

Letters to the Editor

Heroin use, diplopia, largactil.

Sir,

A Saudi male in his late 20's with several years history of intravenous heroin use was admitted for management of mild withdrawals. He complained of insomnia, anxiety and body aches. A single dose of Largactil 100 mg and Brufen 400 mg was given during the night for symptomatic treatment. The next morning he had severe diplopia. He was covering one eye for relief. Examination showed normal pupils, full eye movements and absence of any nystagmus. Paresis of any extro-ocular muscle was not identified. Red glass test was not carried out. He had double vision in primary position of gaze and reported an inconsistent increase in diplopia on looking both towards the right and left. Physical exam including neurological examination was otherwise unremarkable. He was alert and fully oriented. His other complaints were related to heroin withdrawals and showed mild improvement. He attributed the diplopia to Largactil and reported diplopia in the past following its use in a private hospital. He gave no history of any medical illnesses. Largactil was immediately stopped, but he continued with Brufen. The diplopia resolved spontaneously 6-8 hours later. During drowsiness diplopia is commonly reported. In this case, the symptom was not due to drowsiness as the patient was fully alert. Heroin withdrawals can also produce diplopia.¹ However withdrawal symptoms were mild and he reported no diplopia at the time of admission. Furthermore, the diplopia cleared spontaneously shortly after discontinuation of Largactil while other withdrawal symptoms were still present. The fact that the diplopia started within hours of Largactil use, disappeared shortly after its discontinuation and a history of diplopia with similar course in the past indicate strongly that this symptom was induced by Largactil. Largactil (Chlorpromazine) is a widely used medication. Diplopia is not a reported side effect.² Heroin users may be more susceptible to this due to the effects of repeated injections, adulterants added to heroin or changes in neuro transmission induced by opiates.³

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Indications for emergency tracheostomy.

Sir,

Acute upper airway obstruction imposes a very serious threat to life and carries a high risk of morbidity and mortality. Emergency tracheostomy is a commonly practised life-saving procedure, which is performed to bypass an upper respiratory tract obstruction. It is an ancient practice and Albucasis described his own technique in the medieval ages.¹ The majority of cases (56%) are performed on intensive care unit (ICU) patients and delaying tracheostomy is associated with prolongation of ICU stay.² Stridor is the main symptom of airway obstruction and at the same time it is a cardinal audible sign. It is difficult, noisy breathing with effort, which is caused by a compromised airway in the larynx and trachea. Timing of stridor occurrence in relation to the respiratory cycle is of great clinical help in the anatomical diagnosis of the etiology of stridor. Inspiratory stridor indicates etiology at the level of glottis or above. Expiratory stridor indicates distal bronchiolar obstruction, which is usually due to bronchospasm and is relieved by bronchodilators. Biphasic stridor indicates tracheal obstruction. The association between stridor and cyanosis is of utmost clinical importance in relation to the severity of the condition: in mild stridor there is no cyanosis, while peripheral cyanosis indicates moderately severe stridor and central cyanosis indicates severe stridor where respiratory failure is imminent and urgent interference is mandatory. Blood gas analysis and endoscopic examination of the airway are essential tools in the assessment of the severity of stridor.³ In a retrospective study of all patients (147) who had emergency tracheostomy at Wad Medani Teaching Hospital, Wad Medani Central Sudan in the period from January 1988 - December 1997, we studied the indications for the emergency procedure and the

associated factors. One hundred and five cases (71%) were females and 42 cases (29%) were males. Female to male ratio was 2.5:1. Patient's ages ranged from 18 months to 88 years with a mean age of 40.5 years. The main indications were angioneurotic edema due to hair-dye poisoning (42%); tumors of the head and neck (39%) and bilateral abductor paralysis of the vocal cord (14%). Angioedema of the larynx accounted for 42% of the cases in whom emergency tracheostomy was indicated. The most important cause for development of angioedema in Sudanese patients is ingestion of hair-dyes containing paraphenylene diamine.⁴ In this study 54 patients out of 62 (87%) were females and the ingestion was a suicidal act. Malignant tumors of the head and neck accounted for 39% of the cases. Although the role of emergency tracheostomy in the management of these patients is controversial, nearly all these patients came from rural areas with advanced disease and the main presentation was stridor. Bilateral abductor paralysis of the vocal cords accounted for 15% of the cases with a female predominance of 9:1. All patients had the paralysis as a result of thyroid surgery and they presented late after surgery for periods ranging from 6 months to 7 years. These patients only develop stridor when they are exerted or when they develop an upper respiratory tract infection. They do not have hoarseness of voice and that is why they escape notice of the general surgeon who performed the operation. All these patients did not have a laryngeal assessment before or after thyroid surgery. Infective conditions accounted for 3% of the indications for emergency tracheostomy. Among these cases, there were only 2 cases of diphtheria. Thanks to a very successful national immunization program, the number of cases of diphtheria before this study period was much more according to hospital records. In one patient (1%), emergency tracheostomy was indicated for blunt trauma and in another patient it was indicated for congenital sub-glottic stenosis. As most of the patients in this study (80%) came from rural areas, primary health care and community health workers should be acquainted with the diagnosis and emergency management of acute upper airway obstruction. Frosh et al in England recommended that formal training programs in the techniques of emergency airway formation should be available for community General Practitioners.⁵ It has also been found of great help for the patient to teach one of his relatives how to maintain and to care for the tracheostomy tube at home. In all cases, it was up to the laryngologist to take the decision for tracheostomy or to give his opinion regarding the patency of the airway. For the laryngologist to be of great help, he has to be acquainted with the different abnormal types of breathing. It was noticed that

acidotic breathing was the most confusing abnormal type of breathing to junior doctors. Acidotic breathing is noisy, harsh, deep and sighing breathing but lacks the effort which is characteristic of stridor.

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Clinical approach to patient treatment by traditional cauterization.

Sir,

Thermal cauterization (Al-Kowie) is one of the most common methods used by traditional healers in Saudi Arabia. Many authors have drawn attention to this problem in the past.^{1,2} This is one of the most common methods used by traditional healers in Najran, besides many more potentially dangerous methods.³ The patients frequently visit the hospital due to complications of cautery or for the underlying disease for which the patient was cauterized. In order to know the magnitude, pattern and diagnostic value of these thermal burns, we conducted a retrospective study on the patients who were seen in our hospital over a period of 5 years (1995-1999). A total of 119 patients were seen comprising of 63 (53%) males and 56 (47%) females. The age ranged from 18 to 97 years, females having a narrower range than males. The common sites and disease for which cautery was applied are shown in Table 1. Brucellosis was the

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Table 1 - Showing the diseases and the type of cauterly carried out.

Diagnostic category	Number of patients	Approximate %	Pattern of cauterly and the common sites at which skin was burnt
Brucellosis	54	45	Occiput, cervical spine, sacral region, patellar areas, heels and soles
Osteoarthritis of the knees	21	18	Double cauterly marks on either side of each knee
Low backache with radiculopathy	9	7.5	Lower back and legs (involved dermatomal distribution)
Gallbladder disease	12	10	Multiple marks below right costal margin
Cerebrovascular strokes	6	5	Linear cauterly on ball of toes, achilles tendon, popliteal fossa, trochanteric area, side of elbows and shoulders
Bells palsy	8	7	Retroauricular area and in front of tragus, many times on the normal side
Acute myocardial infarction	2	2	Sternum and both sides of the upper chest, conforming to corners of a triangle
Pneumonia/Pleurisy	2	2	Lower axilla
Others	5		Variable

most common underlying disease for which cauterly was carried out. This is because brucellosis continues to be a common problem in Najran, as well as due to the non-specific symptoms in the early course of the disease. Many of these cases come to us for treatment after getting cauterized. Osteoarthritis is the next common cause in females. Many of these patients are obese and have tried analgesics before subjecting themselves to cauterly. It was very interesting to note that patients who had cauterly for low backache invariably had associated radiculopathy. The benefit derived by cauterly in such patients is due to the forced bed rest, which the multiple thermal burns induce. In contrast, patients with somatization syndrome who frequently had low backache as one of the complaints were not cauterized. The most common complications observed were local infection with pus discharge, non-healing ulcers especially in diabetic patients, bed sore on the areas of cauterly and some cases of septicemia. Ugly scars are a common residue of cauterly. The common patterns of cauterly are the coin-shaped marks and linear marks. The former pattern is mostly seen in osteoarthritis, gallbladder disease and chest disorders. Linear marks are common in brucellosis, prolonged febrile illnesses, Bells palsy, radiculopathies, post-herpetic neuralgias and strokes. In a nutshell, despite immense progress made in the diagnosis and therapy of various diseases, people continue to go to traditional healers. Illiteracy, ignorance, wrong beliefs, superstitions,

and lack of proper health education and facilities contribute to the continuation of such practices. Until it is completely eradicated, physicians need to be aware of the pattern and significance of this common method of treatment. The following points need to be considered: 1) Patients with thermal cauterization should be thoroughly evaluated for the underlying disease, which may be serious at times. 2) The pattern of cauterly should be noted and properly interpreted as it may give a clue to the underlying cause. 3) Besides the underlying disease, cauterly marks should be properly managed to avoid the complications mentioned above. 4) Old healed cauterly scars should be noted and may serve as reliable evidence of past disorders.

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