MEDICINE ELSEWHERE

Prepared by

Dilek Dereli, M.D.

Department of Internal Medicine, School of Medicine, Marmara University, Istanbul, Turkey.

Chan TM, Li FK, Tang CSO, et al. Efficacy of Mycophenolate Mofetil in patients with diffuse proliferative lupus nephritis. NEJM 2000; 343:1156-1162

Immuno-suppressive regimens of glucocorticoids combined with cytotoxic drugs, particularly cyclophosphamide, are effective for the treatment of severe lupus nephritis. However, cyclophosphamide has serious side effects, such as bone marrow suppression, gonadal toxicity, hemorrhagic cystitis and cancer. Mycophenolate mofetil (MM), a cytotoxic agent selective for lymphocytes, compares favorably with cyclophosphamide in terms of side effects.

This study aimed to find out whether mycophenolate mofetil can be substituted for cyclophosphamide in the treatment of severe lupus nephritis. Forty-two patients with diffuse proliferative lupus nephritis were randomized in two groups of either a regimen of prednisolone and MM given for 12 months or prednisolone and cyclophosphamide given for 6 months followed by prednisolone and azothioprine for another 6 months.

The incidence of complete or partial remissions and the duration of treatment before a complete remission achieved, were similar in the two groups. MM and prednisolone induced complete remission in 81% of the patients and partial remission in 14 %, as compared with 76 and 14 % respectively for the other group. The improvements in the degree of proteinuria and serum albumin and creatinin concentrations were similar in the two groups. With regard to side effects, the incidence of infections was similar between the two treatment groups and other adverse effects, including leukopenia and death, occurred only in the cyclophosphamide/ azothioprine group. The rates of relapses were similar between the two groups.

In conclusion, MM combined with prednisolone is an effective treatment for patients with diffuse proliferative lupus nephritis, with results and toxicity that are similar to those of treatment with cyclophosphamide followed by azothioprine.

Prepared by

Nevsun Aritan, M.D.

Sub-department of Rheumatology, Department of Internal Medicine, School of Medicine, Marmara University, Istanbul, Turkey.

Herrington DM, Reboussin DM, Brosnihan KB, et al. Effects of estrogen replacement on the progression of coronary-artery atherosclerosis. NEJM 2000; 343: 522-529.

Coronary atherosclerosis is the underlying cause of mortality and disability among women. Several lines of evidence suggest that estrogen replacement should be beneficial in postmenopausal women in the treatment and prevention of heart disease.

The Estrogen replacement and Atherosclerosis trial is a randomized, double-blind, placebo-controlled trial, examining the effects of hormone replacement therapy (HRT) on the progression of coronary atherosclerosis in women. Postmenopausal women (n=309) with angiographically verified coronary disease were randomly assigned to recieve either unopposed estrogen, estrogen plus medroxyprogesteron or placebo and were followed up for a mean of 3.2 (0.6) years. The degree of coronary atherosclerosis was determined quantitatively at the base line and at 3 years by coronary angiography.

Both therapies produced significant reductions in low-density lipoprotein cholesterol levels (9.4 and 16.5 %, respectively) and significant increases in high-density lipoprotein cholesterol levels (18.8

and 14.2 %, respectively) as compared to placebo. However, neither treatment altered the progression of coronary atherosclerosis. The differences between the mean coronary artery diameters at follow-up and changes from the baseline for the active treatment groups and the placebo group were not significant. The rates of clinical cardiovascular events were also similar among the treatment groups.

The results showed that neither unopposed nor combined estrogen affected the progression of established coronary artery disease. According to these results, estrogen replacement therapy does not provide a cardio-protective effect in women with established heart disease. However, estrogen therapy may still be effective for the primary prevention of heart disease, but this has not yet been verified.

Reginster JY, Deroisy R, Rovati LC, et al. Long-term effects of glucosamine sulphate on osteoarthritis progression: a randomised, placebo-controlled clinical trial. Lancet 2001;357:251-256.

Osteoarthritis (OA) is among the most frequent forms of musculo-skeletal disorders and is a major cause of disability. The treatment of OA is usually limited to short-term symptomatic control. The effects of glucosamine sulphate (GS) on the long-term progression of joint structure changes and the symptoms of OA were assessed in this study.

In a randomised, double-blind, placebo-controlled trial, 212 patients with knee OA were randomly assigned to oral GS (1500 mg/day) or placebo for 3 years. Weightbearing, antero-posterior radiographs of each knee in full extension were taken at the enrollment and after 1 and 3 years. Symptoms were scored by the Western Ontario and McMaster Universities (WOMAC) OA index.

Patients using placebo had a progressive joint-space loss of -0.31 mm (95% CI -0.48 to -0.13) after 3 years, whereas no significant joint-space loss in patients on GS (-0.06 mm (CI: -0.22 to 0.09)) was observed. Similar results were reported with minimum joint-space narrowing. As assessed by WOMAC scores, symptoms worsened slightly in patients on placebo compared with the improvement observed after treatment with GS. There were no differences in safety or reasons for early withdrawal between the treatment and placebo groups.

The long-term combined structure and symptom-modifying effects of glucosamine sulphate suggest that it could be a disease-modifying agent in OA.

Sellmeyer DE, Stone KL, Sebastian A, et al. A high ratio of dietary animal to vegetable protein increases the rate of bone loss and the risk of fracture in postmenopausal women. Am J Clin Nutr 2001; 73: 118-122

Nutrition is an important component of bone health and the value of nutrients such as calcium is well documented. However, the value of other nutrients, such as protein, remains controversial. A high intake of dietary protein may adversely affect bone through calcium excretion and acid-base metabolism. Animal foods provide predominantly acid precursors, whereas protein in vegetable foods is accompanied by base precursors not found in animals. Imbalance between dietary acid and base precursors leads to a chronic net dietary acid load that may have adverse consequences on the bone. The aim of this study was to test the hypothesis that a high dietary ratio of animal to vegetable foods, quantified by protein content, increases bone loss and the risk of fractures.

Community-dwelling 1035 white women (aged >65) was prospectively followed with a mean (SD) of 7.0 (1.5) years. Protein intake was measured by using a food-frequency questionnaire and bone mineral density (BMD) was measured by dual-energy X-ray absorptiometry. A 63-item food-frequency questionnaire derived from the second National Health and Nutrition Examination Survey was used to assess recent dietary history of a randomly selected subset of the cohort at the year 2 visit (1989-1990). Food models were used to estimate portion sizes. BMD (in g/cm2) of the total hip and subregions was measured at the year 2 visit and at a follow-up visit an average of 3.6 years later. The rate of bone loss was calculated as the percentage difference between

2 BMD measurements obtained in a subset of participants (n=742) and annualized by time between measurements. Hip fractures were assessed prospectively for 7.0±1.5 years with the use of postcards every 4 months, telephone calls to participants who did not return their postcards and an annual questionnaire.

Women with a high ratio had a higher rate of bone loss at the femoral neck than did those with a low ratio (0.78%/y vs 0.21%/y, P=0.02) and a greater risk of hip fracture (relative risk=3.7, P=0.04). These associations were unaffected by adjustment for age, weight, estrogen and tobacco use, exercise, total calcium and total protein intakes.

Elderly women with a high dietary ratio of animal to vegetable protein intake have more progressive femoral neck bone loss and a greater risk of hip fracture than those with a low ratio. This result suggests that an increase in vegetable and a decrease in animal protein intake may decrease bone loss and the risk of hip fractures.

MEETINGS

12 - 15 September, 2001, Ioannina, Greece

9th Meeting of The Balkan Unicel Laboratory Federation

Contact: E. Bairaktari, Ioannina Biochemistry Laboratory, Regional University, General Hospital of Ioannina, GR-455 00 Ioanina, Greece
Tel.: + 30 - 651 - 99421 Fax: + 30 - 651 - 99418 • e.mail: bclf2001@cc.uoi.gr

* * *

29 September - 4 October, 2001, Fortaleza, Brazil

XXVIIIth Brazilian Urology Congress

Contact: S Dekermacher, Rua Bambina 153, Botafogo / Rio de Janeiro, Brazil
GSM: 222251-050 • Fax: + 55 21 246 - 4092 / 246 - 4194 / 246 - 4265 • e.mail: sbu@urologia.com

* * *

25 - 28 October, 2001, San Francisco, California, USA

39th Annual Meeting of Infectious Diseases Society of America

Contact: IDSA, 99 Canal Center Plaza, Suite 210, Alexandria, VA 22314, USA • e-Mail: www@idsociety.org

* * *

1 - 4 November, 2001, Heraklion, Crete - Greece

11th World Congress of the International Association of Surgeons and Gastroenterologists

Contact: 11th World Congress IASG 2001 c/o Euroyacht Trvel SA - Congress dept. P.O.Box 80678 - 18510 Pireaus , Greece
Tel.: 0030 1 428 19 20 0030 1 7291983 • web page: www.euroyacht.gr • E-Mail: info@euroyacht.gr

ANSWER TO PHOTO QUIZ

Cystic Fibrosis

The patient had a positive sweat test (95 meq/1) which is accepted as the gold standard of diagnosis in cystic fibrosis. Serum Immunoglobulins were normal. His sputum yielded pseudomonas growth. The patient was diagnosed to have cystic fibrosis at the age of 13.

Cystic Fibrosis, inherited in an autosomal recessive manner, is the most common hereditary disorder among Caucasians. In North Europe the incidence is reported to be 1/2000 live births. The incidence in the Mediterrenean area has been accepted to be in the range of 1/3000-4000. The basic defect is in the luminal chloride channel of the exocrine glands (Cystic fibrosis transmembrane conductance regulator-CFTR). Due to the defect in CFTR there is less chloride in the lumen and increased sodium reabsorption from the lumen into the cell. As a result all the secretions within the lumen are dehydrated and thicker than normal individuals.

More than 900 different mutations have been identified as causing the disease. The most common mutation in West Europe ΔF 508, seen in 70% of CF patients. This mutation was found to be around 13-30% in Turkey where patients usually show a wide variety of different mutations.

The clinical symptoms are mainly characterized by thick secretions such as nasal polyps, recurrent respiratory infections, obstructive pulmonary disease, bronchiectasis, fat malabsorption, biliary obstruction, decreased fertility. The mortailty is 90% due to pulmonary disease. Estimated survival of CF patients in the best centers is at present around 40 years.

Treatment is time-consuming and cumbersome both for the caregivers, patients and the health professionals. Pulmonary treatment includes physiotherapy, twice daily inhaled bronchodilators, antiinflammatory medications, nebulized DNAse, nebulized antibiotics. Nutritional care is extremely important to maintain reasonable lung functions. The patients should take 50% more calories than required for their age, 50% of the diet should contain fats together with pancreatic enzymes.

The total number of CF patients followed in all clinics in Turkey do not exceed 500. The Department of Pediatric Pulmonology at Marmara University follows 77 CF patients ages ranging between 1 month to 27 years. Estimations show that the number of CF patients should not be less than 10.000 in Turkey. Severe undiagnosed cases may be contributing to high infant mortality while milder forms contribute to chronic lung disease in adults. Diagnosis of CF will require high suspicion at all levels of care in all medical disciplines.

MACROL

Klaritromisin

250-500 mg Tablet
125-250 mg/5ml Süsp.

Makro Güç...
Makro Çözüm...

Solunum Sistemi Enfeksiyonlarının Tedavisinde Yüksek Klinik İyileşme ve Düşük Yan Etki İnsidansı ile Etkin Çözüm...

MACROL KISA ÜRÜN BİLGİSİ:
FORMÜLÜ: Her film tablet 250-500 mg, her 5 ml süspansiyon 125-250 mg Klaritromisin içerir. **Yardımcı Maddeler:** Boyar Madde (E171, E104, E102), Sodyum Sakkarin, Vanilin. **ENDİKASYONLARI:** Klaritromisin, duyarlı mikroorganizma suşlarının neden olduğu aşağıda belirtilen enfeksiyonların tedavisinde endikedir. **Üst solunum yolu enfeksiyonları:** Streptococcus pyogenes in sebep olduğu farenjit/tonsilit; Streptococcus pneumoniae nın sebep olduğu akut maksiller sinüzit **Alt solunum yolu enfeksiyonları:** Haemophilus influenzae, Moraxella catarrhalis veya Streptococcus pneumoniae nın sebep olduğu kronik bronşitin akut bakteriyel alevlenmeleri; Mycoplasma pneumoniae veya Streptococcus pneumoniae nin sebep olduğu pnömoni. Staphylococcus aureus veya Streptococcus pyogenes e bağlı komplike olmayan deri ve yumuşak doku enfeksiyonları (abseler genellikle cerrahi drenaj gerektirir.) Klaritromisin, Mycobacterium avium veya Mycobacterium intracellulare ya bağlı yaygın veya lokal mikobakteriyel enfeksiyonların ve Mycobacterium chelonae, Mycobacterium fortuitum ve Mycobacterium kansasii ye bağlı lokal enfeksiyonların tedavisinde etkilidir. Klaritromisin, duodenal ülserli hastalarda asit supresyonunun varlığında (bir proton pompa inhibitör ile birlikte kullanılması durumunda) H.pylori eradikasyonu için endikedir. **KONTRENDİKASYONLARI:** Klaritromisin; makrolid antibiyotiklere karşı aşırı duyarlılığı olan hastalarda kontrendikedir. Klaritromisin, sisaprid ve timozid gibi ilaçlarla beraber kullanılmamalıdır. **YAN ETKİLER / ADVERS ETKİLER:** Klinik çalışmalarda gözlenen yan etkilerin çoğunluğu hafif ve geçici türde olup, klasik makrolidlere göre gastrointestinal yan etkilere daha az rastlanmaktadır. İlaca bağlı yan etkilerden dolayı tedaviyi bırakan hastalar %3'den daha azdır. Gözlenen yan etkilerin çoğu gastroentestinal sistemle ilgili olup diyare, kusma, abdominal ağrı, dispepsi ve bulantıdır **KULLANIM ŞEKLİ VE DOZ:** Doktor tarafından başka bir şekilde önerilmediği taktirde Yetişkinlerde; Üst Solunum Yolu Enfeksiyonlarında günde iki kez 250-500 mg 10-14 gün tedavi süresince, Alt Solunum Yolları Enfeksiyonlarında günde iki kez 250-500 mg 7-14 gün tedavi süresince, komplike olmayan Deri ve Yumuşak Doku Enfeksiyonlarında günde iki kez 250 mg 7-14 gün tedavi süresince kullanılabilir. **TİCARİ TAKDİM ŞEKLİ VE AMBALAJ MUHTEVASI:** 250-500 mg 14 film tablet, 125 mg/5 ml 70 ml süspansiyon, 250 mg/5 ml 50 ml süspansiyon. **SAKLAMA KOŞULLARI:** 30 °C altında oda sıcaklığında, nemsiz bir yerde ışıktan koruyarak saklayınız. REÇETELİ SATILIR. -Doktorlara danışmadan kullanılmamalıdır. -Kullanmadan önce prospektüsü okuyunuz. -Çocukların ulaşamayacakları yerlerde ve ambalajında saklayınız. **Ruhsat Tarihi-No:18.08.1997-184/35-36** Macrol 250 mg Tablet Perakende Satış Fiyatı: 10.159.000 -TL, Macrol 500 mg Tablet Perakende Satış Fiyatı: 20.316.000 -TL. Macrol 125 mg/5ml 70ml Süspansiyon Perakende Satış Fiyatı: 7.522.000 - TL, Macrol 250 mg/5ml 50ml Süspansiyon Perakende Satış Fiyatı: 8.646.000 - TL. (KDV Dahil Ocak 2001) **Ruhsat Sahibi ve İmal Yeri: SANOVEL İLAÇ SAN. VE TİC. A.Ş.** Kazım Orbay Cad. No: 98 Şişli / İSTANBUL

FEXOFEN

TÜM ALLERJENLER

TEK NOKTADA BİRLEŞİRSE TEK ÇÖZÜM

- **Allerjik Rinit**
- **Kronik İdyopatik Ürtiker**
- **Diğer Allerjik Rahatsızlıklar**

FEXOFEN 120 mg ve 180 mg FİLM TABLET
FORMÜLÜ: Her film tablet 120 mg ve 180 mg Feksofenadin HCl içerir.Boyar maddeler: Kırmızı demir oksit, titanyum dioksit. FARMAKOLOJİK ÖZELLİKLERİ: Feksofenadin yüksek emniyet profiline sahip spesifik etkili bir Histamin-H1 reseptör antagonistidir. Etkisini selektif olarak periferal H1 reseptörlerini bloke ederek gösterir. Tedavi dozlarında antikolinerjik, antidopaminerjik, 1-adrenerjik reseptörler üzerinde bloke edici etkileri yoktur. Miyokardiyal hücrelerde potasyum kanalını bloke etmediği için tavsiye edilen tedavi dozlarının üstünde bile QT aralığı uzaması ve kardiyak aritmi gibi kardiyotoksik etkilere yol açmaz. Feksofenadin kan-beyin bariyerini geçemediğinden dolayı, santral sinir sistemindeki H1 reseptörleri ile etkileşmez. Feksofenadin oral olarak alındıktan sonra gastrointestinal sistemden hızla absorbe olur ve yaklaşık 2.6 saat içinde doruk plazma konsantrasyonlarına ulaşır. SSağlıklı gönüllülerde günde 2 defa 60 mg'lik oral dozun uygulanmasını takiben denge düzeyindeki ortalama eliminasyon yarılanma ömrü yaklaşık 14.4 saattir. Yaşlılarda (>65) eliminasyon yarılanma ömrü değişmemektedir. Feksofenadin %60-70 oranında plazma proteinlerine bağlanır. Tek oral dozun yaklaşık %5'i metabolize edilir. Bir oral dozun yaklaşık %80'i feçes ile %11'i ise idrarla vücuttan atılır. ENDİKASYONLARI: Fexofen 120 mg, mevsimsel allerjik rinitin semptomatik tedavisinde endikedir. Fexofen 180 mg, kronik idiopatik ürtikerin semptomatik tedavisinde endikedir. KONTRENDİKASYONLARI: Feksofenadin'e veya yardımcı maddelerden herhangi birine karşı aşırı duyarlılığı olan hastalarda kontrendikedir. UYARILAR/ÖNLEMLER:12 yaşından küçük çocuklarda Feksofenadin'in kullanımına dair etkinlik ve emniyeti henüz saptanamamıştır. Hepatik ve renal yetmezlik durumlarında ve yaşlılarda (65 yaş üstü) herhangi bir doz ayarlaması gerekli değildir.Araç ve makine kullanımı üzerindeki etkileri: Farmakodinamik profil ve bildirilen advers etkiler bazında, Feksofenadin'in araç ve makine kullanma yeteneği üzerinde herhangi bir etki oluşturması beklenmez.Gebelik ve laktasyonda kullanımı: Feksofenadin'in ve emziren annelerde etki ve emniyetine adır çalışmalar yetersizdir. Bu nedenle ancak doktorun zorunlu gördüğü hallerde, fayda ve zarar değerlendirmesi yapıldıktan sonra kullanılabilir. YAN ETKİLER / ADVERS ETKİLER: Tedavi dozlarında yapılan kontrollü klinik çalışmalarda gözlenen yan etkiler hafif şiddette ve geçici olup, plasebo verilen hastalarda gözlenen yan etkilerden farklı bulunmamıştır. BEKLENMEYEN BİR ETKİ GÖRÜLDÜĞÜNDE DOKTORUNUZA BAŞVURUNUZ. İLAÇ ETKİLEŞİMLERİ: Antasitler: Feksofenadin in etkinliğini değiştirebilir. Bu nedenle aluminyum hidroksit veya magnezyum hidroksit içeren antasitler alındıktan 2 saat sonra feksofenadin alınmalıdır. KULLANIM ŞEKLİ VE DOZU: Doktor tarafından başka şekilde önerilmediği takdirde:Erişkinlerde ve 12 yaşın üstündeki çocuklarda tavsiye edilen doz; Günde 1 defa (Tercihan sabahları) 120-180 mg'dır. DOZ AŞIMI VE TEDAVİSİ: Herhangi bir aşırı doz durumunda semptomatik ve destekleyici tedavi uygulanmalıdır. Hemodiyaliz Feksofenadin'in kandan uzaklaştırılmasında etkili değildir. SAKLAMA KOŞULLARI: 30 C'nin altındaki oda sıcaklığında saklayınız. TİCARİ TAKDİM ŞEKLİ VE AMBALAJ MUHTEVASI:10 film tabletlik blister ambalajlarda. REÇETE İLE SATILIR.

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