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ISSUE 1 NOVEMBER 1998



*Health
Messenger*

**Distance Learning
Health Magazine**

BURMESE EDITION

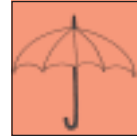
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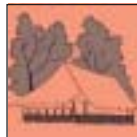
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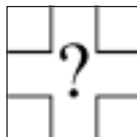
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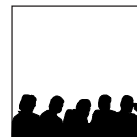
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HEALTH MESSENGER has introduced this system of icons which represent the main topics that are most relevant for the health worker. If the icon above is colored or "on" then one or more articles have been prepared for that topic in this issue. If the icon is grey or "off" then there is no article for that topic in this issue.

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Health worker, faced with a patient who is either ill or injured, must be capable of assessing that patient, in any event. So, arriving at a working diagnosis, he/she should be able to determine to be provided. Often the health worker is alone and may feel isolated. When confronted with an emergency problem, the health worker must react as a competent practitioner: careful, perceptive, determined and efficient. A human life depends on the decisions which are made and the health worker must remain accountable for his/her actions. To be effective, the health worker must have access to training. Eagerness to learn is not enough; everyone needs some help. SAYTAMAN aims to meet even remote communities to promote distance learning and to encourage health staff to revise and improve their knowledge.

In this first issue, we hope that you will find articles are interesting, practical and useful. In order to enable you to review the medical lessons you have learned (and perhaps some that have been forgotten) we will try to put at your disposal a magazine that provides the resources you need to continue learning. Working together, step by step, let's make progress in all fields: Medical Science, Management, Maintenance but, above all, Human Relationship.

Working towards the improved health of our communities is worthwhile!

Sincerely,
The Editor

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Chief Editor
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Drug Administration

The individual's response to a drug is complex and health workers must be mindful of following factors which may influence this response:

1. Absorption

Oral absorption takes place as drug particles move from stomach and small intestine to body fluids.

Drug absorption can be disturbed by many factors such as vomiting or diarrhoea.

2. Distribution

Both lipid-soluble and lipid-insoluble drugs can diffuse across the placenta and some of them have teratogenic effects. They may induce abnormal development of organs or body systems, especially if these drugs are taken during the fourth through the eight weeks of gestation.

Fortunately, the placenta acts as a barrier and separates blood supply of the foetus from the mother.

Compounds that are not easily soluble in fat are prevented from entering into the brain and neoplastic agents are drugs that do not cross the blood-brain barrier.

3. Biotransformation

Bio-transformation is known as metabolism of the medication. Low birth-weight infants and especially neonates have immature liver and kidney function that affect the metabolism of a medication. The elderly also have a loss of kidney function with the same result.

4. Excretion

The main route for drug excretion is via the kidneys but bile, stools, lungs, saliva, and sweat, are also routes of drug excretion.

5. Age

Remember that the elderly are hypersensitive to phenobarbital and central nervous system depressants.

6. Body Weight

Drugs dose may be ordered according to the body weight. Calculation of infant doses must always be based on weight in kilograms.

7. Toxicity

It is more common in persons with liver or renal impairments.

8. Genetic Factors

If parents have an adverse drug reaction, children may also present an identical reaction.

9. Route of administration

Intravenous drug administration allows the drug to act more rapidly than other routes.

10. Time of administration

The presence or absence of food in the stomach can affect the reaction of some drugs.

11. Emotional Factors

Suggestive comments about the drug and its side-effects may influence anxious persons.

12 Pre-existing disease state

For instance, diabetics, of course, should not be given elixirs or syrups containing sugar.

13. Tolerance

Repeated administration of a certain drug may diminish or intensify the effects and a combination of drugs may be given to decrease or delay the development of tolerance for a specific drug.

14. Cumulative effects

This occurs when the drug is excreted more slowly than the rate at which it is being administered.

15. Drug-drug interaction

The action of the combination of drugs may be greater, equal, or less, than the action of a single drug. An adverse reaction may lead to complications such as allergy. Õ



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The "Six Mistakes" in Drug Administration

Medics and nurses should avoid the following six mistakes to provide safe drug administration:

1. Mistake about the patient

Some patients are unable to respond and some will answer to any name. The health worker must verify the patient's identity before administering any drug. This must be done for every patient and each time a drug is given. You must check carefully when two patients have the same name.

2. Mistake about the drug

It is important that the patient receives the drug that was prescribed. The components of a drug order are:

- date the order is written
- drug name
- drug dosage
- route of administration
- frequency of administration
- duration of administration
- prescriber's name and signature.

The person administering the drug must read the labels carefully:

- a) at the time of contact with the drug container or bottle
- b) before pouring the drug
- c) before returning the container or bottle.

3. Mistake about the dose

The right dose is the dose prescribed for a particular patient, within the recommended range for the desired drug.

The implications of drug administration include:

- Correct calculation of the drug dose and double checking of the calculation by another health worker when there is doubt
- Check the patient's weight for weight related doses.

4. Mistake about the time

To maintain the plasma level of the drug, daily drugs are given at specific times during a day.

For instance;

- b.i.d.* = two times a day
- t.i.d.* = three times a day
- q.i.d.* = four times a day
- q6h* = every six hours

Antibiotics should be administered at even intervals throughout a 24hr period to maintain therapeutic blood levels such as q8h rather than t.i.d.

Some drugs are given before meals whereas others are given with meals or food. The latter are those that can irritate the stomach. It is always important to check the expiry date of the drug.

5. Mistake about the route

A right route is necessary for adequate or appropriate absorption. The common routes are:

By mouth

Oral route via drinking or swallowing

Sublingual route

via under tongue for venous absorption

Via skin

Topical route via skin application

Inhalation

Via aerosol, sprays

Instillation

Via nose, eye, ear, rectum, or vagina

Four parental ways

- intradermal
- subcutaneous
- intramuscular
- intravenous either directly or by drip

6. Mistake about the documentation

To avoid this mistake, the nurse must immediately record the appropriate information about the drug administration.

At times you need to record the patient's response to the medication. An unexpected reaction to the medication can be noticed by signs such as skin sensitivity. Delay in charting can result in forgetting to chart the drug administration in which case another health worker may give the drug a second time because they thought the drug had not already been given.

A strict observation of these rules allows excellent drug efficiency and prevents mistakes. However, if an accident occurs, it is because these precautions have not been followed.



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MEDICAL DICTIONARY

A as in *Acute Abdomen*

An abdominal condition of abrupt onset usually associated with: - abdominal pain and tenderness

- constipation
- vomiting.
- and moderate (or no) fever, due to :
- inflammation
- perforation
- obstruction
- infarction (= formation in an area of necrosis, in a tissue due to local ischemia resulting from obstruction of circulation to the area, most commonly by a clot, thrombus or embolus)
- or rupture of intra-abdominal organs.

Emergency surgical intervention is usually required.

Examples are, most often,

- acute cholecystitis
- appendicitis
- perforated peptic ulcer
- strangulated hernia
- splenic rupture
- superior mesenteric artery thrombosis

B as in *Balance*

Of course, it is an instrument for weighing but, in the figurative meaning, is the harmonious adjustment of functions in the medical field.

An example is an acid-base balance; a condition in which the net rate of acid or alkali production is balanced by the net rate of acid or alkali excretion from the body. It results a stable concentration of Hydrogen ions (H^+) in the body fluids.

Acid increases the Hydrogen ion concentration which lowers the pH. Acids react with alkalis to form salts.*

*.[Watch the medical meaning of “salt” : it is not only common salt but any compound of a base (= alkali) and an acid. Base is the non-acid part of a salt.

Alkali is any class of compounds which form soluble soaps with fatty acids.pH is the

symbol relating the Hydrogen ion concentration of a given standard solution.pH 7 is neutral: above it, alkalinity increases and below it, acidity increases

C as in *Calcium*

- is the basic element of lime.
- is found in nearly all organized tissues, being the most important mineral in the body.

In combination with phosphorus it forms phosphate, the dense, hard material of the teeth and bones.

- is an essential dietary element, a constant blood calcium level being essential for the maintenance of the normal heart beat and for the normal functioning of nerves and muscles.

It also plays a role in the multiple phases of blood coagulation, in which it is called “coagulation factor IV”, as well as many enzymatic processes.

D as in *Muscular Defence*

- is the muscular tension and rigidity which accompanies a localized inflammation, more often of the abdominal muscular wall (see above *Acute Abdomen*)

E as in *Elephantiasis*

Is a chronic filarial disease due to infection of the lymphatic channels with the nematode *WUCHERERIA bancrofti* or *BRUGIA malayi* and characterized by inflammation and obstruction of the lymphatics, hypertrophy of the skin and subcutaneous tissues.

The legs and external genitals are principally affected.

The disease begins with attacks of dermatitis. This is associated with:

- enlargement of the part,
- chills and fever,
- and is followed by the formation of ulcers and tubercles with thickening, discoloration and fissuring of the skin.

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Medicine

Within Reach of Everyone

Simple words can explain, as well as medical terms, how some warning signs of cancer, can be detected by means of an easy and painless self-examination. In preventive medicine, early detection often saves lives.

Everybody must know some signs and urged to spend four or five minutes once a month on a self-examination in search of any of these signals. But if one of them is present, do not get panic; it can occur for many other reasons. However, it is necessary to go to the O.P.D without delaying in doing it.

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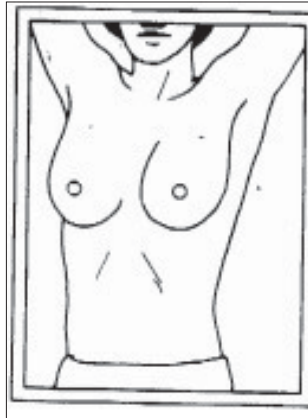
Cancer's Seven Warning Signals

1. Change of bowel or bladder habits
2. A sore that does not heal
3. Unusual bleeding or discharge
4. Thickening or lump in breast or else where
5. Indigestion or difficulty in swallowing
6. Obvious change in wart or mole
7. Nagging cough or hoarseness

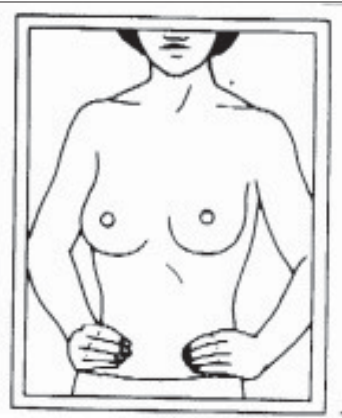
How To Examine Your Breast



(A) Examine your breasts during bath or shower; hands glide easier over wet skin. Fingers flat, move gently over every part of each breast. Use right hand to examine left breast. Check for any lump, hard knot, or thickening.



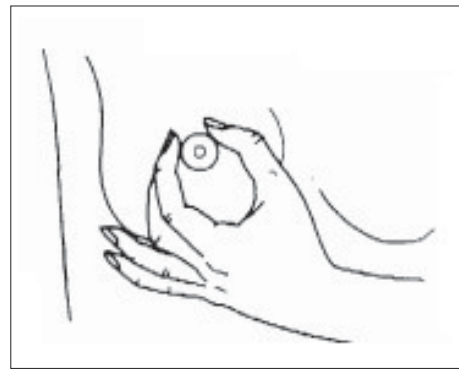
(B)



(B) Stand before a mirror and inspect your breast, first with arms at your sides, then with arms raised high overhead. Look for any changes in the shape of each breast. swelling, dimpling of the skin, or changes in the nipple. Then rest your palms on your hips and press down firmly to flex your chest muscles. Left and right breasts will not exactly match; few women's breasts do.



(C) Lie down on a bed and put a pillow or folded towel under your right shoulder. Place your right hand behind your head, this distributes your breast tissue more evenly on the chest. With left hand, fingers flat, press gently in small circular motions around an imaginary clock face. Begin at outermost top of your right breast for 12 o'clock, then move to 1 o'clock, and so on around the circle back to 12. A ridge of firm tissue in the lower curve of each breast is normal. Then move in an inch toward the nipple and keep circling to examine every part of your breast, including the nipple. This requires at least three more circles. Repeat this procedure on your left breast with a pillow under your left shoulder and your left hand behind your head.



(D) Finally, squeeze the nipple of each breast gently between thumb and index finger. Any discharge, clear or bloody, should be reported to a doctor immediately.



Oxidation

The body's absorption of alcohol begins in the stomach. Approximately, 20% passes directly into the venous drainage of the stomach wall. The majority of alcohol (80%) is absorbed into the venous drainage of the small intestine. Once in the venous drainage, alcohol is transported to the liver for oxidation. When it arrives in the liver, alcohol undergoes oxidation.

The liver is capable of oxidizing 19 g of alcohol per hour. Surplus alcohol is circulated through the body and blood alcohol concentration rises, then gradually falls as the liver metabolizes the remaining alcohol. While alcohol is circulating through the bloodstream, it affects a wide range of cells and particularly, reaching the brain, it can damage and even destroy nerve cells.

Oxidation* = The chemical name of alcohol is ethanol; It is obtained by fermentation of carbohydrate (such as sugars, starches, celluloses, gums and so on) with yeast. Oxidation is accomplished by the removal of a pair of hydrogen atoms from the molecule of alcohol. (molecule is the smallest part of a substance which can exist.)

The Body's Absorption of Alcohol and Oxidation

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Alcoholism

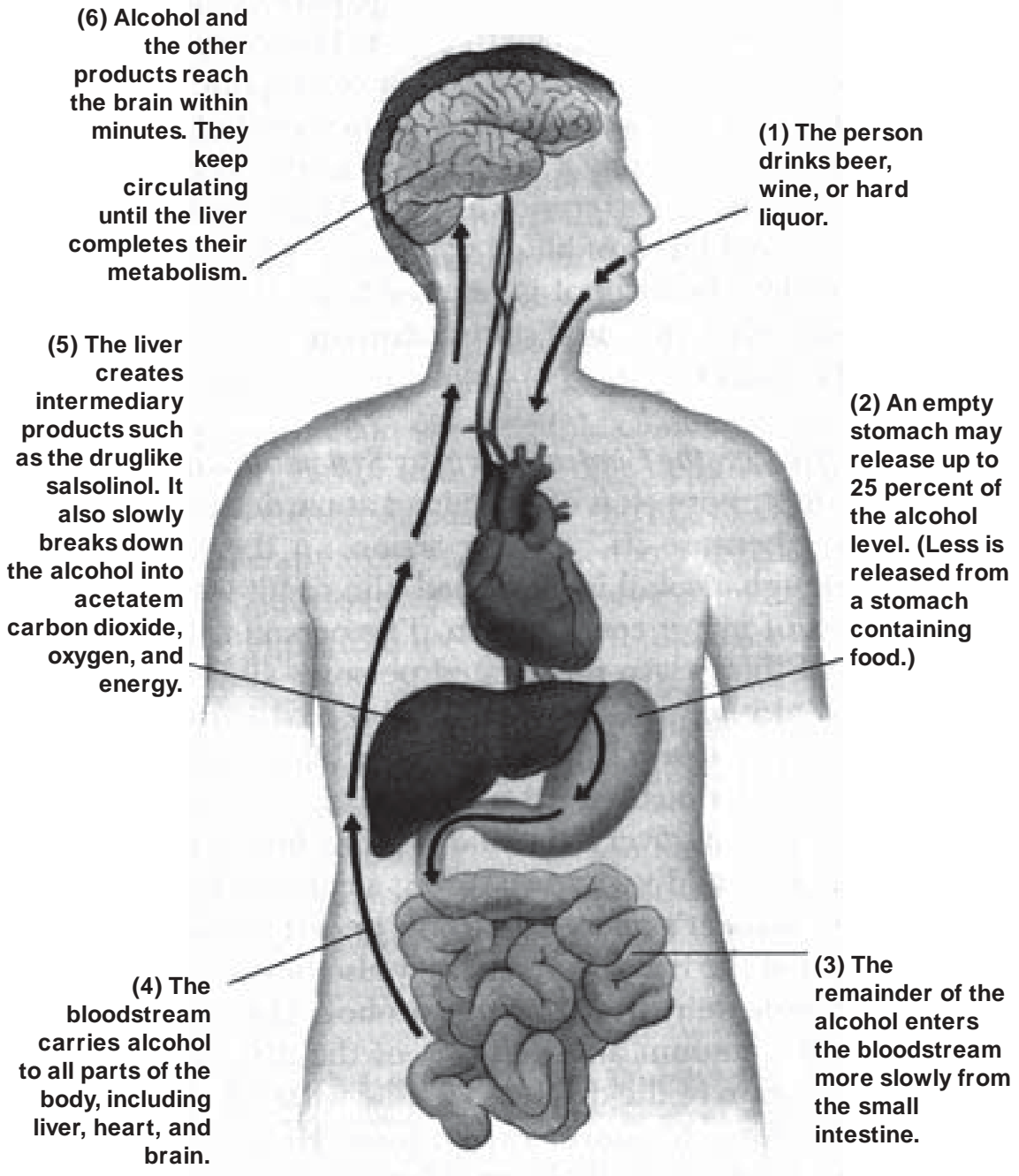
Drinking excessively to the point of damaging the body or seriously disrupting one's life is symptomatic of an underlying disease known as alcoholism.

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Diagrammatic Illustration of The Body's Absorption of Alcohol and Oxidation



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Basic Examination of the Mouth

The Lips

To examine the mouth correctly, we need good light, a tongue depressor and the examiner's eyes helped by the examiner's glove-covered fingers. The examiner has to visualize all areas of the oral cavity. Lips are the easiest part of the mouth for examining but require a very careful examination.

(A) Cleft lip:

This congenital condition is frequently associated with a cleft palate. The palate is the partition separating the nasal cavity, consisting anteriorly of a hard bony part and posteriorly of a soft fleshy part the oral cavity. The osseous palate is formed by the palatine processes of the maxillae and the horizontal plates of the palatine bones; the fleshy part of the roof of the mouth extends from its free inferior border is a projection of variable length the uvula. The cleft in the lip is repaired surgically at about three months of age. Any associated cleft of the palate is usually repaired later at a second operation.

Deformities of the nasal tip (the pointed extremity of the nose) and the anterior nasal septum the partition separating the two nasal cavities in the mid-plane, composed of membranous, cartilaginous and bony parts may be associated with a cleft lip and may require surgery to the nasal tip and septum to correct nasal airway problems in later years.

(B) Mucocele

Mucocele of the lip is firm, indented, somewhat translucent and occurs most commonly on the lower lip in form of a mucous polyp, dilatation of a cavity with accumulated mucous secretion .

Mucocele develops when the duct of one of the mucus secreting gland within the lip becomes damaged by minor trauma. It contains a clear thick mucoid fluid.

Ruptured or simply incised, it usually reforms.

It is necessary to excise the entire lesion under local anesthesia , with the remaining lobules of the associated gland.

(C) Papilloma of the lip

This a benign pedunculated lesion, a stemlike connecting often on a stalk, which is a nonsessile tumor, attached to normal tissue, probably of viral origin. A papilloma is not premalignant. Surgical excision under local anesthesia is the treatment of choice. We excise the entire papilloma including the base.

(D) Hyperkeratosis of the lip:

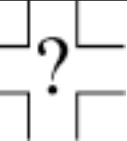
Can develop at a number of sites within the mouth. It is a premalignant lesion and requires biopsy to exclude malignancy. The term leukoplakia is used to describe a white, thickened plaque. Regular observation is required and avoidance of the etiologic factors is important: heat from pipe stems, cigarette butts, etc.

(E) Squamous cell carcinoma of the lip:

Leukoplakia, chronic irritation, radiation, particularly solar radiation and keratosis are the factors predisposing and/or sparking off this most common malignant condition of the lip. It is characterized by an infiltrating and hard usually painful, ulcer. Every hard ulcer of the lip that has not healed within one month must be assumed to be malignant. The treatment consists of a wide excision with tumor-free margins.

(F) Cold Sore (Herpes labialis)

The herpes simplex virus causes a small initially painless cluster . The development of herpes labialis is frequently associated with a febrile illness and occurs in individuals who earlier in life had a primary acute herpetic gingivostomatitis. A local treatment is, most of the time, sufficient. Some other conditions are rare and need specialist's examination. Õ



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t, k q p r s n ; t - u m , t t , t e l c y o d i r s n ; w o f y m e f r [k v a o m a j y m i f v j c i f / , i f t , t e l c y o d i r s n ; E s h q u e g h e a o m a t m u a r ; , t . t p e f w o f , t b ! h t , t q p d i f w o f y m e f r [k v a o m a j y m i f v j c i f r s n ; u a t m u a r ; , t t q p a & m * g j z p a p a o m t a - u m i f r s n ; x l w o f y o i b n ?

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Lower Jaw Joint Disease

It is a joint disease for which symptoms may include:

- ear pain
- facial pain
- headache
- muscle tenderness
- joint noises
- tinnitus or dizziness.

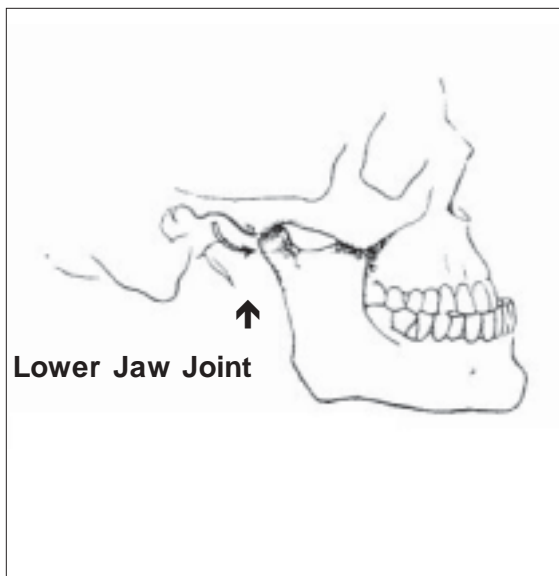
Abnormal bony changes in the articular disk (a pad of dense fibrous tissue located between the articular part of two bones articular rounded projection of the lower jaw, can produce this disease.

Usually, three main signs are met:

- ear pain
- tinnitus (a noise in the ear as ring, buzzing, roaring, etc.) and
- dizziness.

Of course, a careful differential diagnosis should be considered because identical signs may occur with other origin as primary ear disorders or, more severe, a tumor.

When changes are advanced, it results in movements across an irregular area which develop a form of clicking called crepitus. The crepitus may progress to a grating or grinding noise.



Usually the history of patients includes ear or/and joint pain, clicking or grinding noise and limitation of joint function with motion limitation in most cases, there are stress and anxiety. The joint may be very painful because of muscle spasm in the muscles of mastication.

Causes are essentially:

(1) external causes such as jaw injury in an accident, even a light blow in the mandible, or a very broad stretching with dental work and tonsillectomy (when tonsils are taken out) or adenoidectomy (removal of the abnormal development of the lymphoid tissue located between the rear part of the nose and upper portion of the pharynx which communicates with the auditory tube.)

(2) internal causes with dental malocclusion from missing and carious teeth or poorly fitting dentures.

Before asserting the diagnosis of lower jaw joint disease, a close examination of the ear, nose, sinuses and throat, should be done, to preclude these areas as a source of pain. The examination should include an evaluation for tenderness, noise, and range of motion.

Non-surgical treatment is the primary treatment of choice. Relief of symptoms or long periods free of pain are obtained with local heat application, massage, soft diet, removal of central nervous stimulants, and administration of antiinflammatory agents including local corticosteroids by injection.

Only after failure of non-surgical treatment, should surgery be considered. Surgical intervention should be made in clearly defined cases such as bony ankylosis, disk dislocation or perforation, or in patients with unrelenting pain or severe limitation of upper jaw joint motion. An interpositional implant is used in all open surgery cases. Õ

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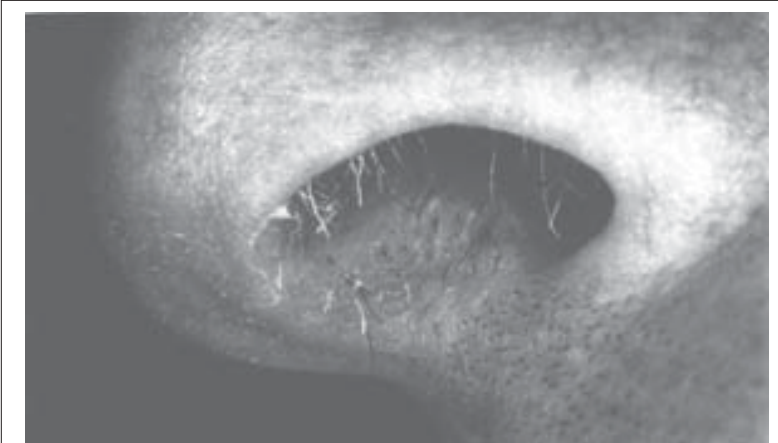
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The red, painful, brawny swelling within the septal portion of the left nasal vestibule is a furuncle. ←

Furuncle of the Nasal Vestibule

A boil or furuncle of the nasal vestibule is an acute, circumscribed infection of the subcutaneous layers of the skin. *Staphylococcus aureus* is usually the causative organism.

Typically, the infecting staphylocococcus is a long term occupant of the patient's nasal vestibule and much such organisms are penicillin-resistant. Nose picking or enthusiastic trimming or avulsion of the nasal hairs are the every-day habits that damage the vestibular epithelium and permit the subcutaneous entrance and subsequent proliferation of the pathogenic organisms.

Clinically, there is an acute local pain or a pricking sensation, within the nasal vestibule. A small, firm, tender, erythematous swelling develops within the vestibule and, in more severe cases, cellulitis can develop. A local abscess develops in 24 to 48 hours.

Although most nasal boils are minor, the patient should be advised to avoid squeezing the furuncle, since a rare but potentially fatal complication of suppuration within the central part

consists to the development of a cavernous sinus thrombosis.

Manipulation of the furuncle predisposes to spread of the bacterial into the cavernous sinus.

Cavernous sinus thrombosis is characterized by

- ophthalmoplegia,
- bilateral gross eyelid oedema
- and severe toxic condition.

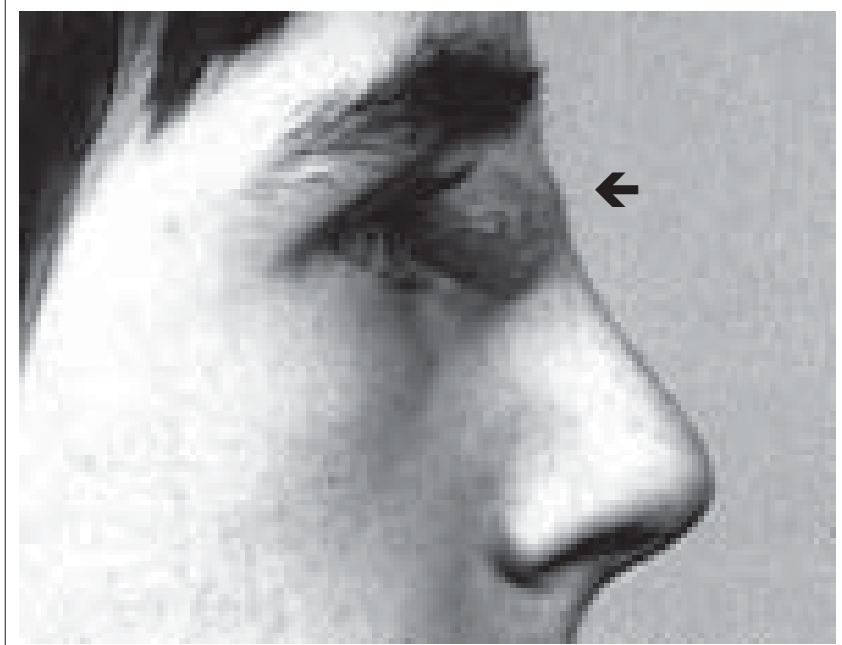
The application of an antibiotic ointment effective against the penicillo-resistant staphylococci and frequent local compresses may treat a nasal furuncle diagnosed at a very early stage.

If there is minor cellulitis, or if the above measures are not effective within one day, cloxacillin or amoxicillin + clavulanic acid taken for 7 days is usually effective.

If there is a very aggressive cellulitis, therapy with continuous drip of antibiotics is mandatory.

Ö

A boil (furuncle) is caused by a staphylococcal infection of a hair follicle with the accumulation of pus.
→



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Dengue Haemorrhagic Fever – (D.H.F.)

It is an arbovirus disease, transmitted by a mosquito's bite: Aedes (In South-East Asia: Aedes aegypti and, often, Aedes albopictus), distinguished from classic DENGUE by haemorrhagic manifestations, including abnormalities of hemostasis, thrombocytopenia and haemoconcentration.

It is a constant problem in South-East Asia considering it is a major cause of child morbidity and mortality, in children ages 3 to 5.

1. Cause

Unfortunately, the cause is still not clear. We know D.H.F. is an arbovirus disease belonging to the group of four dengue virus serotypes. It is currently described as having an immunopathologic basis.

It occurs when multiples types of dengue are simultaneously or sequentially transmitted. D.H.F can occur during primary dengue infection but it is thought that the disease occurs as the result of two successive infections with different dengue serotypes. The first infection sensitizes the patient to the second, producing a severe response. Infection with dengue virus 1, 3, or 4, followed by an infection by dengue virus 2, may be especially important in the development of the disease. A period of about six months or even up to a few years between the two infections, has been thought to be necessary for D.H.F. to occur.

2. Prevalence

Studies in Thailand have estimated the frequency of D.H.F as 11 cases per 1,000 secondary dengue infection

3. Pathology

We observe:

(A) Capillary damage with:

- increased capillary permeability resulting in leakage of fluid,
- haemoconcentration decreasing blood volume,
- reduced tissue perfusion and oxygenation

-disseminated intravascular coagulation (DIC), disorder characterized by reduction in the elements involved in blood coagulation, particularly thrombocytes due to their utilization in widespread blood clotting within the vessels.

(B) Minimal to moderate haemorrhages are seen in the upper gastrointestinal tract.

(C) The liver shows necrosis of parenchyma and Kuppfer's cells with fatty changes.

(D) Petechial haemorrhages are common in the inter-ventricular spectrum of the heart and of the pericardium; equally, on the sub-serosal surfaces of major viscera.

(E) The kidneys rarely show glomerulo-nephritis.

(F) There is a reticulo-endothelial reaction with proliferation of lymphocytes and increase in phagocytosis.

4. Clinical Manifestations

Illness begins suddenly but classical dengue symptoms persist for only a short period, typically 2 – 5 days.

We can notice:

- fever
- cough
- pharyngitis
- headache
- anorexia
- nausea.

A shock syndrome with abdominal pain, which is often severe, develops suddenly. In contrast with classic dengue, myalgia, arthralgia and bone pain are unusual.



5. Physical Signs

- fever, from 38.5° to 40° C and more
- restlessness
- sweating
- low blood pressure
- petechiae, ecchymoses and spontaneous haemorrhages

6. Examination

- tender enlargement of the liver = sore 'hepatomegaly'
- palpable lymph node
- swelling of the tonsils
- cold moist extremities
- warm trunk
- pallid face with cyanosis of the lips
- petechiae on the forehead and distal extremities in 50% of the cases
- macular or maculopapular rash may be seen occasionally

7. Evolution

In the most severe cases, coma, convulsion and unresponsive shock are terminal manifestations in the fourth or the fifth days. Following this critical period, survivors show steady and rapid improvement. Convalescence is fairly rapid in the children who recover from D.H.F.

8. Diagnosis

WHO has established criteria for the diagnosis of D.H.F.:

- acute continuous fever lasting for more than 2 days
- haemorrhagic manifestation on the skin or gastrointestinal tract
- a positive tourniquet-test
- enlargement of the liver
- blood disorders thrombocytopenia haemoconcentration
- haematocrit increased by > 20%

WHO's classification according to severity is

Grade I: fever, Dengue basic symptoms, positive tourniquet-test.

Grade II: grade I, with spontaneous bleeding in the skin, gums, gastrointestinal tract and other sites.

Grade III: grade II, with circulatory failure and agitation

Grade IV: profound shock with undetectable blood pressure and pulse.

9.Prevention

Vector control is the only method available to prevent D.H.F.

10.Treatment

The careful management of fluid and electrolyte balance from the onset of disease is the most important facet of treatment.

Give OXYGEN : useful at first

IV. DRIP with D5W in half-strength normal saline:

(half strength normal saline solution is normal saline that is diluted 50:50) From 50 to 80 and even 100 ml/ kg body weight/ daily. You can start by infusion in one hour of 10 ml/ kg of Ringer Lactate. Blood Transfusion is not recommended in the hypotensive phase during haemoconcentration but may be given to control bleeding or after recovery from shock if signs of severe haemorrhage.

Dexamethasone : 1 mg/ kg bodyweight/ 24 hours and /or: *Aldosterone*: 0.1 ml/ kg daily.

All other drugs, particularly antibiotics, are not indicated. Diuretics and digitalization may be necessary in case of hypervolemia during the fluid reabsorptive phase. Efficacy of new antiviral drugs requires confirmation in the treatment of D.H.F.

Conclusion

Vector control is, by far, the best way to fight D.H.F. The methods are identical to those used in malaria vector control, individual or family mosquito nets soaked with repellent - rooms protected by screens - methods of insecticide spraying or fogging - elimination of all mosquito breeding sites : *Aedes* (and by opportunity *Culex* and *Anopheles*)

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Dengue Haemorrhagic Fever

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Differentiation of Classical Dengue and Dengue Haemorrhagic Fever

Classical Dengue

- Prodrome of fever
- Pharyngitis
- Severe headache
- Ocular pain and tenderness
 on pressure
- Vomiting
- Abdominal pain
- High fevers
- Myalgias
- Bone pain
- Maculo papular (day 3-5)

Dengue Haemorrhagic Fever

- Fever (Acute onset, continuous
 for 2-7 days)
- Haemorrhagic Manifestation
 (Petechiae, purpura, epistaxis)
- Thrombocytopenia
- Hemoconcentration
 (20 % have increase haematocrit)

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Recommendation to Potential Contributors

This magazine is yours and you are strongly recommended to participate by sending your articles. Each article must be accepted by the Editor before publication. We reserve the right to change or simplify the article. Please send contributions to:

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Each medical article must fit in with only one of the following topics:

- Diagnosis
- Prevention
- Case Study
- Treatment
- Sanitation
- Health Education
- Laboratory
- Maternal and Child Health
- Social
- General Health
- Interview

Non-specific medical articles can be accepted too.

e.g., From the field

Size

As far as possible, articles should be between 2-6 pages of 2000 characters each page (space included).

Style and contents

Articles should be written in simple and clear English, French, or Burmese. Difficult words must be explained in a glossary.

Each article must always contain a title; the name and qualification of the author; picture, drawings or ideas for them; boxes summarizing the important parts, references.

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trehav; rsn;u! o, haqmixm;o! h jcnfr#iub # tXlaumifreob! huf, ufrs;yg bn?

(c) ouf, H#H, HAZC, H#Zefrsn;u!lvnhaqmuay;o! h tajcclyppNf (D.N.A) ryg yg (deoxyribonucleic acid = ouf, u vyprfns; tm;vlk. r#H, HAZj'yppNfrsn;ESH@N. A) AHf&y(p) rsn;u!kquvub, haqmix; aom tuqplwcljzpfon?)

(*ouDilmyf, hr; aom t iZlfns;ESHt iZlfns;u!kxlv ay; aomyifae&m (mitochondria) yg bn? aoborh; rsn;u!kxlv wof aw@ #y#d , ifwbf aobcbpo! ht &m [k t "du oq #k m; uon? aq; buqld &m ton t Eef;wof (thrombocytes) [lvnf; ac:on?

2? aobxlwof aoborh; ta&t wuf avsnlenjici

yhsxlwof vnlywfy aoborh; yphiEgrh vvlvms#f (150, 10⁹) r#300, 10⁹) x# bn? (10⁹) 1, 000, 000, 000 yhsxlwof vnlywfy aoborh; yphiEgrh vvlvms#f (50, 10⁹) o!k avsnlen ohr; ygu aobxlwof aoborh; ta&t wuf avsnlenjici (thrombocytopenia) jzpbnf [kt clftrm ajymE#bn?

aobxlwof aoborh; avsnlenjici (thrombocytopenia) onfa tmulgy ta-umifrsn; a-umifjzpe#bn? - aoborh; xlvlyr_r, yE#lvnmjicif/ - aoborh; rsn; ysupf; v#f; rsn; vmjicif o! [lvf t o! y r; rsn; vmjicif/

- &#e&ktg aobxlwof tpm; x#t & nfrsn; a&mpyicifa-umihaooborh; yphiEef avsnlenjici/ - abv#u!aoma-umihabv#r; aobwof i vvyprnf tysuf t p#rsm; u! accszuay; &o! ht wuf aoborh; rsn; tpm; o!k lvwuf & on? x#l-umihaooborh; yrm% avsnlen f l aoborh; avsnbo! ha&m* g (thrombocytopenic disorder) jzplvmon?

T ta-umifrsn; wcb#saog, #ljcif y#ht r#r; u! jzpb E#bn? Oyrn-petechiae: aobuifajymu#i, f(t ay; Ht a&jym; a tmuf, ha; i, haom aoft puf t ajm u)

scattered smallechymoss: jyefuzpby: aeaom aof jcnDi, fsn; (t a&jym; twof oml eubom tyfY aog, kcljicif), ifrh t vit avsnuf o! [lvf tao; tr#r; x#dlf r; a-umifrnob! ha&mvbf ql jzpb; on?

mucosal bleeding: chl#r; ; ae&mrns; aog, kcljicif (Ebacjif/ ygpyf t pmt dESHt b#f wof / qlESHt #lgvrja-umif rsn; wbf t jzprsn; ql jzpb on? o! onf wcv&H wbf A [Ht m, h-um t zbt pnfwbf lvnf jzpb on? wcv&H touf EW&m, f p#d#f o! htaetxm; jzplwvbn?

aobxl; haofcyfym; avsnlupo! hta-umif t& ifrsn; a&m* gyl Oib&muljicifa-umihjzpljicif (aofa-um twof aofcrsn; jyefyif)

- iLzsr; a&m* g
- aobv#lvlnvba& m* g
- clct m; usq ifra&m* g jzpbapom AHf&y p#yl
- Gram(-)ve yha-umif jzpbom aobqylwub&m* g
- cE<mulj ft Elye#jzpljicif; aomw#d
- ulpuatrl#h; lvld qlvlnlem

tjcm; ulpuh&m* g y#r#r; a-umif jzpljicif

- umvmt mZna&m* g
- x&DyE#lvnmulmyylyha-umif jzpboma&m* g
- , #f vlvj#m oefql#m

u! l#p#f tm;ESHquly jzpljicif

- vvlvavm, emvm, hrt a-umif&if rodaofcyfym; avsnlenjicifa-umif jzpbay: vmaom ta&jym; h&armi f ulub&m* g
- aq; Oga-umif jzpbay: vmaom u! l#p#f tm; a-umif haofcyfym; avsnlenf aom a&m* g (heparin, thiazide, diruetics, quinidine, goldsalts, carba-mazepine tp, d#z#)
- aobofy#l#emul jzpbay: vmaom ta&jym; h&armi f ulub&m* g
- a&ausub&m* g *snreDubub&m* g Oubuf a&m* g ygcyl&mi h&m* g SHt jcm; AHf&y(p) a&m* g yha-umif jzpboma&m* g rsn; , lvlfjicif q#lv#r#r; a-umif jzpljicif
- , lvlfjicif q#lv#lyf avsnlenjici
- aofzlo uicqm
- ulpuh&m* g yha-umif jzpbom tonfa&mitom; Oga&m* g jzpljicif emul, lvlfjicif q#lv#r#d jzpbom aoft menfa&m* g
- , lvlf jicif q#lv#lyf yfawf haom q#lv#r; aygjpyf yphi b! ht) u#v
- , lvlfjicif q#lv#r; tr#lvpb#r; rsn; jzif htm; x#lvub-yd

aemul, ifw#p#r; rsn; ylb, mefr#f#h wly#r; icifa&m* g

- ADVmri b#d 12/ zlv#pft ulq#pESHf gvc#lv#r; icif aofedrsn; ylv#r; up#r; icifa-umif jzpljicif - aofa-umi, luav; rsn; ylv#r; jzpicifa-umif jzpbom aoft menfa&m* g - Ta&m* g (Thrombotic Thrombocytopenic Purpura) onf u! l#p#f tm; Saofcyfym; rsn; tay: wlu, luf oub&mu#f_ o! [lvf aofa-ume#ly; oub&mu#fESHqulywlv#r; luf , bn? (jzpb aom ta-umif t& iful#o! ay) cE<mulj jyifjzpbom ta-umif t& mrsn;

- '%&ESHt ya vmjicif
- ab)u! jzpbay: vmaom vuQ% mayg tpESH haofcyfym; avsnlenjici
- Aelvl&m* g (o#uf, lv/tonf u! jicifESH aoft m; enjicif/ aog, jcifw#shw#lv jzpboma&m* g)
 - tonf ulvb&m* g
 - tonf t Oiaofyeh-um (o! [lv) abv#ESH qlhaom aofyeh-um wbf aofcywlvq#lye if



Platelet and Thrombocytopenia

1) A Platelet is a disk-shaped structure, 2 to 4 micro.m diameter,

(a) without a nucleus (nucleus is a spheroid body within a cell consisting of :
- a thin nuclear membrane,
- one or several nucleoli,
- fine net-like threads bearing diffuse irregular granules of chromatin.)

(b) and without D.N.A, (deoxyribonucleic acid = a nuclear acid that constitutes the genetic material of all cellular organisms and the D.N.A. viruses)

(c) containing active enzymes and mitochondria. Platelets are found in the blood and chiefly known for their role in blood coagulation. In medical book they are also called : *Thrombocytes*

2) Thrombocytopenia considering the normal circulating platelet rate:

150 to 300 x 10⁹ per litre of blood, (10⁹ = 1,000,000,000 platelets), thrombocytopenia is asserted when there is a fall to around 50 x 10⁹ in circulating platelets (platelets = thrombocytes).

Thrombocytopenia : may come from

- failure of production,
- increased destruction and/or utilization
- occasionally dilution concerning the platelets,
- thrombocytopenic disorder where platelet sequestration from consumption of platelets by splenic macrophages occurs due to an enlarged spleen.

Each of these disorders may produce various patterns of bleeding such as

- petechiae (small superficial blood spots in the skin)
- scattered small ecchymosis (deeper blood infiltration into the skin), spontaneous or caused by a minor trauma at any site,
- and mucosal bleedings (nose, mouth, gastrointestinal and genitourinary tracts, the most often, but also into the Central Nervous System with, sometimes, life-threatening manifestations).

Causes of Thrombocytopenia

Infections (by disseminated intravascular coagulation)

- Malaria
- Dengue Haemorrhagic Fever
- Human Immuno-deficiency Virus
- Gram-negative Septicemia
- Miliary T.B
- Infectious Mononucleosis
- Many other infections such as:
- Kala Azar
- Trypanosomiasis
- Schistosomiasis

Immune

Acute/Chronic Idiopathic Thrombocytopenic Purpura

Drug-induced Immune Thrombocytopenia (heparin, thiazide diuretics, quinidine, gold salts, carbamazepine and so on).

Post transfusion Purpura

Chicken-Pox, Rubella (German measles), Measles, Mumps, and other viral infections

Bone Marrow Disorders

Marrow Hypoplasia

Leukaemia

Aplastic Anaemia following infectious hepatitis

Megaloblastic Anaemia

Myeloma

Myelofibrosis

B12 and/or Folate (folic acid) and/or Iron

Deficiency

Hemolysis

Microangiopathic Anaemia

Thrombotic Thrombocytopenic Purpura

External Causes

Trauma and Burns

Specific Splenomegalic Syndromes with Thrombopenia

Congestive Splenomegaly (Banti's disease): from

- Hepatic Cirrhosis
- Portal or Splenic Vein Thrombosis

ES/kl̥obul̥p̥l̥pr̥f̥ em;axm̥j̥c̥i̥f̥

ES/kl̥obul̥p̥l̥pr̥f̥ em;axm̥j̥c̥i̥f̥ ES/hpylv̥of̥ I
 aq;r; ; rsm; taeESHt̥cuft̥cl̥rsm;pb̥n̥, ul̥w̥ob̥n̥?
 t̥jcm; aom aq; buft̥jcr̥f̥ ES/hul̥h̥b̥! h̥ae&m
 ES/kl̥obul̥p̥l̥pr̥f̥ em;axm̥j̥c̥i̥f̥ t̥m; aeφ̥ob̥x̥yl̥v̥v̥l̥v̥
 vuāw̥@t̥j̥ud̥f̥ay̥g̥i̥f̥ rsm;pb̥n̥, yv̥ly̥&ef̥ v̥lt̥y̥on̥?
 t̥&n̥ft̥c̥s̥i̥f̥j̥y! h̥om̥ u̥ef̥r̥ma&; v̥ly̥om; on̥f̥ ES/h̥.
 t̥c̥l̥om̥ t̥y̥l̥f̥ o̥l̥ [lv̥f̥ ES/h̥o̥v̥s̥ l̥y̥w̥f̥ ul̥t̥ ḁo; p̥y̥f̥
 t̥x̥l̥w̥v̥n̥f̥, h̥az̥em; axm̥j̥c̥i̥f̥/ t̥av̥; x̥m; t̥m; h̥ul̥y̥d̥
 em; axm̥j̥c̥i̥f̥, yv̥ly̥on̥? t̥o̥m̥ o̥i̥q̥h̥w̥ck̥j̥z̥p̥ḁom̥
 ES/h̥o̥v̥n̥ly̥w̥y̥h̥ ES/h̥. v̥y̥f̥, h̥r; j̥z̥p̥ly̥s̥y̥h̥sm; ul̥t̥ "ul̥
 em; v̥n̥x̥m̥j̥c̥i̥f̥ on̥f̥ ES/h̥ cl̥obul̥p̥l̥pr̥f̥ em; axm̥j̥c̥i̥f̥
 t̥w̥l̥f̥ t̥aj̥c̥h̥t̥ u̥sq̥h̥om̥ v̥lt̥y̥c̥s̥uf̥ w̥ck̥j̥z̥p̥n̥?

ES/h̥ ul̥ob̥m; rsm; z̥d̥, p̥l̥ ul̥p̥i̥f̥ (Systole)
 ES/h̥ ES/h̥, ul̥ob̥m; rsm; ḁj̥y̥av̥sm̥j̥c̥i̥f̥ (Diastole) ul̥
 r̥f̥r̥f̥i̥ue̥f̥ u̥ef̥ c̥j̥m; o̥d̥ h̥m; &ef̥ t̥v̥f̥t̥ ḁ&; j̥u̥on̥?
 ḁum̥ul̥um̥i̥i̥um̥ c̥g̥ j̥cm; o̥w̥r̥s̥v̥j̥c̥i̥f̥ on̥
 r̥f̥i̥ep̥h̥v̥t̥s̥ ḁom̥e̥n̥f̥ v̥r̥f̥ [lv̥ay? T̥ol̥p̥ yv̥ly̥y̥g̥
 o̥i̥on̥f̥v̥n̥f̥ t̥&n̥ft̥c̥s̥i̥f̥j̥y! h̥om̥ u̥ef̥ r̥ma&;
 v̥ly̥om; ḁum̥i̥f̥ wa, m̥uf̥j̥z̥p̥r̥v̥m̥E̥l̥ly̥g̥

y̥h̥f̥t̥m̥j̥z̥i̥h̥ t̥c̥l̥om̥ ES/h̥cl̥ob̥h̥em; axm̥i̥l̥
 &aom̥ ae&m̥rsm; t̥m; t̥q̥l̥p̥, s̥i̥. t̥rn̥j̥z̥i̥h̥ow̥r̥s̥v̥
 ac̥:ḁo; u̥on̥? ES/h̥. y̥h̥f̥r̥ [lv̥f̥ ḁom̥ t̥o̥h̥rm; r̥m; p̥f̥
 (Murmurs) ES/h̥y̥h̥f̥ ES/h̥cl̥ob̥h̥w̥l̥on̥f̥, i̥fae&m̥rsm; r̥y̥
 x̥l̥ay̥: on̥?

(1) The Mitral Area- ES/h̥. x̥y̥d̥y̥l̥f̥ ES/h̥
 ul̥h̥n̥do! h̥ae&m

(2) The Tricuspid Area- ES/h̥. b, buft̥jcr̥f̥ ES/h̥ul̥h̥b̥! h̥ae&m

(3) The Aortic Area- &i̥! ES/h̥. n̥mbu̥ft̥jcr̥f̥ 'lv̥d̥ aj̥rm̥u̥e̥h̥ h̥um; ae&m

(4) The Pulmonary Area- &i̥! ES/h̥. b, buft̥jcr̥f̥ 'lv̥d̥ aj̥rm̥u̥e̥h̥ h̥um; ae&m

t̥x̥u̥ly̥g̥ae&m̥rsm; Yom̥ ES/h̥cl̥obul̥p̥l̥pr̥f̥
 em; axm̥i̥&rn̥f̥ [k̥ r̥v̥f̥ḁo̥g̥ t̥w̥d̥t̥us̥
 o̥w̥r̥s̥v̥l̥ue̥f̥ o̥w̥x̥m; &ef̥ r̥ [lv̥y̥g̥

t̥q̥l̥p̥ s̥rsm; ul̥t̥p̥f̥ y̥l̥ o̥w̥r̥s̥v̥x̥m; aom̥ o̥b̥e̥z̥
 ae&m̥y̥ u̥m; &o! h̥ ES/h̥cl̥ob̥n̥f̥ x̥b̥o̥e̥f̥t̥ q̥l̥p̥ s̥r̥s̥x̥l̥
 ay̥: v̥maom̥ t̥o̥l̥j̥z̥p̥&rn̥f̥ [kr̥q̥l̥w̥y? O̥y̥r̥m̥t̥m̥j̥z̥i̥h̥ (Aorta
 Valve) Y̥ p̥w̥i̥j̥z̥p̥ay̥: aom̥ ES/h̥cl̥ob̥h̥sm; r̥m; p̥b̥o̥h̥w̥l̥ul̥ (Mi-
 tral Area) Y̥ r̥um̥c̥% q̥b̥v̥lt̥ ḁum̥i̥q̥h̥ u̥m; & w̥w̥b̥n̥f̥
 t̥r̥d̥r̥s̥aom̥ u̥j̥y̥m; o! h̥e&m̥rsm; ul̥t̥r̥f̥f̥ u̥ef̥ u̥ef̥ p̥l̥r̥f̥
 em; axm̥i̥l̥w̥w̥ef̥ vuāw̥@, yv̥ly̥j̥c̥i̥f̥ uom̥v̥h̥f̥ t̥ax̥m̥u̥ft̥ u̥

ES/h̥o̥v̥n̥ly̥w̥y̥h̥
 y̥h̥f̥t̥m̥j̥z̥i̥h̥ ES/h̥. b, buft̥jcr̥f̥ c̥ef̥r̥ z̥d̥t̥m; on̥f̥
 ES/h̥. n̥mbu̥ft̥jcr̥f̥ c̥ef̥r̥ z̥d̥t̥m; j̥z̥p̥ay̥: j̥c̥i̥f̥ x̥u̥ly̥h̥ t̥&i̥l̥u̥s̥
 on̥? x̥l̥ay̥: aom̥ t̥o̥k̥u̥ly̥x̥r̥q̥ ES/h̥cl̥ob̥h̥y̥h̥d̥y̥on̥?
 ES/h̥, ul̥ob̥m; z̥d̥, p̥l̥ ul̥p̥i̥f̥ ES/h̥ c̥ef̥r̥ Y̥, h̥om̥ z̥d̥t̥m;/
 ḁo̥g̥ v̥s̥v̥h̥-u̥m̥rsm; w̥f̥, h̥om̥ z̥d̥t̥m; x̥u̥l̥t̥en̥f̥i, f̥
 y̥l̥eon̥? ES/h̥, ul̥ob̥m; ul̥p̥i̥f̥ y̥l̥q̥h̥om̥ t̥c̥g̥c̥ef̥r̥w̥f̥, h̥
 z̥d̥t̥m; on̥f̥ ḁo̥g̥ v̥s̥v̥h̥-u̥m̥rsm; w̥f̥, h̥om̥ z̥d̥t̥m; ḁt̥m̥u̥b̥l̥
 ḁ& m̥ u̥ f̥ ḁ t̥ m̥ i̥ f̥ u̥ s̥ o̥ G̥m; o! h̥f̥ t̥ w̥ G̥ u̥ f̥
 t̥q̥l̥w̥ḁo̥f̥a-um̥t̥q̥l̥p̥ ES/h̥ḁo̥f̥a-um̥r̥ j̥u̥d̥ t̥q̥l̥p̥ s̥rsm;
 y̥v̥ly̥d̥) ḁt̥m̥u̥b̥o̥f̥z̥d̥t̥m; j̥z̥p̥ay̥: v̥m̥on̥?
 om̥r̥e̥f̥t̥m̥j̥z̥i̥h̥ ḁo̥f̥a-um̥r̥ j̥u̥d̥ t̥q̥l̥p̥ s̥r̥f̥
 y̥v̥ly̥d̥) ḁt̥m̥u̥b̥o̥f̥z̥d̥t̥m; j̥z̥p̥ay̥: v̥m̥on̥?
 om̥r̥e̥f̥t̥m̥j̥z̥i̥h̥ ḁo̥f̥a-um̥r̥ j̥u̥d̥ t̥q̥l̥p̥ s̥r̥f̥
 y̥v̥ly̥d̥) ḁt̥m̥u̥b̥o̥f̥z̥d̥t̥m; j̥z̥p̥ay̥: v̥m̥on̥?
 t̥&i̥l̥u̥son̥? c̥ef̥r̥ z̥d̥t̥m; r̥h̥ c̥ef̥aj̥r, m̥i̥z̥d̥t̥m; ḁt̥m̥u̥f̥
 ḁ& m̥ u̥ b̥ o̥ f̥ c̥ e̥ h̥ (Mitral Valve) (ES/h̥ b, buft̥jcr̥f̥
 c̥ef̥aj̥r, m̥i̥ES/h̥c̥ef̥r̥-u̥m; & t̥q̥l̥p̥ S̥) ES/h̥ (Tricuspid Valve)
 (ES/h̥ n̥mbu̥ft̥jcr̥f̥ c̥ef̥aj̥r, m̥i̥ES/h̥c̥ef̥r̥-u̥m; & t̥q̥l̥p̥ S̥) rsm;
 p̥w̥i̥l̥ y̥d̥ h̥v̥m̥on̥? w̥z̥u̥l̥w̥d̥ l̥aw̥@l̥o! h̥t̥ w̥l̥f̥
 ES/h̥cl̥ef̥r̥u̥d̥y̥c̥i̥f̥ (Ventricular Systole) a-um̥i̥h̥ (Mitral
 Valve) ES/h̥ (Tricuspid Valve) rsm; q̥u̥i̥w̥l̥u̥l̥y̥h̥v̥b̥n̥f̥; y̥d̥
 y̥x̥r̥ ES/h̥cl̥ob̥h̥j̥z̥p̥v̥m̥on̥? , i̥faem̥uf̥ j̥z̥p̥ay̥: v̥maom̥
 (Pulmonary Valve) ES/h̥ (Aortic Valve) rsm; y̥b̥l̥ x̥l̥ay̥:
 v̥maom̥ t̥o̥l̥u̥l̥om̥r̥e̥f̥t̥m̥j̥z̥i̥h̥r̥-u̥m; E̥l̥ly̥g̥?
 'lv̥d̥ t̥o̥h̥ t̥p̥v̥f̥t̥y̥l̥f̥ E̥p̥c̥ul̥ (Pulmo-
 nary Valve) ES/h̥ (Aortic Valve) w̥l̥p̥ y̥v̥ly̥j̥c̥i̥f̥ u̥
 j̥z̥p̥ay̥; apon̥? T̥ol̥p̥ j̥c̥i̥f̥ r̥h̥ ES/h̥ n̥mbu̥ft̥jcr̥f̥ z̥d̥t̥m; r̥h̥
 b, buft̥jcr̥f̥ z̥d̥t̥m; ES/h̥ E̥l̥ly̥g̥, h̥u! h̥v̥h̥f̥ z̥d̥t̥m; en̥j̥c̥i̥f̥/
 (Pulmonary Valve) y̥v̥ly̥d̥ aem̥uf̥ S̥ (Aortic Valve) y̥v̥ly̥j̥c̥i̥f̥ w̥l̥p̥ a-um̥i̥h̥
 j̥z̥p̥ on̥? T̥ol̥p̥ y̥d̥ aem̥uf̥ w̥l̥w̥m̥i̥f̥o! h̥t̥ c̥e̥f̥t̥ w̥f̥
 r̥-u̥m; E̥l̥ly̥g̥ v̥m̥u̥b̥om̥ (Mitral Valve) ES/h̥ (Tricuspid Valve) w̥l̥p̥
 y̥v̥ly̥j̥c̥i̥f̥ u̥l̥om̥r̥e̥f̥t̥m̥ ES/h̥ aw̥@rn̥?

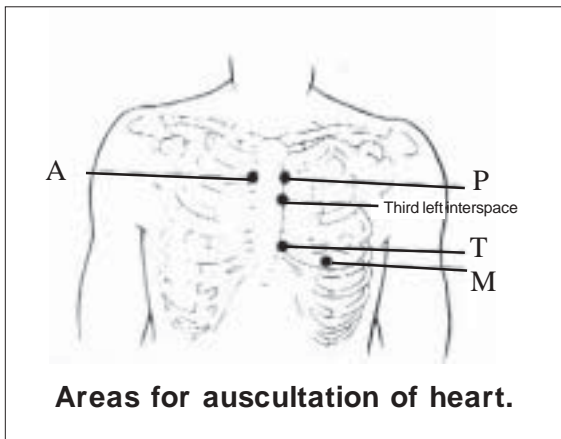
Auscultation of the Heart

Medics may experience difficulties about the auscultation of the heart. As with other clinical examination, it requires a great deal of practice and daily repetition. The skilled health worker listens for particular findings, focusing attention on some part or other of the cardiac cycle. An useful, vital understanding of the events of the cardiac cycle is an essential basis for auscultation. It is very important to identify correctly systole and diastole; Improvisation is not a reliable guide; you do not become a health worker just like that.

Usually, some auscultatory areas of the heart are called by the name of the valve from which murmurs and sounds arise:

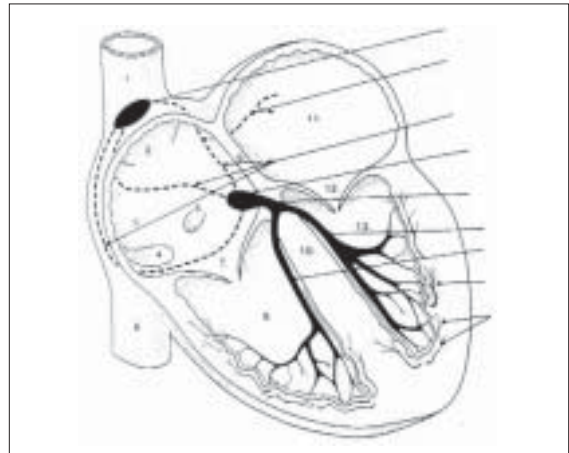
1. **The Mitral Area (M):** which corresponds to the apex beat
2. **The Tricuspid Area (T):** which corresponds to the left side of the lower sternum
3. **The Aortic Area (A):** which lies just to the right side of the sternum in the second intercostal space.
4. **The Pulmonary Area (P):** which is to the left of the sternum in the second intercostal space.

Of course auscultation of the heart should not be confined to these areas, and sounds heard in a particular area do not necessarily come from that particular valve. For instance, sounds and murmurs originating at the aortic valve are frequently best heard at the mitral area. Only practice can give you the right use of the various areas to help you.



The Cardiac Cycle

Normally, the onset of left ventricular systole precedes the onset of pressure rise in the right ventricle. The mitral valve therefore closes before the tricuspid valve. Because the pulmonary artery diastolic pressure is lower than aortic diastolic pressure, the pulmonary valve opens



before the aortic valve. It follows that pulmonary ejection sounds occur closer to the first heart sound than do aortic ejection sounds. During systole, the pressure in the ventricles slightly exceeds the pressure in the corresponding great arteries. Towards the end of systole the ventricular pressure falls below the pressure in the great arteries and when diastolic pressure is reached the semilunar valves close. Normally, aortic valve closure precedes pulmonary valve pressure. The mitral and tricuspid valves begin to open at the point at which the ventricular pressure falls below the corresponding atrial pressures.

As we just saw, at the onset of ventricular systole, the mitral and tricuspid valves close consecutively to give the first heart sound. Opening of the pulmonary and aortic valves occurs next and it is normally inaudible. The closure of the pulmonary and aortic valves gives rise to the two components of the second sound. It will be seen that because of the lower pressure in the right ventricle compared with the left, closure of the pulmonary valve follows that of the aortic valve. After a brief period, the mitral and tricuspid valves open inaudibly in the normal heart. Õ



The Mother's Health Care After Childbirth

Diet

The mother should eat every kind of nourishing, nutritious, easily digestible, and non-spicy foods she can get. Especially eggs, fish, chicken, all cereals (such as rice, corn, barlwheat flour), fruits (bananas and all local fruits), cooked vegetables.

No alcohol, no coffee, no tobacco A little light tea is OK. She should drink a lot because her milk is made essentially of water; from the second week, she has to drink 500ml to one litre more than usual. In fact, she has to drink around three litres a day, especially if she has a fever or sweats profusely. If the mother has lost a great deal of blood, she has to take ferrous and folic acid for one month, at least.

Cleanliness

Bathing is neither harmful nor dangerous after childbirth. Mothers can use soap to wash her private parts except for the breasts; they have to be washed with boiled warm water. In the first two weeks it is better if she bathes with a wet warm towel.

Breast Feeding

Mother's milk is very good for the baby.

So, AS SOON AS POSSIBLE, PUT THE BABY TO THE MOTHER'S BREAST.

Beginning breast feeding early is extremely important because the mother's first milk contains everything a neonate needs in proteins (proteins are the principal constituents of all human cells which are the fundamental unit of our organism) and mother's anti-infective antibodies which are the most effective means to prevent and fight against possible newborn's infection.

When a baby is unable to suck effectively and take much milk, it is necessary that the mother keep milking the breasts by hand, taking hold of the breast, way back, then moving her hands forward to squeeze the milk out by pressing behind the nipple. Then, she gives it to the baby by spoon or dropper.

Care of the Breasts

Regular bathing will help to keep mother's breasts clean. The use of soap may cause cracking of the skin, sore nipples, and infection. It is not mandatory to clean breasts and nipples each time

mother breast-feeds her baby but it is necessary to make sure that nipples are always dry.

Be careful of cracked nipples and/or possibility to breast infection!

Regarding sore nipples it is very important to keep breast feeding the baby even if it hurts. Cracked nipples develop whether the baby sucks the nipples. It is compulsory to teach her to take the nipple and part of the breast, in fact, taking as much of the breast into her mouth as she can. It is necessary the mother gives both breasts to the child. If one nipple is sore, let the baby suck on the other side first, then the baby can suck from the sore nipple. After the baby is finished, let the milk dry before covering the cracked nipple: the milk will help the nipple heal. If the nipple oozes lots of pus, don't give it but, imperatively, milk the breast by hand until the nipple is healed.

Sometimes, breasts get very full and hard then painful. This pain will often go away in one day or two if the baby breast-feeds frequently. Usually antibiotics are not needed. But painful breasts with cracked nipples can lead to an infection or abscess (pocket of pus into the breast). A very painful lump is felt. Fever and chills accompany the pain; often, part of the breast becomes hot, red and swollen with lymph nodes (lymph node = small mass or knot containing lymphocytes, body's defenses competent cells, and serving as a primary regional defense) in the armpit, located along the course of lymphatic vessels from the breast, serving as a mechanism by removing noxious agents such as bacteria and their toxins). A severe abscess may develop. Administer medical care long before it bursts.

In conclusion be careful with some mothers: those that are poorly nourished, very young, mentally slow, single and abandoned by family or who already have malnourished and/or sick children. If a health worker or someone else takes special interest in these mothers and helps them find ways to get the food, care, and companionship they need, it can make a great difference in the well being of both the mother and their child. Every health worker must remember that this is part of their duties.

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1? *Thrombocytopenia* qbnrfñ=

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(c) aofêDrsr, yLjêif jzpon?

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(C) aof wvDvmtwêf *Platelets* 100000ESñ50000, 10^9 xufenjciifullqL/vbn?

(i) aof, zDrsr, cñ wjêif/ (txlojzihaoßxwêf *Thrombocytes* cñ wjêif)

2? *Tourniquet-test* qbnrfñ=

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(c) aof, jêifullzphâpwwhâoma-umihaofvêlvlyhâ&am*gtwêfa, ñiludft yâom tEW&am, f, b! h prfoyr-wrñ jzpon?

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4? *D.N.A.* qbnrfñ=

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(*) aofçhpaomypPñf (*Platelets*) twêf trêlvu, f vñt yâom j'yphvwrñ jzpon?

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Ten Questions

1. Thrombocytopenia is

- a) a venous thrombosis.
- b) a deformation of red cells.
- c) between 100,000 to 150,000 platelets X 10^9 / blood litre.
- d) less than 50,000 platelets X 10^9 /blood litre.
- e) a lack of white cells, particularly T Lymphocytes, in the blood.

2. The tourniquet-test is

- a) a useful test to diagnose Dengue Haemorrhagic Fever.
- b) a dangerous test to avoid in Dengue Haemorrhagic Fever because of bleeding.
- c) a useful test before putting a tourniquet in finger amputation.
- d) no medical use but interesting in minor surgery.
- e) absolutely necessary before blood transfusion.

3. Acute abdomen is seen

- a) in placenta praevia in the last two months of pregnancy.
- b) in myocardial infarction located in the diaphragmatic area.
- c) in acute appendicitis for example.
- d) in obese patients.
- e) in tropical myositis located into the abdominal wall.

4. D.N.A is

- a) a moderately toxic pesticide used in place of D.D.T.
- b) a drug used in cancer chemotherapy.
- c) an essential element of the platelets.
- d) the first grade in the D.N.B (Diplomate of the National Board) in the USA.
- e) Deoxyribonucleic acid.

5. Are you a scrupulous health worker ?

When you are not sure of the diagnosis:

- a) You give any “dummy” medical treatment.
- b) If possible, you speak about the case with a more experienced medic.
- c) You give a broad-spectrum antibiotic hoping it will be effective.
- d) You don't give anything pretending you do not have an available drug.
- e) You give Multivitamin, Ferrous and Folic acid hoping for a cure by the body's defences.

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- (u) rnb! It:cgSraw6 &yj
- (c) aof tly6t&mw6fr6r, 6fr6m/
- (*) r6 ull6 aom ta&jym;a&m*g, 66m/
- (C) a&m*ylpepl w6f jyer-wcl6 w6f
- (i) ar6uifp uav;v6mrsr;w666m/

8? ty6vmijciftonr6n6, 6 rnr#q6Dgonfqb6nfr6 atmuly6v6 teufSwc6ShquE6 hey6on?

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- (c) ty6vmib! h6rsuE6ij6i6&6d m/
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- (C) aof tly6t t66of tly66onf ' %&maysu6re6om aof tly66jpc6i/
- (i) aobv6ly66ib! haobv6666po! lyp6n6f (P6t66t6) c6 w6c6i/

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- (u) r66jz66on?
- (c) *Aedes* jciftr66t6pm; jz66on?
- (*) oel6jz66on6
- (C) *Culex* jciftr66t6pm; jz66on?
- (i) *Anopheles* jciftr66t6pm; jz66on?

9? wly6u66a&m*6pn6

- (u) bu6w666, m;a-umi6jz6666oma&m*6jz666on?
- (c) r66 (*Fungal*)a-umi6jz6666oma&m*6jz666on?
- (*) A66f&y666a-umi6jz6666oma&m*6jz666on?
- (C) oel6-umi6jz6666oma&m*6jz666on?
- (i) y, 6v6666u6y6y6y6 (*Protozoa*) a-umi6jz6666oma&m*6jz666on?

10?y, 66Daq;Ogrsr;onf6t muly66&m*6grsr;teufa&m*6vr66r6sv6 u666&m*6grsr;w6f tenfE66ftrsr; tme66ifx66&mu6f+ , 666pn6

- (u) i6666sr;a&m*6j
- (c) O66E66u66666-umr ta, r, ;a&mi66&m*6j
- (*) aobv6666wly66u666a&m*6j
- (C) ta&jym;w66jz6666om t jymu6uf(ol66omfT ta&jym; t jymu66bnf66ofc66paomt & m avsr6bnf6 jz6666i6 a-umi6hr [lv6y? jy6f x666om ulpu66&m*6vcl6-umi6jz6666w66on?)
- (i) aobv6666om pum;vuf t zsr;a&m*6j (*Scarlet fever*)

(ar;c66f6sr;. tajz66sr;ull66emu66666666r! hr*-Zif tr6sv(2)w6f az: jyy66n?)

6. Could you see a purpura after transfusion ?

- a) never.
- b) only in case of a mistake about the blood group.
- c) always if patient has a skin disease such as naevi.
- d) in some cases by immune reaction.
- e) only in neonate patients.

7. The severity of a burn is related to:

- a) a lack of melanocytes (cells of the epidermis containing a dark pigment called melanin, within the melanocyte).
- b) the surface of the burnt area.
- c) the sex of the patient, because females heal faster than males.
- d) the blood group , O group being the best group for healing.
- e) a lack of platelets (thrombocytes).

8. In South East Asia , the Dengue vector is

- a) a tick.
- b) a mosquito type Aedes.
- c) a flea.
- d) a mosquito type Culex.
- e) a mosquito type Anopheles.

9. Dengue is

- a) a bacterial disease.
- b) a fungal disease.
- c) a viral disease.
- d) a helminthic disease.
- e) a protozoal disease.

10. Antibiotics are an effective treatment in all of the following diseases except one:

- a) Malaria.
- b) Cerebrospinal meningitis.
- c) Dengue Haemorrhagic Fever.
- e) Purpura fulminans.
- f) Haemorrhagic Scarlet fever.

YOU WILL FIND THE ANSWERS IN THE NEXT ISSUE (NUMBER 2)



How to Communicate with Patients, Families, and Friends

When people are afraid of communicating with someone at the end of his or her life, they do not want to express their sadness. It can seem awkward and disturbing. When you are faced with the reality of death, you need to face your own feelings honestly.

But you do not need to hide your feelings, first of all, just be yourself. If the patient is a friend or a relative, hug and touch this human being as much as usual. If you have always joked together, carry on without losing your sense of humour, but let the person talk about whatever he or she wants to discuss. He or she may never bring up the subject of his or her impending death. Whether the person knows or not, you do not reveal information he or she is not aware of.

Perhaps the best you can do when in conversation with the terminally ill is to listen. The health worker must realise is to realize that the patient does not expect or want behaviour any different from the way he or she usually is.

A health worker must behave naturally, without being worried about when the moment of death will arrive. He or she must tend and nurse as he or she is used to doing. But it may be easier to be supportive if they are prepared in advance. As important as learning to nurse and help the recovery of a patient is also learning the type of care a dying person has to receive. Maybe, learning to behave correctly is different whether the health worker has or not the willing to do!

Nursing and Caring For Those Who are Dying

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Note:

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Learning

Health

Magazine

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