Down with Hypertension

Prof Habibuz Zaman

(This is the third article in this series on hypertension)

A trained paramedic is checking the blood pressure of a patient with mature cataract, prior to operation. Untreated or uncontrolled hypertension is a contra-indication for a cataract operation under field conditions in an eye-camp.

BLOOD PRESSURE FLUCTUATES NORMALLY

THE blood pressure fluctuates in a healthy individual with a variety of activities and emotions. It is lowest during sleep, at rest and during periods of relaxation (hearing music, watching TV, reading), and increases with stress or emotional upsets (anger, danger of running over a child during driving, answering the phone, eating, shopping, having sex). Generally the blood pressure recorded by a physician is higher due to a sense of anxiety associated with a medical examination. In a healthy individual these fluctuations remain within narrow limits. For the hypertensive, however, the fluctuations are much wider and take a longer time to reach the base values. This results in progressive weakness and damage to the walls of blood vessels in course of time. In the elderly, with the process of hardening of the arteries and arterioles having set in due to the process of arteriosclerosis, these weaknesses are further accentuated with high blood pressure. This may result in a rupture of the blood vessel with haemorrhage, as happens more frequently in the brain (stroke).

HIGHER DIASTOLIC READINGS ARE MORE SIGNIFICANT

Some hardening of the arteries is quite common in the elderly (above, age 60) even in the absence of hypertension. This is reflected in a higher systolic pressure (from the greater resistance offered to the passage of blood when the heart contracts). Thus a slightly raised systolic pressure (say upto 150) in individuals above ago 50 may or may not reflect a true state of hypertension. Abnormal diastolic pressures in the elderly, however, are associated with hypertension and need prompt attention; and these are considered more significant. It is an accepted practice to take the average of two blood pressure readings and to repeat these readings a second time after a brief interval. Findings are considered definitely abnormal in any age group should these averages consistently remain above 90 diastolic.

NUTRITIONAL AND HYGIENIC MEASURES TO REDUCE BLOOD PRESSURE

It may be mentioned that there is no controversy regarding the use of medications for the hypertensive, who have diastolic readings above 105. There is a growing consensus that individuals with several risk factors, who consistently have diastolic readings above 90, despite several months of non-medicinal interventions described below, should also be placed on a step-wise treatment with drugs with a view to preventing the blood pressure reaching higher and more dangerous levels in course of time. Also individuals at high risk, who have consistent diastolic readings of 80 to 89, need to be kept under observation (with recordings of blood pressure and changes in life style).

If your physician is not in the habit of checking your blood pressure as a routine, you may request him to do so, whenever you undergo a clinical examination. This applies to children as also adults of all ages.

Watch your weight. You are over-weight if you are 20 per cent over the standard for your build, age and height. Ask your physician as to what should be your normal weight (or consult a standard table).

As a knowledgeable individual, get interested in the food you eat (both in quality and quantity).

Restrict your daily intake of calories on the basis of your age, height, weight, and normal physical activity. An average 5 feet 6 inch sendentary adult worker does not normally require more than 2200 calories, depending on the amount of physical activity undertaken. One engaged in manual labour may been 3000 calories or more. Take cereals and complex carbohydrates upto 50 per cent of your intake, divided between your three main meals and two snacks; 20-30 per cent fat and upto 30- per cent proteins, of both vegetable and animal origin, the latter preferably in the form of lean meat with a low fat content (chicken or meat) and fish. Take plently of legumes and other vegetables, having a high content of fibre and enjoy seasonal fruits. Avoid having more than a few teaspoons of refined sugar a day, full cream dairy products (full cream milk, cheese, ice-cream, pastry, cakes, butter, ghee) and sweet-meat preparations like rasgoolas, except in small amounts.

Avoid alcohol altogether : If you are already habituated, remember more than two standard — sized drinks any evening is likely to cause a rise in your blood pressure. Four or more drinks in one evening will almost certainly cause an elevation of your blood pressure, besides other problems.

Physical exercise : Unless you are engaged in an occupation involving a good deal of physical effort in your daily activities, you must supplement your normal activity with some kind of regular exercise. In its simplest form, brisk walking for 20-30 minutes at least once a day will improve the state of your physical fitness. Physical effort involves contraction of muscles; improved return of blood to the heart through the veins; a larger output of blood by the heart with each contraction and an improved oxygenation of the tissues of the body including the heart muscle itself. Exercise by healthy individuals is usually associated with a sense of well-being.

If you are diabetic, make every effort in cooperation with your physician to maintain your blood sugar level within the normal range.

(Fasting level 70 to 120 mg per 100

ml blood or 3.88 to 6.66 units;

Two hours after a meal within 180 mg

per 100 ml blood or 10 units).

Smoking : Make every effort to give up smoking altogether. In combination with hypertension heavy smoking is a serious risk factor for heart attacks.

Oral contraceptives : Women at risk (smokers who are obese, physically inactive and are used to a high fat diet) must avoid the use of oral contraceptives. These hormonal drugs are known to increase the blood pressure, and may cause the clotting of blood within blood vessels (thrombosis).

ARE YOU A "BORDER-LINE" OR "MILD" HYPERTENSIVE ?

If your diastolic blood pressure generally exceeds 90 and/or your systolic 140, you must have your blood pressure readings taken at frequent intervals (may be once a week or more often). In the event that the actions outlined above do not bring down your blood pressure below these levels, you are well advised to consult a physician, especially trained in cardiovascular diseases (preferably a trained cardiologist), well within a period of one to three months.

You may also try for a couple of weeks a reduced salt diet using less salt in cooking (upto 5 grams a day) and also avoiding use of salt at the table.

THE HYPERTENSIVE MUST TAKE CHARGE

The most important factors in controlling hypertension and its serious complications (stroke, heart attacks, kidney failure and damage to the eyes), once the diagnosis is established, are the regular monitoring of the levels of blood pressure and the continuing use of drugs as indicated, and the non-medicinal measures mentioned above. A periodic check-up by a physician is mandatory in following the progress of the disease and in changing anti-hypertensive medications and their dosages, as and when required. However, the essential and perhaps the most crucial element in the outcome and prognosis of an individual with hypertension is the determination of the patient to take charge, to learn how to self-monitor the blood pressure; to use the prescribed medicines regularly and without fail and to follow scrupulously the other recommended measures, viz, non-smoking; low fat, low cholesterol and low salt diet; avoiding obesity and alcohol and undertaking regular physical exercise. In these circumstances, hypertension can be controlled and complications avoided, delayed or much reduced in severity.

(Concluded)

(Prof Zaman is a former Regional Advisor of the World Health Organization.)

Frustrations of a Young African Doctor

by Charles Rukuni

AFRICA is losing its young doctors because they are frustrated by lack of facilities and drugs — as well as by the poor quality drugs they have to use because their countries are forced to buy cheap. Often the problems result from the dumping of drugs by industrialised countries. Gemini News Service talks to a 25-year-old doctor who, typical of many, says he will have to emigrate.

JOHN Moyo is only 25, but he is one of the most sought-after people in Zimbabwe. Moyo (not his real name) is a doctor. He clearly understands the need for more local doctors, especially in government hospitals, and knows that between five and 10 doctors are leaving the country each month.

Every time you meet him, he complains about the frustration in the profession. He cannot wait to finish his housemanship and emigrate.

No amount of persuasion will make him change his mind unless the hospital administration system and the way junior doctors are treated generally is drastically changed. Moyo is not only overworked and underpaid. He does not have much needed transport or decent accommodation. He sees no prospects of getting out of this squalid life unless he leaves Zimbabwe. He wants to specialise, but he believes he will not get a chance to do so if he stays in government service. He believes it is better to work elsewhere rather than in an institution administered by people who do not known anything about medicine.

He finds himself denied the tools of his trade by some political appointee in charge of buying drugs and equipment who does not know what to buy and does not consult those who do known.

Moyo wants to become a paediatrician. He says he likes children because they never lie to you about the history of their illness.

It was therefore a terrible blow when an 18-month-old baby died before his eyes because he could not find the right drug to treat the child.

Moyo says: "I was called at about 9 pm and told that the child was dying. I was there within five minutes. I had last seen the child at 3 pm and knew he had respiratory problems.

"The first thing I asked for was an ETT tube (Endo tracheal tubes) to help keep the child breathing. They didn't have any, so I had to send someone to get the tube.

"They spent about 30 minutes looking for the tube. There was nothing in the casualty emergency cupboard. There were only adult tubes. When they brought one the child was still alive.

"I had been giving him oxygen, but it was not enough. I put the tube down the child's trachea, and then I realised there were no drugs. Before the nurses could find any drug the child died."

"I felt that the child should not have died and I started crying. I just couldn't help it. If it was an adult, someone say 50 or 60 or more, I would not have minded that much because, at least, I know he has seen a few things, even perhaps his own children.

"If it had been someone who had been drinking heavily, for example, and had developed cirrhosis I wouldn't have cared that much because it's of his own making.

"A child is so innocent. He has not even been absorbed into the system. Moreover, the child had died not because we couldn't save him buy because someone had not ordered the right drugs. This is so boring.

"This was not inefficiency. There are cases where someone can be inefficient. I admit that, if things are there and one cannot use them that is inefficiency, but if the things are not there what can one do? You cannot be accused of being inefficient when the things are not there.

"The problem is that the people who order drugs are not medical professionals. They are just administrators. They do not know what is required. Most have never been seen in the wards they do not even know what s used.

"For example, we had some Rhodesian-made cannulas (drips) coming on the market just a few weeks ago. They are useless. They were made in the days of Prime Minister Ian Smith and are definitely out of fashion, but they are buying them because they are very cheap.

"I do not know where they are buying them from since they have been in hibernation for the 12 years, but everyone knows they are useless.

They just buy drugs without consulting the medical persons who use the drugs. Like now they are buying some Chinese needles which are useless. They are blunt. They are buying them because they are cheap, but you can't use them.

"Today I had this patient who is hypertensive, there was no EM dopa, the drug was not there. "Third World countries are the dumping ground for useless drugs because we look for cheap drugs."

While Moyo's sentiments may be scoffed at as those of a disgruntled young doctor trying to make an excuse to leave the country, I had first-hand experience of what Moyo was talking about. I took a baby to hospital at 11 am. A doctor who examined the baby recommended that he be admitted for observation. This simple process took some six hours and the child was given a bed only at 5 pm.

On admission the child was given an injection and had to spend the whole night coughing without any medication because the ward did not have cough medicine. The child was discharged by a specialist at 10.00 am the third day, but only left at 4 pm because the nurses had been looking for the medicine prescribed by the specialist. In September, Health Minister Dr Timothy Stamps admitted that there was some mismanagement in the handling of drugs. He said drugs valued at Z$600,000 had been destroyed because they had expired. The drugs were ordered in 1988 and 1989.

Charles Rukuni is a freelance journalist. He was the Harare editor of Moto a Zimbabwean weekly and later Deputy news editor of the Bulawayo Chronicle.

CHILDREN AT RISK

India bars ads of baby food

by Priya Darshini

THE breastfeeding campaign in India has notched a significant victory in its nine-year struggle to introduce legislation on the issue.

A Bill is now in Parliament prohibiting the advertising of infant milk foods and feeding bottles — a decade after the passage by the World Health Organisation (WHO) of a resolution banning such promotion of baby milk powder. The Bill further prescribes measures to ensure that in the marketing of infant milk foods, no impression is given that these are equivalent to or better than breast milk.

Lobbying for the Bill's passage is the National Alliance for the Nutrition of Infants (NANI), which has been campaigning for such legislation for several years now. The Bill requires the monitoring of advertisements of baby milk powder and feeding bottles. Provisions relating to labelling and quality control of such products will be implemented by the Ministry of Health and Family Welfare.

An equally important aspect of the Bill is its definition of breastfeeding as "an integral part of the reproductive process." Breastfeeding is "the natural and ideal way of feeding infants and provides a unique biological and emotional basis for child health development," it adds.

The Bill points out that mother's milk provides a degree of immunity to the infant against diseases, and that the promotion of infant foods and related products constitutes a health hazard as it is more pervasive than the promotion of information concerning the advantages of mother's milk. A working group of the Ministry of Social Welfare had formulated a code on the marketing of milk powder even before the WHO came out with its resolution in 1981.

But the code remained just another document largely due to the pressure exerted on the government by manufacturers of infant milk foods. The manufacturers had argued that no ban on product promotion was needed because only 2 per cent of Indian babies were bottlefed and these babies belonged to families with a high health awareness and access to clean water.

But official studies have shown otherwise. For example, the incidence of bottlefeeding in urban areas was found to vary from 10 to 30 per cent among poor families and to be over 60 per cent in middle-class families. A trend toward bottlefeeding has also been observed in rural areas.

The mother's milk bank, the first in India, has grown tremendously in its one year of existence. There was time when it took the bank a month to collect one litre of milk, but today it does this in only 24 hours.

Mothers get a thorough medical checkup before they are accepted as donors. Milk collection, coordinated by a lactation management nurse, is very scientific and hygienic. Once the milk is collected in small bottles, with each mother's sample stored separately, this is sent for bacteriological culture. If infection-free, it is categorised and stored; if not, it is sent for pasteurisation.

"We do not like to pasteurise all the samples because this process kills some of the antibodies," says Dr Fernandez.

Milk declared fit for consumption is stored in deep freezers at minus 20 degrees centigrade.

"Initially we operated in a haphazard manner," says Dr Fernandez. "We did not screen the donors. Nor did we send the milk samples for culture. But a visit to Britain made me realise my mistake." The Taj Group of Hotels, she says helped her establish the bank.

Although the bank, officially opened a year ago, a similar scheme had been operational for a long time but not as systematically.

Another hospital advocating breastfeeding is the Sion Hospital in Bombay which has been giving only mother's milk to all babies born there for the last five years.

— (Depthnews)

Breastfeeding wins the battle

Birth Control Compatible with Islam

by Mounir B. Abboud

BEIRUT: Family planning has gained widespread support in most Muslim societies because of Islam's deep concern for family welfare.

Islamic scholars say that Islam has probably shown more concern for the family than any other religions or social system. This concern is embodied in an enormous body of Islamic legislation relating to the family, its structure, and its internal and external relationships.

Mahmud Zayid, professor of Arab and Muslim history at the American University of Beirut, explains Islam's pervasive influence even in family matters.

"Islam is not only a religion, but also a way of life. Consequently, its sacred law, which is the embodiment of the divine will, regulates the whole of the religious, political, social, economic, domestic and private life of the believer," Mr Zayid says.

But the professor points out that despite the religious character of Islamic legislation as a whole, it is flexible enough to allow it to adapt to the new needs of society.

Mr Zayid says that contrary to what some people think, the type of family Islam favours is not the extended one. It endorses instead a closely knit and compact nuclear family consisting only of parents and children. The emphasis is on family solidarity and the members' allegiance to it.

This deep concern for the welfare of the family is reflected in Islam's instruction to parents to have only the number of children they can adequately care for. Parents who are unable to provide for children and to bring them up well are urged not to have big families.

While it is true that the Muslim's religious book, the Koran, states that wealth and children are the joys of life, it not forbid us. If this were something to be prohibited, the Koran would have forbidden us to do it."

Mr Zayid's views on contraceptions and Islam are shared by leaders of the religion.

Grand Mufit Sheikh Ahmad Kuftaro said in an international conference in Moscow in 1990, that because Islam is

Abortion remains a subject of intense debate among Muslim scholars and there are no clear statements yet on sterilisation

does not unreservedly endorse the begetting of any number of children.

Thus, contrary to notions held by some non-Muslims, it is natural for Islam to approve the use of contraception.

In fact, contraception has been known to Muslims for many centuries as it was both approved by the Prophet Muhammad (SM) and practised by his followers.

Mr Zayid cites strong and undisputed evidence of this from authentic reports of events during the Prophet's lifetime.

One such account said: "We used to practise 'uzl' (coitus interruptus) during the time of the Prophet. The Prophet came to know about it, but did concerned about ensuring the general welfare of the people, fertility regulation is considered necessary for the achievement of this goal.

The Syrian Grand Mufti, or supreme judge of Islamic civil law, stresses that in the Islamic religion, the welfare of society and the family dictates the size of the family.

The International Congress on Islam and Population, which was held in Indonesia in 1990, pointed out that Islam and population policies are not incompatible.

Participants noted that population policies aim to improve human life and eliminate hardships. Islam stresses human responsibility towards current world problems.

Abortion remains a subject of intense debate among Muslim scholars. Islam also does not have any clear statements on sterilisation as a form of contraception.

Views on abortion, particularly during the first four months of pregnancy, range from unqualified approval to total prohibition. Majority of scholars, appear to favour a middle course which will allow abortion on considered valid grounds.

With regard to sterilisation, scholars stress that it should not be confused with castration which is unconditionally prohibited in Islam.

While Islam had always regarded it desirable for people to multiply and have offspring, the religion has also taken note of the fact that the rapid growth of population in the world is threatening not only to lower the quality of life of people but their very survival.

As concerned men and women in almost every country are promoting family planning, Muslim leaders have not been unaware of the critical global situation.

"Islam, as a religion of pristine nature, has never been opposed to what is good to man. Indeed, it has always been ahead in the effort towards the achievement of this good as long as it is not in conflict with the purposes of God's law," Muslim leaders say. —

Depthnews Asia