Steroids and penicillamine has been disappointing. Palliative surgery for SVC obstruction in the form of autogenous Saphenous vein graft, woven silicon rubber prosthesis and bovine pericardial conduits for venous reconstruction are recommended along with dilatation of bronchial and esophageal strictures.[7] Stenting of vessels, bronchi and esophagus can be of some help.[5]

The immediate and ultimate risk to life is small. But the inconvenience is considerable and sustained. As the time passes the development of venous collateral circulation mollifies some of the distress, but the clinical state never returns to normal unless the mechanical obstruction can be overcome.

REFERENCES

TUBERCULOSIS OF URINARY BLADDER PRESENTING AS PSEUDOURETEROCELE

Sir,

A 35-year-old man presented with recurrent episodes of hematuria, increased frequency of urination and occasional mild dysuria of 1 year duration. There was no fever, weight loss, or loss of appetite. Ultrasound examination showed mild dilatation of intramural portion of the left terminal ureter projecting into the lumen of the bladder (Fig. 1). The wall of the dilated intramural ureter was irregular with few internal echos. There was no change in size of the lesion on real time scanning. No obvious sonological abnormality was seen in the kidneys. Plain radiographs of chest and abdomen were normal. Urine microscopy showed plenty of white blood cells and 10–15 red blood cells. No organism was grown in the routine cultures. Other investigations, including haemoglobin, erythrocyte sedimentation rate, leucocyte count, blood sugar, and serum creatinine, showed normal results. On cystoscopy, bladder wall was erythematous and edematous with involvement of left ureteric orifice. Inflammatory exudate was seen at ureterovesical junction. Biopsy from the bladder wall adjacent to the left ureteric orifice revealed chronic granulomatous inflammation consistent with tuberculosis (Figure 2). He was given antituberculous therapy. Follow-up ultrasound examination done after 6 months showed resolution of the pseudoureterocele and the patient was asymptomatic.

Ureteroceles are obstructive cystic dilatations of the intravesical or intramural portion of the ureter that result in ballooning of the distal ureter into the bladder.[3] Ureteroceles were one of the common incidental observations at sonography on asymptomatic patients. On sonography, they appear as a well-defined

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**Figure 1:** Ultrasound oblique view of the bladder showing pseudoureterocele with irregular wall and few internal echoes.

**Figure 2:** Photomicrograph from the bladder mucosa adjacent to the ureteric orifice showing tuberculous granulomatous cells with caseation.
round-cyst-like structure within the bladder called cyst within cyst appearance. The wall of the ureterocele is thin and smooth. It may change the size in relation to the ureteric peristalsis. Many conditions mimic ureterocele and are grouped as pseudoureteroceles. Pseudoureterocele is defined as dilatation of the intravesical ureter in response to contiguous disease.[1] The wall of the pseudoureterocele is thick and irregular. On intravenous urography, appearance of the radiolucent wall surrounding the dilated distal ureteral segment is an important differentiating point between an ureterocele and a pseudoureterocele. The lucency or halo surrounding a pseudoureterocele is thicker than that of an ureterocele and is poorly defined.[2] Causes of pseudoureteroceles include radiolucent calculus, bullous edema of trigone, Mullerian duct cyst, steinstrasse following shock wave lithotripsy, an ectopic ureter, and infiltrative tumor.[1][2] Imaging features on intravenous pyelography (IVP) and Ultrasound allows differentiation of Pseudoureterocele from ureterocele in most situations, though cystoscopy would be required for confirmation.

We report an unusual presentation of tuberculous infection involving the urinary bladder and terminal ureter presenting as pseudoureterocele on ultrasound. Urographic features of a few similar cases have been reported in the literature previously.[3] To the best of our knowledge, there are no case reports describing sonographic findings of tuberculous pseudoureterocele. In conclusion, chronic inflammatory conditions like tuberculosis should be considered in the differential diagnoses of pseudoureterocele, especially in developing countries like India, where tuberculous infection is common. Whenever the wall of the ureterocele is thickened or irregular on sonography, pseudoureterocele is a possibility and mandates further investigation with cystoscopy to establish the diagnosis.

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NEW SURVEY SHOWS LACK OF TRAINING ON TOBACCO CESSATION TECHNIQUES FOR HEALTH-PROFESSION STUDENTS

The World Health Organization (WHO) is encouraging health professionals to be proactive in minimizing the problems caused by tobacco addiction, consumption and exposure to tobacco smoke. As a result, this year’s World No Tobacco Day on May 31st is dedicated to the important role of health professionals in tobacco control under the banner of ‘Health Professionals against tobacco, action and answers’.

“Tobacco continues to be a leading global killer, with nearly five million deaths a year”, notes Dr LEE Jong-wook, WHO Director-General, “the health community plays a key role in the global effort to fight this epidemic. Health professionals are on the frontline. They need the skills to help people stop smoking, and they need to lead by example, and quit tobacco use themselves.”

Without additional efforts to implement solutions now, an estimated ten million tobacco-related deaths a year will occur by 2020, most of them in developing countries.

Health professionals, including doctors, dentists, pharmacists, nurses, midwives and others, are trusted sources of information and advice, and are themselves role models in matters related to health. They are in contact with a high percentage of the population and can be instrumental in helping people change their behaviour. Studies show that even brief advice from health professionals can increase tobacco abstinence rates up to 30%. Interventions for smoking cessation led by nurses have shown to increase the chance of successfully quitting smoking by up to 50%

However, data from a newly-released survey by the Canadian Public Health Association (CPHA), the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (CDC) and WHO shows that a more systematic approach to engaging health professionals in tobacco control is needed, starting with training. The Global Health Professionals Survey was conducted among third year students in four health-related disciplines (dental, medical, nursing and pharmacy) from ten countries. Most students surveyed (between 87% and 99%) believed they should have a role in counselling patients to quit smoking. Over 90% of students across all countries (with the exception of Croatia at 72%) and disciplines think health professionals should get specific training on cessation techniques. However, as few as 5%, to a maximum of 37% of those surveyed had actually received any formal training.

Smoking prevalence among health professionals is itself often a barrier for their involvement in tobacco control. Seven out of ten countries reported cigarette smoking prevalence greater than 20%, and in 8 out of the 16 surveys, it was over 30%. Prevalence ranged between 0.5% and 47%, the lowest found among nursing students in Uganda and the highest among pharmacy students in Albania.

“It’s important for schools, public health organiza-