SPONTANEOUS REDUCTION OF POSTERIOR SHOULDER DISLOCATION FOLLOWING REPEATED EPILEPTIC SEIZURES

Sir,

Early diagnosis, prompt reduction and adequate rotator cuff exercises are vital in preventing recurrent instability following shoulder dislocation. We present a case of posterior shoulder dislocation and subsequent auto-reduction during two episodes of convulsive seizures, where the diagnosis could have easily been missed.

A 29-year-old healthy manual labourer presented to our Accident and Emergency department following two episodes of generalised convulsions. He noted that his left shoulder was extremely painful and stiff after the first seizure episode that ‘eased off’ following the second one that occurred almost an hour later. There was no prior history of epilepsy or shoulder problems. Examination of his shoulders was unremarkable except for minimal loss of terminal internal rotation on the left side. An axillary radiograph revealed a large reversed Hill-Sachs lesion in the humeral head suggesting prior posterior dislocation of the shoulder. He was followed up regularly and underwent a course of physiotherapy to strengthen his rotator cuff muscles. At six months follow up, the shoulder was stable in all directions and in fact he then told us that he had returned to manual labour two weeks after the seizure episodes!

Here, the postulated mechanism of injury is posterior shoulder dislocation during the first episode of seizures that got reduced by anterior displacement of humeral head during the second episode. This kind of an auto-reduction of the shoulder is the first of its nature to be reported.

This case reveals that there is a subset of patients with epilepsy, whose shoulders dislocate and reduce during seizure episodes. This can happen in electrocution injury and electro-convulsive therapy also. The diagnosis of this potentially disabling injury was near to impossible due to lack of clinical findings in the case presented here. It is important not to miss this diagnosis, as recurrent shoulder instability occurs far less frequently with adequate seizure control and rotator cuff strengthening after prompt reduction (auto-reduction in this case) of the dislocation. Excellent history given by the patient and the presence of a large reversed Hill Sachs lesion on axillary radiograph, the hallmark of prior posterior shoulder dislocation, made the diagnosis possible.

This serves as a timely reminder for clinicians to obtain a thorough history and have a low threshold for obtaining antero-posterior and axillary shoulder radiographs in these patients with shoulder symptoms even when clinical examination is normal. It is also imperative to examine the contra-lateral shoulder and obtain radiographs if necessary, as there is a reported bilateral involvement in as many as 30%.

Sankar B, Ng ABY, Rameto AS, Ali F,

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Ultra-rapid opioid detoxification procedures in India: How far they are ethical?

Sir,

During recent years, opiate detoxification procedures have created renewed interest particularly in field of neuro-biological mechanisms and the new pharmacological approaches to opiate dependence.

Ultra-rapid detoxification (URD) emerged in the mid-1990’s and attracted the attention of both media and clinicians. URD, also known as anesthesia-assisted opiate detoxification, is a procedure for detoxifying opioid-dependent patients with opiate antagonists, such as naloxone/naltrexone. While under deep sedation, opiate antagonists are administered to the patient as well as symptom-relieving medications in some cases. Patients are examined and prepared for the procedure for 4 to 6 hours. They then undergo URD procedure for 5 to 8 hours. After this procedure, patients are kept in the hospital for next 12 to 24 hours for observation. Claims have been made for its efficacy as a complete cure for opiate addiction.

In India, these detoxification procedures are the object of increasing controversy and are becoming increasingly common among private clinics and their de-addiction facilities. Most opiate addicts seeking treatment in India are served by the public sector. A wide range of treatment approaches are available, including supportive local social services, public and private detoxification centers, therapeutic communities, and local self-help groups.

URD was introduced in India by private sector de-addiction facilities. These facilities claim in media that URD provides 100 percent success results in opiate addicts without any conscious effort. This conveys a misconception to the addict that there is a quick, easy, and sure method to come out from dependency. Clearly, this approach contradicts the traditional view of dependency as a bio-psycho-social problem that requires an intensive and comprehensive management for achieving long-term abstinence. It is seen from day to day clinical practice that many URD clients subsequently requested treatment in the public system. Similar doubts were raised by researchers working in Western countries who were skeptical of any method claiming “cure” via a simple, short, and uni-dimensional approach. They believe that detoxification and medication alone cannot provide long-term abstinence. Some scientific studies also claim that URD may be much less effective and more expensive than traditional treatment which
CAUSES OF IRON DEFICIENCY

Iron deficiency is a consequence of: (a) decreased iron intake, (b) increased iron loss from the body or (c) increased iron requirements.

(a) Decreased iron intake may be due to inadequate diet or impaired absorption.

Inadequate diet
In infancy, iron deficiency is most often the result of use of unsupplemented milk diets which contain inadequate amounts of iron. Milk products are very poor source of iron and prolonged breast or bottle feeding of the infant frequently leads to iron deficiency, unless there is iron supplementation. This is especially true for premature infants.

In older children, a predominantly milk and cereal based diet and food fads can also lead to iron deficiency anemia (IDA). An average American diet provides around 6 mg iron per 1000 Kcal and nearly half of this is in the form of fortified cereals. Hence amount of absorbable and assimilable iron is nearly 50% of total iron intake. In India, since cereals are not routinely fortified with iron, the total iron consumption is still less. Also a large proportion of Indian population is strictly vegetarian, and most vegetables and fruits are poor in iron content.

Increasing use of refined foods such as white bread and white rice leads to consumption of a diet poor in iron. Similarly increasing use of “junk” foods like pizzas, potato chips, French fries and packaged snack foods – all have high fat content, are conducive to obesity, atherosclerosis and type II diabetes – but are low in iron content.

Iron requirements of adult male are very small; needs to absorb only about 1 mg iron daily from diet in order to maintain normal iron balance. But women in child bearing age need to absorb at least 3 mg iron daily. Blood losses during menstruation and increased iron requirements during pregnancy and lactation predispose the women to have poor iron stores. Traditionally, the Indian housewife eats last after all male members and children have eaten, and in many families, the women eat only the left over. Hence, even though food prepared for family is same, women are more prone to develop IDA than other members of the family.

Deficient absorption
Iron absorption is enhanced by gastric acidity further challenges its feasibility in developing countries.

However, much controversy currently surrounds URD because of its associated risks of mortality and morbidity which usually hided by private de-addiction facilities. There is need of proper psycho-education among service utilizers and legal authorities must be sensitized regarding these procedures. It is evident from some clinical studies that no specific subgroup of clients benefited more from URD. Nevertheless, limited data is available regarding patient outcome after URD. Finally, one should bear in mind that detoxification is only the initial step of a prolonged therapeutic process with biological, psychological, social and environmental aspects that may influence the final outcome, that is abstinence.

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PRACTITIONERS SECTION

IRON DEFICIENCY ANEMIA – PART-II
(ETIOPATHOGENESIS AND DIAGNOSIS)
ASHA SHAH

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