

each of first and third branchial remnants. Branchial sinuses, fistulas, and cartilaginous remnants are usually present at birth, while cysts become apparent later in childhood or early adulthood when they fill with secretions and produce a cystic swelling in the neck. Clinically, second branchial cleft sinuses and fistulas are found along the anterior border of the sternomastoid muscle between its middle and lower third, whereas second branchial cysts are found in the upper third of the neck along the anterior border of the sternomastoid muscle. First, branchial cleft cysts mainly present as a swelling posterior or anterior to the ear or in the submandibular region inferior to the ear lobe, and those with a sinus or a fistula, the external opening is located inferior to the mandible in a suprahyoid position. Approximately a third however have an opening in the bony or cartilaginous portion of the external auditory canal. Third branchial cleft remnants are extremely rare and have seldom been reported. A fistula tract that is leading to or in proximity to the pyriform sinus is considered to be of third branchial pouch origin, and although initially was described as a cause of recurrent suppurative thyroiditis, it has also been recognized as a cause of cysts and abscess formation.^{2,3} The importance of this needs to be emphasized, and a fistula tract from a third branchial remnant must always be considered in those with suppurative thyroiditis specially those on the left side. The reason for this exclusively left sided occurrence is not known. The treatment of those who present with suppurative thyroiditis should be with antibiotics, incision, and drainage. Once the infection subsided, the fistula can be delineated with barium swallow.⁴ To obviate recurrence, surgical excision should be advocated, and to facilitate dissection of the fistula intraoperatively, the fistula can sometimes be cannulated endoscopically.

The majority of these lesions (90%) are lined by squamous epithelium and 10% are lined by ciliated epithelium.¹ Cholesterol crystals may be seen when the fluid is aspirated from branchial cysts as in one of our patients. Lymphoid tissue with or without germinal centers is typically seen beneath the lining epithelium. Extremely rare, squamous cell carcinoma or branchiogenic carcinoma can develop in neglected cases.⁷

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Professionalism: Are we doing enough?

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Profiteri is the Latin word of English Profession. Around the 16th century the meaning of the word profession included the occupation of physicians, priest, and lawyers.¹ In the present day practice of medicine, it appears that medical professionals have forgotten the word of Sir William Osler² who said in 1932 that "the practice of medicine is an art, not a trade; not a business, a calling which your heart will be exercised equally with your head". The fundamentals and practice of professionalism, ethics and morals have long been available in the Islamic law and literature but presently these teachings are left on the bookshelves for decoration. The essential values to practice medicine, honesty and integrity has become a rare commodity. Fraudulent claims by the unprofessional physicians caused a loss of \$66 billion a year for health care programs in the United States of America (USA) alone.³ Unfortunately, unprofessionalism is creeping in along with the westernization of our society as well. It is an open secret that physicians spend barely the required time at the hospitals they are supposed to work full time, more interest in their private practice, refer patients from the government to private hospitals under various pretexts. The long waiting lists in the government institutions are helping these physicians in their unprofessional endeavors. It appears that situation in private sector is worse; competition not only among different hospitals but between physicians of the same hospitals, commission on the final hospital bills is making doctors to practice medicine for their benefit, rather the suffering patients. The million riyal question is "are we doing enough to improve the professionalism among the doctors of today and tomorrow?" Stern⁴ believed that values like honesty, accountability and caring are rarely taught in the internship and residency

training programs. Herbert et al⁵ reported that in 60% of US Medical Schools, professionalism is taught and many academicians believe if we wish to make the doctors of tomorrow more professional, honest to their patient much needed to be carried out.⁶⁻⁸ Medical profession around the world is engrossed in different national cultures and traditions and academicians in respective countries need to come to the fore and set professional values and impose on the physicians of today and doctors of tomorrow to follow the principles of professionalism with dedication, honesty and integrity to patients and to the society as a whole. We believe that the time has come when academicians, policy makers and professionals in the Kingdom of Saudi Arabia, should come together to formulate guidelines, objectives, self regulations and to set remedy and discipline for the professionals who go astray in their duties.

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Rigid ureteroscopy for treating ureteric stones, Yemen experience - Al Thawra Teaching Hospital, Sana'a University

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Ureteroscopy came to light in our society in late 1989, using the wide caliber rigid ureteroscope (11.5Fr) which should be preceded by dilation of the lower ureter.¹ This was due to the society being poor and the prevalence of a giant ureteric stone which needs open surgery. With miniaturization of ureteroscopes, we restarted ureteroscopy again during 1995 using the 8.5-11.5Fr Wolf rigid one. However, ultrasonic renal scanning (URS) is more invasive than extracorporeal shock wave lithotripsy (ESWL), it became the treatment of choice for stones of one cm or less in the ureter especially its distal part from the points of stone free rate and cost effectiveness.² The basic URS technique has been well standardized through dilation of the lower ureter, stone retrieval and fragmentation using different lithotrites and ending by stenting the ureter for a few days.³

Introduction of fiberoptic imaging bundles within the rigid endoscope has made its downsizing possible and introduction of a flexible ureteroscope, in addition to a skilled hands, led to high success rate up to 90-100%.⁴ The overall complications, for the same reasons, reported in the recent literature⁵ are 5-9% with only one% significant complications like ureteric avulsion and stricture.⁶

Two hundred and forty-eight patients with ureteric stones in different levels who were treated by ureteroscopy over the 4 year period at Al-Thawra Hospital, Sana'a University were retrospectively reviewed. Two hundred and eight patients were males while 40 were females and their age range was between 7-65 years (mean 30-6). The size of the stones ranged between 6-25 mm (mean 11 mm) and 147 cases were in the left while 101 were in the right. As regard to the site in the ureter, 200 cases were in the lower, 38 in the middle and 10 cases were in the upper part. Preoperative follow up including laboratory investigations in the form of bleeding and coagulation time, hemoglobin determination, platelets count, urine analysis, culture and sensitivity, creatinine and blood urea nitrogen. Imaging studies such as abdominal ultrasound, kidney ureter bladder radiography (KUB) and intravenous urography (IVU) was recorded.

Ureteroscopy started by negotiating of 0.038 guide wire through cystoscope followed by ureteric dilation using polyethylene dilators from 6-12Fr down to the level of the stones, then the ureteroscope was introduced. In 10% of the cases, failure to introduce the guide wire necessitated the introduction of the ureteroscope under vision without dilation. If the stone is impacted and the guide wire could not bypass it, disintegration should be carried out until the guide can pass though up to the kidney. Swiss pneumatic lithoclasts was used for fragmentation and to avoid migration of the stone upward, Dormia basket was used to lodge the