The next day, he had right hypochondrial rebound tenderness. Investigations revealed thrombocytopenia (13 × 10⁹/L), raised serum transaminases (10 times the upper limit of normal) and low albumin (24 g/L). Dengue IgM serology was positive. ESR and CRP were normal. On the eighth day of illness, she developed shock accompanied by rebound tenderness in the right hypochondrium. Ultrasonography showed thickened gallbladder wall. A final diagnosis of DHF with AAC was made, and she was also managed conservatively. Within 3 days, the platelet count and albumin level improved, with disappearance of rebound tenderness.

The second patient, a 23-year-old woman, presented with a four days’ history of fever and shoulder pain. Examination showed a generalized petechial rash. Investigations revealed thrombocytopenia (13 × 10⁹/L), raised serum transaminases (10 times the upper limit of normal) and low albumin (24 g/L). Dengue IgM serology was positive. ESR and CRP were normal. On the eighth day of illness, she developed shock accompanied by rebound tenderness in the right hypochondrium. Ultrasonography showed thickened gallbladder wall. A final diagnosis of DHF with AAC was made, and she was also managed conservatively. Within 3 days, the platelet count and albumin level improved, with disappearance of rebound tenderness.

Sir,

We report on two cases of dengue hemorrhagic fever (DHF) complicated by acute acalculous cholecystitis (AAC) and localized peritonitis that resolved on conservative management.

The first patient, a 15-year-old boy, presented with a 3 days’ history of fever, headache, lethargy and a generalized petechial rash. Investigation showed thrombocytopenia (13 × 10⁹/L), hypoalbuminemia (31 g/L) with high transaminases (six times the upper limit of normal). Dengue IgM serology was positive. The next day, he had right hypochondrial and epigastric pain. He was in shock (80/60 mmHg), had tenderness with guarding and rebound tenderness in the upper abdomen. Ultrasonography showed a thickened gallbladder wall [Figure 1]. He was diagnosed as having DHF with AAC and was treated conservatively with fresh frozen plasma and platelet transfusions. The rebound tenderness persisted for 72 h and he made full recovery. Repeat imaging 2 weeks later was normal.

The second patient, a 23-year-old woman, presented with a four days’ history of fever and shoulder pain. Examination showed a generalized petechial rash. Investigations revealed thrombocytopenia (13 × 10⁹/L), raised serum transaminases (10 times the upper limit of normal) and low albumin (24 g/L). Dengue IgM serology was positive. ESR and CRP were normal. On the eighth day of illness, she developed shock accompanied by rebound tenderness in the right hypochondrium. Ultrasonography showed thickened gallbladder wall. A final diagnosis of DHF with AAC was made, and she was also managed conservatively. Within 3 days, the platelet count and albumin level improved, with disappearance of rebound tenderness.

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Sir,

We read the article ‘Outcome of coronary artery bypass grafting in patients……artery disease’ by Nozari et al., which was published in the October 2007 issue of the journal. […] It is an interesting article; and in the extant literature, one finds an endless list of articles focusing on the outcome of coronary artery bypass grafting (CABG) surgery. Under ‘Material and methods,’ the authors describe a stenosis of 50% or more in the left main coronary artery as significant. We would appreciate an exact anatomical location of the stenosis under such circumstances. As anatomists, we also wonder if 70% or greater than
that can be considered as significant stenosis. It has to be spelt out in detail if there is any criterion for classifying such stenosis. The authors have mentioned in Table 5, left main disease as the risk factor. It needs to be described what they mean by ‘left main disease.’

In the present-day scenario, the researchers have even identified the inflammatory markers like cardiac troponin I (cTnl), interleukin-6, SC5b-9 involved in such surgical procedures. Perhaps the atrial fibrillation occurring after the surgery is best explained by the presence of these markers. Interestingly, it has been seen that the neurocognitive dysfunction (NCD) continues to occur in a significant number of patients after cardiac procedures. It has been observed that acute renal failure is a major complication following CBAG surgery that is strongly associated with in-hospital mortality. There is a need to discuss all such complications in detail.

We would have appreciated if the authors had made some sincere efforts to link the body mass index to the mortality. There are research reports on the study of body mass index in weight classes that can influence the hospital mortality after CBAG surgery. Many factors have to be taken into consideration for the assessment of mortality and morbidity. The present study has more of statistical data and less new facts over existing literature.

REFERENCES


BACKGROUND

High blood pressure is an independent risk factor for cardiovascular and cerebrovascular disease. At the defining cutoff of 140/90 mmHg, 28-44% of the world population has hypertension, with ethnic variations. It is estimated that the prevalence of hypertension in India is about 25% among urban adults and 10% in the rural areas. The lifetime risk of developing hypertension is estimated to be 90%. Even blood pressure (BP) not in the hypertensive range but above optimal increases the cardiovascular risk. Indeed, blood pressure is a continuum and any increase above optimal confers additional independent risk of coronary heart disease, stroke, congestive heart failure, end-stage renal disease and...