Discussion

In English literature care reports of PAM has been reported from 51 countries where 40.6% of patients are from Asian countries and 42.7% of patients are from European countries.

In English literature, PAM has been reported from 51 countries where 40.6% are from Asia [2]. The mean age at presentation is 35 years [3]. There are two varieties described, familial and sporadic [4]. Autosomal recessive familial form has female preponderance. 50% of patients may be asymptomatic despite fluorid interstitial shadows on chest radiograph, or present with dyspnoea, prolonged cough, chest pain or haemoptysis [4]. In later stages, they may also present with features of corpulmonale [4]. Initially there may be no functional impairment, but later there may be restrictive type of defects [4]. Diagnosis is made by bronchoalveolar lavage or open lung biopsy. Typical sandstorm appearance in high resolution computed tomography scans also have a diagnostic value. The only curative treatment is bilateral sequential lung transplantation [4]. Other pharmacological agents which have no proven benefit include disodium etidronate 10 mg/kg per day for 1 year [1]. Few cases of PAM during pregnancy have been published [5].

References


Remission of diabetes mellitus after treatment with pioglitazone

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Introduction

Type 2 diabetes is a complex disease that involves insulin secretion abnormalities and defects in the action of insulin on its target tissues. This chronic metabolic disorder is associated with high mortality and morbidity from long-term microvascular and macrovascular complications [1]. Thiazolidinediones (pioglitazone, rosiglitazone, and troglitazone) are synthetic peroxisomes proliferated receptor-α agonists that decrease insulin resistance, may also have direct beneficial effects on pancreatic â cells [2]. Previous reports shows that decrease in fasting plasma insulin with pioglitazone associated with the improvement of insulin sensitivity [2]. Treatment with pioglitazone was associated with beneficial effects on blood lipid levels as well. Here we present a patient who got a remission of type 2 diabetes mellitus after 2 months of pioglitazone therapy (15 mg).
Method
Fifty-six year old female, diagnosed having type 2 diabetes with initial 218.2 mg/dL of fasting blood glucose, was recruited to our kinetic study in improvement of insulin resistance with pioglitazone. She was followed up for the effects of pioglitazone on body weight (BW), body mass index (BMI), blood pressure (BP), fasting blood sugar (FBS), lipid profile and fasting insulin (FI). Before the treatment, BMI was 23.63 kg/m², BP - 120/80 mmHg, total cholesterol (TC) - 260.64 mg/dl, triglyceride (TG) - 122.71 mg/dL, HDL-cholesterol (HDL) - 69.76 mg/dL, LDL-cholesterol (LDL) -166.34 mg/dL and FI was mU/L. She was on pioglitazone 15 mg/daily with dietary control and followed up for six months at monthly intervals.

Results
There was a reduction in FBS from 218.2 mg/dL to 185.7 mg/dL and it was 108.36 mg/dL at the end of the second month. Decision was made to withdraw the pioglitazone therapy due to normalization of glucose levels and advised to continue with proper dietary control. Changes in her FBS and FI during the follow up period of six months are given in figures 1 and 2. Her plasma insulin level was 31 mU/L at baseline and declined to 13 mU/L after one month of pioglitazone. FI further declined to 11 mU/L at third month. It again increased to 14 mU/L at the end of six months.

Discussion
People with diabetes have a higher risk of cardiovascular disease [1]. For all cardiovascular syndromes, the mortality is virtually doubled in patients with diabetes [3]. Large clinical trials have provided clear evidence of the reduction in cardiovascular risk that can be achieved by treating hyperglycaemia as well as traditional risk factors such as hypertension and hyperlipidaemia [3]. History of our patient shows blood glucose normalisation within two months of pioglitazone monotherapy. The patient was managed only with dietary control for the next four months. In the sixth month, her FBS came up to 127.72 mg/dL. FI was 31 mU/L before the commencement of the treatment and declined to 13 mU/L after 2 months and further to 11 mU/L at the end of the third month. This evidence shows that decrease in fasting plasma insulin levels correlate with effects of pioglitazone.

History of this patient suggests that pioglitazone is effective in improving insulin sensitivity and good glycaemic control. Normoglycaemic period of two months in the absence of drugs further indicates that insulin sensitivity persisted even in the absence of therapy. Her fasting blood sugar raise at the sixth month up to 127.72 mg/dL and FI level has risen to 14 mU/L. In this patient TC and LDL levels started to decline with the treatment and also through the follow up period. HDL level rose initially with the treatment, but again declined after cessation of the therapy. Though TG level reduced
to 106.14 mg/dL at the end of first month it increased throughout the follow up period.

Therefore early intervention with the agents targeting insulin resistance and increase in secretors that are associated with pancreatic β-cell failure, can delay progression or even prevent type 2 diabetes for relatively long periods of time, affords great promise in addressing the global epidemic of diabetes.

References

Hydrocele – are we treating the cause or the effect?

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Introduction
Among the general public, the awareness of filariasis as one of the aetiological factors responsible for hydroceles is poor [1]. Even the clinicians rarely attempt to find out the aetiology of hydroceles when the patients are treated. Since lymphatic obstruction can cause secondary hydrocele, and filariasis is a common cause of lymphatic obstruction in the tropics, it may be useful to investigate or to treat empirically for filariasis, when adult patients present with hydroceles.

Case report
A 35 year old patient who complained of bilateral hydroceles was vague about the duration of the illness. In addition to bilateral hydroceles, the left testis was enlarged with a cystic lump on its upper pole, while the right testis was normal in size. There were no palpable para-aortic lymph nodes. Patient did not have an early morning cough or any limb swelling. The hydrocele on the right side was recurrent and it has been associated with an inguinal hernia. Inguinal herniorrhaphy has been done 3 years ago while the hydrocelectomy on the same side had been performed one year ago.

An ultrasound scan should testes, normal in size and echo-texture. A large cyst measuring 4.5 cm in diameter was found in the head of the left epididymis. Multiple cystic translucencies were seen in the tissues surrounding the right testis with suspicion of a varicocele or a mass lesion arising in the right epididymis. Abdominal scan was normal. The levels of β-hCG and α-fetoprotein in the serum were normal.

Six days later, the patient developed severe bilateral testicular pain and tenderness with high fever (101 °F). Urine analysis was normal and the patient was started on levofloxacin on suspicion of an infected hydrocele. Since the response to antibiotic was poor, it was decided that the left sided scrotal swelling be explored. An inguinal incision was used and the sac of the hydrocele was opened to find straw-coloured fluid, which