumulation can be expected. The widespread use of topical formulations of erythromycin and clindamycin to treat acne has resulted in significant dissemination of cross resistant strains of Propionibacteria. But benzoyl peroxide has distinctive advantage that, so far, no resistance has been detected against it.

Systemic antibiotic most commonly used in acne vulgaris to act against P. acnes are tetracycline, erythromycin, clindamycin and doxycycline. The widespread and long-term use of antibiotics over the years have unfortunately led to the emergence of resistant bacteria. Resistance to tetracycline and cross-resistance to doxycycline are also common the incidence of P. acnes resistance in the UK is estimated to be approximately 65% for erythromycin & clindamycin and 40% for tetracycline & doxycycline whereas there are no reports on resistance to azithromycin.
Material and method:
It was an open controlled clinical trial study which was conducted in the department of Dermatology and Venereology, Bangabandhu Sheikh Mujib Medical University, Dhaka.

Duration of the study was from July 2016 to December 2016.

A total number of 37 patients were primarily selected. Complete history, general physical and dermatological examinations were done for all enrolled patients. For women of reproductive age reproductive history, lactation and pregnancy plan was carefully judged. History and physical findings were recorded in a structured questionnaire. Finally those patients, who matched the inclusion and exclusion criteria, were selected for the study.

Inclusion criteria were:
Patients clinically diagnosed as acne vulgaris, Having age >12 years and of both sexes,
Patients with non inflammatory (comedones) lesions and inflammatory (papules, pustules) lesions on the face
Patients suffering from nodulocystic acne,

Exclusion criteria were:
Pregnant and lactating mother,
Female who were not on oral contraceptive pill.
Person having hypersensitivity to benzoyl peroxide and
Patients with other dermatological conditions interfering with the treatment of acne vulgaris

Scoring of acne vulgaris:
In all the cases the acne lesions will be graded according to the severity index described by Michaelsson et al by counting the number of open or closed comedones, papules, pustules, and cystic lesions. Michaelsson described the severity index as 0.5 for comedones, 1 for papule, 2 for pustules and 3 for cystic lesions. The total severity score of disease will be calculated by multiplying each type of lesion with its severity index and adding them together.

Study assessment:
The overall evaluation made by the percent reduction of baseline total scores. Five comparative categories generated i.e. cleared; when 100% resolution occurred; excellent, when 75% or greater reduction observed; moderate, when 50-74% reduction in total score occurred; poor, when <50% reduction observed and worse, if exacerbation of disease occurred.

Data processing and analysis:
All collected data was checked and rechecked for omissions, inconsistencies and improbabilities. Data analysis was performed by Statistical Package for Social Science (SPSS), version-12. Data was edited, coded and entered into the computer. Statistical analyses were done and level of significance was measured by using appropriate procedures like chi square lest ($X^2$), relative risk (RR) measurement, t-test, proportion test, ANOVA test and others where applicable. Level of significance (p value) was set at 0.05 and confidence interval at 95%.

Results:
Socio-demographic data

<table>
<thead>
<tr>
<th>Table-I</th>
<th>Shows the age group of study population (N=37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>Total N (%)</td>
</tr>
<tr>
<td>13-15 years</td>
<td>7(18.9)</td>
</tr>
<tr>
<td>16-20 years</td>
<td>24 (64.9)</td>
</tr>
<tr>
<td>21-25 years</td>
<td>3 (8.10)</td>
</tr>
<tr>
<td>26-30 years</td>
<td>3(8.10)</td>
</tr>
<tr>
<td>Total</td>
<td>37 (100.0)</td>
</tr>
</tbody>
</table>

Age distributions of patients with acne vulgaris are presented in Table-I. The youngest patient was of 13 years while the oldest one aged 30 years. The average age was 18.7±4.0 years and most of the patients were belonged to <20 years age groups (83.8%). Among the study population 28 (75.7%) were female and 9 (24.3%) were female.

Clinical data

<table>
<thead>
<tr>
<th>Table-II</th>
<th>Shows age at onset of acne vulgaris (N=37).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>Total N (%)</td>
</tr>
<tr>
<td>&lt;15 years</td>
<td>19(51.4)</td>
</tr>
<tr>
<td>16-20 years</td>
<td>16 (43.2)</td>
</tr>
<tr>
<td>(11-21 years)</td>
<td></td>
</tr>
<tr>
<td>21-25 years</td>
<td>2(5.4)</td>
</tr>
<tr>
<td>Total</td>
<td>37 (100.0)</td>
</tr>
</tbody>
</table>
Distribution of patients by age at the onset of acne vulgaris are presented in Table-2. The lowest age of 11 years while the highest age was 21 years. The average age was 15.8±2.5 years when most of the patients experienced acne vulgaris.

Occupation:
Occupation of study population is illustrated in Figure-1. More than three quarter of the patients evaluated was students (81.1%).

Site of involvement:

Table-III

<table>
<thead>
<tr>
<th>Site of acne involvement</th>
<th>N</th>
<th>Present (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheek</td>
<td>37</td>
<td>(100.0)</td>
</tr>
<tr>
<td>Chin</td>
<td>34</td>
<td>(91.9)</td>
</tr>
<tr>
<td>Forehead</td>
<td>34</td>
<td>(91.9)</td>
</tr>
<tr>
<td>Nose</td>
<td>19</td>
<td>(51.4)</td>
</tr>
<tr>
<td>Back of the neck</td>
<td>2</td>
<td>(5.4)</td>
</tr>
<tr>
<td>Shoulder</td>
<td>5</td>
<td>(13.5)</td>
</tr>
<tr>
<td>Chest</td>
<td>3</td>
<td>(8.1)</td>
</tr>
<tr>
<td>Upper back</td>
<td>9</td>
<td>(24.3)</td>
</tr>
</tbody>
</table>

Most of the patients had cheek, chin and forehead involvement and only few patients had upper back, shoulder, chest and back of the neck involvement.

Reduction in the number of acne:

Table-IV

Reduction in the number of different types of acne lesions in response to acne regimens.

<table>
<thead>
<tr>
<th>Types of acne lesions</th>
<th>Number of lesion</th>
<th>Mean±SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Week 0</td>
<td>Week 4</td>
</tr>
<tr>
<td>Comedones</td>
<td>41.0±18.0</td>
<td>16.8±9.8</td>
</tr>
<tr>
<td>Papular lesion</td>
<td>30.7±10.9</td>
<td>20.2±9.1</td>
</tr>
<tr>
<td>Pustular lesion</td>
<td>22.1±10.9</td>
<td>7.65±5.0</td>
</tr>
<tr>
<td>Cystic lesion</td>
<td>4.1±5.3</td>
<td>4.1±5.3</td>
</tr>
</tbody>
</table>

At the end of first 4 weeks there were significant reduction in the number of comedones and this reduction remained significant throughout the treatment period. Similarly popular acne significantly reduced in number throughout the treatment period. Treatment regimen also reduced the number of pustular acne in same fashion. Cystic lesions showed no improvement throughout the treatment period.

Percent reduction in the number of acne:
Percent reduction in the number of acne lesion showed highly significant improvement in case of comedones, papular and pustular lesions throughout the treatment period but cystic lesion showed no significant improvement.

Michaelsson Acne Severity Index:
Percent reduction of Michaelsson Acne Severity Index in response to study regimens is illustrated in Figure-3. The study regimens showed highly significant percent reduction of Michaelsson Acne Severity Index throughout the treatment period.
Overall assessment:
Presented in Figure 4, investigator’s evaluation carried on 37 patients who have completed the study with compliance. Among them acne lesion cleared in 22% cases, excellent improvement observed in 65% cases and 13% showed good response.

Adverse effect:
Adverse effect of two drug regimens observed during treatment period illustrated in Figure 5. Of 32 patients, 8 (25%) complained of heart burn during treatment period, 5 patients (15.6%) reported abdominal cramp, 4 patients (12.5%) reported tinnitus and 2 reported headache. 9 patients (6.7%) complained of mild binning sensation (irritation) on facial skin.

Discussion:
Acne vulgaris is a chronic inflammatory disease typically begins at puberty and primarily a disease of adolescent with 85% of all teenagers being affected to some degree. Due to multifactorial pathogenesis of acne vulgaris, combination therapy provides the opportunity to get the target multiple pathogenic causes of acne. Combination therapy utilizing agents with complementary mechanisms, such as, topical benzoyl peroxide and oral antibiotics, is frequently used in the management of the disorder.

As a first line systemic treatment in adolescence most authors recommend the use of systemic antibiotics, including tetracycline, doxycycline, minocycline and erythromycin. Recently, azithromycin has been added to this list. Comparative clinical trials have shown that the tolerability profile of azithromycin is superior to that of erythromycin and doxycycline. Moreover, tetracycline can cause both mucocutaneous and systemic adverse effects.

In this study the concomitant use of oral azithromycin pulse therapy & daily topical benzoyl peroxide in the treatment of acne vulgaris is assessed. A total 37 patients with acne vulgaris those fulfilled the inclusions criteria were enrolled. Azithromycin 500 mg orally once daily during the first three days of 7 days cycle & topical benzoyl peroxide (4%) at night.

Patients were clinically evaluated at 4 weekly intervals. At baseline and all follow up visits, all parameters were examined & graded by using Michaelsson Acne Severity Index. Both the total scores & number of each type of acne lesions were compared to baseline scores & five comparative categories were generated i.e. cleared, excellent, moderate, poor improvement & worse.
The mean age of patients was 15 to 35 years. More than 75% was female & most of the patients were students. At the end of 4 weeks treatment 99.8% of comedones, 98.7% papular lesions & 94.3% pustular lesions were cleared. Only 2.9% cystic lesions responded to the regimens. Percent reduction of Michaelsson Acne Severity Index was 40.7% after 4 weeks of treatment, 70.7% after 8 weeks & 87% after 12 weeks of treatment, which was statistically highly significant. Overall assessment revealed acne lesions cleared in 22% cases, excellent improvement observed in 65% & 13% showed good response.

The safety & efficacy of oral azithromycin and topical benzoyl peroxide in the treatment of acne have been reviewed and articles on clinical trials published in many Western Journals. In this study, the treatment regimens showed highly significant improvement from the first follow-up visit. At the end of 12 weeks treatment 87% improvement observed in term of percent reduction of Michaelsson Acne Severity Index. These findings are superior to those observed in different studies by using azithromycin & topical benzoyl peroxide alone. During the period of study, patients develop various side-effects such as heartburn, abdominal cramp and mild irritation of facial skin. None of these reactions were severe and most occurred within the first weeks of initiation of therapy and was observed to resolve with continued use of the drugs. So, azithromycin pulse therapy and topical benzoyl peroxide is indeed effective and safe in the treatment of acne vulgaris.

Conclusion:
This study revealed that combination regimen of azithromycin and benzoyl peroxide (4%) is indeed more efficacious and safe in the management of acne vulgaris. Study with larger group of patients for longer period may result in superior outcomes assess the relapse rate in clinical practice through improve compliance.

References:
2. Webster GF The pathophysiology of acne. Cutis. 2005; 76 (2suppl): 4-7
Patients’ Profile Regarding Physiatric Management of Facial Palsy in a Tertiary Care Hospital

PK CHAKRABORTY a, MJ ISLAM b, MS HOSSAIN c, MN HASAN d, MMNH KHANDKER e, ASMM UDDIN f

Summary:
Introduction: Facial palsy is commonly treated by various physical therapy strategies and devices, but there are many questions about the profile of patients with facial nerve palsy. The aim of the study was to outline profile of patients with facial palsy receiving Physiatric management.

Materials and Methods: A retrospective hospital records-based study was carried out at the department of Physical Medicine and Rehabilitation (PMR) in National Institute of Neurosciences and Hospital (NINS&H), Dhaka for the period of two year from 1st July 2013 to 30th June 2015.

Results: Total 5240 patients were studied, of which 58.87% were male and 41.13% were female. Maximum patients (26.58%) belong to 31-40 years of age. Maximum patients (72.36%) came from Dhaka city and most of the studied patients were housewife (31.68%). Largest disease group was Bell’s palsy (56.2%). Regarding disease pattern, 61.18% of patients peripheral nervous system (PNS) and 38.82% central nervous system (CNS) condition. Among etiologies of Facial palsy, 56.2% Bell's palsy, 36.95% stroke, 3.40% Guillain-Barre' syndrome, 2% traumatic, 0.52% were Ramsay-Hunt syndrome.

Conclusion: Profile of patients should be considered for Physiatric management of Facial nerve palsy.

Key words: Facial nerve palsy, Patients’ Profile.

Introduction:
The face plays a major role during interpersonal communication, and facial expression is of interest from both an evolutionary and a social standpoint. Facial nerve palsy causes weakness or paralysis of the facial muscles, accompanied by other complications. There are numerous causes of facial palsy (FP). Bell’s palsy is a commonly encountered paralysis of the facial nerve occurring worldwide. In facial paralysis, alterations occur in the facial expression muscles depending on the level of the facial nerve lesion. In most cases, this is a spontaneously reversible phenomenon or is reversed after some type of treatment, either clinical or surgical. However, about 20% of patients develop some type of sequelae, which range from a light degree of paralysis to unilateral or bilateral complete paralysis of facial muscle movements.

National Institute of Neuro-sciences (NINS) in Bangladesh was established with the vision of making this institute as the center of excellence not only in this country but also for others. It is a matter of pride that the institute has started functioning from September 2012. There are more than 15 departments. Physical Medicine and Rehabilitation is one of them. Almost all the patients came to this department were referred from different departments of NINS. Currently, lesions resulting in facial paralysis are difficult to treat and may cause facial expression alterations, with serious
emotional consequences. To minimize sequelae, it is important to understand the causes and factors that could influence disease evolution.

**Objectives:**

**General:**
- To observe the profile of patients with facial nerve palsy attending the department of PMR in a tertiary care hospital.

**Specific:**
- To identify demographic characteristics of patients with facial nerve palsy attending the department of PMR in a specialized hospital.
- To discuss the findings of this study with other available studies.

**Materials and Methods:**
We undertook a retrospective review of the records at Physical Medicine and Rehabilitation department of National Institute of Neuroscience and Hospital, Dhaka over a period of two year from 1st July 2013 to 30th June 2015 and determined the facial nerve palsy (FNP) diagnoses of attending patients. Information was extracted from the patients’ records by means of a questionnaire assessing the participants' demographics and diagnoses. The subjects were enrolled on an individual basis, despite the varying number of visits by a given patient during the period of study.

**Ethical approval:** Permission was obtained from the concerned department and authority of the institute for compiling and publication of data records.

**Statistical analysis and software used:** Data were compiled into an Excel spreadsheet (Microsoft Corporation, Redmond, USA), which was used to tabulate demographic and etiological information. Simple proportions were used for categorized data.

**Variables:**
- **Primary variables:**
  - Disease profile
- **Secondary variables:**
  - Age
  - Sex
  - Catchment area
  - Occupation

**Results:**
Between July 2013 and June 2015, 5240 patients (3085 men and 2155 women) received Physiatric management for FP of whom the demographic distribution of the frequencies were presented in Table-1.

Of the 5240 cases of FP, Table-2 emphasizes the results related to the patients’ profile. Patients received Physiatric management in the form of drugs, infrared therapy, electrical stimulation of facial muscles, ultrasound therapy, exercises of facial muscles, patient’s instruction and counseling.

**Table-I**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of patients</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3085</td>
<td>58.87</td>
</tr>
<tr>
<td>Female</td>
<td>2155</td>
<td>41.13</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 years</td>
<td>27</td>
<td>0.52</td>
</tr>
<tr>
<td>10-20 years</td>
<td>144</td>
<td>2.75</td>
</tr>
<tr>
<td>21-30 years</td>
<td>937</td>
<td>17.88</td>
</tr>
<tr>
<td>31-40 years</td>
<td>1393</td>
<td>26.58</td>
</tr>
<tr>
<td>41-50 years</td>
<td>1323</td>
<td>25.25</td>
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<tr>
<td>51-60 years</td>
<td>814</td>
<td>15.53</td>
</tr>
<tr>
<td>60-70 years</td>
<td>431</td>
<td>8.23</td>
</tr>
<tr>
<td>Above 70 years</td>
<td>171</td>
<td>3.26</td>
</tr>
<tr>
<td>Catchment area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dhaka city</td>
<td>3792</td>
<td>72.36</td>
</tr>
<tr>
<td>Outside Dhaka city</td>
<td>1448</td>
<td>27.64</td>
</tr>
<tr>
<td>Occupations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service holder</td>
<td>550</td>
<td>10.49</td>
</tr>
<tr>
<td>Retired Service holder</td>
<td>377</td>
<td>7.20</td>
</tr>
<tr>
<td>Housewife</td>
<td>1660</td>
<td>31.68</td>
</tr>
<tr>
<td>Laborer</td>
<td>322</td>
<td>6.15</td>
</tr>
<tr>
<td>Farmer</td>
<td>400</td>
<td>7.63</td>
</tr>
<tr>
<td>Businessman</td>
<td>575</td>
<td>10.97</td>
</tr>
<tr>
<td>Student</td>
<td>629</td>
<td>12.00</td>
</tr>
<tr>
<td>Unemployed</td>
<td>436</td>
<td>8.33</td>
</tr>
<tr>
<td>Others</td>
<td>291</td>
<td>5.55</td>
</tr>
</tbody>
</table>
Discussion:
A uniform data system (UDS) for Medical Rehabilitation is maintained in USA and published annually. No such system exists in Bangladesh. In this study it has been tried to find out the age, sex, occupation, residency and disease profile of patients with FP attending the department of PMR, NINS.

In this study, 58.87% were male and 41.13% were female. Junior NA et al showed that FP were predominant in males (55.5%). Batista KT studied in a rehabilitation hospital that most of the patients were male patients. But, Hohman MH et al found 61% percent of patients were female. Lamina S et al found that males(56.2%) were higher incidence of FP than females(43.8%). Stanley M et al showed male patients were more in number (64.6%) than the females.

In present study, occupations of patients were housewife (31.68%), labourer (6.15%), serviceman (17.69%), farmer (7.63%), businessman (10.97%) and student (12%). Lamina S et al found that males(56.2%) were higher incidence of FP than females(43.8%). Stanley M et al showed male patients were more in number (64.6%) than the females.

In our study, 0.52% of patients were under 10 years of age, 2.75% were 11-20 years, 17.88% were 21-30 years, 26.58% were 31-40 years, 25.25% were 41-50 years, 15.53% were 51-60 years, 8.23% were 61-70 years and 3.26% above 70 years of age. Batista KT showed the prevalence of facial paralysis was greater among patients younger than 20 years. Lamina S et al showed that the middle age subcategory (20-34yrs) had the highest incidence of FP (40.3%), while the old-age category (65yrs and above) had the least (3.7%) incidence. Stanley M et al showed the case notes of the patients in the age group of 23-32 years were in majority (37.5%).

Our study showed 61.18% of patients were peripheral nervous system (PNS) and 38.82% central nervous system (CNS) condition. Stanley M et al showed Lower motor neuron FNP (56.2%) predominated over upper motor neuron type (43.8%).

Side of face affected in our study were right side 54.6%, left side 43.26% and both side 2.14%. Junior NA et al showed right side (66.6%) and left side (33.4%). Lamina S et al showed that 52.2% had right side, 46.1% had left side and very few 1.7% had bilateral FP.

Among etiologies of FP in this study, 56.2% were Bell’s palsy, 36.95% stroke, 3.40% Guillain-Barre' syndrome, 2% traumatic and 0.52% were Ramsay-Hunt syndrome. Junior NA et al showed that Bell’s palsy was the most
frequent etiology (53.7%), followed by traumatic (24%), Ramsay Hunt syndrome (9.2%), Cholesteatoma (5.5%), malignant otitis media (3.7%) and acute otitis media (3.7%). Batista KT observed that majority of patients (42.8%) had Bell’s palsy, 16.8% of congenital paralysis, 6% deriving from traumatic brain injuries, 18.9% due to stroke, 3.2% due to facial trauma, 3.2% due to tumors, 2.4% due to vestibular schwannoma, and 6.7% due to other etiologies. Study performed by Hohman MH et al found Bell’s palsy accounted for 38% of cases, acoustic neuroma 10%, cancer 7%, iatrogenic injuries 7%, varicella zoster 7%, benign lesions 5%, congenital palsy 5%, Lyme disease 4%, and other causes 17%. Lamina S et al showed that the commonest cause of FP was idiopathic accounting for 39.1%, followed by stroke (30.0%). Otitis media however recorded 12.8%, Herpes zoster being a cause of facial palsy had an incidence of 1.3%, and least was measles with 0.3%. Stanley M et al showed Bell’s palsy was reported as the highest cause of FNP, while the least cause of FNP was Ramsey-Hunt syndrome. However, stroke was implicated as the second highest cause of FNP in their study.

From the above discussion, it is clearly demonstrated that the findings of the study performed in PMR department of NINSH is consistent with the findings of different available studies.

Limitation of the study:
This study was done in one tertiary level hospital of Bangladesh in a small population and it may not reflect the total scenario of FP patients getting treatment from PMR department.

Conclusion:
Multidisciplinary approach and referrals in the management of FNP is essential for effective resolution of this ailing condition. Clinicians treating this condition must possess an awareness of the wide variety of FP etiologies; codifying the decision-making process is likely to result in fewer missed diagnoses and better outcomes. Although the data presented in this series are informative, they do not quantify the overall incidence or etiologic breakdown of FP.

Recommendation:
• A large scale multi-centered study should be performed in the country.

• A uniform data system should be constructed for Medical rehabilitation in Bangladesh.

Acknowledgement:
We express deepest regards and a profound debt of heart full gratitude to Head of PMR department, Joint Director and Director of NINS, Dhaka. We would like to thank our fellow colleagues, medical technologist and finally our family members for their kind cooperation and assistance in carrying out the study.

Reference:
Outcome of Near Miss Cases in a Periurban Hospital

S NAZMEEN\textsuperscript{a}, S TASNIM\textsuperscript{b}, I ARA\textsuperscript{c}

Summary:
A near miss or severe acute maternal morbidity (SAMM) means a woman (in pregnancy/labour/peurperium) who was almost dead but survived. It is often poor, socially excluded women that suffer most.

The objective of this study was to explore the outcome of near miss cases admitted in the hospital along with their presentation, socio demographic characteristic and medical and surgical intervention needed.

It was a cross sectional study conducted from 1\textsuperscript{st} July 2009 to 31\textsuperscript{st} December 2009 at Institute of Child and Mother Health. Among cases who got admitted in the hospital in moribund condition with pregnancy related complications. Total 91 patients were enrolled consecutively. Data were collected by structured questionnaires. Analysis was done using SPSS program.

About 72% of women were at second decade of their lives and 71% of them were from poor socioeconomic condition. About 39% patients did not take any antenatal checkup.

Introduction:
A near miss or severe acute maternal morbidity means a woman (in pregnancy/labour/peurperium) who was almost dead but survived by chance\textsuperscript{1}. A “near miss” used to be thought of as a case where a woman had a near brush with death; she would have died were good fortune and medical care not on her side. This characterization was also used for women with severe organ dysfunction or organ failure who survived, that is with intensive medical intervention, a maternal death was avoided and turned into a survival\textsuperscript{2}.

SAMM refers to the morbidity a woman actually suffers. Essentially, it can be thought of a pyramid of disease in pregnancy, the base being the numerically larger general pregnant population, the “tip of ice berg” being maternal death and much hidden morbidity beneath the surface\textsuperscript{2}.

Definition of near miss or acute maternal morbidity cases varied among different studies. Three types of approaches have been proposed for defining life threatening obstetric complications and near miss events, those are based on management, clinical sign and symptom and organ systems respectively\textsuperscript{2}. By Mental GD et al, a near miss describes a patient with acute organ system dysfunction, which if not treated appropriately, could result in death\textsuperscript{3}. Prual A et al, has defined severe maternal morbidity as severe complications from 28\textsuperscript{th} weeks of gestation to 42\textsuperscript{nd} day postpartum that would have resulted in death of the mother or a definite invalidating sequels without medical intervention\textsuperscript{4}. Some studies have used intensive care unit admission to define near miss morbidity\textsuperscript{3}.

In some studies management criteria was used in the definition of life threatening complications and that include the cases requiring use of emergency hysterectomy, caesarean section, hospitalization for more than four days and anesthetic accident\textsuperscript{5,6}.

Eclampsia (43\%) was the prime cause of SAMM. Next were postpartum haemorrhage (17\%), obstructed labour (11\%), antepartum haemorrhage (6\%), ectopic pregnancy (6\%), chorioamnionitis (4\%), severe preeclampsia (4\%), septic abortion (2\%), ruptured uterus (2\%), uterine perforation (1\%), shock (2\%), puerperal sepsis (1\%), and severe anaemia (1\%). Along with medical care, surgical intervention such as LUCS, D&C, salpingoophorectomy, hysterectomy were needed for the management of SAMM. More than 4 bags of blood transfusion needed in 24.50\% of patients. Only 4\% patients needed ICU admission.

Most of the causes of SAMM were apparently preventable. Awareness and education about the danger signs of pregnancy, proper antenatal care, delivery by skilled birth attendant and proper auditing of care provided will be helpful to prevent SAMM.

Key Words: Near miss, Outcome of pregnancy, Severe acute maternal morbidity (SAMM).

Severe maternal morbidity is prevalent throughout the world, mostly in the developing countries. It is often poor, socially excluded women that suffer most. Incidence of SAMM vary between 0.80%-8.23% in studies that use disease specific criteria while the range is 0.38%-1.09% in the group that use organ system based criteria and included unselected group of women. The rates are within the range of .01% and 2.99% in studies using management based criteria. There is a big difference of incidence of severe acute maternal morbidity cases between developing (South Africa 1:5; India and Niger 1:11) and developed countries (UK 1:118, France 1:222).

The concept of “the three delays” was developed to analyze the obstacles that threaten to postpone treatment of women with obstetric complications. Any delay in either of three phases of delay would likely to aggravate SAMM. The first phase of delay involves the decision to seek care. Recognition of illness is defined by the patient’s view, not by the criteria defined by the health workers.

The second phase of delay concerns transport, the time from the decision to facility where this assistance is expected. Distribution of facilities, distance and nonexistent public transports are the main problem in a situation where there is “too far to walk”.

The third delay is perhaps most crucial as it reflects the receiving of appropriate treatment in time. Insufficient and unqualified staffs, mismanagement of patients, unavailability of blood and storage of essential drugs and equipment constitute the third delay at many places.

The level of delay interconnect in the way that low quality of care at the third level and long distance and troublesome transports at the second level will affect the decision making at first level.

Objective of the study was to see the outcome of near miss cases admitted in the hospital along with their presentation, socio demographic characteristics and treatment required for near miss cases.

Methodology:
It was a cross sectional study conducted at Institute of Child and Mother Health from 1st July 2009 to 31st December 2009.

Among the cases who got admitted in the Gynae & Obstetrics department of hospital in moribund condition with severe preeclampsia and eclampsia (diagnosed with the history of convulsion, hypertension, urine albumin), postpartum haemorrhage (diagnosed with the finding of vaginal bleeding, maternal hypothermia, tachycardia, loss of consciousness, hypotension, number of pad soaked), obstructed labour (diagnosed with prolong labour, dehydration, fetal distress), ectopic pregnancy (diagnosed with history of amenorrhoea and pain in abdomen, tachycardia, syncopal attack or loss of consciousness), puerperal sepsis (diagnosed with subinvolution of the uterus, fever, uterine tenderness, foul smelling vaginal discharge), severe anaemia (diagnosed with the finding of palor, tachycardia, low Hb level), shock (diagnosed with the finding of hypotension, hypothermia, tachycardia with or without unconsciousness), septic abortion (diagnosed with the history of abortion, fever, foul smelling vaginal discharge), ruptured or perforated uterus (diagnosed with the finding of tachycardia, per vaginal bleeding, shock). Total 91 patients were enrolled consecutively during study period.

Patient who died following severe morbidity were excluded from the study.

Data was collected from hospital records and interviewing patients and their attendants using structured questionnaire. Ethical clearance was obtained from ethical review committee of Institute of Child and Mother Health. Written informed consent was obtained from the patients. Data analysis was done by using SPSS program.

Result:
Most of the SAMM cases were in 21-30 years of age group (72%) and 71% was of low socio economic condition. About 60% were multi para (Table 1). More than one third patients had no antenatal checkup. One third (1/3) patient took antenatal care less than four times (Table 2). Most frequent presentation was convulsion (43%), bleeding 30.77%, about 5.5% were unconscious. Hyperthermia present in 14.3%, 17.6% had severe anaemia and 17% had dehydration (Table 3). The incidence of eclampsia was the highest (43%) followed by postpartum haemorrhage (17%), obstructed labour (11%), antepartum haemorrhage (6%), ectopic pregnancy (6%), severe preeclampsia (4%), chorioamnionitis (4%), ruptured uterus, septic abortion and shock (2%), uterine perforation and...
puerperal sepsis (1%) (Figure 1). Regarding treatment, anticonvulsant (37.3%), antibiotics (49.4%), uterotonic drugs (32.9%), antihypertensive drug (14.2%) were commonly prescribed. Blood transfusion was needed in more than half of the patients and 24.5% need more than 4 bags of blood (Figure 2). Common surgical interventions were LUCS (60.3%), NVD (13.2%), D&C (10.3%) and 3% needed salpingoophorectomy, repair of cervical tear and hysterectomy respectively (Figure 3). 4.4 % needed ICU admission (Table 4). Maximum patients (59.3%) stayed in the hospital for 5-8 days. 10.9% patients stayed for more than 12 days (Table 5). During discharge 86.7% patients were well and 13.3% patients had some sorts of morbidity. Types of morbidities were hysterectomy (16.67%), salpingoophorectomy (16.67%), renal failure (8.34%), heart failure (8.34%), chronic hypertension (41.65%) and Sheehan’s Syndrome (8.34%) (Table 6). Among all these patients, 2 patients died during the study period.

### Table-I

<table>
<thead>
<tr>
<th>Socio Demographic Characteristics (n=91)</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>11</td>
<td>12%</td>
</tr>
<tr>
<td>21-30</td>
<td>66</td>
<td>72%</td>
</tr>
<tr>
<td>31+</td>
<td>14</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House Wife</td>
<td>90</td>
<td>99%</td>
</tr>
<tr>
<td>Day Labour</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Socio Economic Condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>65</td>
<td>71%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>16</td>
<td>18%</td>
</tr>
<tr>
<td>Lower Middle Class</td>
<td>10</td>
<td>11%</td>
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<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primi</td>
<td>36</td>
<td>40%</td>
</tr>
<tr>
<td>Multi</td>
<td>55</td>
<td>60%</td>
</tr>
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### Table-II

<table>
<thead>
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<th>No. of Antenatal Visit in Current pregnancy</th>
<th>Number</th>
<th>%</th>
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</thead>
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<tr>
<td>No Visit</td>
<td>36</td>
<td>39.60%</td>
</tr>
<tr>
<td>1—4</td>
<td>40</td>
<td>44.00%</td>
</tr>
<tr>
<td>More Than 4</td>
<td>15</td>
<td>16.40%</td>
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### Table-III

<table>
<thead>
<tr>
<th>Distribution According to Clinical Feature of the Study Population</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complications</strong></td>
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<td></td>
</tr>
<tr>
<td>Convulsion (n=39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antepartum</td>
<td>31</td>
<td>79.48%</td>
</tr>
<tr>
<td>Postpartum</td>
<td>8</td>
<td>21.52%</td>
</tr>
<tr>
<td>Bleeding (n=28)</td>
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<tr>
<td>Antepartum</td>
<td>7</td>
<td>25.00%</td>
</tr>
<tr>
<td>Postpartum</td>
<td>21</td>
<td>75.00%</td>
</tr>
<tr>
<td>Oedema (n=91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>31</td>
<td>34.06%</td>
</tr>
<tr>
<td>Absent</td>
<td>60</td>
<td>65.94%</td>
</tr>
<tr>
<td>Conciousness (n=91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concious</td>
<td>73</td>
<td>80.20%</td>
</tr>
<tr>
<td>Semi Concious</td>
<td>13</td>
<td>14.30%</td>
</tr>
<tr>
<td>Unconcious</td>
<td>5</td>
<td>5.50%</td>
</tr>
<tr>
<td>Temperature (n=91)</td>
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<td></td>
</tr>
<tr>
<td>Hypothermia (&lt;97.5 F)</td>
<td>2</td>
<td>2.20%</td>
</tr>
<tr>
<td>Normothermia (97.5-99.5 F)</td>
<td>76</td>
<td>83.50%</td>
</tr>
<tr>
<td>Hyperthermia (&gt;99.5 F)</td>
<td>13</td>
<td>14.30%</td>
</tr>
<tr>
<td>Blood Pressure (n=91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic (More than 140)</td>
<td>28</td>
<td>30.70%</td>
</tr>
<tr>
<td>Diastolic (More Than 90)</td>
<td>36</td>
<td>39.50%</td>
</tr>
<tr>
<td>Anaemia (n=91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Anaemia</td>
<td>12</td>
<td>13.10%</td>
</tr>
<tr>
<td>Mild</td>
<td>45</td>
<td>49.50%</td>
</tr>
<tr>
<td>Moderate</td>
<td>18</td>
<td>19.80%</td>
</tr>
<tr>
<td>Severe</td>
<td>16</td>
<td>17.60%</td>
</tr>
<tr>
<td>Dehydration (n=91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>76</td>
<td>83%</td>
</tr>
<tr>
<td>Moderate</td>
<td>12</td>
<td>13%</td>
</tr>
<tr>
<td>Severe</td>
<td>3</td>
<td>4%</td>
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Fig.-1: Diagnosis at the time of Admission

Fig.-2: Distribution of Patients by Medical Treatment Required

Table-IV

<table>
<thead>
<tr>
<th>Distribution According to Admission Required in ICU</th>
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<tr>
<td>Admission Required in ICU (n=91)</td>
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<tr>
<td></td>
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<tr>
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<td></td>
</tr>
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<td>No</td>
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Table-V

<table>
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<tr>
<th>Distribution of Patients by Duration of Hospital Stay</th>
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<tr>
<td>Number of Days</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>1—4</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5—8</td>
</tr>
<tr>
<td>9—12</td>
</tr>
<tr>
<td>More than 12</td>
</tr>
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</table>

Table-VI

<table>
<thead>
<tr>
<th>Distribution of Patients According to Type of Morbidity</th>
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</thead>
<tbody>
<tr>
<td>Types of Morbidity (n=12)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Salpingoophorectomy</td>
</tr>
<tr>
<td>Renal Failure</td>
</tr>
<tr>
<td>Heart Failure</td>
</tr>
<tr>
<td>Chronic Hypertension</td>
</tr>
<tr>
<td>Sheehan’s Syndrome</td>
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</tbody>
</table>
Discussion:
This study represents a fraction of scenario of severe acute maternal morbidity in Bangladesh. The study shows that 72% of the affected women are in the second decade of their lives and majority of them are from poor socio economic condition. Zwart and Richters et al, show in Netherland incidence of SAMM is more in age 20-35 years, it is about 70% and they are from middle socioeconomic status (44%)\(^10\).

According to this study about 39% patients had not taken any antenatal checkup. Those who took antenatal check up most of them went to government hospital. In Netherland, 85% of women start prenatal care by community midwives. In case of complication during pregnancy or labour, care is taken over by an obstetrition\(^11\). In India, similar of their cases shows that 61.9% are not registered for antenatal care\(^12\).

Identifying women at risk is important. The risk factors of severe maternal morbidities have been identified as maternal age more than 34, social exclusion, nonwhite, hypertension, previous PPH, delivery by emergency caesarean section, multiple pregnancy and maternal admission to hospital\(^13\). In this study risk factors identified were multi parity, women aged of second decade, absent or irregular antenatal checkup or took irregular antenatal checkup, anaemia. Low status of women who do not attend antenatal care in a given health unit but are referred there when they developed life threatening obstetric complications, contribute significantly to maternal morbidity\(^12\). Induced abortions conducted by untrained village midwives are still a major cause of morbidity in the developing countries\(^14\).

This study shows that 43% of the patients are admitted due to eclampsia and the second highest cause is PPH (17%), this is consistent with other studies. In South Africa, the most common initiating obstetric conditions are hypertension (26%), haemorrhage (26%), abortion or peurperal sepsis (20%)\(^8\). In India, common causes of severe maternal morbidity are haemorrhage, hypertensive disorder, sepsis and obstructed labour. The proportions of these conditions are similar to those reported from other developing countries\(^15\). However, the study from West Africa reported a higher proportion of dystocia (30%) as the second most common cause after haemorrhage. Studies from Europe have reported haemorrhage and hypertensive disorder as the most common cause in their region\(^16\).

Moderate to severe anaemia, which are observed in a very high proportion (moderate 46%, severe 12%), accompanied by other cause of SAMM. Severe anaemia alone is responsible for SAMM in 1% cases in this study, but it worsen the condition in association with other diseases like PPH. Only the study by Oladopa et al, classified anaemia separately, they reported it as a cause in about 4% of near miss cases. Other studies based on the disease specific criteria of severe maternal morbidity have not categorized severe anaemia as a separate condition\(^17\).

Surgical interventions as LUCS (60%), D&C (20%), salphingoophorectomy (3%), hysterectomy (3%) etc are needed for better management of SAMM. Only 13% are normal deliveries. Prenatal death of the babies is also related with it. Extensive medical intervention is also needed regarding antibiotics, antihypertensive drugs, uterotonic drugs, sedative. Zwart et al, showed that caesarean section and induction of labour which were often performed because of compromised maternal condition. Preterm birth is also related\(^10\).

The patients who needed blood transfusion among them 24.5% patients needed more than 4 units of blood. In Netherland, major obstetric haemorrhage is estimated at 29% and these cases also required 4 units of blood\(^10\).

According to this study, only 4% patients needed ICU admission. Bibi et al, shows 1.34% of obstetric patients are transfer to general ICU, corresponding to 1.34% and 1.4% of developing country reports. However rates seem to be slightly raised from 0.026 and 0.17 documented from developed world\(^18\).

This study highlights the facts that severe maternal morbidity cases place a significant burden on health resources and reflects the quality of health care available in our country. Eclampsia, severe preeclampsia, haemorrhage, sepsis, obstructed labour, ectopic pregnancy are major cases for severe maternal morbidity. These cases causes residual disability like chronic hypertension, hysterectomy, salphingoophorectomy, heart failure, renal failure and Sheehan’s syndrome. Therefore these cases should be identified and treated without delay in order to improve fetomaternal outcome.

Severe obstetric morbidity and its relation to mortality may be more sensitive measures of pregnancy outcome than mortality alone\(^13\). Reduction of severe maternal
morbidity seems a mandatory challenge. Including SAMM in maternal death audit increase rapidity with which health system problems can be identified.

**Conclusion:**
Most of the patients of this study are in second decade and in their second pregnancy, which is not usually regarded as a risk factor for obstetric complications. This signifies that every pregnancy should be monitored vigilantly. Proper medical and surgical intervention, improving awareness and education about the danger sign of pregnancy, antenatal and delivery care by skilled birth attendant could be some positive intervention to prevent SAMM and reduce the complication. Severe maternal morbidity is an indicator of the quality of obstetric care. Proper auditing of SAMM will be helpful to improve quality of care and ensure better survival.

**Reference:**
Summary:
Hormone replacement therapy (HRT) is the most effective therapy of menopausal symptoms for perimenopausal and menopausal women. When HRT is individually tailored women gain maximum advantages and the risk are minimized. There are different types of hormones with different doses and different routes of delivery exist. The use of HRT is an individual decision which women can only make once she has been given correct information and advice from healthcare professionals. HRT should be recommended in women with premature ovarian insufficiency with advice to continue until the average age of menopause at 51.4 years. This review item promotes confidence in prescribing HRT in most symptomatic women. Prescribing HRT in women with relative contraindication where evidence is limited. Quality of life is priority. Multidisciplinary approach may be necessary and informed written consent documented.

Key words: Hormone replacement therapy (HRT), Menopause, Quality of life.

Methodology:
It is a literature review item. It reflects the need of HRT in perimenopausal and menopausal women. It also notices the adverse effect of HRT. It reviews in Bangladesh medical journal (BMJ), the topic on menopause and hormone therapy. This review is supported by information from the latest evidence on HRT in gynecology. It also collected from different journals e.g. TOG, Evidence based assessment of the impact of HRT. Information also collected from different web side like FIGO, American menopausal society recommendation of hormone replacement therapy and systemic review of Cochrane database study.

Introduction:
Permanent cessation of menstruation for at least 1 year in a normally menstruating woman is called menopause\(^1\). The mean age of menopause is different in different region of the world. In European country mean age is 51.4 years. Common menopausal symptoms are vasomotor symptoms, mood changes, loss of concentration, dryness of vagina, atrophy of secondary sexual characteristics, loss of libido, musculoskeletal pain, osteopenia, osteoporoses etc.\(^2\) Frequency of vasomotor symptom varies on different geographical region. Distressing symptoms last for 2-3 yrs in the premenopausal period. It is predominant in premature ovarian failure and iatrogenic menopause. Vasomotor symptom responds effectively to replace estrogen. HRT in which the estrogen is similar to natural ovarian production should not be confused with the potent ethinyl estradiol used in combined oral contraception regimens. The addition of a progestogen or micronized progesterone is essential of women still has a uterus to prevent endometrial hyperplasia and cancer. Estradiol can be delivered orally (an micronized estradiol, estradiol valerate estrone, estriol or conjugated equine estrogens) or transdarmally 17beta-estradiol. Topical vaginal administration of estrogen is used for localized symptoms. Various progestogen are used in combination with estradiol, either is a sequential cyclical regimen or as continuous combined therapy (CCT). Progestogen is mostly administered orally. Only two formulations being available one is transdarmal and another one is levonorgestril intrauterine system. Tibolone is an oral synthetic steroid with estrogenic, androgenic and progestogenic actions that can be used as HRT in postmenopausal women. The role of supplemental testosterone will not be covered in this article\(^3\).
Discussion:

Epidemiology-

Mean age of menopause is different in different region of the world. Median age of 42.1-49.5 years South Asian countries but in European countries median age is (50.1-52.8) is 51.4 years. Vasomotor symptoms (hot flushes and night sweats) are common, affecting about 70% of women (severely in about 20%), for a median duration of 5.2 years, but may continue for many more years in about 10% of women. Menopausal symptoms adversely affect quality of life. In the 1970s epidemiological studies identified that the most common cause of death in women with early onset of menopause is cardiovascular diseases (CVD). The possibility that estrogens may be protective to the female cardiovascular system led to much research into looking at the effect of estrogen on the cardiovascular system. Since epidemiological studies was the heart and estrogen/progesterone replacement study designed to identify if HRT prevented recurrence of coronary heart disease in women with established coronary heart disease.

Pathophysiology:

Menopause is due to the depletion of ovarian follicles secondary to apoptosis or programmed cell death along with changes in the hypothalamic and pituitary hormones, the ovary fails to respond to the pituitary hormones. Menopause also occurs due to premature ovarian insufficiency which includes genetic, infection, autoimmune and metabolic factors or due to surgery. Women born with around seven million oocytes but during their reproductive lifespan only release up to 500 oocytes. Therefore ovarian insufficiency may be due to lower number of follicles present in the ovary or increase rate of follicle loss. Another possibility is that abnormal pairing during meiosis may result in oocytes apoptosis. Surgical menopause occurs due to surgical removal of ovaries, commonly ovarian malignancy, cervical cancer radical hysterectomy or severe endometriosis. It also occur due to chemotherapy (Anthracycline, cyclophosphamide) and or radiotherapy.

Randomized control trial on post menopausal women (an average age of 66.7 years) with conjugate equine estrogen and medroxy progesterone acetate did not showed any benefit but increase various thromboembolism more pronounced is the first year of use and gall bladder disease.

Effect of HRT

Premature ovarian insufficiency

In the developed world menopause under 45 years in classified as premature ovarian failure. Women with premature ovarian insufficiency have an earlier onset of both CVD and osteoporosis. They are also noted to have reduced breast cancer risk compared with their menstruating peers. The risk of breast cancer with HRT use in these women in deemed to be not greater than population risk for their age, while the benefits are greater by prevention of long term morbidity. Hence it is strongly advised that these women should consider taking HRT, at least until the age of 50.

Effect of HRT on cardiovascular events in recently post menopausal women:

A randomized study by Schaefer et al. that was carried out in Denmark in 1990-1993, has been the first one to address the correct timing and the long term effect of HRT on CVD in recently postmenopausal women. After 10 years women on HRT were found to have had a significant reduction in mortality and CVD related events, with no apparent increased risk of VTE, stroke or cancer. The health benefits were seen up to 6 years after stopping. 2012 Cochrane collaboration systemic review assessed the clinical effects of using HRT for 1 year or more. Twenty three randomized double blind studies were included involving 42830 women aged 26-91 yrs. Since 70% of data were derived from the women’s health initiative and HTRS most participants were post menopausal. This review included that there was no indication to use HRT for primary or secondary prevention of CVD or dementia or for protection of cognitive function. There was a significant benefit and reduction in the risk of bone fracture after 5 years use. So no single recommendation for optimum duration of treatment or safe upper age limit for use of HRT is therefore possible because they will be specific to every woman’s circumstances. For most women, short term treatment will be sufficient to relieve vasomotor symptoms for others; HRT may need to be continued for longer. For all women the lowest effective dose should be used for the shortest possible time and the need to continue HRT should be reviewed at least yearly.
3. Practical guidance on prescribing HRT:

HRT in Low risk women:

There are few women in whom HRT is an absolute contraindication. The fear of increased breast cancer risk is foremost for most women and physicians. The risk as a result of taking HRT is much lower than the risk associated with obesity, moderate alcohol intake or delaying first pregnancy until after 35 years. \(^\text{12}\) The absolute increase in breast cancer risk is 6 times per 1000 women for 5 years of estrogen and progestogen and reverts back to the population risk 5 years after stopping.\(^\text{13}\) Three months trial of HRT will enable a woman to assess her quality of life, whether HRT has been of benefit or not and decide on duration, having been made aware that the breast cancer risk will be duration dependent.

A full history will reveal any existing medical problems or family history or CVD or cancer. This information will point the clinician to the correct regimen, dose and route of administration. Baseline measurement of body mass index (BMI) and blood pressure give guidance as to the need for further investigation. There is no indication for a pretreatment mammogram or breast examination pelvic examination, cervical smear or endometrial thickness measurement by transvaginal scan.

Once established on HRT a woman should not discontinue abruptly but should wean of treatment gradually. Continuing or restarting on HRT is a decision based on quality of life.

Troublesome menopausal symptoms can start in the perimenopausal state. To avoid unnecessary investigation or unscheduled bleeds these women should be commenced on sequential (cyclical) HRT for 12-14 days per months. If periods are reasonably frequent, the HRT should start with the next bleed, but if infrequent (more than three months apart) the HRT can be commenced without awaiting a period.

The most common adverse effects include headache, breast tenderness, bloating and muscle cramps. Weight gain is not an adverse effect of HRT.\(^\text{14}\) Adverse effects are transient and usually resolve by 3 months. Any unscheduled bleeding should be investigated. Persistent progestogen adverse effects can be addressed by altering the progestogen or by using an intrauterine system. This will give the benefit of contraception, reduction to periods and endometrial protection with continuous estrogen use.

Once established on HRT an annual review is all that is necessary. HRT does not increase blood pressure and there is no indication to monitor more frequently. Women who wish to stay on HRT for more than 5 years should be encouraged to switch to combined contraception to avoid an increased risk to endometrial hyperplasia seen in women on long term sequential therapy. Lower doses may be evaluated prior to switching and if tolerated. Then the women can switch to a lower dose of CCT by completing the month of sequential treatment. So that the withdrawal bleeding occurs before starting the CCT. As a rule, women aged 54 years would be advised to switch as 80% of women at this age will be menopausal.

CCT (continuous combined therapy) or Tibolone are used in postmenopausal women (amenorrhea for 12 months). Such women will have been estrogen deficient for this time and starting with a low dose combination will minimize adverse effects and breakthrough bleeding. The dose can be increased after 3 months if menopausal symptoms remain. Initial breakthrough bleeding is common but usually reduces and ceases with time. Persistent bleeding should be investigated after 6 months with an ultrasound scan and/or endometrial biopsy. The risk of endometrial cancer is lower in those using CCT than in those not using HRT. If bleeding occurs after a time of amenorrhea, then investigation is still required even if a causative factor is identified. Causative factors included:

- Forgotten pills, poor patch adhesion, poor compliance.
- Introduction of new medication or over the counter predations.
- All other cases of post menopausal bleeding.\(^\text{15}\)

Patients with relative contraindication to HRT could be referred to specialist service for advice. Quality of life may be the deciding factor for women with contraindication and in such circumstance a written statement from the women in helpful and may avoid any future medico-legal complication.

Thrombosis risk:

According to Canadian society incidence of VTE and PE increased from 0.12% (in general population) to 0.2%
in HRT user. The risk of VTE associated with HRT use is mostly seen after using 12 months. This risk depends upon type of HRT, dose of drugs and route of administration. Transdermal HRT is associated with a lower risk of VTE than oral but lower doses may be less likely to promote this risk. Women who are sedentary, overweight and smoker increased risk of VTE\textsuperscript{16-17}.

**Other benefits of HRT:**
Other observed benefits of HRT other than those affecting vasomotor symptoms, include improvement of low mood and protection against loss of tooth. Several studies have identified a risk reduction of bowel cancer in women using HRT, but this is not deemed to be as indication to prescribe HRT as preventative for this disease. Some forms of Estrogen replacement therapy appear to be neuroprotective, preserving cognitive function and reducing the risk of Alzheimer’s disease. Some protection against Parkinsonism disease has also been seen. It is suggested that there may be a ‘Window of opportunity’ for preserving cognitive function if HRT is used early in the menopause.\textsuperscript{18} HRT is effective in preventing the bone loss normally associated with the menopause.\textsuperscript{19}

![Fig-1: Guidance on HRT prescribing with permission from the West Midlands Menopause Society.](image-url)
Topical vaginal estrogen

Atrophic vaginitis is treatable with topical estrogen, resulting in cornification and regeneration of the vaginal epithelium. This improves lubrication and sexual function. Systemic absorption is insignificant with low-dose topical estrogen. Additional systemic progestogen is not required. Vaginal estrogen may reduce symptoms of urgency of micturition and recurrent urinary tract infections. Vaginal symptoms can persist even when on adequate systemic HRT; in such cases both topical and systemic are required. The safety of topical vaginal estrogen has not been assessed in patients with breast cancer, where theoretically the risks are small. The benefits to the genitourinary tract along with improved sexual intimacy may outweigh the risk.

HRT after breast cancer\textsuperscript{20-23}

Breast cancer is a common condition that affects women of all ages. The vast majority of breast cancers are estrogen receptor positive (ER+) and require adjuvant tamoxifen or aromatase inhibitors, the adverse effects of which can be exacerbated and debilitating menopausal symptoms. Many breast cancers and precancerous change (ductal carcinoma in situ) are screen detected and caught at an early stage, with excellent prognosis. Adequate studies have not been done where such individuals have continued on adjuvant treatment with the addition of HRT. Some case-control studies\textsuperscript{3S} have shown no defrayment to the mortality rate or recurrence rate with HRT.

Therefore, HRT use is a patient choice. There is inadequate information on the risks and benefits of herbal and alternative over-the-counter preparations.

The specialist needs to consider the following factors when discussing management in order to predict prognosis:

- Stage of the disease at diagnosis (size, ER status, grade of tumor and lymphnode status). This gives a guide to the prognosis.
- Type of adjuvant therapy currently or previously used.
- Time since diagnosis.
- The woman’s attitude to her symptoms.
- The woman’s fear of recurrence/fear of using hormones.
- What she has tried already.

Non-hormonal treatments

Women in need of treatment may be offered clonidine, selective serotonin reuptake inhibition (SSRI)(if not on tamoxifen) or selective nor adrenaline reuptake inhibitors(SNRI) (unlicensed indication for vasomotor symptoms), or gabapentin, along with self-help tips for a trial period of 3-4 months. If this is ineffective, then the next option may be evaluated. When all alternative prescribed medications have been tried, then a discussion about quality of life and survival is relevant. Should the patient wish to try HRT, it is recommended that this is discussed with her oncologist and care providers.

TIBOLONE

Tibilone, a selective tissue estrogenic activity regulator, is effective in treating symptoms in postmenopausal women. The evidence of a reduced stimulatory effect on breast tissue compared with other HRT preparations meant that it was feasible to evaluate its safety in a randomized controlled trial in women with recently diagnosed breast cancer\textsuperscript{24}. Quality of life was improved in the treatment group, but a higher rate of breast cancer recurrence was seen only in the women with ER+ disease. There are no data on whether it is safe to use in disease-free survivors who still experience menopausal symptoms many years after their initial treatment.

Family history of breast cancer

As seen in the Nurses’ Health study\textsuperscript{25} HRT did not increase the risk of breast cancer in those women with a family history. Therefore a family history of breast cancer is not a contraindication to HRT, rather an opportunity for the clinician to identify whether the history is significant and warranting a referral to ‘the clinical geneticist and additional screening under 50 years of age.

Carriers of BRCA mutations

BRCA1 and BRCA2 mutation carriers are at increased risk of breast and ovarian cancer. Risk-reducing surgery with mastectomies and bilateral salpingooophorectomy (BSD) is usually carried out when the family is complete\textsuperscript{26}. Surgical menopause in these premenopausal women causes acute and severe symptoms. Preoperative counseling will help the patient decide between BSO only, or hysterectomy plus BSO. The progestogen required when the uterus remains may influence the decision. HRT is indicated in these young women to
avoid the early onset of osteoporosis and CVD associated with a premature menopause. The use of HRT following risk-reducing surgery appears to be safe with no additional increase of breast cancer, especially if estrogen-only therapy is used.27-28

FIGO recommendation in menopausal syndrome, 201729
1) Certain type of HRT may protect memory loss
2) Bisphosphonate continue significantly prevent hip fracture in compare with no user or stop use more than 2 years
3) Soya protein an reduce coronary heart diseases.
4) Avoidance of caffeine significantly reduces menopausal symptoms.
5) HRT does not shorten the lives.

American menopausal society recommendation of HRT 30

The 2017 hormone therapy position statement of the north American menopause society recommend that hormone therapy remains the most effective treatment for vasomotor symptoms and genitourinary syndrome of menopause and has prevent bone loss and fracture. The risk of hormone treatment differ depending on type, dose, duration of use, route of administration, timing of initiation and whether a progestogen is used. For women aged younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the benefit risk ratio is most favorable for treatment of bothersome VMS and for those at elevated risk for bone loss or fracture. For women who initiate hormone treatment more than 10 or 20 years from menopause onset or aged 60 years or older, the benefit risk ratio appears less favorable because of greater risk of coronary heart diseases, stroke VTE, and dementia. Longer duration of therapy must be periodic reevaluation.

Conclusion:
Symptomatic women benefit from the use of HRT. Strictly speaking, there are no absolute contraindications to HRT. Relative contraindications are personal or family history of VTE, cardiovascular diseases. Alternative therapies are limited in there effectiveness and safety. Combined HRT should not routinely recommended for all postmenopausal women. It can be offered in symptomatic postmenopausal women for reduce distressing menopausal symptoms, for prevention of hip fracture, vaginal dryness when alternatives are ineffective. It should not offer for protection and prevention of CVD, breast carcinoma, colorectal diseases.

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Surgical Management of a Case of Severe Coarctaton of Aorta with Bicuspic Aortic Valve

MN HASAN, MA SIDIQUE, SK BANERJEE, AS ABDULLAH

Summary:
Coarctation of the aorta is a congenital cardiac malformation that can go undiagnosed until old age with only hypertension as a marker of its presence because clinical signs can be subtle and overlooked if a complete physical exam is not performed. Long-term survival is exceptional in patients with untreated aortic coarctation. In this case report, we present a late diagnosis of aortic coarctation in a 45-year-old male. Our patient was relatively asymptomatic until he presented with exertional dyspnea and fatigue in his fourth decade of life. The patient was managed by surgery of aorta. After the 6 months follow-up visit, the patient was in good clinical condition.

Keywords: Congenital malformation, aortic coarctation, bicuspid aortic valve, aortic surgery.

Introduction:
Aortic coarctation is a congenital vascular lesion typically diagnosed in early life, accounting for 5 to 10% of all congenital cardiovascular malformations but may go undetected well until adulthood. It manifests as childhood hypertension, lower extremity fatigue or weakness, diminished lower extremity pulses and or congestive heart failure. Diagnosis is usually based on clinical suspicion and physical findings. The latter include blood pressure difference between the upper and lower extremities, pulse delay and systolic murmur over the thoracic spine. Other manifestations can include bicuspid aortic valve systolic ejection sound and/or murmur and neurological complaints. Prognosis and survival depend on the disease severity and patient’s age at the time of correction. Death in these patients is usually due to heart failure, coronary artery disease, aortic rupture/dissection, concomitant aortic valve disease, infective endarteritis/endocarditis, or cerebral hemorrhage. There are few reports of patients first diagnosed with uncorrected aortic coarctation at very late age. Treatment consists of aggressive hypertension therapy, endocarditis prophylaxis and corrective treatment for coarctation lesions with a high gradient. In this case report, we present aortic coarctation with bicuspid aortic valve in a 45-year-old male.

Case Report:
A 45 year-old man was admitted with increasing fatigue and exertional dyspnea. He had been well until 5 months previously. The patient had a medical history of dyslipidemia and hypertension. His hypertension was
poorly controlled despite a combination of antihypertensive agents (beta-blocker and angiotensin receptor blocker). Physical examination showed blood pressure 140/90 in both arms, a heart rate of 74 beats/minute and an apical gallop sound (S4) with a continuous murmur over the left parasternal area. There was another systolic murmur over the aortic area. Femoral pulses were palpable bilaterally but weak and delayed compared to the brachial pulses. His echocardiogram showed bicuspid aortic valve with minimal regurgitation, segmental wall motion abnormalities and mild mitral insufficiency and continuous Doppler echocardiography showed a peak systolic gradient of 69 mmHg and a low grade antegrade diastolic flow in the descending thoracic aorta. A cardiac silhouette at the upper limits of normal and notching of the ribs were observed on the chest radiography. Due to the significance of the cardiac dysfunction and his clinical presentation, the patient underwent a cardiac catheterization to evaluate his coronary artery disease. The left ventricular ejection fraction was significantly reduced (Ejection fraction: 30-35%). There was no evidence of mitral valve prolapse. Computed Tomography (CT Scan) of chest showed a discrete narrowing of the thoracic aorta just distal to the left subclavian artery. Aortography showed a mildly dilated aortic root, minimal aortic valve insufficiency and a significant ring-like stenosis in the thoracic descending aorta. The gradient across the stenosis measured 69 mmHg. The coronary angiography was negative for significant focal coronary artery obstruction. The patient was then referred to cardiothoracic surgery. The procedure was done via left posterolateral thoracotomy from the fifth intercostal space. Since, the collaterals were well recognized before surgery, the procedure was achieved without major bleeding and any adverse event. Furthermore, the patient was adult and any minor

![Fig.-3: X-ray chest showing Cardiomegaly with presence of Rib notching in 3rd and 4th rib.](image)

![Fig.-2: Continuous Doppler echocardiography showing a peak systolic gradient of 69 mmHg and a low grade antegrade diastolic flow in the descending thoracic aorta (saw tooth).](image)

![Fig.-4: Computed Tomography (CT Scan) of chest showing a discrete narrowing of the thoracic aorta just distal to the left subclavian artery.](image)
bleeding has not resulted in requirement of blood transfusion. The coarctated segment was resected totally and end to end anastomosis of thoracic aorta was performed in a standard fashion. The coarctated segment was short in our patient and it was not difficult to get the two ends together without tension on the anastomosis so that we do not considered an interposition graft. The cross clamp time was 26 minutes and because the collaterals were left intact, no malperfusion syndrome occurred. Total hospital stay after procedure was only four days. At the 6 months follow-up visit, the patient was in good clinical condition.

Discussion:
Coarctation of the aorta (CoA) is typically a discrete narrowing of the thoracic aorta just distal to the left subclavian artery. However, the constriction may be proximal to the left subclavian artery or rarely in the abdominal aorta. In some cases, coarctation presents as a long segment or a tubular hypoplasia. The most frequently associated lesions include bicuspid aortic valve (up to 85% of the cases), different levels of aortic stenosis, mitral valve stenosis (parachute mitral valve, a complex known as Shone syndrome) 5. Aortic coarctation presenting during adult life, most frequently represents cases of re-coarctation, following previous transcatheter or surgical therapy, or missed cases of native coarctation. Aortic coarctation may be recognized in the adult, usually because of systemic arterial hypertension and discrepant upper- and lower-extremity pulses. Patients may complain of exertional headaches, leg fatigue or claudication. The reduced life expectancy of patients without correction due to several complications like systemic hypertension, accelerated coronary heart disease, stroke, aortic dissection, and congestive heart failure, demand an early treatment in these patients6.

There are different methods employed for the treatment of CoA in adults, including surgical or percutaneous balloon angioplasty with or without stent placement, and medical therapy.

The 2008 American College of Cardiology/American Heart Association (ACC/AHA) guidelines for adults with congenital heart disease (ACHD), recommend intervention for coarctation in the following circumstances: peak to peak coarctation gradient less than 20 mmHg, in the presence of anatomic imaging evidence of significant coarctation with radiologic evidence of significant collateral flow (class IC indication)7.

Surgical repair of coarctation can be achieved by several techniques: resection with end-to-end anastomosis, subclavian flap aortoplasty in infants with long-segment coarctation, a bypass graft across the area of coarctation when the distance to be bridged is too long for an end-to-end repair or prosthetic patch aortoplasty8. Problems with these techniques have included a significant incidence of aneurysm formation with Dacron patch aortoplasty, and an unacceptably high recoarctation rate with the subclavian flap aortoplasty. The technique of extended end-to-end anastomosis appears to give good short-term to intermediate-term results with a low complication rate and has gained in popularity as the technique of choice when possible to use. A complication associated with all the surgical techniques is aortic dissection, which can occur even late after surgical repair. Surgical mortality is rare (usually less than 1 percent). Morbidity includes early postoperative paradoxical hypertension, left recurrent laryngeal nerve paralysis, phrenic nerve injury, and subclavian steal. Paraplegia due to spinal cord ischemia and mesenteric arteritis with bowel infarction are rare complications9. Nowadays, it is generally accepted that these patients require indefinite follow-up by a cardiologist, specialized in the field of congenital heart disease. The frequency in which outpatient visits and tests should take place is highly dependent on the clinical history, the presence of associated cardiac anomalies, type of repair, and the patient’s blood pressure. The guidelines recommend that patients who have had surgical repair or percutaneous intervention for coarctation of the aorta should have at least a yearly follow-up and, the evaluation of the coarctation repair site by MRI/CT, should be performed at intervals of 5 years or less, depending on the specific anatomic findings before and after repair (Class I, Level of evidence C). Even if the coarctation repair appears to be satisfactory, late postoperative thoracic aortic imaging should be performed to assess for aortic dilatation or aneurysm formation10.

Conclusions:
The case presented best illustrates that coarctation of the aorta is a congenital cardiac malformation that can
go undiagnosed until adulthood, having only hypertension as a marker of its presence, because clinical signs can be subtle and overlooked if a complete physical exam is not performed. Nowadays, different surgical and interventional types of treatment are available but this should be individualized for each patient and for each type of coarctation (native coarctation or recoarctation after surgical or interventional treatment).

References:
Difficult ERCP with Aberrant Papilla
A Report of Three Cases

S PERVEEN a, SMM RAHMAN b, MSMM HOSSAIN c, NG CHOWDHURY d, MA AHMED e

Summary:
The ampulla of Vater encompasses the openings of both the common bile duct (CBD) and pancreatic duct (PD). Presently ERCP has allowed better observation of the papillae in ectopic locations. The diagnosis of ectopic papillae can be done by radiological studies also but they are expensive and not affordable by all patients so most of the cases of ectopic papillae are identified by ERCP. An ectopic location, distal to the second part, in the third or fourth parts of duodenum has been described frequently but a proximal location is rare. Only a few cases have been found to be located in the gastric, pyloric and duodenal bulb areas. We report three such rare cases of anomalous ectopic ampullae discovered during the performance of ERCP from the Department of Gastroenterology, Combined Military Hospital, Dhaka and also a short review of the literature. In these three subjects one papilla was located in the pylorus and other two in the first part of the duodenum. All of them presented with features of choledocholithiasis with cholangitis. They were successfully managed by therapeutic ERCP. Clinical implications of these rare anomalies and anatomical variations can assist the gastroenterologists in effective patient management.

Key words: Common bile duct, Pancreatic duct, Ectopic biliary drainage, Endoscopic retrograde cholangiopancreatography, Ampulla of Vater.

Introduction:
The ampulla of Vater is ideally located in the posteromedial wall of the second part of the duodenum. The common bile duct (CBD) normally goes through an oblique, 1-2 cm long intramural part and then opens within the wall of the duodenum surrounded by the small circular and longitudinal muscular segments that comprise the sphincter of Oddi. At times, the ampulla of Vater may be anomalous in ectopic locations and in uncommon sites such as the third and fourth portions of the duodenum, the duodenal bulb and the stomach. It has hardly ever been found at the pylorus [1]. An ectopic location of the ampulla distal to the second part has been described frequently but in a proximal location is rare. In three subjects one papilla was located in the pylorus, one in a normal duodenal bulb and another one in the first part of duodenum within two large duodenal diverticuli. All these patients were successfully managed by some modification of therapeutic ERCP procedure. So awareness of such rare conditions can assist the gastroenterologists in effective patient management.

Case Report:
Three male patients of forty four, fifty eight and eighty two years of age presented with fever and jaundice with abdominal pain and altered liver enzymes. All of them had recurrent cholangitis, elevated Alkaline phosphatase and one had raised CA 19-9. Their total bilirubin ranged from 4.6 to 9.4 mg/dl, C-reactive protein level was 30 to 190 mg/dL, alanine-aminotransferase 44 to 95 IU/L, leucocytes 15,500 to 18,400/mm 3 and Abdominal ultrasonography showed dilatation of the extrahepatic bile duct with stones, a feature of choledocholithiasis in all three and cholelithiasis in one. History of cholecystectomy was present in 2 of the cases and duodenal ulcer in one. After the diagnosis of obstructive jaundice with dilatation of the bile ducts, ERCP was performed.

During ERCP, in case 1 no area suggesting the presence of the papilla of Vater was found within the second part of duodenum or lower down. Front view endoscope was...
employed to search for the papillary opening. Finally, the papilla was found to be located in the anatomical pyloric channel (Fig 1). Cholangiogram was also done with endoscope due to technical difficulty in using duodenoscope. It showed dilated CBD with filling defect (Fig 2). In two other cases during ERCP, being unable to find the papilla down we searched up and found them in duodenal bulb. In case 2 it was in normal bulb while in case 3 it was in between two large duodenal diverticulae (Fig 3) with a separately identifiable pancreatic opening (Fig 4). Controlled Release Expansion (CRE) balloon dilatation of the CBD rather than papillotomy was chosen for therapeutic technique (Fig 5) in these cases as in the literature. Alteration in anatomy and diverticuli increased technical difficulty and risk of perforation during papillotomy with a theoretically higher risk of other complications. After dilatation of the papilla with a CRE (controlled release expansion) balloon (Fig 6) and removal of stones using extraction balloon and Dormia basket, the free flow of bile was established (Fig 7) which solved the problem of obstructive jaundice. In the first case, a single large stone was retrieved by balloon sweeping and in the other cases multiple stones were cleared by Dormia basket without further complications.

Fig.-1: Ectopic location of papilla at pylorus

Fig.-2: Cholangiogram done with Endoscope

Fig.-3: CBD and PD amidst two Duodenal Diverticulae

Fig.-4: CRE Balloon in CBD

Fig.-5: CRE Balloon in CBD
In these three subjects one papilla was located in the pylorus, one in the first part of duodenum within two large duodenal diverticuli and another one in a normal duodenal bulb. Normal formation of papilla were absent in these patients and a slit-like opening was found instead. Pancreatic duct (PD) was opening separately in one case where it was possible to visualize. All presented with fever and jaundice with right upper abdominal pain and altered liver enzymes. Ultrasound showed dilated common bile duct with stone. A feature of choledocholithiasis with cholangitis. All these patients were successfully managed by some modification of therapeutic ERCP procedure.

Discussion:
The origin of ectopic papillae has usually been suggested during embryonic life. The liver originates in the hepatic diverticulum which is divided into the hepatic pars and the cystic pars during embryogenesis. The hepatic pars then develops into both the liver and the hepatic ducts while the cystic pars develops into the gall-bladder and the cystic duct. The common bile duct originates in the hepatic antrum, which is the common area of the hepatic diverticulum. Earlier subdivision of the hepatic diverticulum could cause the common bile duct to empty into different locations other than the usual location. Ectopic papillae located in the duodenal bulb may be secondary to a duodenal pathology like ulcer and scarring leading to anomalous drainage in the duodenum. The location of the papilla in our patient beside diverticuli might be related to such duodenal ulcer followed by development of diverticulae formation. In these cases we could not find signs of the papilla in the second duodenal portion or distally. Papilla in the pyloric channel and the duodenum might be related to a congenital malformation with anomalous biliary and pancreatic drainage. In our subjects we observed the diagnostic requirements for an ectopic papilla as described by Lee et al. Criteria for an ectopic location of papilla were:

1. An orifice observed in the bulb by duodenoscopy and upper endoscopy and the bile duct and/or the pancreatic duct directly visualized radiographically when contrast was injected through this opening.

2. There was direct drainage of the common bile duct into the duodenal bulb without evidence of any other drainage into the duodenum on cholangiography and
There was no evidence of a papilla-like structure in the second or third portion on duodenoscopic examination.

Fistula secondary to peptic ulcer disease or choledocholithiasis, spontaneous or iatrogenic surgical fistula and surgical choledochoenteric diversion should be excluded.

The clinical importance of ectopic location of the papilla is due to the fact that due to the lack of a sphincter mechanism there is a tendency for the development of choledocholithiasis through anomalous bile drainage. It can lead to mucosal damage in the area with swelling and ulcer formation due to the action of biliary and pancreatic secretions.

The absence of a sphincter allows passage of the gastro-duodenal contents into the common bile duct causing cholangitis in association with biliary obstruction. A case has been described where the papilla was located in the posterior duodenal wall below the pylorus presenting as recurrent upper GI bleeding. In a recent study by Disibeyaz et al on 39 patients where the papilla was located in the bulb recorded episodic abdominal pain in 95% of patients and cholangitis in 59% of patients. Recurrent abdominal pain explain a high percentage of patients undergoing cholecystectomy. The predominance of male sex and an association with ulcerous duodenal pathology in 61.5% of the patients were emphasized. An ectopic location distal to the second duodenal portion within the third and fourth duodenal portion had a frequency rate of 5.6% to 23%.[4] Technical difficulty and a higher probability of perforation due to the lack of anatomical reference during a papillotomy makes its use inadvisable and balloon dilatation is the preferred therapeutic technique.[5] Normal formation of papilla were absent in these patients and a slit-like opening found instead. Pancreatic duct (PD) was opening separately in one case where it was possible to visualize. All these patients were successfully managed by therapeutic ERCP. So in difficult ERCP where the papilla cannot be found in its usual location ectopic biliary drainage and abnormal situation of papilla must be considered and searched. The frequency of ectopic biliary drainage by ERCP is 2% (10 out of 400 ERCP).[6]

**Conclusion:**

Ectopic location of the papilla though a rare finding, frequent use of ERCP, MRCP, endoscopy and surgical procedures may increase the number of cases diagnosed.

With these case reports, we intended to remind that ectopic biliary drainage must be considered in the differential diagnosis before postponing or declaring failure when the clinician faces difficulty in finding the papilla during ERCP. Cases of peptic ulcer disease or gastric outlet obstruction due to peptic ulcer accompanied by cholangitis or cholestasis should raise the suspicion of an ectopic papilla.

Although a distal location is found most frequently, a proximal location must be taken into account in whom the papilla cannot be found in its usual location. Technical difficulty and a higher probability of perforation due to the lack of anatomical reference during a papillotomy makes its use inadvisable. Balloon dilatation was the chosen therapeutic technique in our cases due to its low rate of complications.

**Acknowledgement:**

The authors like to thank Sainik Anisur Rahman and Corporal Jamal Uddin, ERCP technician, CMH Dhaka for their technical support during performance and documentation of the procedures.

**References:**


A 57 years female patient presented to our breast clinic with a painless palpable mass in her right breast for 2 months.

On examination, a mass was felt in her right breast at 9 to 10 O’clock position which was not fixed with the skin. No palpable axillary lymphnode was found. Patient was advised for breast ultrasound.

2D breast ultrasound revealed an ill defined hypoechoic area with cluster of microcysts (size about 43 mm x 16 mm) at 9 to 11 O’clock position of right breast and USG diagnosis was Low suspicious for malignant lesion( BIRADS 4a). No axillary lymphadenopathy was seen (Figure 1).

Then patient was undergone volume breast ultrasound. Volume breast imaging showed size of the mass measuring about 95 mm x 90 mm with cluster of microcysts, ill-defined margin, thick walled dilated ducts, microcalcifications and USG diagnosis was Highly suspicious for malignant lesion ( BIRADS 5) (Figure 2,3,4).

Core biopsy revealed ductal cell carcinoma.
LETTER TO THE EDITOR

To
Editor in chief
Journal of Bangladesh College of Physicians and Surgeons

Dear Sir

I would like to thank you for publishing the original article:’ Medico-social Profile of Women Experiencing Menopausal Syndrome Attending a Peri-urban Hospital’in your journal. I must thank the authors for conducting the primary research work on this topic. I have gone through it. The topics of the study, objective, method, and conclusion were written in proper way. The introduction was properly written. There are some observation. In result section the description does not correspond with the table. The mean age at menopause was 44.65±6.4, but there is no corresponding table for this important variable. Mean age at first marriage was 15.2±34. The Standard deviation of mean age at first marriage was 34, which is too wide. The class interval of age of marriage is inadequate. In table VI there seems to be repetition of same variable (not dependent & self earning is the same). In the discussion section it is written that the researchers found that about 40% had premature menopause, but there is no corresponding table. It would be better if they mentioned which group they called premature menopause.

At the end, I must thank and appreciate the authors for their hard work. The study is informative. I would request them to be generous to accept my soft criticism on the topic.

Dr. Nazneen Begum
Associate Professor
Dept. of Obs & Gynae
Dhaka Medical College

To
Editor in chief
Journal of Bangladesh College of Physician and Surgeon

Sir

We would like to appreciate Dr. Nazneen Begum for her keen observation and comments on the article.

Regarding the first comment, there was a table on Age at Menopause in the manuscript which was omitted according to reviewer’s suggestion, mistakenly the mean age been retained in result section. Mean age at first marriage was 15.2± 3.4 years, 34 was typo error. We do agree that not dependent and self earning is same.

Premature menopause was defined as menopause before 40 years of age

Thank you

Prof. Dr. Saria Tasnim
MBBS, FCPS (OBGYN), Masters Medical Education (England)
Diploma in Community Epidemiology (England)
Prof. & Head of Dept. of Obs & Gynae
Centre for Woman and Child Health
Jamgora, Ashulia, Dhaka.
Ex. Executive Director
Institute of Child & Mother Health (ICMH)
Cell : 01819221096
Greetings for Christmas. Happy New Year. Hope this year will be blessed with memorable achievements.

We are trying hard to get international recognition of our journal. For this we need lot of quality articles regularly to publish four issues of the journal every year in time.

I invite our fellows specially juniors to contribute more in the field of research and submit their articles in the journal.

My earnest request to our respected reviewers to return the reviewed articles at their earliest convenient time.

Please stay with journal committee for ensuring better achievements.

Prof. Dr. Ferdousi Islam