Obituary - Prof. Samir Huraib

To the Editor

It was a heartrending obituary of Professor Samir Huraib published in the last issue of Saudi Med J 2003; 24: 810. Obviously, Prof. Huraib had a very fruitful and productive life, and considering his contribution to the development of Medicine and Nephrology in the Kingdom of Saudi Arabia were irrefutable commendable. However, the writer has quoted in writing "He was stolen from us by Allah" in the obituary, which seems inappropriate and unacceptable in the Islamic Religion

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Thrombolytic therapy for acute myocardial infarction

To the Editor

We have read with keen interest the paper published by Abba et al.[1] It was very stimulating in an important subject of great clinical interest to most physicians. It described the results of treating myocardial infarction in the setting of a major hospital in the Kingdom. In a myocardial infarction setting, the aim of an ideal management is 'door to needle in less than 30 minutes'. The center achieved this goal in only 1.5% of the patients studied. The author mentioned that the "majority of the patients received thrombolytic therapy within 2 hours". As a matter of fact, the manuscript stated that only 53% of their patients did so. With such delay "these, results are not similar/comparable to the findings in other centers. The comparison to a study in Finland is not applicable, since this study was 'symptoms to door', while the author's study was 'door to needle'. The discussion did not offer any explanations for the results obtained, especially those related to hospital factors, which can be addressed or rectified locally. The value of the study would have been greatly increased and furthermore provided a useful guide for future planning strategy for other institutions in the Kingdom, if delays were identified and eliminated and where not possible, the causes of delay or improvement should have been discussed fully with suggestions for their prevention for the benefit of their own hospital and other small centers in the country, since the study emanates from a large and active center. However, the delays in this study appear to be only local. The author only discussed what is operative and available in other countries, while local practice has not been addressed. Although he mentioned in-hospital factors, these factors need to be defined and characterized. For example, the practice of nursing triage, where any patient presenting to an Emergency Department with chest pain or symptoms suggestive of ischemic heart disease should be screened by electrocardiogram on arrival at Emergency Department, ensuring immediate attention to such high-risk groups. This is a modification of the idea of thrombolysis nurse, which is used to screen and identify those patients requiring emergency attention.

I will recommend for the perusal of the authors a related article by Erhardt et al[2] in which these issues are discussed in full. I would also like to point out that the level of hypercholesterolemia was not defined, and although it was reported in only 3.3% of patients, 4.8% (higher percentage) received treatment.

These comments are offered for the benefit of a large population of physicians who are interested in this subject and for the younger colleagues in the discipline.

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Reply from the author

We appreciate the keen interest shown by Dr. Kinsara in our article and appreciate his valuable comments. The ideal time of 30 minutes, from door to injection of thrombolytics is hardly achievable in practice. Fifty-three percent we feel can be considered a majority – albeit a simple one. The aim of this audit is to calculate the door to needle time, which was achieved. However, finding factors for delay and redressing them requires a prospective study instead of an audit. We, in addition, identified the rather long median "pain to door" time of 300 minutes. Factors accounting for such substantial delay are probably of equal, if not more, significance than the door to needle time. The discussion therefore tended to skew more to these factors, hence, the reference to the Finnish study. We took a bit of satisfaction from the audit, as ours was not an ideal situation with regard to staff, availability of beds, lack of fast track system and chest pain units. In addition, our patient population is a largely poorly educated and indigent expatriate population from the Indian subcontinent.

These are some of the factors, which are now being studied for correction. It will be of great interest to conduct a prospective study in this and other centers after the introduction of this very interesting topic to the discourse.

Secondly regarding the use of lipid lowering agents, we are aware of some studies recommending the use of these agents for acute coronary syndromes during the admission in the coronary care units, although with marginal benefit of 16% only.[3] During this retrospective study only those patients with hyperlipidemia were prescribed statins as per the National Cholesterol Education Program (NCEP) guidelines.[4] In addition, during the acute stage of myocardial infarction, lipids may reveal normal values and we agree the drugs might have been underused. Thanks again to Dr. Kinsara for raising these interesting points.

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Erratum

In manuscript "Study of HER2/neu status in Qatari women with breast carcinoma" Saudi Med J 2003; Vol. 24 (8): 832-836, the authors name Bener A. Bener should have appeared as Abdulbari Bener.

Erratum

In manuscript "Does regular garlic intake affect the prevalence of *Helicobacter Pylori* in asymptomatic subjects?" Saudi Med J 2003; Vol. 24 (8): 842-845, Table 1 mentioned in the text for the second time should have appeared as Table 2 .

Erratum

In manuscript "Mayer-Rokitansky-Kuster-Hauser syndrome of Mullerian agenesis" Saudi Med J 2003; Vol. 24 (5): 532-534, Rokintansky should have appeared as Rokitansky in the title.