Correspondence

Disclosure of cancer diagnosis and stress in women physicians

Many thanks for the April-June 2003 issue of Pakistan Journal of Medical Sciences. The same has been forwarded to HEC Library. The article on Disclosure of cancer diagnosis was great. The same was the stress in Women by Dr. Niaz because they are particularly related to my field. However regarding the later I could not find if there were any results that were significant statistically (because t test was applied). Similarly the practice setting reported by most of the participants as “other institutions” was unclear and not interpreted through Table-I. Similarly in the discussion it may not be justified to conclude that the level of stress is low among house officers because they are unmarried and had no stress of demand of in-laws unless it was specifically asked. (We all have our own demands which drive us crazy). Perhaps if respondents have been asked the number of places they are practicing it would have yielded more information than number of children.

Anyway letter from experts like Dr. Rehan actually shows that Pakistan Journal of Medical Sciences is widely read by true academics.

References


This refers to the above mentioned research paper published in your journal. It is about the effect of iodized salt on goiter prevalence in a formally endemic area and the situation of iodine deficiency in 1996-1997. The presentation of data and conclusions drawn by the authors are not consistent and need revision. For example:

1. Iodine deficiency in the study subjects was determined by two indices according to authors i.e. urinary iodine levels and urinary iodine/creatinine ratio. The fact is that prevalence of goiter and the urinary iodine excretion are two important indicators of iodine nutrition in a community. Urinary iodine levels were expressed per gram of creatinine excretion in the past. The determination of creatinine was used only as a correction factor not as an independent index. But now it is obsolete. It is because studies have indicated that the creatinine level is variable depending on the general nutritional status of the population. This contributes an impendent source of variation, which invalidates the iodine/creatinine ratio. Moreover, urine creatinine decomposes after three days without refrigeration whereas urinary iodine remains stable for months. Simple determination of urinary iodine is recognized as the best indicator of iodine nutrition in a community.

2. Table-II showed that with the introduction of iodized salt prevalence of goiter drastically reduced in all age groups and at the time of study goiter prevalence was 25%. According to recommendations of WHO, UNICEF and International Council for the
Control of Iodine Deficiency Disorders (ICCIDD), iodine deficiency is indicated by prevalence of more than 5% of clinically detectable goiter\(^1\). A goiter prevalence of 20-29.9% in school-aged children indicates moderate iodine deficiency\(^2\). It means study group was moderately iodine deficient according to this criteria. It would have been much appropriate if this conclusion is confirmed by determination of urinary iodine excretion in all or randomly selected study subjects. But the authors have determined urinary iodine in goiterous subjects only. Therefore, the status of iodine nutrition according to urinary iodine criteria is not understandable nor it is mentioned that findings of both indicators support each other or otherwise.

3. The recommended amount of iodine is 150 µg/day for adults\(^7\). About 90% of iodine is eventually excreted in the urine. Recommendations by international organizations like WHO/UNICEF/ICCIDD set 100 µg/l (10µg/dl) as the minimal urinary iodine excretion for iodine sufficiency; this figure corresponds roughly to a daily intake of 150µg iodine\(^8\). Urinary iodide excretion data classified in Table-IV is also not correct. The cut off levels of urinary iodide used in this Table for IDD grading are not according to internationally accepted levels endorsed by international organizations. The recommended cut off levels are >10 µg/dl, 5.0-9.9 µg/dl, 2.0-4.9 µg/dl and <2.0 µg/dl urinary iodide respectively for non, mild, moderate and severe IDD\(^4,5,6\). If this criterion is applied, all goiterous subjects are iodine deficient. According to Table-IV 95.3% study subjects have no IDD albeit goiterous!

4. Authors have mentioned the relation between goiter prevalence rate and economic status of districts but detail is missing.

Reference

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Diagnostic Role of Barium Enema in Carcinoma Rectum

I read this article in Pakistan Journal of Medical Sciences Vol. 19 No. 2 and found very challenging data and conclusions.

In this article, I was unable to find the prevalence of colorectal cancer in Pakistan. I don’t think the colorectal cancer is second common cancer in Pakistan and using western database will only overestimate the disease. I assume this is because genetic predisposition and dietary habit is different in East and West.

Interestingly, of 165 patients 24 have colorectal cancer, 13 of which have rectal carcinoma. If you add 13 and 24 that becomes 37 but you said only 35 have colorectal cancer so where are other two gone? Furthermore, you diagnosed more rectal than colonic cancers.
with barium? That is completely opposite to present evidence which suggest colonic cancer are far more than rectal.

The age in male patients vary from 25-80 and female 35-55. Why you screen patient age as young as 25? The chance of having rectal cancer below 50 in both sexes are slim and surely does not warrant screening. Similarly, there were no female above 55. Do you realize that you are leaving most high-risk female group patients? You didn’t mentioned in 24 colonic tumors what were the distributions of tumor in different part of colon and neither you commented on distribution within rectum?

The best diagnostic tool is proved to be colonoscopy in screening group. The cost and expertise in colonscopy remain a challenge even for western countries. In a National colorectal cancer screening in UK only patients found to be FOB +ve are undergoing colonoscopy. There is now strong evidence to support that symptoms are poor indicator of colorectal pathology.

In our experience, flexible sigmoidoscopy remains the best diagnostic tool for screening, particularly in rectal carcinoma. Two-third of the colorectal cancer are found in the left sided colon and by using flexible sigmoidoscopy, one can will visualize left sided colon and have biopsy of the suspicious lesion at the same time. However, barium enema will be helpful in screening whole of colon for metachronus tumor and in some center it is part of the pre-operative investigation although CT may be more helpful.

In this article, I haven’t seen any statistical analysis or p value etc. There was no power size calculation? In summary I regret to say that conclusions are untrue and it is sending a wrong impression to others. I appreciate if the author comments on these above points.

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Author’s Response: Thanks for forwarding me the comments on my papers by Dr. Shakil Ahmed. I am extremely grateful to the worthy reader for his guidance and valuable comments. Para wise reply to his observations is as under:

1. Colorectal cancer is the second common cancer in many parts of the world. The statement, quoted with a foreign reference is not specific to Pakistan where accurate data is not available.

2. Yes, 24 and 13 makes 37 instead of 35. This is a typing mistake, which was pointed out during proof reading before its final publication but somehow it could not be incorporated in the final text. As regards your question about splitting up these 37 patients and diagnoses of rectal and colonic cancers with barium, please read the first paragraph of “Results” which will, certainly, give complete and satisfactory answer to your query.

3. Yes, the age in male patients vary from 25-80 and female 35-55. This ranking was based on the actual age of 37 patients, investigated. So, the screening of patient age as young as 25 is not the self-orientation of author but the actual age, recorded. The distribution of tumor in different parts of colon and within rectum has also been mentioned in “Results”.

4. The author agreed and mentioned in “ conclusion” that the best diagnostic tool is colonoscopy in screening group. But, under the given scenario, least facilities for colonoscopy prevail in most parts of the country from technical and financial points of view. Colonoscopy is being practiced in a few resourceful/big cities of Pakistan. While, Barium enema is safe, accurate, cost-effective test for colo-rectal cancer (CRC) screening in both average and high risk patients, approved by the American Cancer Society (ACS) and Health Care Financing Administration (HCFA).
5. Symptoms of diseases have always been the first indicator of any medical problem; provide first-hand information for further investigations.

6. Frequencies and percentages were calculated and tabulated across respondents for comparison. This technique is as acceptable as other statistical tools.

7. Two reviewers had evaluated the manuscript and the text was finalized in the light of their observations. The conclusion, drawn, was based on actual findings and proper investigations.

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