Coronary Artery Graft Bypass Operation Saves Lives

Prof. Habibuz Zaman

A male physician, 50, was getting ready to go the Dhaka airport to catch his return flight for his duty station outside of Bangladesh, when he was seized with heaviness and agonizing precordial pain. As a medical doctor, he realized immediately that he was going in for a real heart attack this time. Previously he had suffered from chest pains on exertion (angina), which had disappeared with rest and nitroglycerine ("angesid") tablet, held under the tongue. But this time it was the real stuff, and gaining in intensity almost every minute. He had quickly decided to cancel his departure from Dhaka and had asked a near relative to try to reach a number of physicians over the phone.

Momentarily his thoughts had drifted away to his wife — left all by herself at a forlorn duty station in a different country, several hundred miles away. Of course, she could not be told the truth. The doctor's mind was still working. A cable had to be dispatched to his official supervisor, informing him of the situation and also requesting him to arrange for the travel of his (the afflicted doctor's) wife to Dhaka, under the pretext that her husband would be held up in Dhaka for several weeks on an unexpected but important official work. Within minutes he had dictated a telex to a relative and given instruction on how to dispatch it.

The doctor could not help recall how his life had been so adversely affected by a sudden transfer to his present duty station. How the family life had been disrupted — the son had to be left behind at the doctor's previous duty station to enable the boy to proceed with his professional studies. Two teen-aged daughters had to be sent away to a boarding school in England to pursue their studies. And here he has in Dhaka in the jaws of death but not all alone, as he would find out soon enough.

He had remained conscious when the first help had arrived — a good doctor friend had despatched his assistant with an E. C. G. machine, an ambulance and a supply of medicines. The ECG readings had shown definite signs of a developing myocardial infarction. An injection was given to relieve the pain and cause sedation. Within minutes the doctor patient was rushed to a local hospital — the doctor had chosen to go to a quiet and clean place with a reasonably dependent and caring medical and nursing staff. There were no facilities for continuous cardiac monitoring at the bedside in those days in Dhaka. Because of the almost immediate attention he had received, the doctor had an uneventful recovery — no complications at all. After six weeks of treatment and rest at Dhaka, he was fit to travel to his duty station and to continue his works.

Within two years, after he felt some heaviness in the precordium, he underwent a coronary angiography at London. This procedure determines the state of patency (openness of the passage) of the coronary arteries by injecting a radio opaque dye through a thin catheter. It was seen that three of the main trunks of the coronary arteries had some degrees of narrowing (65-90%). A coronary artery bypass graft operation was required. The patient was hospitalized for 16 days in all and then asked to remain in London for two more weeks for a final check up, after which he was allowed to travel home. On his return, he had monthly check-ups by his local cardiologist during the initial period of six months. The doctor returned to full time work and retired from service in due course, seven years later.

He is still active and in reasonably good health, more than 11 years after undergoing the coronary artery bypass graft operation a procedure, in which a piece of a superficial Ven from the patients leg or the internal mammary artery is used as a graft to bypass the area of obstruction in one or more coronary arteries. In well established medical centres, the operation has been very successful in the vast majority of cases, on whom it is undertaken. The relief of symptoms is dramatic and the quality of life improves remarkably. Once again the patient can live a full and vigorous life.

If so indicated, it is preferable to have a coronary bypass graft operation, before suffering an attack of myocardial infarction. When the cardiologist feels that there are enough changes in the electro-cardiogram following exercise, to indicate a very severe degree of ischaemia (lack of blood supply) of the heart muscle, he may refer the patient for coronary angiography. When the suspicions are confirmed, the patient may be advised to undergo a coronary bypass graft operation — thereby saving the patient's heart muscle from suffering infarction with consequent weakening (of the heart muscle).

The coronary bypass operation requires facilities for open heart surgery. A heart — lung machine is used to carry on the pumping action of the heart and to maintain the circulation throughout the body while the operative procedure is on, and the grafts are bring stitched to the coronary arteries to bypass the areas of obstruction to the passage of blood.

This procedure is presently being carried out successfully in many centres in several countries throughout the World, including some countries in our neighbourhood. Teams from friendly countries have also carried out this operation successfully at the Institute of Cardio-Vascular Diseases, Dhaka. Resources for this procedure are understandably being established at the Combined Military Hospital Dhaka. Perhaps in the not too distant future, reliable facilities for this operation will be available routinely at Dhaka, so that patients in serious cardiac distress do not have to travel abroad at great personal inconvenience and expense.

Obviously coronary bypass operation is not the answer to coronary heart disease; perhaps it may be regarded as a last resort to save an individual from imminent danger and death. Does the answer lie in preventing coronary heart disease in the first place? Is that possible?

Larissa's Pregnant Again

Offering a wide range of contraceptive methods is the key to successful family planning programmes says the State of World Population Report, just published, from the United Nations Population Fund. But, as Peter O'Neill learns from Larissa Verbitskaya, in the USSR there is a desperate lack of contraceptives. And so, each year, some 12 million Soviet women have abortions.

LARISSA Verbitskaya's story is typical. She lives in a plain suburb in the east of Moscow, sharing a two-bedroomed flat with her husband and two daughters, Galya, aged six and Ira, three.

Qualified as a construction engineer, Larissa lectures at an institute in Moscow. Her husband works in the same field. Both are well aware of the importance of contraception.

"I don't want to have any more children," says Larissa. "But finding suitable contraception is a real problem." She feels that sterilization is not an option for her at the moment — her children are still young and, at 33, so is she.

Oral contraceptive pills are not an option for Larissa either. They have a bad reputation throughout Eastern Europe and are believed to cause breast cancer and high blood pressure. This is partly due to the fact that the only pills available are the high dosage, high-hormone variety— long rejected on health grounds by women in the West. The pills are imported from Poland and Hungary.

"I did use oral contraceptives for four or five years," Larissa recalls. "But I did not feel good in myself. The local doctor advised me to use an IUD. But I could not find one in any of the pharmacies."

Even if she had found one it would have been a poor quality, plastic model likely to cause infection.

It's not just contraceptives that are hard to find. Doctors who are prepared to even discuss different methods of contraception are few and far between.

"Usually, they don't like to waste time," says Larissa. "They only tell you — "that and that and that." Most often their advice is "use a condom"."

The advice does not always help. Larissa explains: 'Last summer I had an enormous problem trying to find condoms in Moscow. And in the country village where we spent our summer holidays I could find no contraceptives at all'.

At least Larissa and her husband are prepared to use condoms. Many soviet women and men will not even consider them— partly due to their poor quality.

Organisations like UNFPA, IPPF and WHO, however, have been working together to increase the supply to the USSR of high-quality contraceptives made in Asia. But in the public mind condoms are still 'galoshes' — clumsy and crude, thick, rubber appliances.

Black-market supplies of Western condoms exist— but they are prohibitively expensive even for 'middle-level', educated Soviets like Larissa and her husband.

For young people the situation is much worse. According to a study conducted by sociologist Dr Larissa Remenik, up to two-thirds of the 15 and 16 year olds in Leningrad have had sex. But they received virtually no sex education about personal relationships, contraception or venereal disease.

As a result, young women are most likely to resort to abortion. A young woman's first abortion may be one of many, leading to chronic complications and infertility. It can also ruin her sex life. According to Dr Archil Khomassuridze — a pioneer for the provision of free advice and modern contraception— 50 per cent of the women he sees have completely lost their sex drive due to the trauma of repeated abortions. 'Sex had become like a chore, like having to get down and scrub the floor'.

Larissa — and so many like her— want change. They want sex education at school and well-organised family planning services.

With only 17 per cent of the Soviet Union's sexually active population using any form of contraceptive — including withdrawal or rhythm methods — the task of making family planning easily available to all is going to be formidable.

But the costs of not doing so will carry on being borne by women like Larissa who came back from her condom-less holiday to find that she was pregnant again.

'We had tried to use the rhythm (calendar) method — but if failed. After a month back in Moscow the doctor said "You're five weeks pregnant.

You need an abortion." So I had one.'

—UNFPA

Reaching more people: Television gives opportunities to give family planning messages in an entertaining way. Many countries have devised soap-operas, mini-dramas, jingles and slogans to reach increasing numbers of people the world over

Why Tobacco Cultivation ?

by Rahat Fahmida

Since tobacco cultivation is a marginal crop, banning its cultivation will not incur a significant loss in the country's economy.

The harmful effects of smoking are no longer questioned except by the tobacco industry. Smoking increases the incidence of lung cancer, throat cancer and other cancers, cardiovascular diseases, bronchitis, emphysema, asthma and other diseases and illness. Yet many smokers think that anti-smoking slogans and banners are signs of modesty. They put, their faces they see — "No Smoking" or "Smoking is injurious to health."

Tobacco was discovered in the interest of human beings. Man had to discover diversified use of tobacco for economic and financial reasons.

Tobacco is a necessity, comfort and luxury in a man's life in different perspectives. Use of tobacco attained a cultural dimension in the national life of many nations. It was in certain cases, representation of artistic attainment. There was a time when science ceaselessly endeavoured to improve tobacco and use of tobacco. Tobacco did not only fetch money, it was an exchange-instrument in international business. Contemporary technology and capital were massively engaged to develop various machines to process tobacco.

Craftsmen with global fame applied their finer skills and knowledge to create containers for tobacco products. We have heard of a snuff box selling for millions of Taka in the auction market. An obscure leaf of a tobacco plant traversed from the thatched cottage of a beggar to the majestic palaces of the emperors as an economic commodity. In some places this commodity was sold against a pence, and in some other place it was sold in lieu of a diamond.

Our history runs short of record but tradition is no less eloquent and documentary. Our chroniclers would not or did not record the time of inception of use of tobacco. Even then, we can assert doubtlessly that the use of tobacco in our country is as old as the nation itself. From cultivation to use of tobacco millions of people use it differently. Some smoke, some chew and a few inhale.

In the days of cigarettes, the pomp and splendour of majestic use of tobacco is inconceivable. By all considerations, tobacco was a matter to muster. In order to reach tobacco on to that exalted position, man had to work hard, generations after generations. But now is the time when history has been called upon to change direction.

Science has been engaged in discovering various dimensions of health-hazards created by use of tobacco. It will continue to do so. The subject of my consideration is economics of tobacco. Man does not involve himself in any act having no economic significance and consequence except a few very personal and secret matters.

Tobacco may be the name of a small plant but in reality it is a gigantic "money machine." At present tobacco is grown annually.

The process of cultivation is finished within 75 to 130 days. The huge number of labour involved in the process can be shifted to newer industries.

If we want to eliminate demand of tobacco, we have to totally abandon tobacco cultivation.

Even if cultivation of tobacco could be prohibited by law and enforced strictly, it may not be rational in the face of the realities. What has to be done is, adverse economic signal has to be focused about the prospect of tobacco cultivation.

The farmers have to feel that cultivation of tobacco will not remain economic anymore. The way indigo took its farewell, tobacco has to be driven out in the same economic way. The peasants have to be showed alternative economic use of their land during the period tobacco is planted.

This is not supposed to be a very difficult job in Bangladesh. If there is a successful economic use of their lands, the peasants under natural economic principle will cultivate alternative crops. Cultivation of paddy in the jute lands have already started.

The farm workers, thus, do not pose any problem. There are then the industrial workers. Manufacturing of biri was once prohibited in this country.

There was no big national loss. It is possible to create new employments in new industries under planned and phased programme of industrialisation. A new life is rightly expected to come into play in the overall economic gamut.

The point to decide is how far we shall go and how long we shall take to reach the destination. In the wake of our total disliking, the historic golden fibre is in difficulty. Since tobacco cultivation is a marginal crop, banning its cultivation will incur an insignificant loss in the country's economy.

Essential Measures of Diarrhoea Treatment

by K. M. A. Aziz, R. B. Sack and M. R. Islam

IN this summer of 1991 Bangladesh is experiencing a widespread diarrhoea outbreak throughout the country. In the big flood year of 1988 the total number of reported diarrhoeal disease cases were 3,711,457. Among these cases there were 3676 deaths for a case fatality rate of 0.09%. Though the number of reported diarrhoea cases after the flood was very large there were a minimum number of deaths recorded due to proper case management, timely intervention, and adequate preventive measures. In the post-cyclone period of 1991 in Bangladesh similar and further improved measures can keep the deaths from diarrhoea to the lowest level. This article deals with the general information regarding treatment of diarrhoea.

During diarrhoea, salts and water are lost from the body, resulting in dryness or dehydration and other serious complications. This dehydration can be prevented or corrected through timely administration of Oral Rehydration Solution (ORS).

Every mother, care giver of young children, family and community should take note of the following measures in treating diarrhoea :

(1) It is essential to give a child with diarrhoea plenty of liquids to drink. Dehydration can often be prevented if certain procedures are followed at home as soon as diarrhoea starts. Family members can learn about treatment of diarrhoea from various sources as radio, television, the community health workers, or responsible staff at the local health centre.

(2) The child should be given locally available drink or liquids, such as rice water (bhater mar) or chira water (panite kachlano chira) mixed with a little bit of salt upto the individual's taste, green coconut water (daber pani), and fruit juices. When ORS packets are available, it should be used after properly dissolving in water. After each loose stool the child should be given 1/4 — 1/2 cup (50-100cc) of Oral Rehydration Solution (ORS) for a child less than two years of age. Half to one cup (100-200cc) may be used for an older child. Adults can take as much as they want. If the child vomits, wait for about 5 minutes and then continue slowly giving small amounts by spoon. If ORS packets are not available then alternatively labon-gur oral solution can be used by following the same procedure. Labon-gur saline is prepared by mixing a pinch of common salt with the tips of three fingers up to first crease and a fistful of brown sugar (gur) in a half litre of drinking water well stirred. Care should be taken to mix salt, gur and water in right amount. ORS packet solution or labon-gur oral saline should be started promptly soon after the first loose motion and continued as long as diarrhoea persists. It should be remembered that oral saline does not stop diarrhoea but it helps to replace water and salt loss from the body and thereby saves from death. Also, the prepared saline should be discarded after 12 hours because after that bacteria can grow in it.

(3) A child with diarrhoea needs food. There is a common belief that food aggravates diarrhoea. Unfortunately, this is a misconception which causes restriction or withholding of food to diarrhoea patients. Even breast feeding sometimes is stopped. There is no justification for such measures. Indeed, lack of nourishment worsens a diarrhoea patient's condition. Children under age five, who are growing rapidly, need additional food. All diarrhoea patients should be allowed usual normal food during diarrhoea.

(4) Breast-fed babies should continue to suckle. Children who are partially breast-fed should continue to suckle and to eat usual normal foods. It is wrong to believe that breast milk can be harmful. Food intake of common preparations such as khichuri, suji, payesh, fruits, etc. should be increased to help the child to recover from the losses due to diarrhoea.

(5) Drugs should not be used for diarrhoea, except on medical advice.

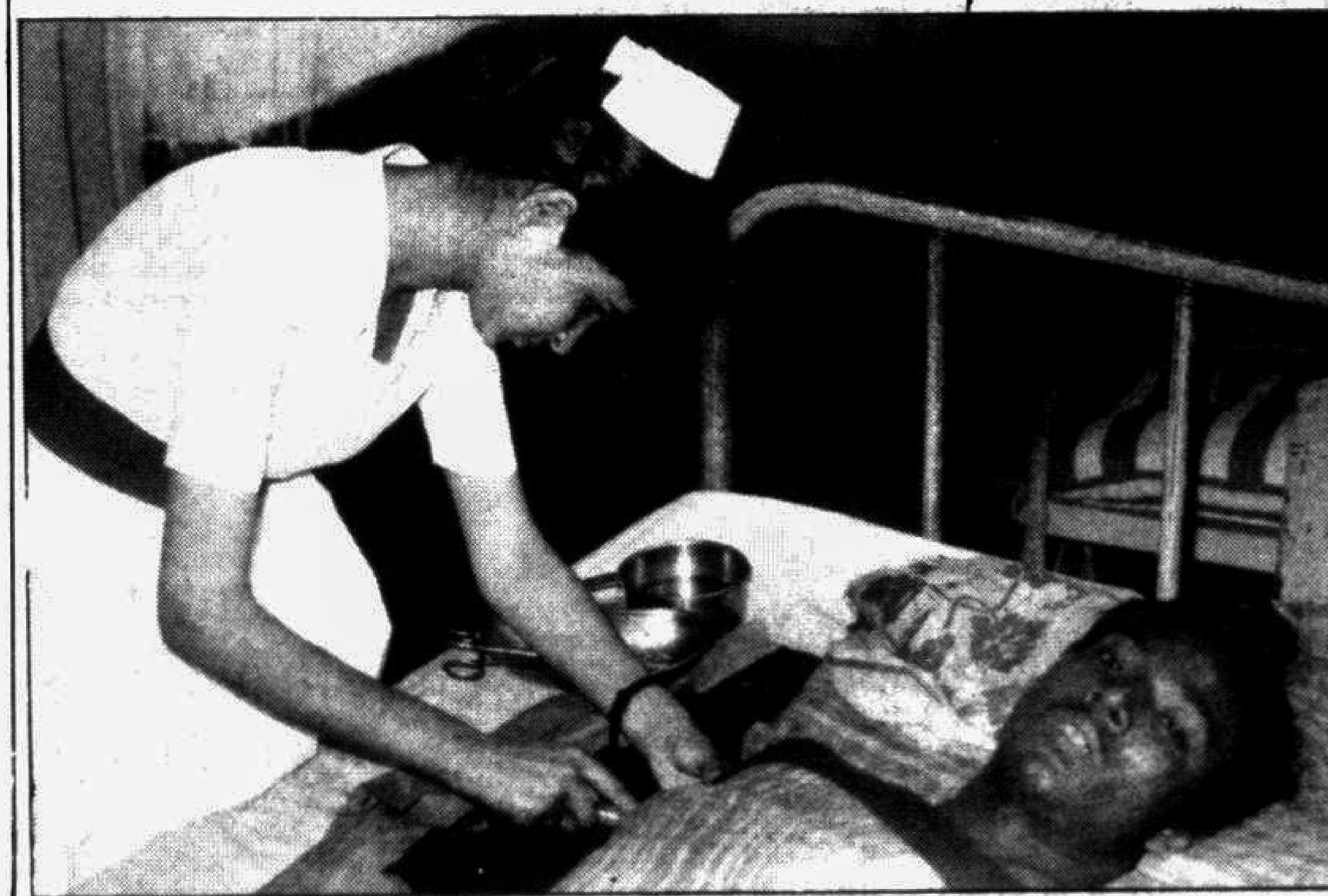
(6) In certain cases the body looses water very rapidly leading to the following sings and symptoms :

1. Excessive thirst;
2. Progressive weakness;
3. Sunken eyes;
4. Depression of the vault of head in babies under 6 months:
5. Hoarseness of voice;
6. Dry tongue;
7. Looseness of skin;
8. Reduced urination;
9. Wrinkled fingers;
10. Low body temperature;
11. Feeble pulse;
12. Repid breathing;
13. Muscle cramps (especially in adults);
14. Convulsions which may be due to fever;
15. Unconsciousness.

Treating a patient promptly with ORS can prevent most of these symptoms. If they appear, a patient immediately should be taken to the nearest treatment centre or to a doctor.

The treatment of children with diarrhoea is applicable to adults as well. Although in the case of adults, more amount of ORS will be needed. Oral rehydration solution can be used for the treatment of most (about 90%) of the diarrhoeal cases except the severe ones where intravenous therapy will be required.

In summary it should be noted that diarrhoea is both an infectious as well as a nutritional problem. Hence, oral rehydration at home should be started as soon as diarrhoea starts. In severe cases when ORS fails to improve the conditions, the patient should immediately be taken to a nearby treatment centre for intravenous therapy.



A patient being treated at a hospital. —Star Photo

Black Women Lose Out on Cancer Treatment

Philippa Garson

BREAST cancer is essentially a curable disease these days, but for most black woman sufferers in South Africa it is still a killer.

Ignorance of the warning signs of cancer, prevailing traditional beliefs, an inadequate primary health care system and poor socio-economic conditions are to blame.

While the cancer form has a far higher incidence among whites, the disease is rising rapidly among urban blacks. The trend is world-wide.

The most recent statistics released by the National Cancer Association of South Africa show breast cancer to be the second most common form of cancer to strike women — after cervical cancer among the blacks and skin cancer among whites.

The link between breast cancer and a diet high in animal fats now seems undisputed and may explain its growing incidence in lower socio-economic communities.

Local surgeon and breast cancer expert Dr Myron Lange says: "The fastest increase among city-based blacks could be related to the high consumption of fat-containing foods, junk foods like hamburgers and eggburgers."

The increasing number of sufferers can, for the most part, be attributed to a fast-growng population, an increasingly aware public and earlier detection with the new widely-used mammogram, a low-dose x-ray which can detect lumps too small to feel during physical examination. Mammograms are expensive and not always available in outlying areas.

Research has shown that most black women, often lacking education and access to health care, will either ignore the lump until it has reached an advanced stage, visit a sangoma (traditional healer) who cannot treat the cancer effectively, or fail to return for the follow-up treatment required for cancer sufferers.

Breast clinics around the country report that up to 70 per cent of their black patients do not return for preventative or curative treatments.

"And most of our patients are either too scared or too unaware to present themselves in good time in the first place," says Dr Lesley Seymour, who is based at the breast clinics attached to Johannesburg and Hillbrow hospitals, both in Johannesburg.

She sees a marked difference between the patients at the two hospitals. "At Johannesburg Hospital (with predominantly white and Asian patients) it is unusual to find women in the breast clinic who have not had mastectomies.

"Whereas at Hillbrow, for the majority who have breast cancer, the disease has spread to the extent that it is too late for surgery."

These women must queue for hours on end for chemotherapy or radiotherapy and are often too poor to pay the travel expenses to return for further treatment.

Sister Joyce Lehoka started the breast cancer clinic at Garankua Hospital, mainly servicing surrounding rural areas, eight year ago.

She has conducted unique research on 100 sufferers. Their attitudes, levels of understanding, the treatment they sought, led her to conclude that "breast cancer is a killer amongst blacks. This is due to lack of information in the community, lack of screening facilities, fear and ignorance."

Almost half of them thought the lump in their breast was an abscess which "would open up, release puss and heal." Roughly 35 per cent were "not unduly alarmed," taking no immediate action. The rest saw the lump as either caused by their baby burp on the breast during feeding, keeping coins inside the bra or a witche's curse.

Ninety per cent of the patients first consulted traditional healers, churches or visited local clinics only when the cancer had reached an advanced stage.

She found that the clinics, whose nursing sisters were not always aware of the tell-tale signs of cancer, where often slow in referring patients to hospitals with cancer-treating facilities.

Many women believed their "abscesses" had to be "doctored" by traditional healers or home-made potions which "spit out" the pain and poison.

Lehoka found that patients tended not to lose faith in traditional healers who were unable to cure them, but instead believed that the worsening condition was due to the potency of the witchcraft, causing illness — a belief which grew stronger when western medicine failed to cure the patients' terminal cancer.

Many women are loath to have mastectomies because of superstitious beliefs. They fear ancestors may not accept them if they are buried with out parts of their bodies or believe that the removal of the left breast will affect their hearts, says Lehoka.

Reach for Recovery, a support group for women with breast cancer, whose members must too be breast cancer sufferers, has had little success recruiting volunteers in black communities to counsel patients on the emotional and physical traumas of mastectomy, the follow-up treatment and awareness of possible recurrence of the disease.