

كتاب أرشيف البحوث

RESEARCH ARCHIVES

Prof. A Hadi Al Khalili

Compiled in 2022

This book is a collection of my research projects and ideas which I have documented during the difficult years of sanction on Iraq.

I hope it will benefit and inspire our young researchers and professionals. I apologize for documenting some of the contents as copies of the handwritten original.

Prof. Abdul Hadi Al Khalili

Washington,

2022

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إختبار (Trial) عقار الزوفيراكس (Zovirax) 1985

عبر تواصلني مع ممثل شركة شركة ولكم الدولية (Welcome International) الدكتور عادل العولقي، الذي كان يعمل معي طبيبا مقيما في مدينة ليدز البريطانية وهو من اليمن السعيد، استلمت عام 1985 من الشركة ما يزيد على المائتي جرعة مجانية من عقار الزوفيراكس لاستخدامه في علاج حالات التهاب الدماغ الفيروسي. أبلغت الزملاء الاختصاصيين في طب الاعصاب في مستشفى مدينة الطب بتوفر العقار الذي لم يتوفر في الاسواق المحلية في ذلك الوقت. كنت أجهزهم بالعقار حين الطلب مرفقا بالاستمارات الخاصة التي تعتمدها الشركة لتقييم نتائج العلاج على أن يرسلوها الى الشركة مباشرة.



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AAMA/sh

29th November 1985

Dr Abdul Hadi Khalili
P O Box 707
Baghdad
Iraq

c/o Mr M Buxton-Hoare

Dear Dr Khalili

I have pleasure in sending you case record forms for the encephalitis trial you are conducting. Please discuss with Martin, if you need any more and I shall photocopy them for you. In the meantime, enclosed please find half a dozen to start you off.

With regard to the CSF examination, the enclosed article by Skoldenbery and page 2 of the case record forms give excellent guidelines as to the methodology of what you need to look for in the CSF. I hope this will be sufficient for your purposes but do let me know if you need any further details. I wish you success with the trial and I hope to send you the artwork for the X-rays of the Moya moya disease as soon as they are in hand but I am afraid I have been having problems there, basically due to the fact that the definition of the vascular abnormalities are poor and you know what artists are like!

With the kindest of regards to you and yours.

Yours sincerely

Summa stillingpocasting

Dr A A M Aulqi
Medical Adviser

P.S. I have not forgotten about your computer.

Protocol for an Open Study of
Intravenous Freeze-dried Acyclovir - ZOVIRAX* -
in Herpes Simplex Encephalitis

Investigator:

Dr A Hadi Khalili

MEDICAL ADVISERS:

Dr A A M Aulagi

* Trade Mark

The clinical review at 3 months and 6 months will be accompanied, if possible, by a CT scan and psychometric assessment.

PROTOCOL FOR AN OPEN STUDY OF
INTRAVENOUS ACYCLOVIR
IN HERPES SIMPLEX ENCEPHALITIS

1.0 INTRODUCTION

1.1 Abstract

All patients (adults and children) considered to be suffering from herpes simplex encephalitis will be entered in the study.

1.2 Rationale

Encephalitis due to herpes simplex virus is a rare but serious disease with a mortality thought by some investigators to approach 70 per cent. Necrotizing lesions particularly affect the temporal lobe. Focal neurological signs are common and sequelae are to be expected in those who survive. They are often devastating. Treatment early in the disease, before brain damage has occurred, offers the only hope of a therapeutic advance. At the present time a definitive diagnosis in the early stages can only be made by brain biopsy, but serological techniques allow the diagnosis to be confirmed or refuted in convalescence. It is thus now possible to design a study in which treatment is started early in patients in whom brain biopsy might be considered unwarrantable.

Acyclovir is an antiviral compound which has been shown to have high activity, both in vitro and in vivo, against viruses of the herpes group (Schaeffer, B.J. *et al* 1978, Nature 272, 583-585). The drug confers a high specificity for infected cells as follows:

It enters virus infected cells preferentially.

It is phosphorylated to the active triple compound by virally coded thymidine kinase and as yet unidentified other enzymes.

HOSPITAL

INVESTIGATIONS

CT SCAN

EEG

SPECIAL X-RAYS

CSF EXAMINATION

DATES

CELLS No
Type

Protein

Sugar

Serology Ple
wit

Brain biopsy

Virology

Histology

TREATMENT PR

- 1 Dexamethasone
- 2 Other

ENCEPHALITIS RECORD SHEET

SURNAME _____	WEIGHT _____ (kg)
FIRST NAMES _____	HEIGHT _____ (cm)
DATE OF BIRTH _____	AGE _____ SEX _____
HOSPITAL _____	CLINICAL TRIALIST _____
ACV _____	ADMISSION DATE _____
	TRIAL NUMBER _____

Herpes Encephalitis

A past history of recurrent herpes?

Cold Sores	Yes/No
Genital	Yes/No

History of present illness:

(Please list the development with dates of major symptoms, admission to other hospital with name etc.)

Onset of neurological illness (Date _____)

Clinical examination and assessment:

Any other evidence of herpetic infection eg cold sores: _____

ENCEPHALITIS RECORD SHEET

SURNAME _____ WEIGHT _____ (kg)
FIRST NAMES _____ HEIGHT _____ (cm)
DATE OF BIRTH _____ AGE _____ SEX _____
HOSPITAL _____ CLINICAL TRIALIST _____
ACV _____ ADMISSION DATE _____
TRIAL NUMBER _____

Herpes Encephalitis

A past history of recurrent herpes?

Cold Sores	Yes/No
Genital	Yes/No

History of present illness:

(Please list the development with dates of major symptoms, admission to other hospital with name etc.)

Onset of neurological illness (Date _____)

Clinical examination and assessment:

Any other evidence of herpetic infection eg cold sores:

HOSPITAL

NAME

TRIAL NO

INVESTIGATIONS

CT SCAN

EEG

SPECIAL X-RAYS

CSF EXAMINATIONS

DATES					
CELLS No Type					
Protein					
Sugar					

Serology Please record antiherpes titres in the blood and CSF together with reference antibody.

Date	Herpes Serum/CSF	Reference (Specify) Serum/CSF		

Brain biopsy Was a brain biopsy carried out? Yes/No DATE
If yes, please record.

Virology - Electron microscopy Not done/positive/negative
- Immuno-fluor Not done/positive/negative
- Culture Not done/positive/negative

Histology

TREATMENT PRIOR TO ADMISSION TO TRIAL CENTRE

- 1 Dexamethasone
- 2 Other

HOSPITAL

NAME
TRIAL NO.

PROGRESS SUMMARY (Day 1-21)

DAY 22 ONWARDS

Tick appropriate box
and describe

Date	Normal	Mild Sequelae*	Moderate Sequelae*	Severe Sequelae*	Dead
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL

PHYSICAL

CONDITION ON
DISCHARGE OR
TRANSFERRAL

Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL

PHYSICAL

Date of death

- * Mild Sequelae - some neurological deficit but independent and able to
- Moderate Sequelae - quality of life affected, unable to resume previous wo
- Severe Sequelae - grossly incapacitated - almost or totally dependent on others.



HOSPITAL

- 6 -

NAME

TRIAL NUMBER

Other drugs

Dose

Dates

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Any adverse effects

Other comments

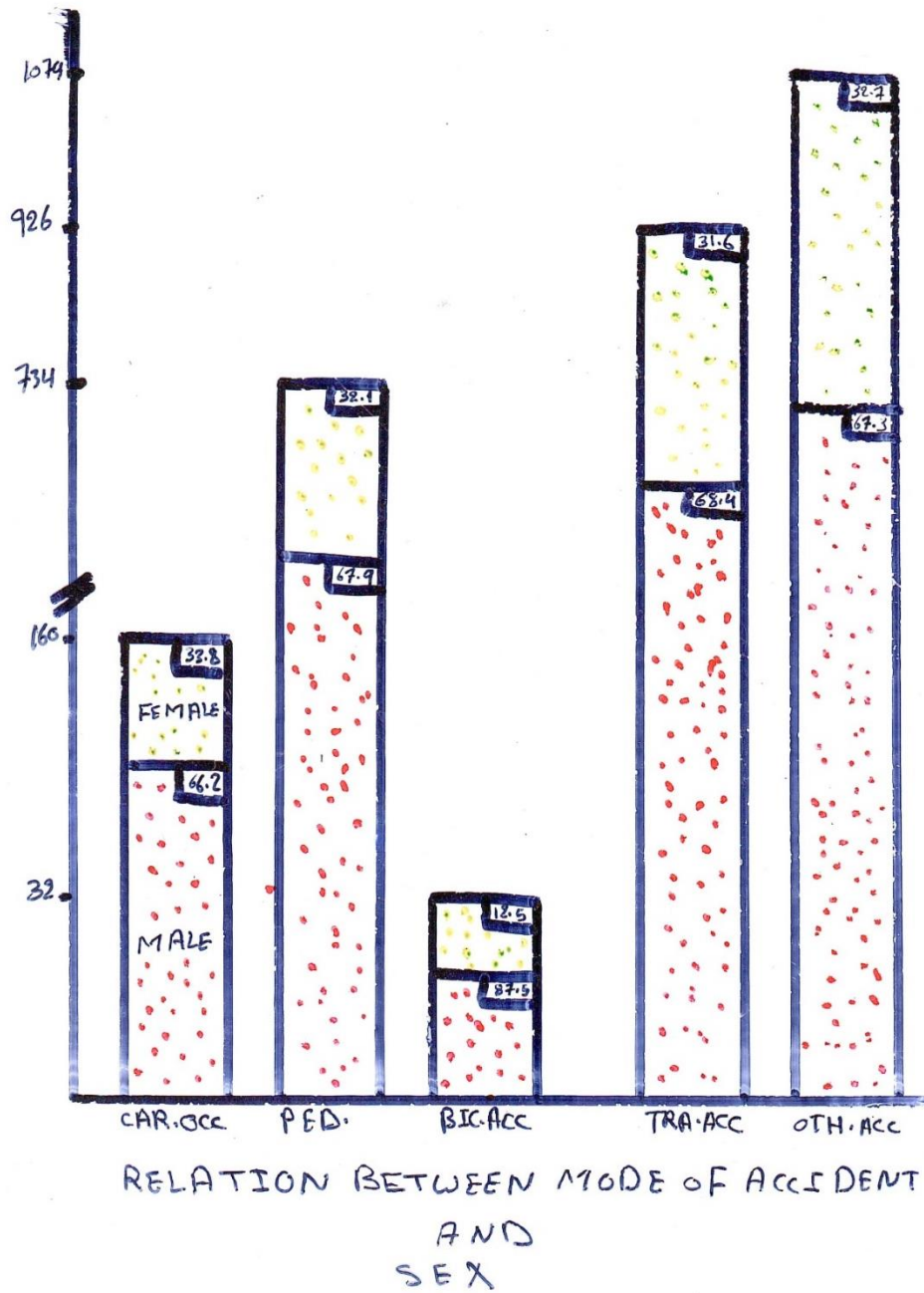
Signed

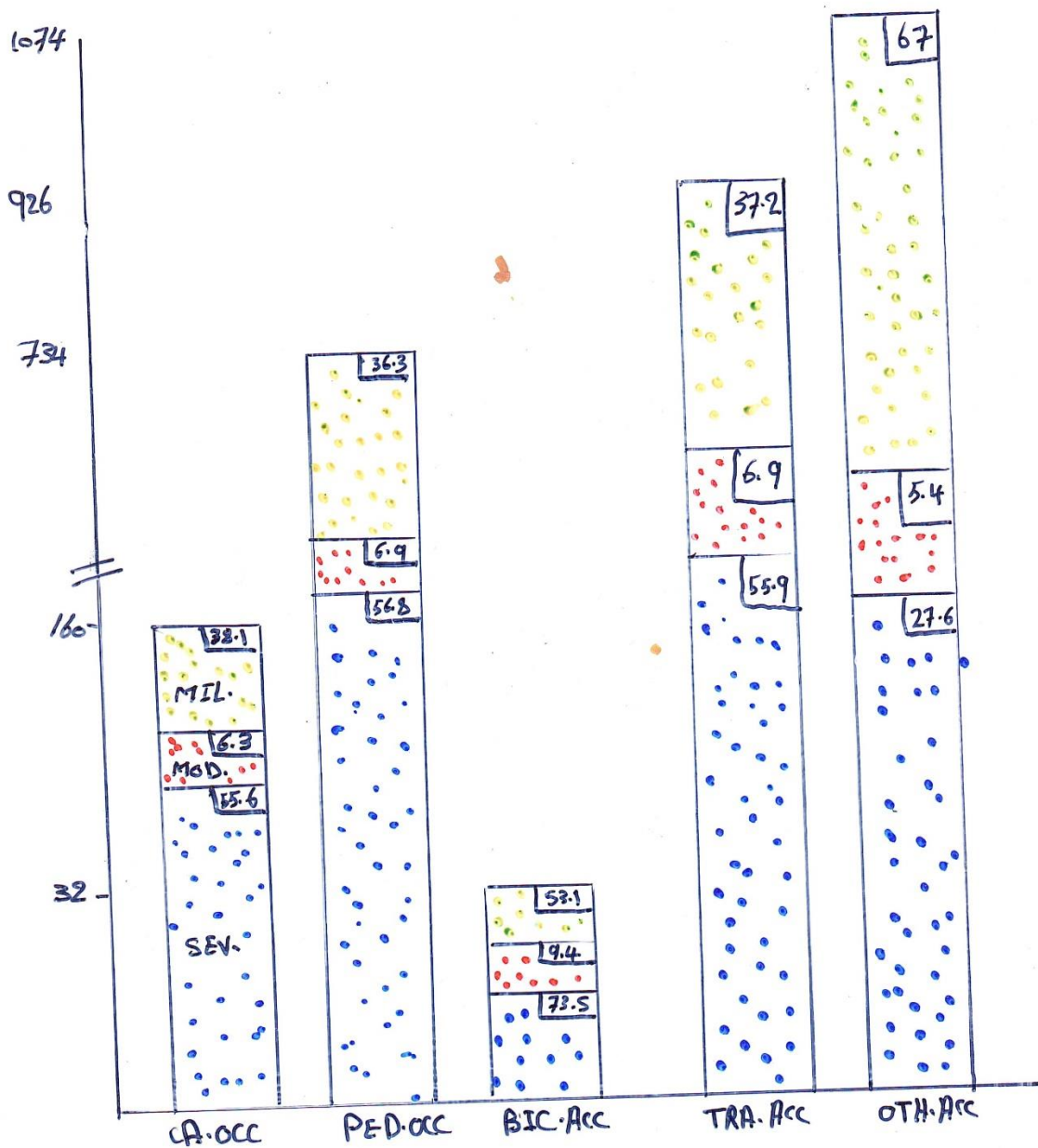
CLINICAL TRIALIST

If patient died - autopsy report with virology and neuro-histology

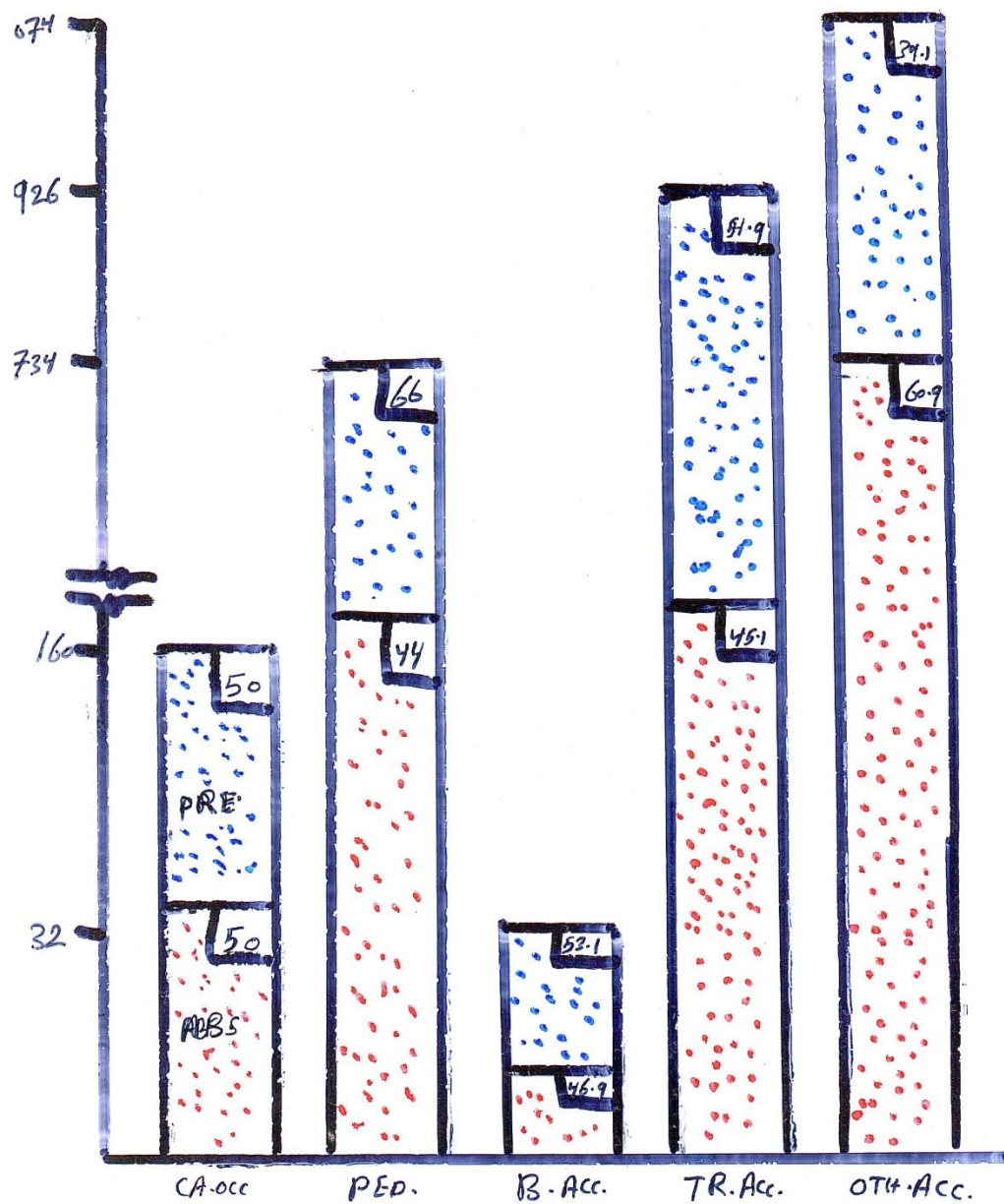
ADULT HEAD INJURY : (1074) PATIENTS

يوم العلم كلية طب جامعة بغداد 1987



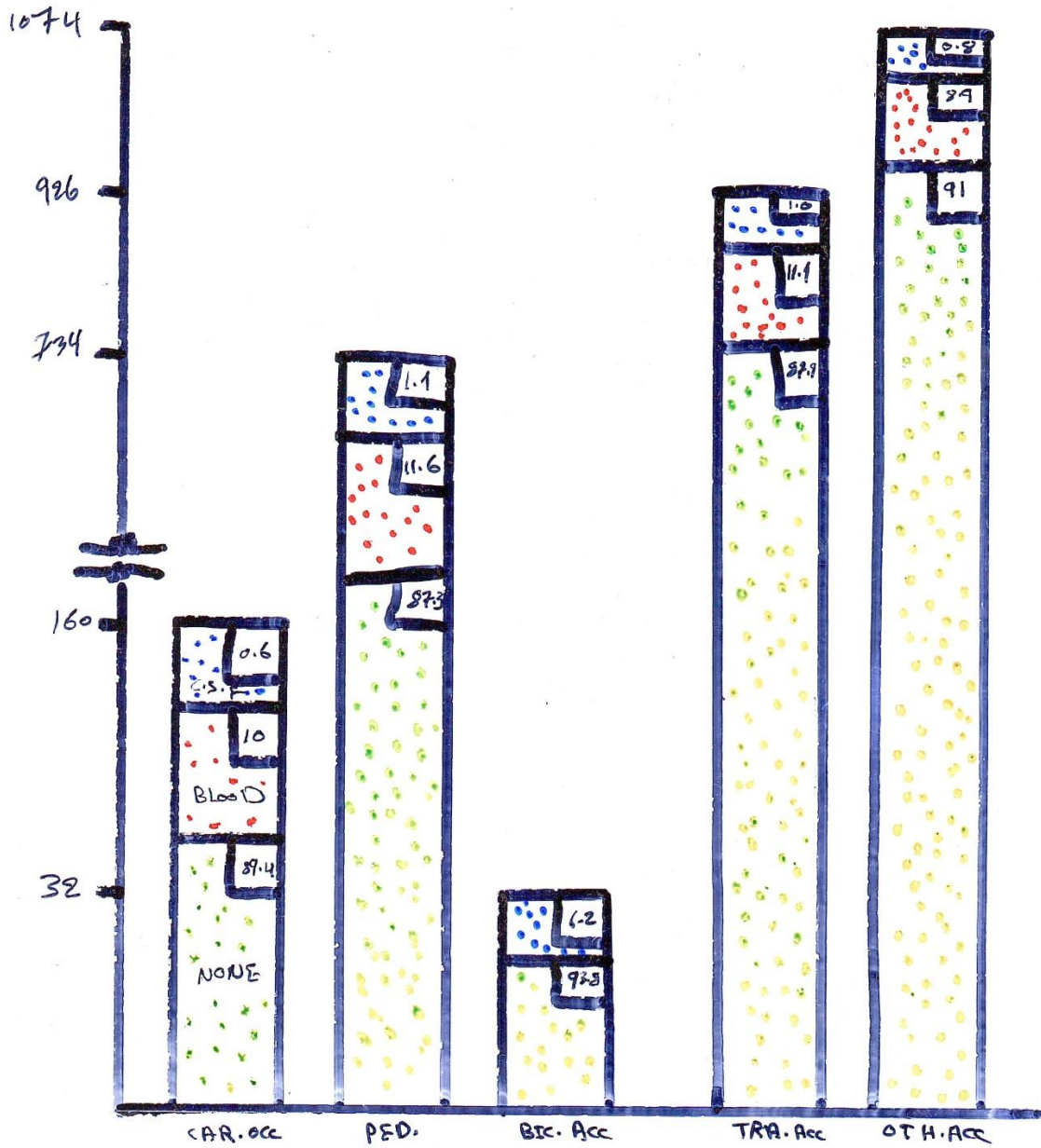


RELATION BETWEEN MODE OF ACCIDENT
AND
LEVEL OF RESPONSE

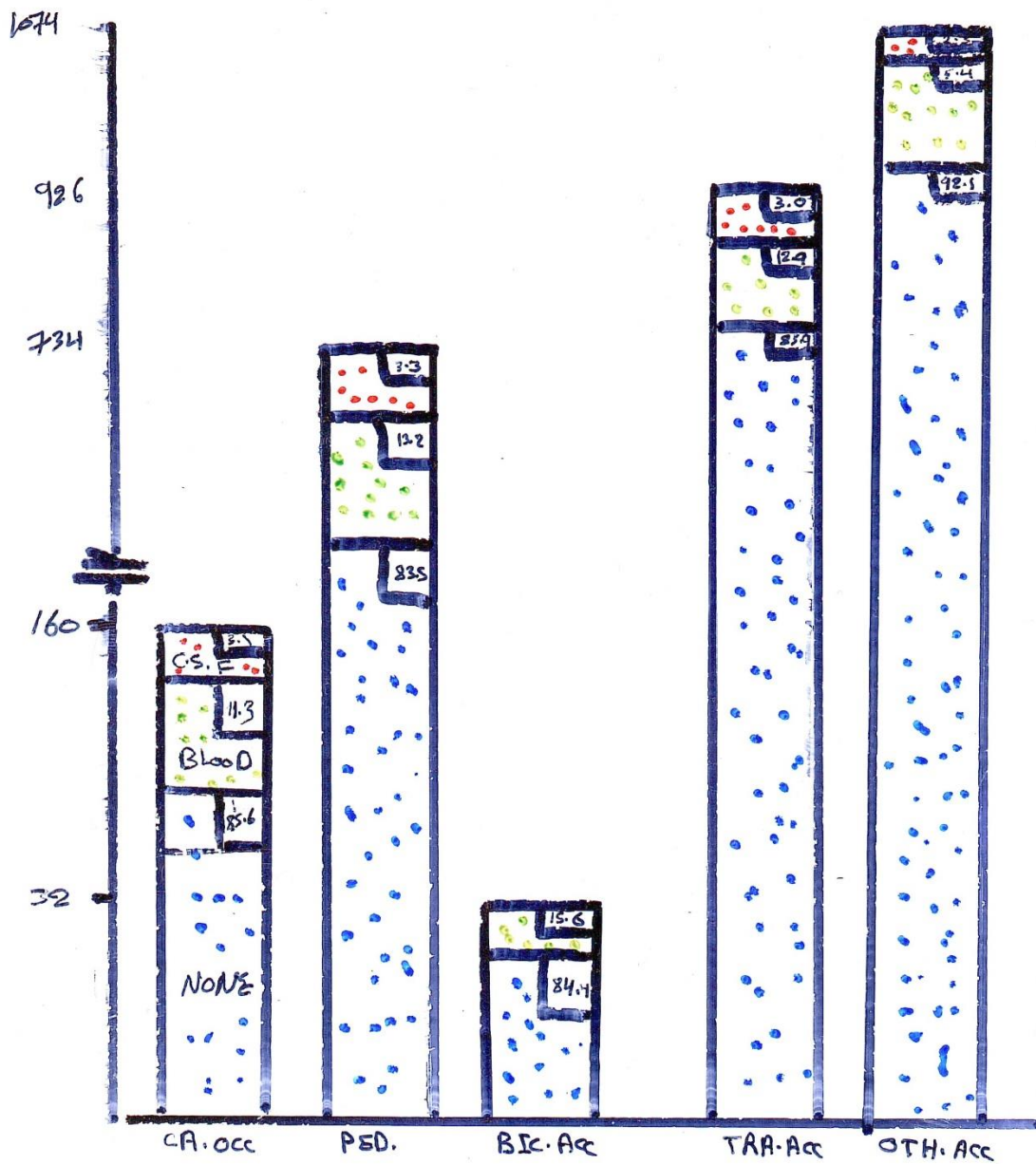


5.6

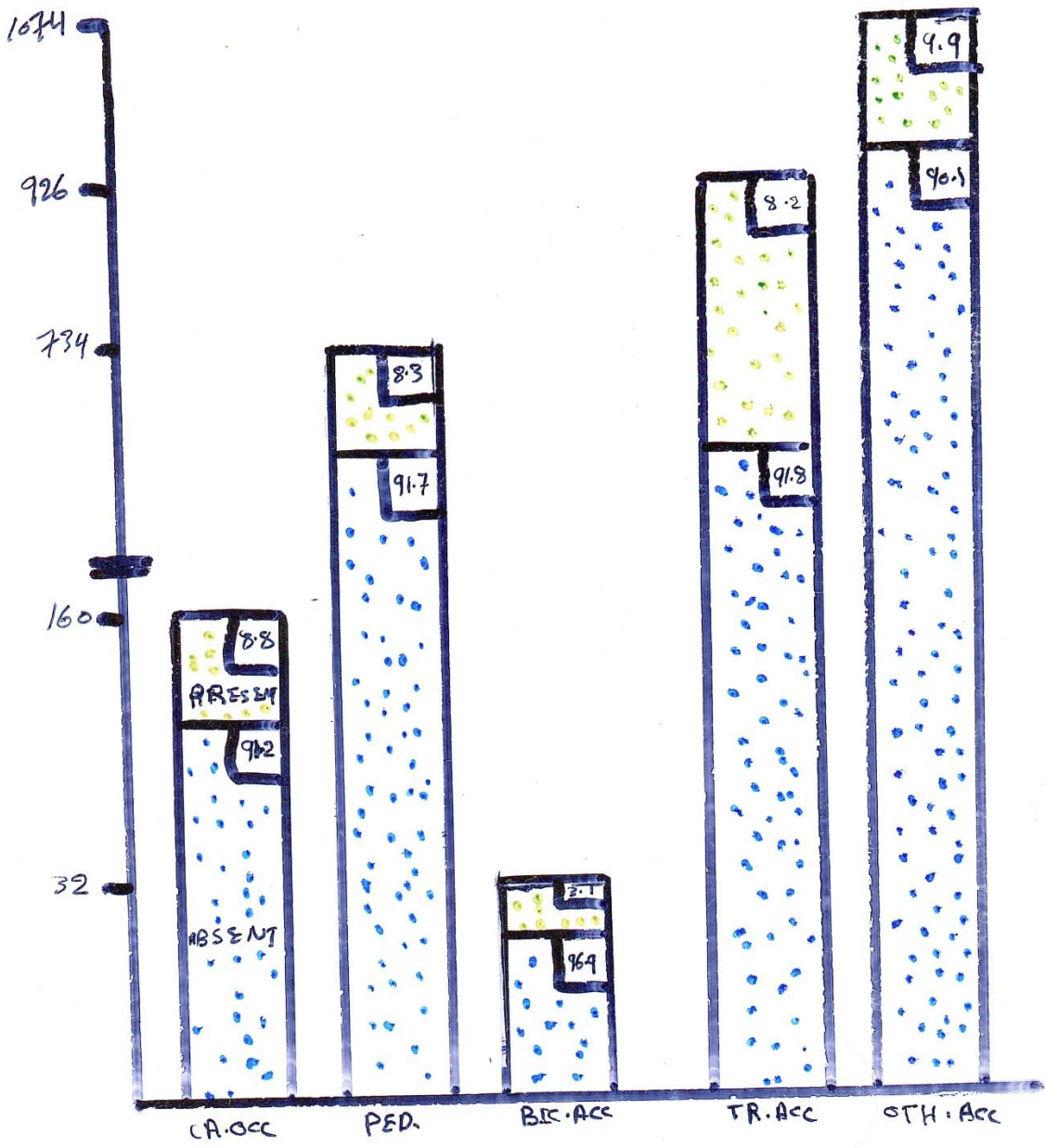
RELATION BETWEEN MODE OF ACCIDENT
 &
 SCALP INJURY



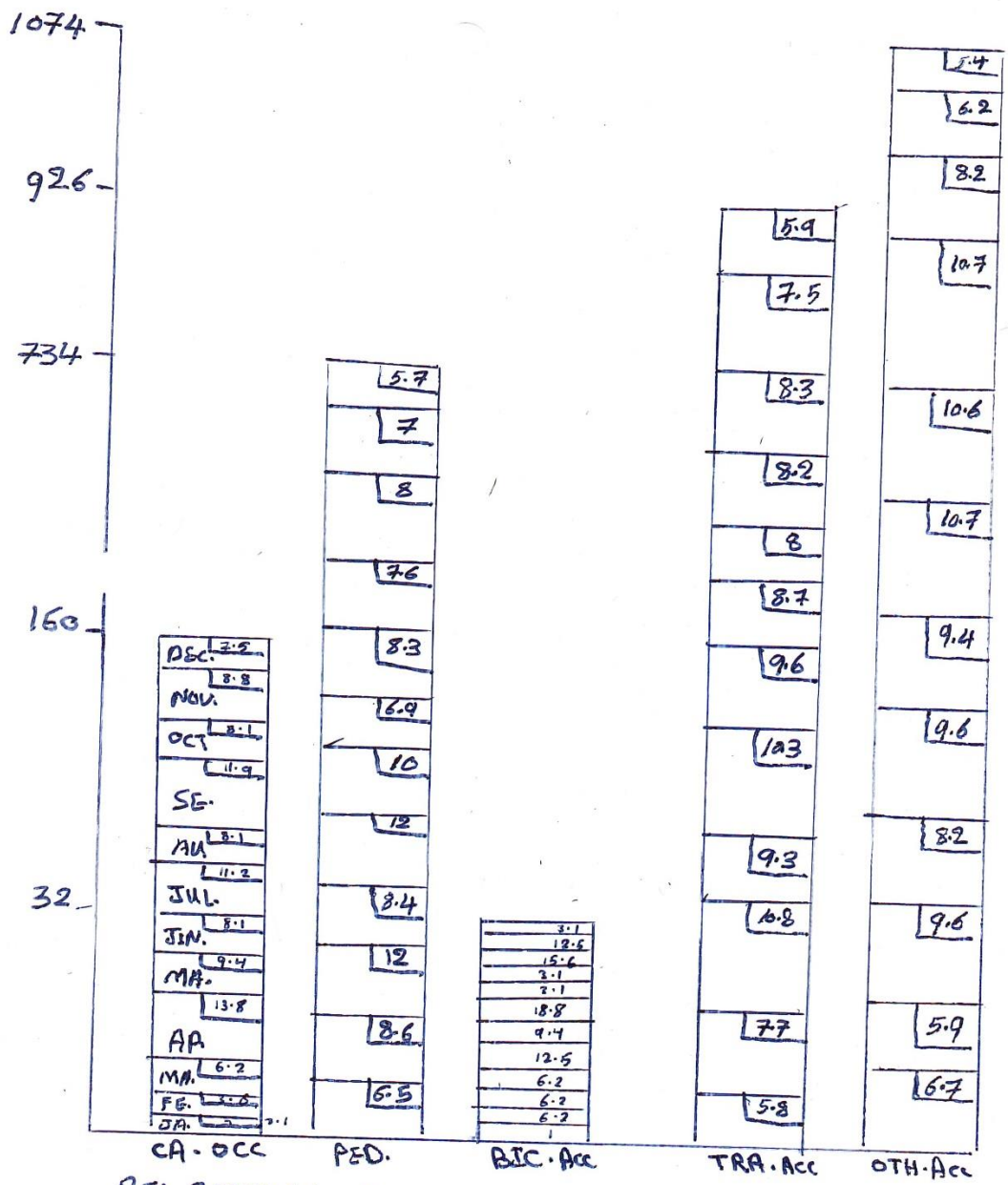
RELATION BETWEEN MODE OF ACCIDENT
AND
NOSE DISCHARGE



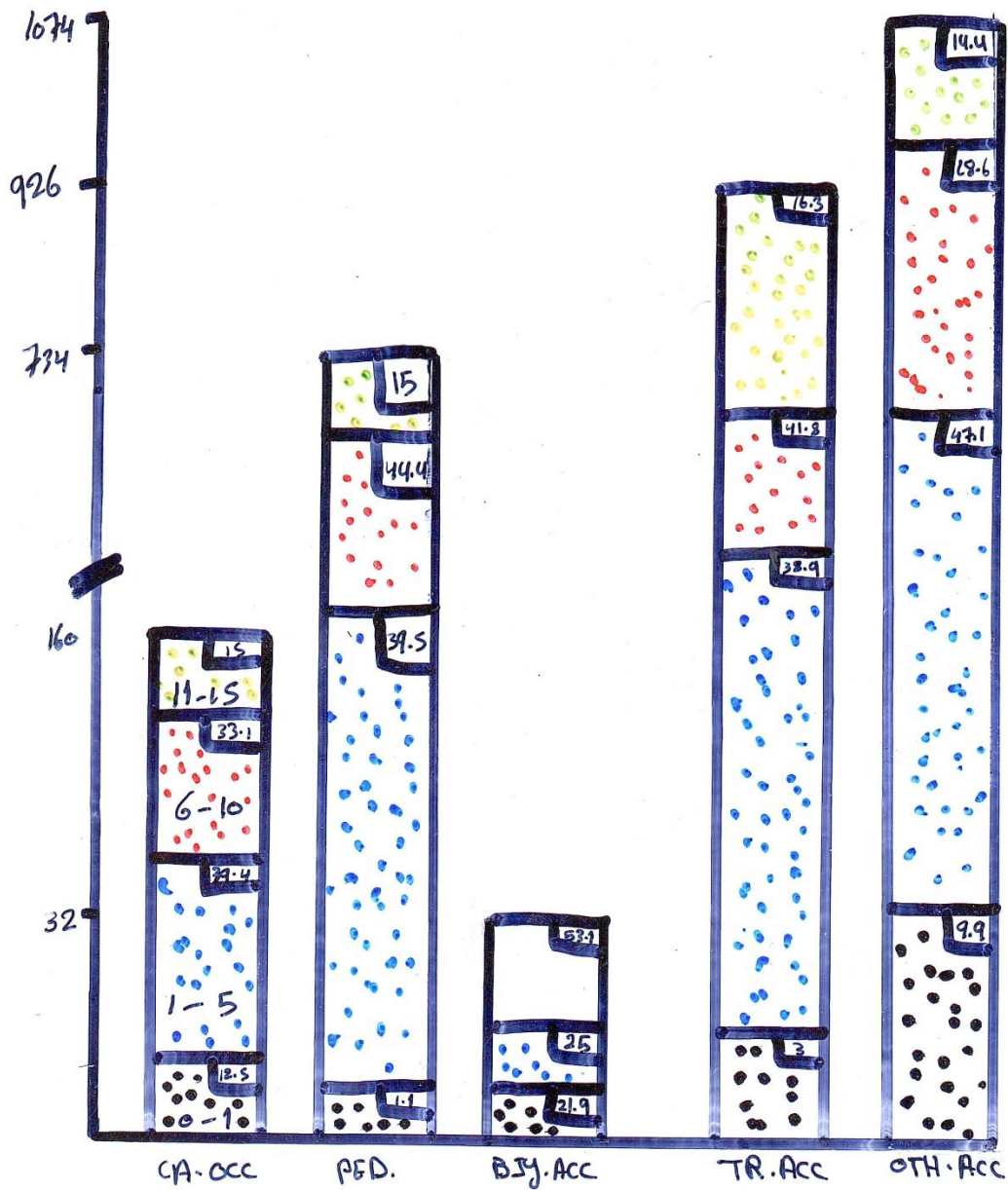
RELATION BETWEEN MODE OF ACCIDENT
AND
EAR DISCHARGE



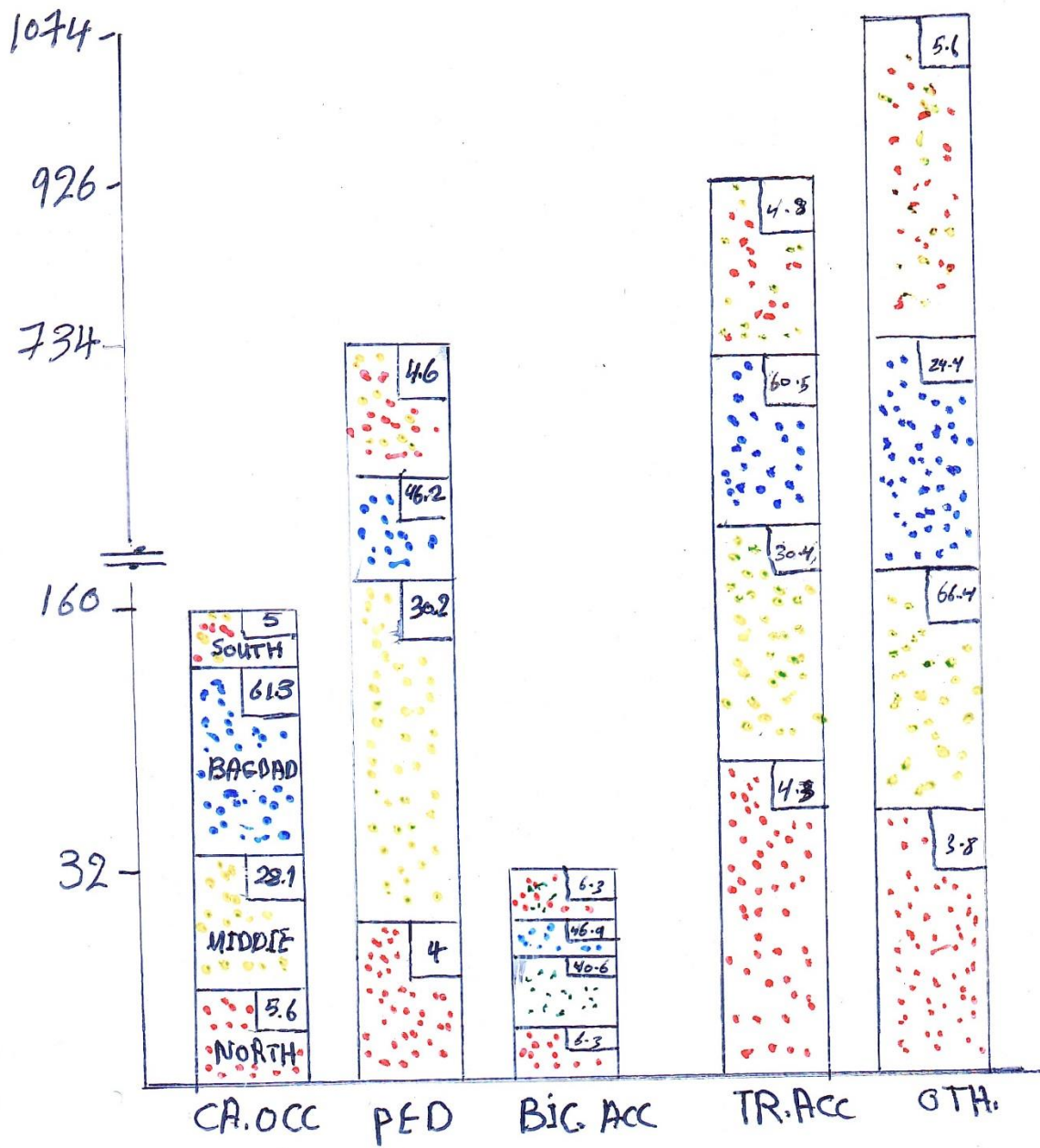
RELATION BETWEEN MODE OF ACCIDENT AND EPILEPSY



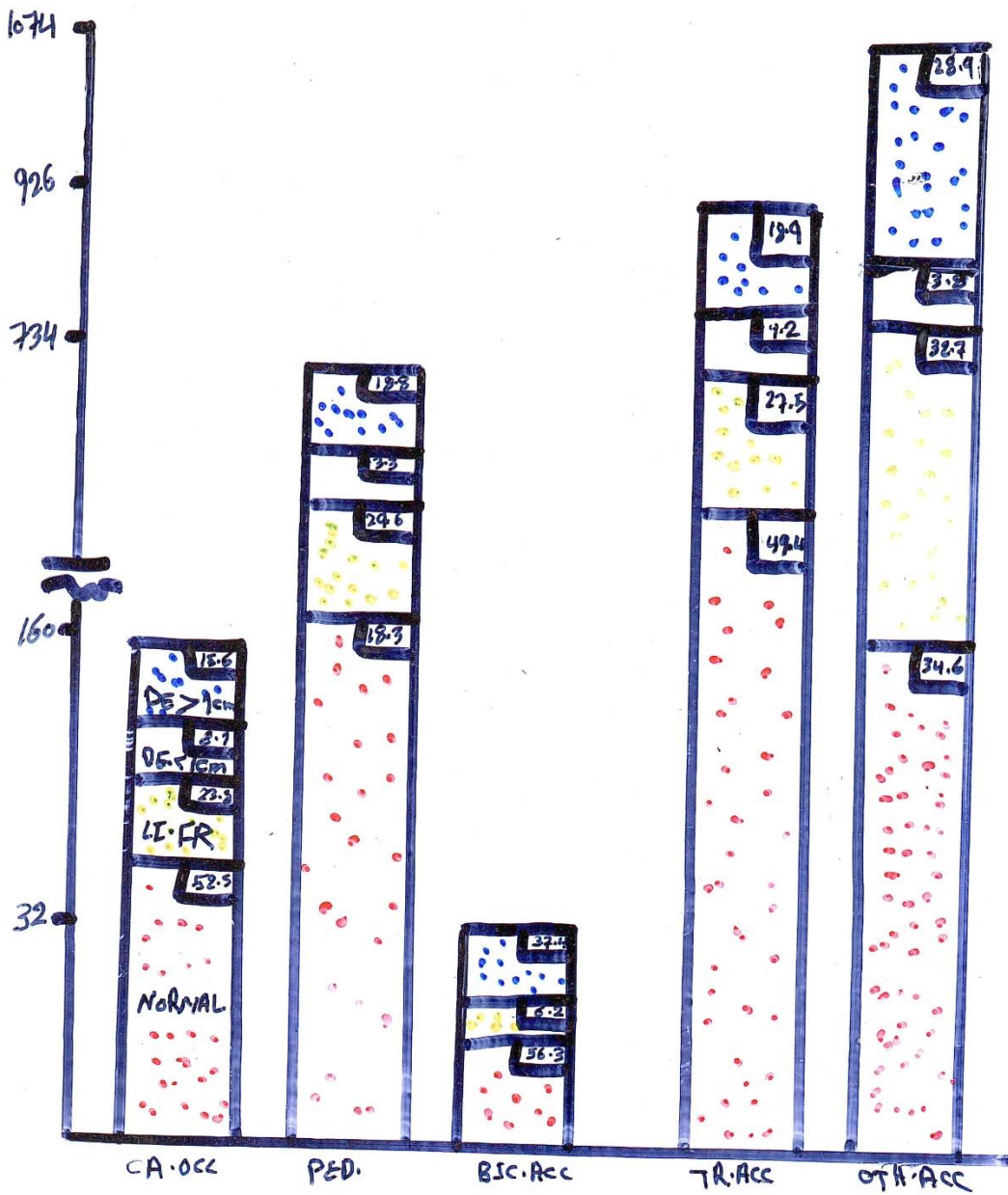
RELATION BETWEEN MODE OF ACCIDENT AND MONTHS



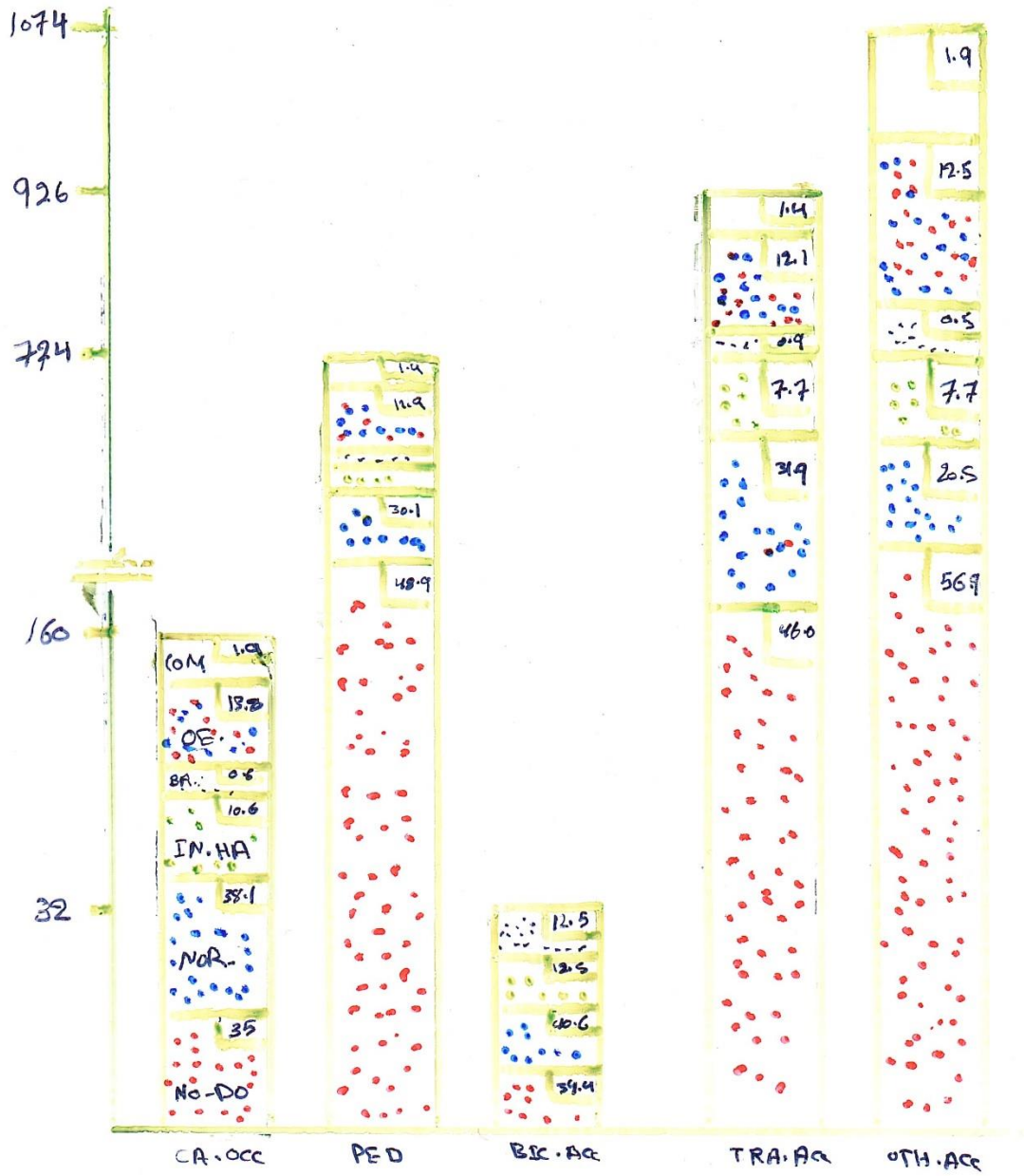
RELATION BETWEEN MODE OF ACCIDENT
AND
AGE



RELATION BETWEEN MODE OF ACCIDENT
AND
PROVINCES



RELATION BETWEEN MODE OF ACCIDENT
AND
SKULL X-RAY



RELATION BETWEEN MODE OF ACCIDENT AND CT-SCAN

CONCLUSION

- # MORE IN YOUNGER GROUP
- # DOESN'T RELATE TO SEVERITY
- # MORE IN ASSAULT & FALL

■ CSF LEAK SAME WITH #

■ CSF LEAK DOESN'T RELATE TO SEVERITY

■ EDH MORE WITH FALLS

■ IDH MORE WITH TRAFFIC

▨ EXTRACRANIAL INJURIES MORE WITH PEDESTRIAN

▨ DEATH MORE WITH #

▨ DEATH MORE WITH PEDESTRIAN

CONTINUATION SHEET.

SHEET No.

Aneurysm & Hypertension
1975

Does the presence of pre-existing
BP↑ constitute a significant risk
factor following ruptured intracranial
aneurysm? (circle of Willis)

1.

aneurysm	aneurysm
known BP↑	without BP↑
month of admission	
age	
sex	
size of aneurysm	
site of aneurysm	
operation or not	
multiplicity	
first or second (etc) bleed	
angiography and its complication	
Spasm	
Clinical BP	ECG
	LV++
	BP↑ before CP.
PM	

ANEURYSMS - INITIAL SYNTHESIS

64 fatal cases of subarachnoid haemorrhage due to ruptured berry aneurysms have been studied. A control group of non-fatal cases matched by age and sex will be available for direct comparison.

The major question to be answered on an analysis of these combined figures will be:- what are the prognostic factors separable as indicating a likely fatal outcome? At this stage it is expected that hypertension will constitute at least one such factor. On this basis the 64 cases have been divided into 18 hypertensive subjects, and 46 normo-tensive subjects. This gives an overall percentage of hypertension of 28.13%. There is no significant difference between male and females in this percentage. It is noted however that the incidence of hypertension between 40 and 59 is 36.36% in females, and 30.77% in males.

If hypertension does constitute a poor prognostic association it is necessary to consider the possible reasons for this association.

The distribution of aneurysms is different in hypertensive patients when compared to normo-tensive patients. There is a very much smaller percent (5.5% of middle cerebral aneurysms compared to 17% in normo-tensives). There is a correspondingly higher percentage of anterior communicating artery aneurysms (55% hypertensive, 39% normo-tensive). Anterior communicating artery aneurysms have a higher mortality ~~in~~ than other aneurysms, but the difference is in the region of 2% only from previous series.

The average size of aneurysms in hypertensive patients is 2 - 5 mms, compared to 5 - 10 mms in normo-tensive patients. The number of aneurysms greater than 10 cms. is very much smaller. Hypertensive patients (6.25%)

compared to normo-tensive patients (30%). This suggests that aneurysms in hypertensive patients ruptured at a smaller diameter, possibly due to early rupture. This latter suggestion is not borne out by examination of the average age at rupture, with hypertensives having an average age of 50 when compared to normo-tensives' average age of 45. It would therefore appear that the hypertensive patient is more likely to rupture an aneurysm when it is a smaller size than that of a normo-tensive patient. Hypertensive patients do not have a higher mortality because they do not survive to definitive surgery. 27% of hypertensive patients underwent definitive surgery compared in fact to only 19% of normo-tensive patients. The percentage of patients undergoing palliative surgery only (in the form of burr-hole exploration or haematoma evacuation) was 11% hypertensive, 17% normo-tensive.

Hypertensive patients have a 44% incidence of multiplicity compared to a 19% incidence of multiplicity in normo-tensive patients. The incidence of multiplicity ~~in normo-tensive patients. The incidence~~ is the same in male and female, and this appears to indicate a true difference.

Hypertensive patients have an 83% incidence of intracerebral haemorrhage compared to 74% in normo-tensive patients. Statistical analysis will be necessary to see these differences are real.

The incidence of distal ischaemic phenomena is 44% in hypertensive patients and 37% in normo-tensive patients. Again statistics will be necessary at this level. The incidence of pulmonary oedema is 40% in both hypertensive and normo-tensive patients.

Do hypertensive patients die more rapidly than normo-tensive patients? The answer to this is emphatically no, both groups having an average survival

from haemorrhage to death of 15 days.

Analysis of mortality related to number of bleeds provides interesting figures.

23.43% of patients succumb at the first bleed with an overall incidence of 53.3% intracerebral haemorrhage. A further 70.3% succumb at the second bleed with 82.2% having intracerebral bleeds. The remaining 6.25% succumb following third or subsequent bleeds with a 100% incidence of intracerebral haemorrhage.

A similar analysis of hypertensive patients indicates only 16% succumbing at a ~~fresh~~^{first} bleed with 33% intracerebral haemorrhage. 83% however succumb at second bleed with 93.3% having intracerebral haemorrhage. No hypertensive patients survived a second bleed. The overall incidence of intracerebral haemorrhage in hypertensive patients was 83.3% compared to 73.9% in normotensive patients. The comparable figure for all fatal cases is 76.56%.

It therefore appears that hypertensive patients have a low incidence of middle cerebral artery aneurysms, rupture their aneurysms at a smaller size, have a higher incidence of multiple aneurysms, and are unlikely to survive a second bleed. When their aneurysm does rupture it is more likely to rupture intracerebrally than in normotensive patients, but the latter also have a relatively high incidence of intracerebral bleeds. The hypertensive is just as likely to survive long enough to undergo definitive surgery, is no more at risk of developing pulmonary oedema, nor probably ischaemic changes. The average age of hypertensive patients appears to be slightly higher than normotensive but again this is probably not statistically significant.

The fact that rupture occurs at a ~~same~~ smaller size than hypertensive patients suggests that hypertension is a significant factor in aneurysm rupture, and the high percent of multiplicity indicates it to be an important factor ~~link~~ in development also. It is not immediately apparent from analysis of these figures just how hypertension achieves a higher mortality in subarachnoid haemorrhage. It will be important to compare the relative distribution of aneurysms in non-fatal cases to see whether the distribution changes in fatal cases represents a true biological difference or is an indicator of the mechanism of high ~~mortality~~ fatality viz high incidence of anterior communicating artery aneurysms in non-fatal hypertensive cases would indicate the high mortality to be due to aneurysm site rather than any intrinsic affect of hypertension. The low incidence of middle cerebral artery aneurysms is interesting but may indicate early natural selection in that Sarnar and Crawford have shown that patients with middle cerebral artery aneurysms are more likely to die rapidly and may therefore be selected out from a neurosurgical series.

ANEURYSM SURVEY

NAME:

UNIT NO:

1. Year
2. Month 1 - 12
3. Time of bleed
 1. 8am - 8pm
 2. 8pm - 8am
4. Age
 1. < 20
 2. 20 - 30
 3. 30 - 40
 4. 40 - 50
 5. 50 - 60
 6. 60 - 70
5. Sex
 1. Male
 2. Female
6. Size
 0. Not known
 1. < 2 mm.
 2. 2 - 5 mm.
 3. 5 - 10
 4. 10 - 20
 5. > 20
7. Site
 1. Ant. comm.
 2. Post. comm.
 3. Mid. cereb.
 4. Int. carotid
 5. Ant. cerebral
 6. Others (specify)
8. Operation
 - 0 - No
 - 1 - Yes
9. Type of operation
 1. Wrap
 2. Clip
 3. Others (specify)
10. Multiplicity
 - 0 - 1
 - 1 - 2
 - 2 - 3
 - 3 - 4
 - 4 - 5
 - 5 - 6
11. Complications (operative)
 0. None
 1. Rupture
 2. Oedema
 3. Temporary clip of feeding artery.
 4. Others (specify)
12. 1st or 2nd bleed
 1. 1st
 2. 2nd
 3. Others (specify)
13. Time of death from operation.
 1. < 24 hours
 2. 2 - 4 days
 3. 5 - 10 days
 4. Others (specify)
14. Angiography
 0. Not performed
 1. Carotid Unilateral
 2. Carotid Bilateral
 3. Vertebrals (specify)
 4. Both
15. Complications of Angiography
 0. None
 1. Aspiration
 2. Intramural injection
 3. Neurological deficit
 4. Others (specify)
16. Spasm
 - 0 None
 - 1 Mild
 - 2 Severe
17. Urea
 - 0 Normal
 - 1 2 x N
 - 2 3 x N
 - 3 3 x N
18. Electrolytes (Na)
 - 0 Normal 135 - 140
 - 1 Low 135
 - 2 Mod High 145 - 150
 - 3 Very High 15

19. Electrolytes (K)

- 0 Normal 3.5 - 4
- 1 3.5
- 2 4

20. ECG

- 0 Normal
- 1 LVH
- 2 Others (specify)

21. Diastolic Pressure (prior to admission.)

- 0 Not known
- 1 50
- 2 50 - 69
- 3 70 - 79
- 4 80 - 89
- 5 90 - 99
- 6 100 - 109
- 7 110 - 119
- 8 120 - 129
- 9 > 130

22. Systolic Pressure (prior to admission)

- 0 Not known
- 1 50
- 2 50 - 79
- 3 80 - 99
- 4 100 - 119
- 5 120 - 139
- 6 140 - 159
- 7 160 - 179
- 8 180 - 199
- 9 > 200

23. Systolic pressure on admission

- 0 Not known
- 1 50
- 2 50 - 69
- 3 70 - 79
- 4 80 - 89
- 5 90 - 99
- 6 100 - 109
- 7 110 - 119
- 8 120 - 129
- 9 > 130

24. Diastolic pressure on admission

- 0 Not known
- 1 50
- 2 50 - 79
- 3 80 - 99
- 4 100 - 119
- 5 120 - 139
- 6 140 - 159
- 7 160 - 179
- 8 180 - 199
- 9 > 200

25. Cardiomegaly

- 0 Not known
- 1 Absent
- 2 Present
- 3 Others (specify)

26. Previous Cardiovascular Disease

- 0 Nothing
- 1 Angina
- 2 Infarction
- 3 Claudication
- 4 Others (specify)

27. Other Diseases

- 0 None
- 1 Diabetes
- 2 Others (specify)

28. Medication

- 0 None
- 1 Antihypertensive
- 2 Mannitol
- 3 Dexamethazone
- 4 Mannitol and Dexamethazone

29. Outcome

- 1 Survival
- 2 Death

30. Autopsy

- 0 Not done
- 1 Done

31. Site

- 1 Ant. comm
- 2 Post. comm.
- 3 Mid cerebral
- 4 Int. carotid
- 5 Ant. cerebral
- 6 Others (specify)

32. Haemorrhage

- 1 Subarachnoid
- 2 Intracerebral
- 3 Both
- 4 Other (specify)

33. Multiplicity

- 0 - 1
- 1 - 2
- 2 - 3
- 3 - 4
- 4 - 5
- 5 - 6

34. 1st or 2nd bleed
- 0 Not known
 - 1 1st
 - 2 2nd
 - 3 Others (specify)
35. Distal phenomena
- 0 None
 - 1 Infarct (parent artery distribution)
 - 2 Others (specify)
36. Carotids
- 0 Not known
 - 1 Normal
 - 2 Angiography trauma
 - 3 Atheroma Mild
 - 4 Atheroma Mod
 - 5 Atheroma Severe
 - 6 Others (specify)
37. Heart Weight
- 0 Not known
 - 1 200 - 249
 - 2 250 - 299
 - 3 300 - 349
 - 4 350 - 399
 - 5 400 - 449
 - 6 450 - 499
 - 7 > 500
38. L.V. Thickness
- 0 Not known
 - 1 1 - 1.5
 - 2 1.6 - 2.0
 - 3 2.1 - 2.5
 - 4 > 2.5
39. Coronary Arteries
- 0 Not known
 - 1 Normal
 - 2 Atheroma - mild
 - 3 Atheroma - mod
 - 4 Atheroma - severe
 - 5 Thombosis
40. Ischaemia (heart)
- 0 Not known
 - 1 Normal
 - 2 Old
 - 3 Recent
 - 4 Microscopic
41. Kidney weight (right)
- 0 Not known
 - 1 0 - 50
 - 2 51 - 100
 - 3 101 - 150
 - 4 151 - 200
 - 5 > 200
42. Kidney weight (left)
- 0 Not known
 - 1 0 - 50
 - 2 51 - 100
 - 3 101 - 150
 - 4 151 - 200
 - 5 > 200
43. Renal histology
- 0 Not known
 - 1 Normal
 - 2 Arteriolar hyaline
 - 3 Nephrosclerosis
 - 4 Arterial intimal hyperplasia
 - 5 Others (specify)
44. Other findings
- 1 Coarctation
 - 2 Polycystic kidneys
 - 3 Pulmonary oedema
 - 4 Pulmonary haemorrhage
 - 5 Pneumonia
 - 6 Others (specify)

CONTINUATION SHEET.

Name

U N.

SHEET No.

Time of bleed

Year

month

eye

Sex

SI

Size

SI

op

multiplicity

type

~~operational~~ complication

Bleed

post

nasal

Time of death in relation to op

angiography

SI

ES

complications

specimen

ECC

BPT

prior to admission

BP at admission

EV

clinical

Previous cardiovascular disease

other disease

Medications

POI

SI of heart

ES

multiplicity

First or second bleed

Distal phenomenon

Carotid artery

Heart

Carotid

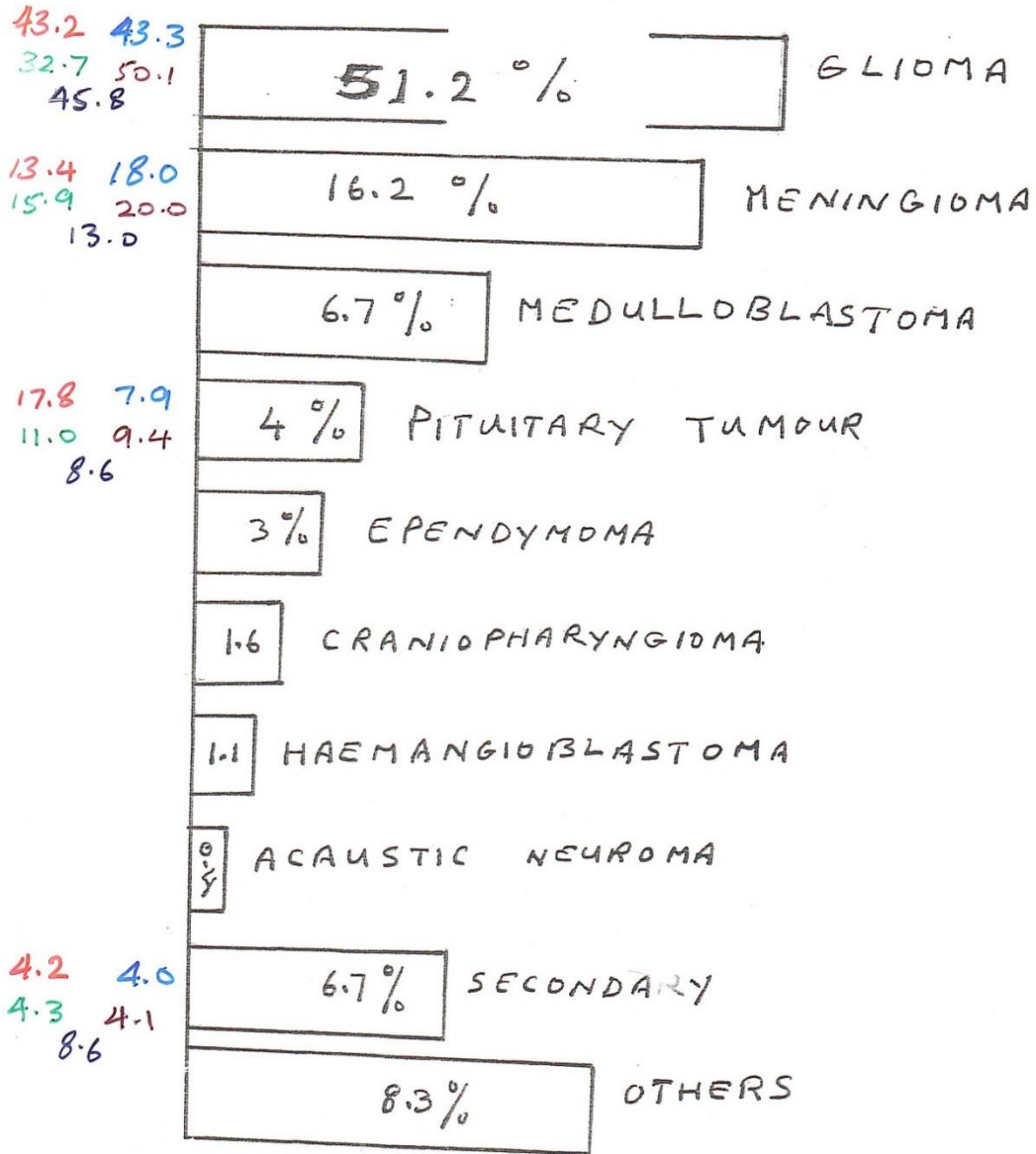
LV

ischemia (no infarct)

Kid

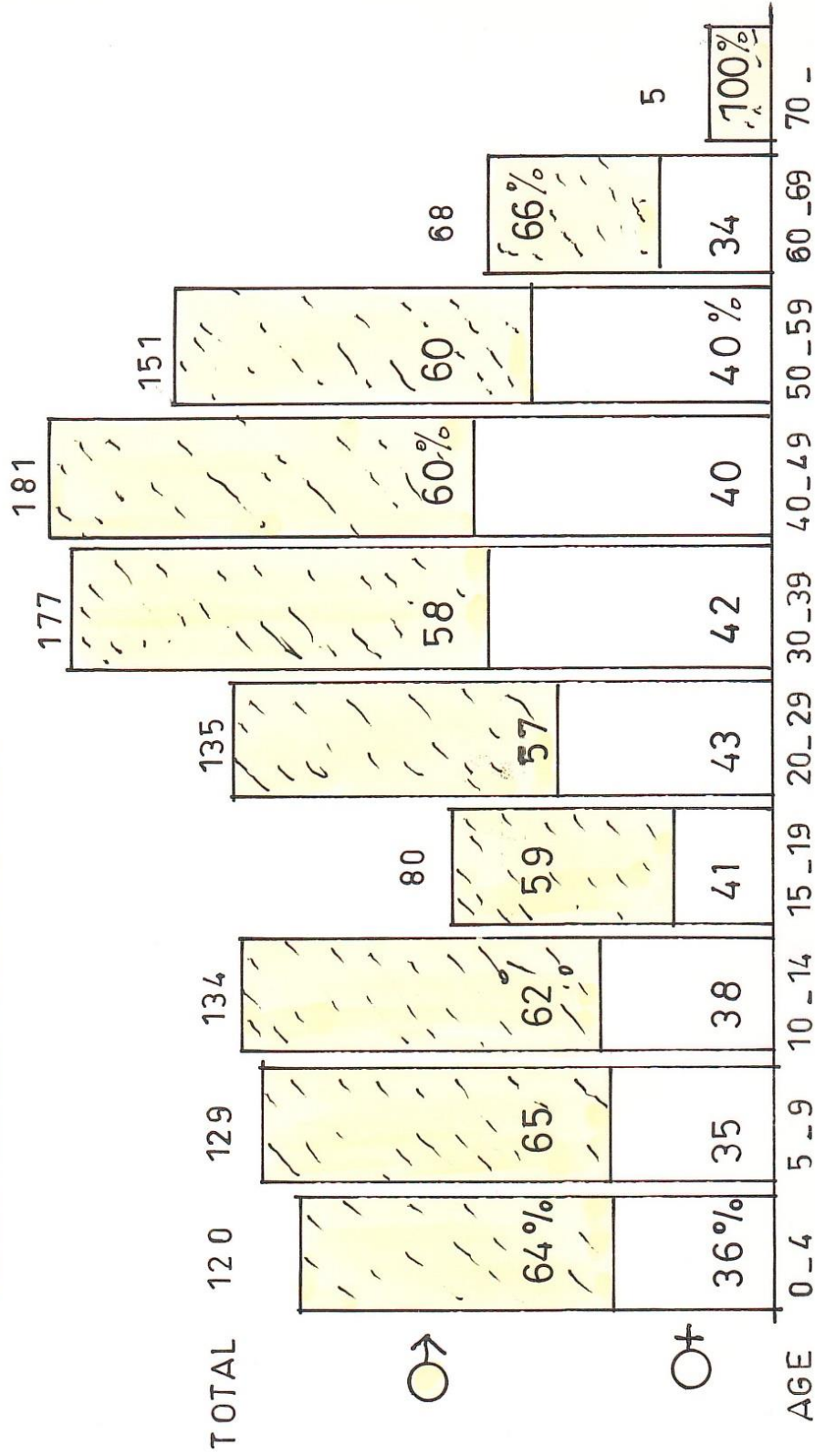
BRAIN TUMORS

مؤتمر اليوبيل الفضي لجمعية مكافحة السرطان العراقية 1987



- USA
- GERMANY
- JAPAN
- SWEDEN
- INDIA

AGE GROUP & SEX



O→ 60 %
O+ 40 %

TOTAL 1180

MENINGIOMA INCIDENCE

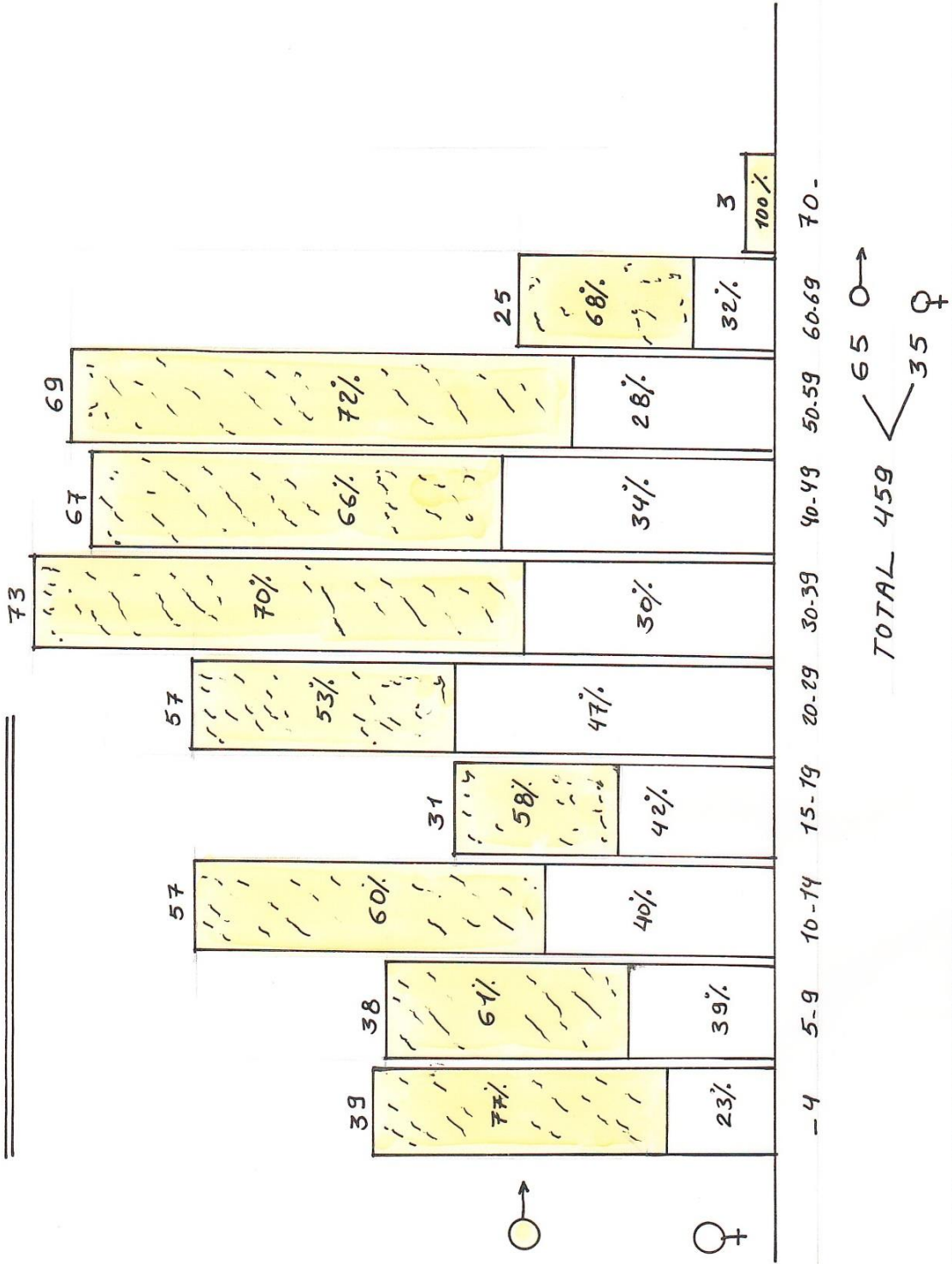
AGE GROUP	GRANIAL		SPINAL		TOTAL
	○→	○+	○→	○+	
- 4	7	7	1	4	19
5 - 9	5	1	0	1	7
10 - 14	2	3	0	0	5
15 - 19	7	1	1	0	9
20 - 29	5	10	0	1	16
30 - 39	7	25	4	1	37
40 - 49	23	31	1	3	58
50 - 59	13	12	1	6	32
60 - 69	5	5	0	0	10
70 -	0	0	0	0	0

○→ 42%
 ○+ 58%
 TOTAL 193

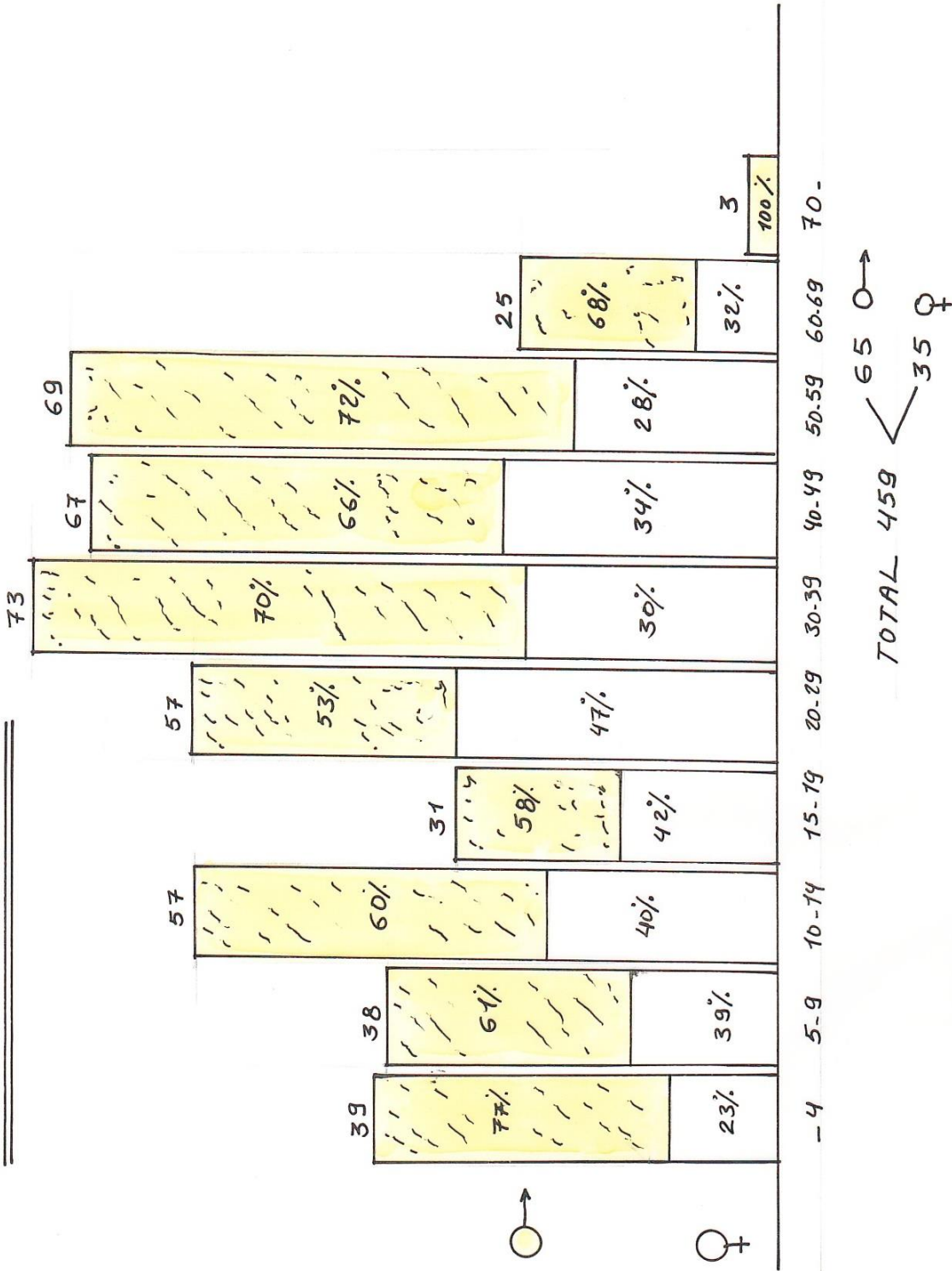
○→ 44
 ○+ 56%
 88% GRANIAL 169

○→ 33%
 ○+ 67%
 12% SPINAL 24

GLOMA INCIDENCE



GLOM A INCIDENCE



Cersoid aneurysm 1988

Local injury is an important predisposing factor

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ
الجمهورية العراقية

وزارة الصحة
مستشفى جراحة الجملة العصبية

١٤ / ٢ / ٨٨

فادي جرجيس خ.ع

Fall down on face 1/2 injured his scalp
~~3 days later on his~~ by a steel door frame.
3 days later fell on forehead & injured his
scalp. No + KO - all was well.

Only few days ago mother noticed that
a pulsatile swelling developing.
Pulsation going down in prearterial direction

٨٨٨٩٧٨١ هاتف
بدالة/خمسة خفارط

بغداد / شارع بور سعيد

to the supf temp artery.
No basis. No other artery \rightarrow
to be related.

\Rightarrow Picture taken
to address a gap.

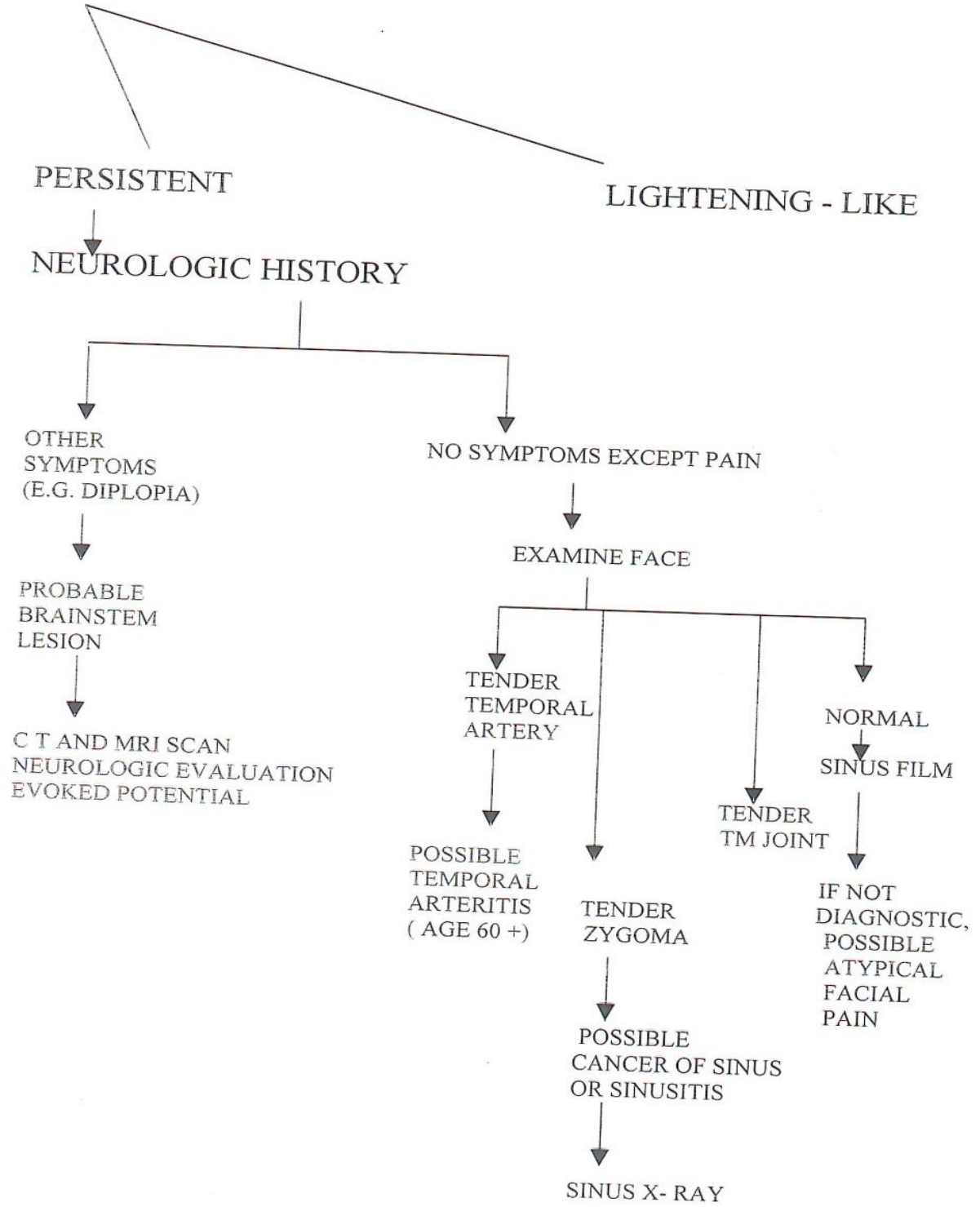
FACIAL PAIN

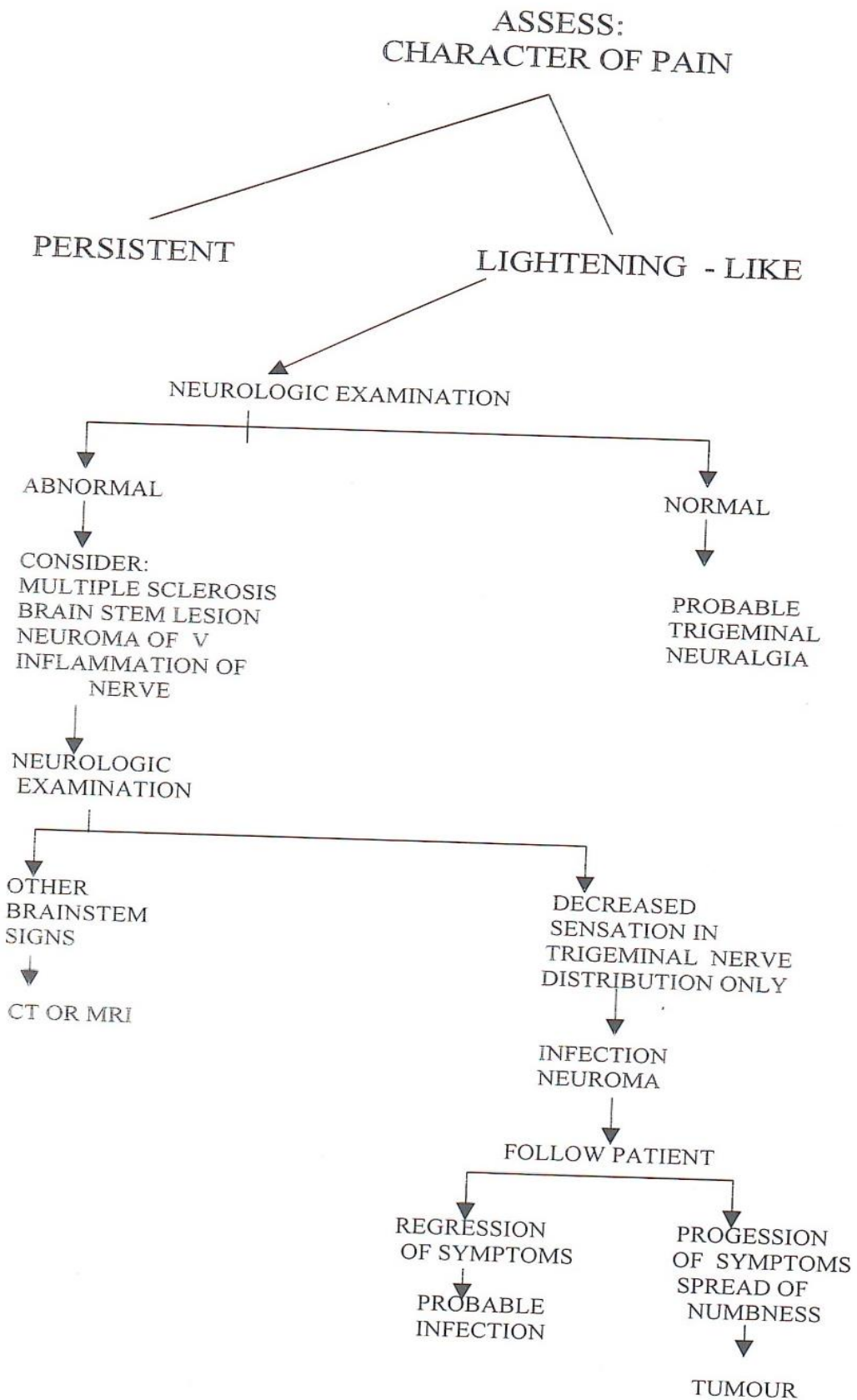
مؤتمر اتحاد اطباء الاسنان العرب 1997

- N** NEURALGIA OF V TERRITORY
 - T TRIGEMINAL NEURALGIA TPP
 - P PARATRIGEMINAL
 - P POSTHERPETIC
- N** NONTRGEMINAL NEURALGIA
 - G GLOSSOPHARYNGIAL NEURALGIA
 - G GENICULATE
 - O OCCIPITAL GGO
- N** NONNEURALGIC
 - O** OPHTHALMIC
 - T TOLOSA HUNT SYNDROME
 - P PSEUDOTUMOR
 - D DIABETES
 - O OPTIC NEURITIS
 - G GLAUCOMA
 - U UVEITIS
 - E EYE STRAIN
 - M** MASTICATORY
 - D DENTAL
 - T TMJ
 - P POST-TRAUMATIC
 - P** PARANASAL SINUSES
 - N** NEOPLASIA-RELATED
 - B** BIH
 - E** EMPTY SELLA BCDE MNOP PPV
 - D** DECREASED ICP
 - V** VASCULAR
 - M MIGRAINE
 - C CLUSTER
 - C COLLAGEN DIDEASES
 - I INTRACRANIAL BLEED
 - O OCCLUSIVE CV DISEASE
 - P** POSTRAUMATIC
 - P POSTCONCUSSION
 - S SUBDURAL HEMATOMA
 - C** CERVICAL SPINE
 - P** PSYCHOLOGICAL

FACIAL PAIN

ASSESS:
CHARACTER OF PAIN





Diagnostic approach:

1. Site of pain:

TRIGEMINAL NEURALGIA:

- 4 per 100 000 population.
 - Over 50 years of age
 - Usually V2 alone > V3 > V1
 - All branches 2%
 - Bilateral pain only in 5%
 - More in women
 - More in right side
 - spontaneously or may be triggered
 - Initiated by eating, washing, brushing teeth, and talking.
 - Most attacks occur soon after rising from bed.
 - When sleeps the painful side is up.
-
- ❖ Any attack in the young think of MS or CPA tumor.
 - ❖ Other causes: CPA tumors, meningioma, epidermoid, AVM, aneurysm, arachnoid cyst. Posterior fossa or supratentorial mass pushes the tent against the V. Or tumor at the region of Meckel's cave.
- ◀ ETIOLOGY: Distortion of the REZ by a branch of superior cerebellar artery or veins.
Some shown demyelination within the nerve
- ◀ DIAGNOSIS: Entirely on patient's history and description.
Pain: sudden, intermittent, "electric like", and confined to one or several branches.
Unilateral, trigger points, maneuvers that activates pain, history of remission and exacerbation.
Relief of pain during sleep.

Branch of superior cerebellar artery or veins.

CNS EXAM is normal

CT and MRI are normal.

Good response, at least initially, to carbamazepine

MEDICAL TREATMENT OF TRIGEMINAL NEURALGIA

CARBAMEZAPINE

EPANUTIN

LIORESAL

SURGICAL TREATMENT

MINOR PROCEDURES:

1. PERCUTANEOUS TRIGEMINAL GANGLION COMPRESSION:
2. PERCUTANEOUS GLYCEROL GASSERIAN RHIZOLYSIS:
3. PERCUTANEOUS RADIOFREQUENCY TRIGEMINAL GANGLIOLYSIS:

MAJOR PROCEDURES:

1. MICROVASCULAR TRIGEMINAL DECOMPRESSION
2. PARTIAL SENSORY RHIZOTOMY
3. TRIGEMINAL TRACTOTOMY

DEVICES:

NEUROSTIMULATION

PARATRIGEMINAL (RAEDER'S)

NEURALGIA:

- ◀ Caused by lesions at the skull base near the sella or away from it.
- ◀ Can be tumor of the base , fracture, granuloma.

PAIN IS USUALLY:

- Deep and boring,
- Concentrated around the orbit
- Worse in the early morning,
- Often associated with nausea and vomiting.
- No trigger points
- No exacerbation with particular maneuver,
- Miosis with or without ptosis, light reaction is spared.
- Tearing, erythema, enophthalmos.
- Alcohol and vasodilators make the pain worse.

POSTHERPETIC NEURALGIA:

- ✓ Reactivation of a dormant varicella virus by:
- ✓ Trauma, spontaneously, Hodgkin's disease or by immunodeficiency
- ✓ Octogenarian are affected three times more the population.
- ✓ Rash, Vesicles then dry and crusty

PAIN HAS TWO PHASES:

1. Acute herpes zoster pain. Inflammation of the nerve.
 - Precedes skin eruption by few days.
 - Pain is deep and continuous, but can be lancinating.
 - Pain may last few weeks.
 - Acyclovir may reduce it but not postherpetic.
2. Postherpetic neuralgia.
 - Pain is continuous for at least 6 months.
 - Burning and dysthetic

TREATMENT

- Start with antidepressants
- Anticonvulsants.
- Spray with ethyl chloride.
- Local massage
- Mechanical vibrator
- Transcutaneous electrical stimulation
- Local anesthetic block.

NEURALGIC NON TRIGEMINAL:

1. GLOSSOPHARYNGIAL NEURALGIA:

1/100 of trigeminal neuralgia

Over 60 years Male = female

Left side more

Pain at: pharynx, tonsils, base of tongue, deep angle of jaw

Exacerbated by swallowing, yawning, , or touch around ear

PICA or branches may compress on the X or IX

Diagnosis by history: type and radiation of pain

CNS exam is normal

10% cocaine to the pharynx should relieve pain

Treatment is by carbamazepine.

Neurectomy may be required

2. GENICULATE NEURALGIA:

Ramsy Hunt

Herpes zoster of geniculate ganglion.

Pain deep within the ear

Rash: tongue, soft palate, external auditory canal, or pinna

differentiate from: ca nasopharynx, otitis media, otitis externa,
referred pain from upper molar, TM joint or larynx.

CT and MRI are normal

Local anesthetic can relieve pain temporarily

3. OCCIPITAL NEURALGIA:

Pain along the course of greater occipital nerve

Paroxysms at vertex and temporal region

Aggravated by movement

Tinel's sign present along greater occipital nerve with hypo or
dysesthesia

Muscle spasm and tenderness over shoulder and scapular area
ipsilateral

Cause blunt local trauma, or entrapment

Local causes of the posterior fossa and in the neck may be
present.

C1 or C2 may be the cause.

NON NEURALGIC

OPHTHALMIC

- TOLOSA HUNT SYNDROME
- PSEUDOTUMOR
- DIABETES
- OPTIC NEURITIS
- GLAUCOMA
- UVEITIS
- EYE STRAIN

MASTICATORY

- DENTAL
- TMJ
- POST-TRAUMATIC

PARANASAL SINUSES

NEOPLASIA-RELATED

BIH

EMPTY SELLA

DECREASED ICP

VASCULAR

- MIGRAINE
- CLUSTER
- COLLAGEN DISEASES
- INTRACRANIAL BLEED
- OCCLUSIVE CV DISEASE

POSTRAUMATIC

- POSTCONCUSSION
- SUBDURAL HEMATOMA

CERVICAL SPINE

PSYCHOLOGICAL

HYDATID CYST OF CNS

Paper written by Dr. Hiyad Al Husaini under my supervision (1989)

Followed by my own figures

HYDATID CYST OF THE CENTRAL NERVOUS SYSTEM

HIYAD JAWAD AL-HUSAINI

SUPERVISED BY PROF. ABDUL HADI AL-THALILI

HYDATID DISEASE OF THE CENTRAL NERVOUS SYSTEM

The nervous system is impaired whenever the larval stage of *Taenia echinococcosis* lodges in it. In 1928 Harold Dew described the prognosis of hydatid cysts of the brain as gloomy & placed the operative mortality at 50-74%. Anatomical sites for Hydatid cysts of the brain are : cerebral, vertebral, orbital & cranial.

Patients & methods :

A retrospective analysis was made of the medical records of all patients admitted with the diagnosis of hydatid disease to the hospital of neurosurgery in Baghdad during the 10 years period (1978-1987). Almost always the diagnosis hydatid disease was confirmed operatively however in rare cases the diagnosis was strongly suspected the clinical condition with either previous operation on hydatid cyst of the same organ or evidence of hydatid cyst by CT scan. The clinical data were obtained from the hospital records.

The study included 132 patients from 4-27 years old (mean age 19.35 years) 65 males, 67 females (Male:Female ratio=0.9).

Patients were referred from hospitals, clinics in & outside Baghdad & I think we may be correct to a far extent assuming that our data represent hydatid disease of the Central Nervous System in Iraq.

Patients were divided into 6 groups according to the site of hydatid disease. These are : cerebral hydatidosis in adults, cerebral hydatidosis in adults, cerebral hydatidosis in children,

vertebral echinococcosis, orbital echinococcosis, cranial echinococcosis & hydatid cysts in other sites. A preformed protocol was applied to all the cases which included: age, sex, presenting symptoms & duration, examination findings, multiplicity, presence of hydatid disease elsewhere in the body & previous history of hydatid disease. CT scan results of cerebral hydatidosis were reviewed, eosinophilic count was reviewed (if done) but serological studies & x-ray findings were not reviewed for technical reasons. Urban or rural residencies could not be gained from the records. Much of our results were compared to the work of R. Arana-Iniguez (1955).

Results :

74.2% of the 132 cases collected 95 were cerebral hydatidosis 74.2%, 53 cases below 15 years & 42 case 15 years or older, 28 were cases of vertebral echinococcosis 15.6%, 8 were cases of orbital echinococcosis 6.25%, 2 cases of soft tissues hydatid cyst, one case of pulmonary hydatid cyst (Table 1) & 4 cases of unknown site.

Hydatid disease of the brain in children : 53 cases were collected which comprise 41.4% of the total hydatid disease of the C.N.S. & 55.7% of hydatid disease of the brain. Hydatid disease of the brain in both children & adults comprises 74.2% of the total hydatid disease of the C.N.S. in this study.

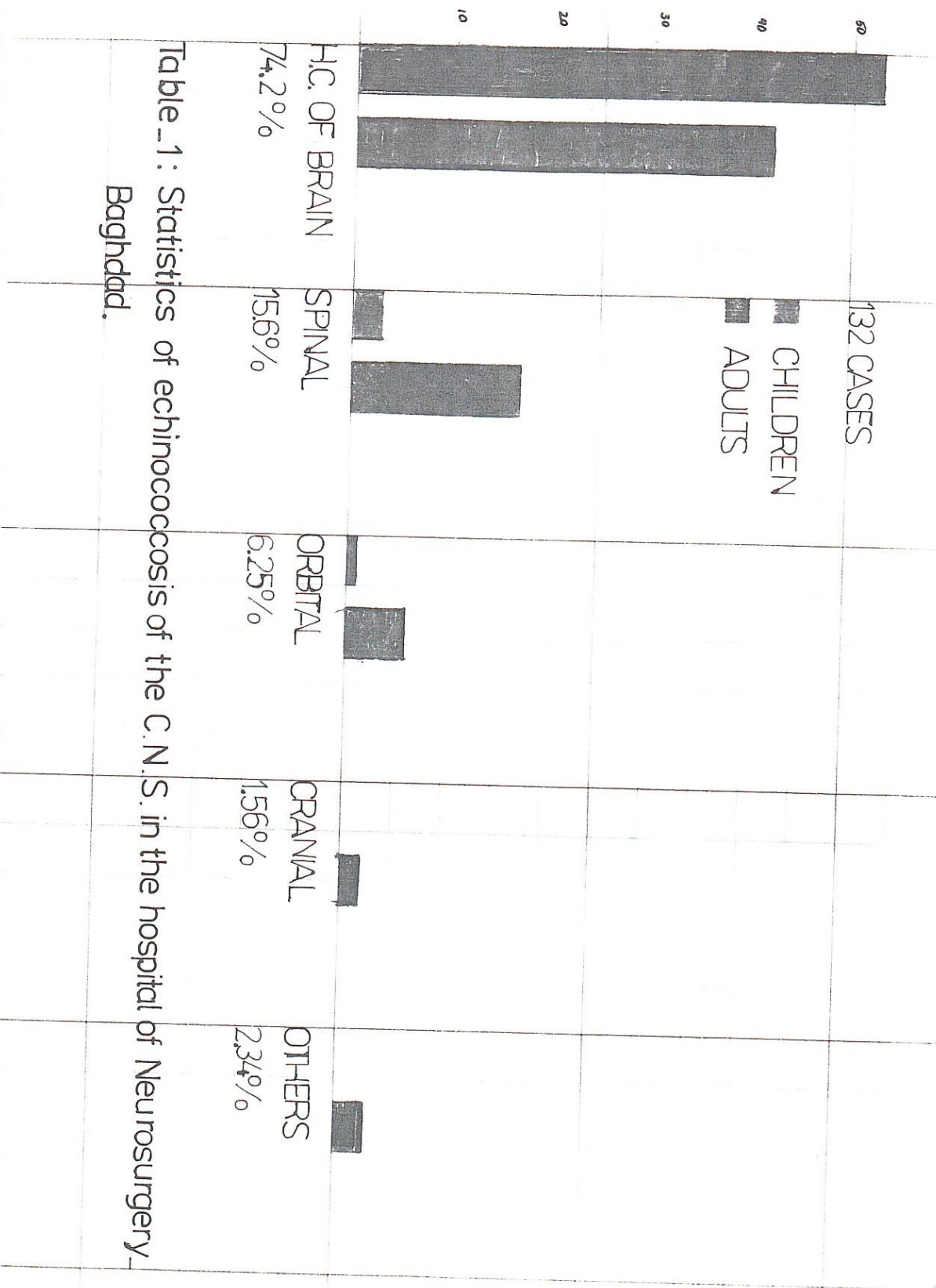


Table -1: Statistics of echinococcosis of the C.N.S. in the hospital of Neurosurgery - Baghdad.

30 cases were males & 23 were females with male:female ratio of 1.3:1.

Presentation : 20 cases (37.7%) presented with weakness of those 19 patients presented with sided weakness. blurred vision was the presenting symptom in 10 cases (18.3%) while this symptom was present in 16 cases (30%). Headache & vomiting were present in 39 cases (73.5%) yet they were the presenting feature of only 4 cases (7.5%). Walking abnormalities were present in 6 cases (11.3%). Behavioural alterations were the presenting in 5 cases (9.4%). Fits were present in 7 cases (13.2%) & were the presenting symptoms in only three cases (5.6%). Speech disturbance was presenting in one case, altered consciousness in two, tremor in one case & pain in the arm in another case (table 2).

The duration of these symptoms was less than two weeks in 4 cases (8.8%), about one month in 13 cases (28.8%), about two months in 11 cases (24.4%), above 2-6 months in 11 cases (24.4%) & about one year in 6 cases (13.3%). In 86.6% of the cases the duration of the history was 6 months or less.

Examination of those children showed papilloedema in 36 cases (80%), motor disturbances in 30 cases (66.6%), facial weakness in 23 cases (51%), altered consciousness in 9 cases (20%). Skull changes in the form suture diastasis, deformities, hydrocephalus were present in 8 cases (17%). Deranged ocular movement were found in 6 cases (13%). Sensory impairment were found in 5 cases (11%). Gait disturbances were present in 5 cases & cerebellar

4

13

11

11

6

? 45

3/6

30

signs in 4 cases (Table 3).

The outcome of this disease : improvements were achieved after surgical treatment in 38 cases (71.6%), while no improvement was the outcome in 9 cases (16.9%), three children got recurrent disease (5.6%) & three children died (5.6%) as seen in (Table 4)

Death is calculated as the no. of deaths within the same admission so this does not represent the operative mortality but mortality of the disease.

Hydatid cyst of the brain in adults : 42 cases were collected in this 10 years which comprises 32.8% of hydatid cyst of the nervous system & 45.3% of hydatid disease of the brain. 24 cases were females & 18 were males with male:female ratio of 0.75:1, if we think this female preponderance is due to male engagement in military service this will not explain the slight male preponderance in hydatid disease of the spines only if we think that hydatid disease of the spines is a crippling disease that keeps young males away from the military service.

Presentation : 13 cases (37%) presented as altered vision which was present in 17 cases (48%), weakness was the presenting symptom in 8 cases (22.8%) & sided weakness was the presenting symptom in 7 out of those 8 cases however 15 cases (42%) were having weakness. Headache & vomiting were present in 29 cases (82%) however they they were the presenting symptoms in only 5 cases (14%). Fits were presenting in 3 cases (8.5%) & present in

<u>SYMPTOM</u>	<u>No.</u>	<u>%</u>
weakness	20	37.7
blurred vision	10	18.3
head. & vomit.	4	7.5
walk. abnormal.	6	11.3
behav. changes	5	9.4
fits	3	5.6
<i>speech dis</i>	<i>1</i>	
<i>alt. conv</i>	<i>2</i>	
<i>Tremor</i>	<i>1</i>	
<i>pain</i>	<i>1</i>	

Table 2 : presenting symptoms of cerebral hydatid disease in children

<u>SIGN</u>	<u>No.</u>	<u>%</u>
papilloedema	36	80
motor distur.	30	66.6
facial weak.	23	51
alter. consc.	9	20
skull changes	8	17
abn. ocular move.	6	13

Table 3 : examination findings of cerebral hydatid disease in children

<u>OUTCOME</u>	<u>No.</u>	<u>%</u>
improvement	38	71.6
no improvement	9	16.9
recurrent ds.	3	5.6
death	3	5.6

Table 4 : outcome of cerebral hydatid disease in children

9 cases (25.7%). Walking abnormalities were presenting in 2 cases (8.5%). Speech abnormalities were presenting in 2 cases (5.7%) & mental alterations were present in 10 cases (28.5%) & presenting in only 10 cases (2.8%) as shown in (Table 5).

The duration of those symptoms was 15 days or less in 6 cases (17%), between 16-30 days in 9 cases (25.7%), between more than 1 month up to 2 months 9 cases (25.7%), between more than 2 months up to 6 months 6 cases (17%), about 1 year 2 cases (5.7%) & about 2 years 3 cases (8.5%). In 85.7% of the cases the duration of the symptoms was 6 months or less.

Examination showed papilloedema in 24 cases (68%), motor disturbances in 21 cases (60%), altered consciousness in 12 cases (34.2%), impaired vision in 7 cases (20%), facial weakness in 7 cases (20%), 6th. nerve palsy in 5 cases (14.2%) & speech disturbances in 5 cases (14.2%) as shown in (Table 6).

The outcome : 25 cases improved after surgical treatment (59.5%). No improvement were obtained in 8 cases (19%). Death occurred in 7 cases (16.6%) & 2 cases recurred during this 10 years period or were already recurrent cases (4.7%) as seen in (Table 7).

Site : The most common site for hydatid cyst of the brain in children was the parietal lobe while in adults the parieto-occipital region was the commonest site. There was one case of hydatid cyst in the ~~phalamic~~ region in adults & another case in the posterior fossa in children. There was no difference between right & left side both in children & adults.

<u>SYMPTOM</u>	<u>No.</u>	<u>%</u>
alter. vision	13	37
weakness	8	22.8
head. & vomit	5	14
fits	3	8.5
walk. abn.	3	8.5
speech alter.	2	5.7

Table 5 : presenting symptoms of cerebral hydatid disease in adults.

<u>SIGN</u>	<u>No.</u>	<u>%</u>
papilloedema	24	68
motor disturb.	21	60
alter. consc.	12	34
impaired vision	7	20
facial weakness	7	20
6th n. palsy	5	14
speech disturb.	5	14

Table 6 : examination findings of cerebral hydatid disease in adults.

<u>OUTCOME</u>	<u>No.</u>	<u>%</u>
improvement	25	59.5
no improvement	8	19
death	7	16.6
recurrence	2	4.7

Table 7 : outcome of cerebral hydatid disease in adults

Multiplicity : 9 cases (18%) of hydatid cysts of the brain in children were multiple, of those 2 cases were recurrent cases & non of them were having hydatid cyst elsewhere in the body.

11 cases (30.5%) of hydatid cysts of the brain in adults were multiple, 4 cases (36.3%) of them were recurrent cases with or without hydatid cysts elsewhere, 2 cases (18%) of those 11 cases were not recurrent but were having hydatid cysts in another site in the body, so 6 cases (54.3%) were recurrent cases and/or having hydatid disease elsewhere, 5 cases (45.45%) of those 11 cases died during admission.

In both children & adults & in the presence of hydatid disease elsewhere in the body or with recurrent hydatid disease of the brain itself multiple cyst were found in 8 out of 14 cases (57%), while in the absence of the hydatid disease elsewhere in the body & in non recurrent cases 12 out of 71 cases (17%) were multiple, (17.2% in adults & 16.6% in children).

Role of CT scan : CT scan was done in 75 cases. It gave accurate diagnosis in 72 cases (96%). It gave false -ve results in 1 case out of 75 (1.3%). It gave false number of cysts in 2 cases (2.6%). So sensitivity is 98.7% & specificity is 96% at least.

Vertebral echinococcosis : 20 cases (15.6%) between the ages of 9-55 years (mean age 29.4 years), 11 were males & 9 females with male:female ratio of 1.2:1. Between the ages 15-44 years 14

cases (70%) were recorded. 9 cases (52%) were in the dorsal spines, 5 cases (29.4%) were in the lumbar, 1 case (5.8%) in the dorso-lumbar region & 2 cases (11.7%) were in the cervical spines (Table 8). 5 cases (29.4%) with hydatid disease elsewhere 11 cases (64.7%) were recurrent or recurred during 10 years period.

Presentation : 14 cases (82.3%) presented with weakness or complete paralysis, 2 cases (11.7%) as retention of urine & case (5.8%) as pain.

During examination motor weakness or paralysis were present in 15 cases (88.8%), sensory level was present in 12 cases (70.5%) & urinary symptoms or incontinence were present in 4 cases (23.5%).

Myelography showed extradural block in 10 cases (76.9%), intradural block in one case (7.6%) & destructive or osteolytic lesion in 2 cases (15.3%).

Orbital echinococcosis : 8 cases (6.25%) were collected in this 10 years period. All of them were females between 12-45 years. 4 cases (66.6%) in the left orbit & 2 (33.3%) in the right orbit.

Presentation : 6 cases (85.9%) presented as protrusion of the eye ball of 2-6 months duration & 1 case as progressive drooping of the eyelid.

Examination : examination revealed proptosis in all the cases, 3rd nerve palsy in 3 cases, papilloedema in 2 cases, blind eye

in 2 cases, optic atrophy in other 2 cases, 6th nerve palsy in 2 cases & ophthalmoplegia in 2 cases.

Inadvertant rupture of the cyst occurred in 3 cases during operation.

Eosinophils count : was done in 45 cases only. eosinophilia was found in 18 cases (28.57%) only & it was +ve in 32% of hydatid cysts of the brain in children & 17% in adults, & in 36% of vertebral echinococcosis.

<u>SITE</u>	<u>No.</u>	<u>%</u>
dorsal	9	52
lumbor	5	29
dorso-lumbor	1	5.8
cervical	2	11.7

Table 8 ; site of vertebral echinococcosis.

Discussion:

Human beings act as intermediate hosts to *Echinococcus granulosus*. Hydatid disease of the nervous system is caused by the larval stage of *Taenia echinococcus* which lodges in the central nervous system or in the craniovertebral bony tissues. Deve (1946, 1949) has described primary & secondary hydatidosis. Primary hydatidosis is the disease caused by the larval development of the hexacanth embryo in the nervous system after successful passage through the hepatic & pulmonary capillary filtering systems

Secondary hydatidosis results from the rupture of a primary hydatid cyst in an organic surroundings. Where several hydatid brain cysts are encountered, a condition considered rare by Arana-Iniguez, & attributed to involvement of the heart & rupture of a hydatid cyst in the left heart chambers which is responsible for the general dissimination. In our series 17% of non recurrent cases of hydatid cyst of the brain with no hydatid disease elsewhere in the body where multiple & even in children 25% of the cases were multiple & none of those cases with multiple brain cysts in children had the disease elsewhere in the body. Saidi did not consider number of brain cysts an indicator to primary or secondary hydatidosis, in fact he regarded the distinction "of academic interest, except for the fact that any patient with hydatid cyst of the brain requires a thorough investigation & search for the possibility of coexisting hydatid cysts elsewhere in the body."

it infiltrates the neighbouring tissue with brood vesicles which develop into new small cavities within the bone & this what makes it resistant to surgical excision. 11 cases (64.7%) were recurrent cases or recurred during this 10 years period.

Conclusion :

*Hydatid disease of the C.N.S. is a disease of young population (mean age 19.35 years).

*Hydatid disease of the brain is a disease of childhood (mean age 15.69 years) contradictory to vertebral hydatidosis which is a disease of adulthood (mean age 29.45 years).

*Hydatid disease of the brain is a serious disease (mortality 10.5% & morbidity 23%).

*In hydatid disease of the brain the outcome is better in children.

*Contradictory to other world series multiple brain cysts were high in our series & multiple brain cysts in children were much higher (18% versus 1.3%) even in the absence of hydatid disease elsewhere in the body.

*Multiple brain cysts were present in 57% of the cases in the presence of hydatid disease elsewhere in the body or when the disease is a recurrent one in the brain while multiple cysts were present in 17% of the cases where the disease was not recurrent & not associated with other hydatid in another organ.

*CT scan found very sensitive (98.7%) in diagnosing hydatid cysts of the brain.

like the case

*Vertebral hydatidosis attacks mainly the lower dorsal spines

*Vertebral hydatidosis is an intractable disease with 64.7% recurrence rate.

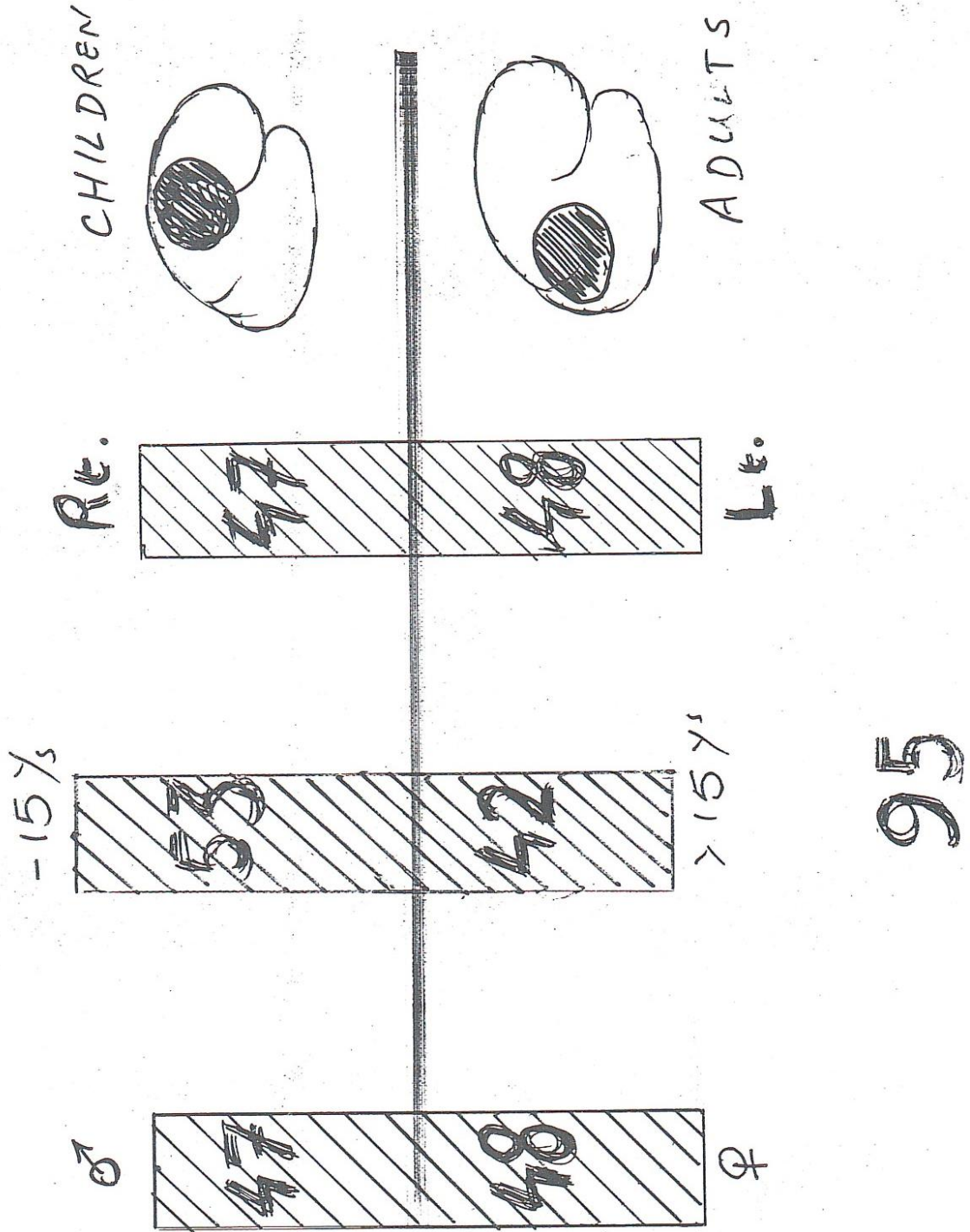
Summary :

In a retrospective analysis of all cases admitted to the hospital of neurosurgery in Baghdad from (1978-1987), 132 cases were collected (mean age 19.35 years) 55.7% of brain hydatid cysts younger than 15-years. Mortality of hydatid disease of the brain is 10.5%, morbidity is 23% & the outcome is better in children. Multiple brain cysts were much higher in recurrent cases & in presence of hydatid cyst elsewhere in the body. CT scan was accurate in diagnosing hydatid cyst of the brain. Vertebral echinococcosis is an intractable disease which attacks mainly lower dorsal spines.

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MY NUMBERS



■ PRESENTATION

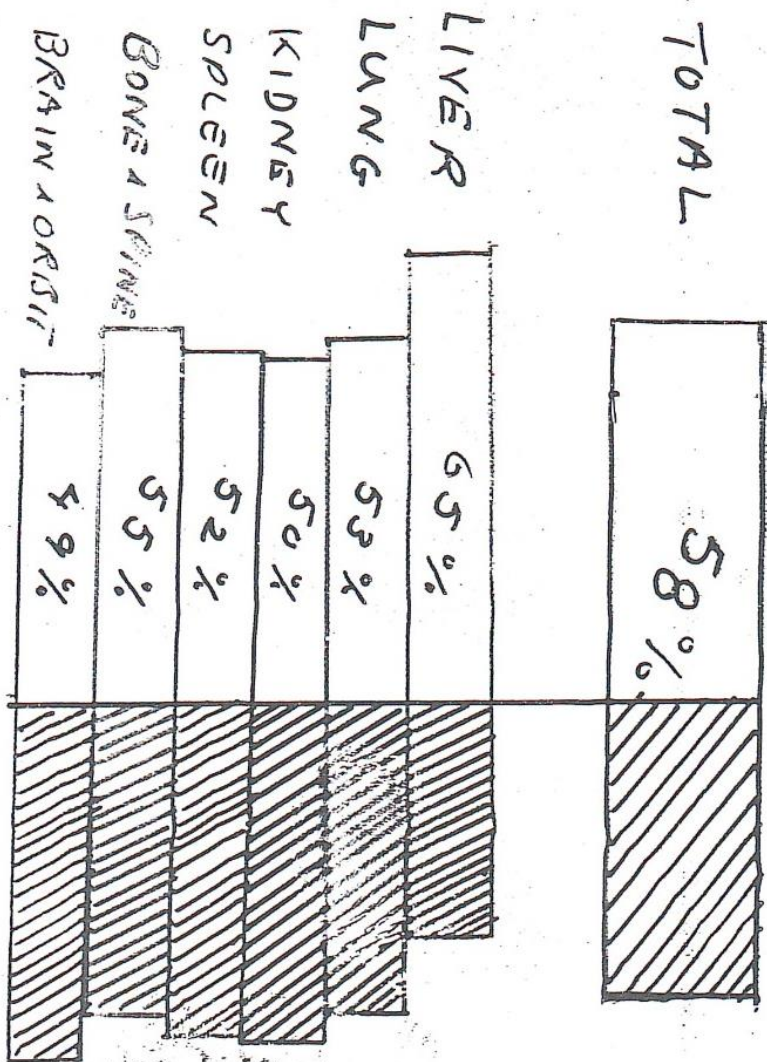
MOTOR	28 → 45
VISUAL	23 → 33
HEAD.&VOM.	9 → 68
ATAXIA	6
BEHA.&SPEE.	15
FITS	6 → 16

SUMMARY

- CEREBRAL H.D IS OF YOUNG AGE GROUP 15.3 Ys
- MULTIPLE H.C. 18%
+ OTHER ORGANS 57%
- SYMPTOMS MOTOR
VISUAL
- SIGNS PAPILLEDEMA
MOTOR
- SPINAL H.D. IS OF OLDER AGE GROUP 29.5 Ys
- CLINICALLY WEAK LEGS
- RECURRENCE 70%
- MORE IN LOWER DORSAL

SIGNS

PAPILLEDEMA	60
MOTOR DEF.	51
FACIAL WEAK.	30
ALTERED CONS.	21
EOM	12
GAIT	7
VISUAL IMP.	7

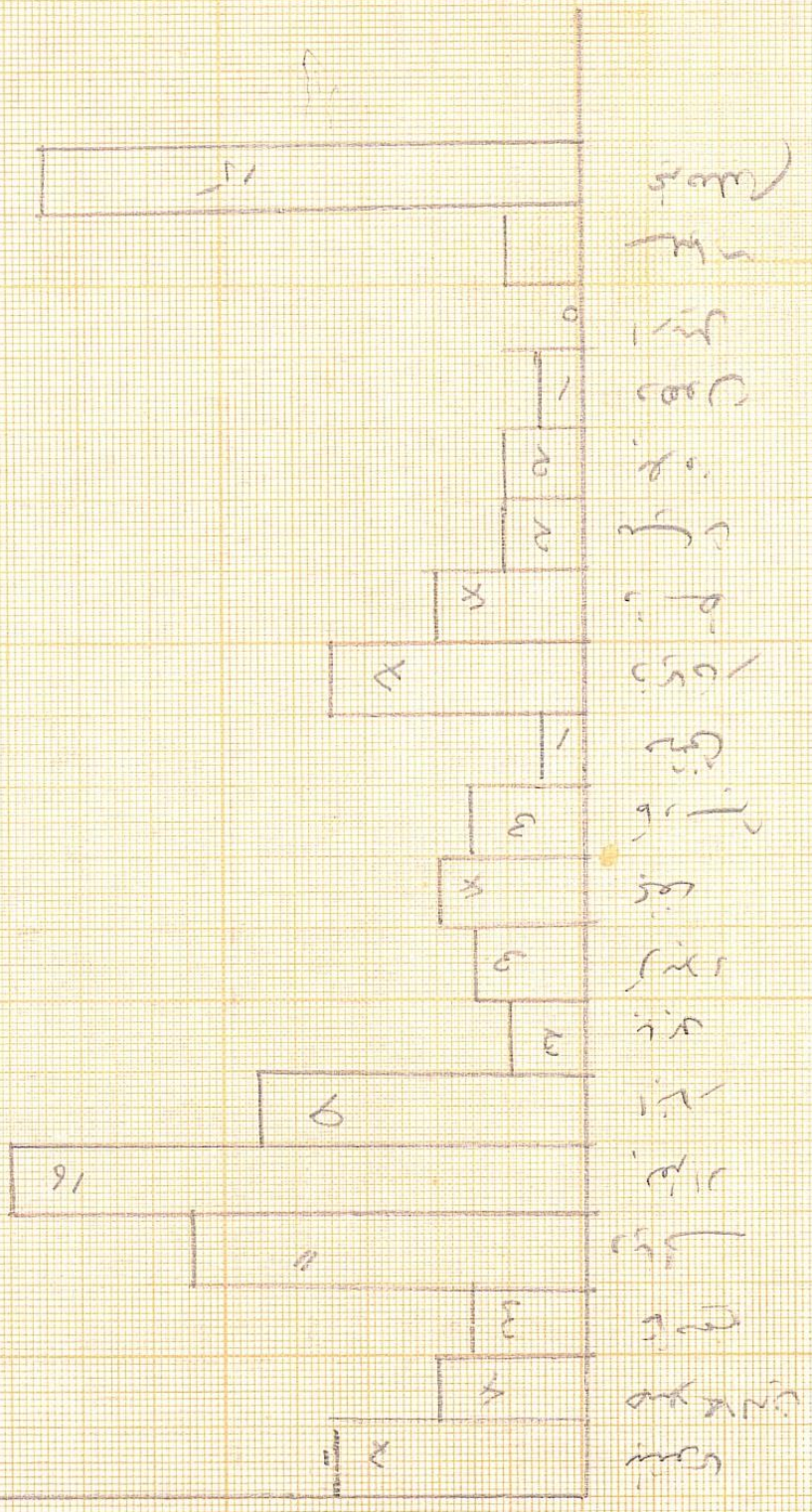


ORGAN & SE

Brain Province

B2

10 9 8 7 6 5 4 3 2 1

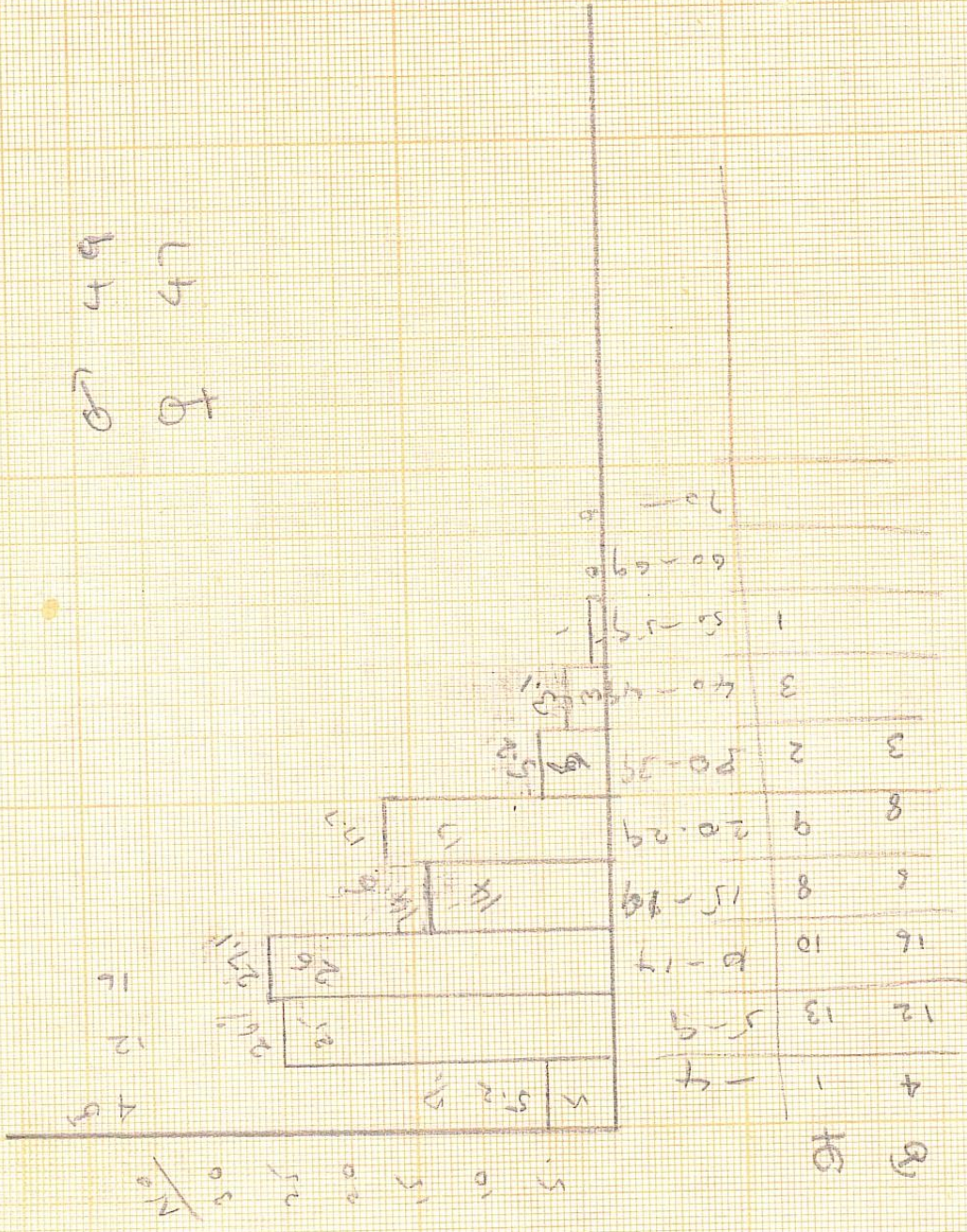


(6)

Birds age group

♂ 49
♀ 47

♂
♀



صبر سعدون	13	5/86	♂	ديار	طالب	6/52	HV	SD	RF		pay
عبدان محمد	9	5/84	♂	بغداد	طالب	12/52	HV		LFT	Rweat	pay+
اسماعيل	9	1/81	♀	ناصر	طبيب				LF		
فاخر صخر	9	1/81	♂	ناصر	طالب	12/2	HV/1/1 alaska		LFTP	Rweat	pay+
مواطن عبيد	12	12/84	♀	ناصر	طالب	2/12	H Dip		LP		?
كريم زمان	11	9/84	♂	صدام	طالب	4/7	Rweat EPI		DTP	Rweat	.
محمد ناصر	8	2/85	♂		طالب	4/12	Rweat	SD	RP	Dweat	pay+
معتز محمد	4	1/85	♂	ناصر	طبيب	6/12	weat K/1/10	SD	LOP	Rweat	pay+
زينب عارف	9	10/86	♀	بغداد	طالبة	1/12	inemo		ROP	R	
نادية جوار	9	6/84	♀	بغداد	طالبة	3/52	Rweat		LFP	RHem	pay+
سعيدة حبيب	5	6/86	♀	صدام	طبيب	12/2	Rweat		LPO	RHem	pay+
سورية سيد	4	2/85	♀	بغداد	طالبة	1/12	fito		RF	RHem	pay+
فهد عباس	7	4/85	♂	بغداد	طالب	6/12	Dweat Fit		RP	LHem	pay+
(M) خالد بغداد	12	9/85	♂	بغداد	طالب	1/12	weat	SD	RF	microm	+
عباس عزال	10	9/86	♂	بغداد	طالب	2/12	H		RTP		
محمد عباس	4	6/79	♀	بغداد	طالبة	1/12	alaska	SD	RF		pay+
فان لينا	9	2/83	♀	بغداد	طالبة	4/12	weat	SD	LOP		pay+
سلام نسيم	10	10/82	♀	بغداد	طالبة			SD	F	op activity	
فيصل حيدر	8	9/79	♀	بغداد	طالبة	1/12	aph		RFP	aph Dweat	pay+
امير فهد	10	1/86	♂	بغداد	طالب	2/12	weat		RFP	LHem	
وائل محمد	13	6/85	♂	بغداد	طالب	2/12	Dweat	SD	RP	DFT	dec
هيام خديجة	5	4/81	♀	بغداد	طالبة	4/12	Dweat		RFT	DVI	aph
فهد محمد	13	2/85	♂	بغداد	طالب	2/12	Ep...	SD	LF		pay+
نسيم صليحة	13		♂		طالب				O		
محمد حبيب	5		♂		طالب						
باسم هادي	12		♂		طالب						
محمد صبيح	12	3/85	♂	بغداد	طالب						
المدى كافي									RP		pay
رسالة ايم	17	77	♂		طالب					→ ochemical	
نجسان محمد	20	10/81	♀	بغداد	طالبة				R T	Multiv loc.	

Name	age	month year	Sex	Provi	Other	Site	Dunk	Point	try	CF	Sign	find
الهدية	9	9/86	♂	بستان	طالب	① point	3/12	F. T. Blurry	Subm. dist	Ⓟ P. Ⓟ	Ⓟ weak	?
هدية صبي	17	2/85	♀	فزار	Hw	② point	1/12	Blurred H. weak		Ⓟ F. P. Ⓟ	Henni	clear
...	14	1/84	♀	فزار	طالب	④ F. Ⓟ	3/12	weakness H.V.		Ⓟ F. Ⓟ	Henni	pay
احمد سراج	6	9/85	♂	بستان	طالب	④ Point	5/12	H.V. weak	S.D. dist	Ⓟ P. Ⓟ	Ⓟ Henni	pay
نور بستان	10	9/84	♀	بستان	طالب	Ⓟ F.	2/12	V. Blind H. Dist.	S.D. dist	Ⓟ F.	"	pay.
نار ك خلف	12	6/77	♀	انبار	طالب	Ⓟ F. A.	4/12	H. weak	cells covered	Ⓟ P.	Ⓟ weak	pay.
	18	"			?	Ⓟ P.	20/7	H. Dizz.	"	Ⓟ P.	Long hair	my p.
انعام صبي	10	11/87	♀	بستان	Hw	Ⓟ P.	3/12	H. weak		Ⓟ P.	Ⓟ weak	pay
جزال كرم	10	9/86	♂	بستان	طالب	Ⓟ F.	2/12	E. white		Ⓟ F.	weak	pay.
نار جبار	5	10/86	♂	فزار	فزار	Ⓟ F.	2/12		sur. Dist.	Ⓟ F.	opt. c. type	pay
محمد علي صبي	14	11/84	♂	فزار	طالب	Ⓟ P.	7/12	V. & H. Dist. Henni	sur. +	Ⓟ F. T.	long hair	?
نار ك رديت	9	6/87	♀	بستان	طالب	Ⓟ P.	12/12	L Henni	S.D. dist	Ⓟ P.		
ارنه طه	4	12/83	♂	جواني	فزار		2/52	H.V.		Ⓟ P. opt. c. type	Ⓟ weak	pay +
سعدية كرم	7	6/86	♀	بستان	طالب		12/12	Ⓟ weak	sur. Dist.	Ⓟ P.	normal XII XI Henni	pay +
طلحة صاه	10	12/83	♀	فزار	طالب		2/12	Ⓟ weak H.	S.D.	Ⓟ F.	Ⓟ Henni	pay +
كلوة شادامي	7	2/84	♀	فزار	طالب		2/12	H.V.	S.D.	Ⓟ P.		pay +
امل كرم	12	5/80	♀	فزار	طالب		4/12	H.V. vision	S.D.	Ⓟ P. O.	Ⓟ Henni	pay.
نار ك صدي	4	10/78	♂	انبار	طالب		4/12	Ⓟ w. H.V.		Ⓟ P.	Ⓟ Henni	pay
صبي صبي	8	10/78	♂	فزار	طالب		1/12	H.V. P. weak		Ⓟ P.	Ⓟ Henni alert	pay +
باب كرم	11	4/79	♂	بستان	طالب		2/12	H.V. N. poor		Ⓟ F.	plaxer T.F.	pay +
هدية صالح	9	12/87	♀	انبار	طالب		3/52	H.V. Diplop		Ⓟ T. P.		
محمد مربي	8	9/80	♂	فزار	طالب		6/52	Ⓟ weak		Ⓟ T.	Ⓟ weak	pay +
زهرا رجا	12		♀	انبار	طالب		2/52	H.V. vision		Ⓟ P.	Ⓟ weak	
كلية شادي	14		♀		طالب		2/12	H.V. vision		Ⓟ P. O.	Ⓟ weak	
الهدية	4		♂				4/12	Speech weak		Ⓟ F. P.	Dy. pl. weak	
لقمان محمد	8		♂		طالب		12/12	H.		Ⓟ P.		pay +
حسين نعمان	10		♂		طالب		1/12	H.V. F. ill		Ⓟ P.	Ⓟ weak	pay +
فاخر فاضل	9	4/81	♂	فزار	طالب		1/12	H.V.		Ⓟ F.	vision ↓	pay +
كلية نصر	7	4/80	♀	بستان	طالب		2/12	H.V.	S.D.	Ⓟ P.	Ⓟ weak	pay +

ذیاب ۲	216	9/88	♂	دبای	نوی		H Weak		Multip ① OP	Weak ②	Pup +
	16	3/80	♂	دبای	نوی						Pup +
گهریہ علی	27	7/87	♀	واط	HW	5/2	② Weak Epilep	Sella destroyed	① FP	② Hemi + Face	Pup +
گھمیا	17	10/85	♂	واط	HW	12/12	Blind Epilepsy	Comm. mark	① OP		Pup +
سختہ ستر	40	8/83 2/85	♀	نوی	HW	2/12	V.L. ↓ Fur Fur		① T.	2 HC	Pup +
امام علی	20	3/84	♂	نوی	HW	2 y	Paraplegia MD	Sella enlarged SD.	① F		Pup +
نوی	21	9/81	♀	نوی	HW		Fracture Hemip		① P		Pup +
بشارت	16	6/81	♀	نوی	HW	3/52	HV VI path abnorm		① OP 3 yps	3 cps	Pup +
گھریہ علی	16	1/85	♀	نوی	HW	1/12			① O		Pup +
سید احمد	26	11/84	♀	نوی	HW	3/12	Hemp.		① TO		Pup +
آمینہ بی	18	1/85	♀	واط	HW	2/12	HV		① P		Dead
خوجہ مران	18	10/84	♀	نوی	HW	4/52	P weak H	Su and	① FT		Pup +
امام علی	20	5/82	♀	نوی	HW		HV		① P		-
امام علی	21	8/87	♂	نوی	HW	1/12	② VI H		① F		Pup +
امام علی	26	9/85	♂	نوی	HW	7/7	① Hemi anomaly		① PO 3 yps	kid w/pt like spleen anomaly	Pup +
سید احمد	20	10/84	♀	نوی	HW	3/12	HV V.L. ↓		① O		Pup +
گھریہ علی	30	2/81	♀	نوی	HW	2/12	HV ② W. in		① T		-
نظرہ علی	55	11/80	♀	نوی	HW	2 yps	② Hemi VI Fract		① PO 2 yps	2	Pup +
گھریہ علی	40	6/82	♀	نوی	HW	2/12	① Hemi	Dir sella	① R PO	2	optic atrophy
گھریہ علی	30	4/83	♀	نوی	HW	1/12	① Weak		① FP		?
عبدالحمید علی			♂			10/7	HV		① F Multip	2	Dead
زینب علی	29	8/84	♀	نوی	HW	2/12	HV unable to walk.		① FP		Pup +
عزیز علی	25	9/84	♂	نوی	HW	2/12	HV.		① FP Long limb	Long limb rec.	Pup +
علی علی	34	10/84	♂	نوی	HW	2 yps	① Weak Fur		① P. Multip	check	?
سید احمد	15	12/86	♂	نوی	HW	14 y	Dizzy Hem		① acc R	off	

احمد رحمة	41		♀					L3	Rec
کریم عبود	17		♂						
لطيفة مخلون	10		♀						
هندا حدرار	17		♀						
محمد عباس	16	8/87	♂	بیل	شوک				D6/7
سورویونائی	55	2/82	♂	بیل	شوک			D	Rec
احمد حیدر	11	1/86	♀	بیل	شوک				D12 12/1
امال المصیز	36	7/79 4/78 81/89	♀	بیل	شوک			D.5 L.2	Rec (Lump)
کاظم عبدالمجید	43	5/81	♂	بیل	شوک			D 12	Rec. + live lump
مخلف خلیل	42	69-72 26/84	♂	بیل	شوک			D2-3	40p
صوبیح سہیل	45	7/79	♂	بیل	شوک			D2	
عید کریم	35	7/87	♂	بیل	شوک			D12	Rec.
ارشد احمد	16	10/81	♂	بیل	شوک			L3/4	
قصود زین	9	10/85	♀	بیل	شوک			D	Rec 11/12 pancreas
احمد علی	28	83/84	♀	بیل	شوک			D3	Multiple
فاد حلف	20	7/81	♂	بیل	شوک			D2	Rec Multiple
کیا تار	33	85/86	♀	بیل	شوک			L1	Rec
علی احمد	27	84	♀	بیل	شوک			L2	Rec Multiple
محمد حسین	40	84	♂	بیل	شوک			L3/4	Rec.
علی احمد	49	81/82 83/84						C3	
OTHERS									
محمد حسین	43	84	♂	بیل	شوک				Examined

HYDATID CYST TYPES AND HYDATID OF CNS, SPINE, ORBIT 1989

THREE SPECIES OF ECHINOCOCCUS CAN CAUSE INFECTION IN HUMAN BEINGS *E.granulosus* , *E.multilocularis* , *E.vogeli* .

FOR ALL THREE OF THESE SPECIES OF ECHINOCOCCUS THERE ARE THREE DEVELOPMENTAL STAGES ; THE 1st IS THE ADULT TAPEWORM ; THE 2nd IS THE ONCOSPHERE , WHICH IS PRESENT WITHIN THE EGG RELEASED FROM THE ADULT TAPEWORM ; & THE 3rd IS THE METACESTODE , THE HYDATID CYST , WHICH CONTAINS PROTOSCOLICES . THE LIFE CYCLE OF THESE ECHINOCOCCAL SPECIES INVOLVES TWO MAMMALIAN HOSTS , ONE IS THE INTERMEDIATE HOST , IN WHICH THE HYDATID CYST DEVELOPES , & THE OTHER IS THE DEFINITIVE HOST , IN WHICH THE ADULT TAPEWORM DEVELOPES . THE MAMMALS THAT NATURALLY SERVE AS THE INTERMEDIATE & DEFINITIVE HOSTS ARE DIFFERENT FOR THE THREE SPECIES . WHEN HUMAN BEINGS HAVE HYDATID DISEASE THEY ARE INTERMEDIATE HOSTS .

IN THE WILD *E.granulosus* IS TRANSMITTED TO THE DEFINITIVE HOST , THE WOLF , BY ITS CARNIVOROUS CONSUMPTION OF HYDATID CYSTS WITHIN THE VISCERA OF WILD UNGULATES . TO PURPETUATE TRANSMISSION OF *E.granulosus* DOGS MUST HAVE THE OPPORTUNITY TO CONSUME HYDATID CYSTS IN THE VESCERA OF SLOAUGHTERED SHEEP , & IN THIS REGARD THE PRACTICE OF ALLOWING DOGS TO FEED ON SLAUGHTERED ANIMALS FACILITATES TRANSMISSION OF INFECTION .

AFTER DOGS CONSUME INFECTIOUS PROTOSCOLICES WITHIN HYDATID CYSTS ADULT TAPEWORMS DEVELOPE IN THE INTESTINES OF THE DOGS , & MATURE TAPEWORMS LIBERATES EGGS THAT ARE PAST IN THE CANINE FECES . INTERMEDIATE HOSTS ACQUIRE THE INFECTION WHEN THEY INGEST THE ECHINOCOCCAL EGGS . AFTER INGESTION THE ONCOSPHERE WITHIN AN EGG IS RELEASED IN THE INTESTINE , PENETRATES THE INTESTINAL MUCOSA , & ENTERS THE VENUS & LIMPATIC CIRCULATIONS . MOST LARVAE ARE CARRIED TO THE LIVER SOME MAY REACH THE LUNGS , & LESS FREQUENTLY THEY MAY REACH OTHER ORGANS . WITHIN THE HOST ORGAN THE ONCOSPHERE DEVELOPES INTO A METACESTODE . THE METACESTODE IS THE HYDATID CYST , & TYPICALLY THE METACESTODE OF *E.granulosus* IS FLUID-FILLED & UNILOCCULAR & EXPANDS CONCENTRICALLY OUTWARD . THE CYST WALL CONSISTS OF THREE LAYERS - AN OUTER ADVENTITIAL LAYER THAT IS DERIVED FROM THE HOST , AN INTERMEDIATE PARACITE-DERIVED LAMINATED LAYER , & AN INNER GERMINAL LAYER . THE GERMINAL LAYER PROLIFERFERATES & FORMS OUTPOUCHINGS , WHICH DEVELOPE INTO BROOD CAPSULES THAT CONTAIN PROTOSCOLICES . SOME OF THESE CAPSULES , IF LARGE , CAN DETACH FROM THE GERMINAL LAYER TO BECOME DAUGHTER CYSTS FREE WITHIN THE FLUID-FILLED CAVITY OF THE HYDATID CYST . THE PROTOSCOLICES HAVE DUAL CAPACITIES . IF THEY ARE INGESTED PROTOSCOLICES CAN DEVELOPE INTO MATURE TAPEWORMS IN THE DEFINITIVE HOST , OR IF RELEASED BY RUPTURE OF THE HYDATID CYSTS PROTOSCOLICES CAN DIFFERENTIATE TO FORM ADDITIONAL HYDATID CYSTS .

IN INFECTED ^{human} ADULTS HYDATID CYSTS DEVELOPE MOST COMMONLY IN THE LIVER & NEXT MOST COMMONLY IN THE LUNGS . TWENTY FIVE PERCENT OF PATIENTS WITH HEPATIC CYSTS ALSO HAVE CYSTS IN THIER LUNGSC . IN CHILDREN SOME SERIES INDICATES THAT PULMONARY INVOLVEMENT IS MORE FREQUENT THAN HEPATIC UNILOCCULAR HYDATID CYSTS. ENLARGE CON-

CENTRICALLY , BUT THE RATES OF INLARGEMENTS ARE NOT UNIFORM & DEPEND IN PART ON THE DENSITY OF THE ORGANS IN WHICH THEY ARE LOCATED . THE DIAMETER OF A CYST CAN INCREASE 1-5 cm PER YEAR & AT TIMES INLARGES EVEN MORE RAPIDLY IN THE LUNG .

AS HYDATID CYSTS INLARGE , MOST PATIENTS REMAIN ASYMPTOMATIC . THE MANIFESTATIONS THAT DO DEVELOPE ARE OFTEN THOSE OF A SPACE -OCCUPYING LESION & ARE DEPENDENT ON THE ORGAN CONTAINING THE CYST .

HYDATID DISEASE OF THE NURVOUS SYSTEM IS CAUSED BY THE LARVAL STAGE OF *Teniaschincoccus* WHICH LODGES IN THE C.N.S. OR IN CRANIOVERTEBRAL BONYTISSUES .

WHEN THE PARASITE IS LOCATED IN THE BRAIN & IT'S SCOLEX IS TRANSFORMED INTO A VESICLE , THE CYST FINDS ITSELF IN IDEAL CONDITIONS FOR GROWTH , SURROUNDED BY BRAIN TISSUE OF FLUID -LIKE CONSISTENCY & PLACED IN A CAVITY WHERE NO RESISTANCE DEVELOPES UNTILL THE CRANIAL WALL IS REACHED .

ON THE OTHER HAND , CRANIOVERTEBRAL LOCATION SHOWS THE CHARACTERISTICS OF ANY HYDATID BONE DISEASE . A VESICLE WITHIN BONE DOES NOT EASILLY EXPAND ; IT INFILTRATES THE NEIGHBOURING TISSUE WITH BROOD VESICLES WHICH DEVELOPE INTO NEW SMALL CAVITIES WHITH IN THE BONE , GIVVING RICE TO HYDATIDOSIS OF THE CRANIUM & VERTEBRAE .

WE HAVE THEREFORE , ON ONE HAND , THE HYDATID CYST OF THE BRAIN WHICH MAY GROW TO A LARGE SIZE (600 or 700 gm IN WEIGHT) , PRODUCING AS A RULE A WELL DEFINED CLINICAL PICTURE WITH CHARACTERISTIC & GEOGRAPHIC FEATURES , & AMENABLE TO SURGERY . ON THE OTHER HAND , WE HAVE THE BONY HYDATID LESIONS , DIFFUSED & INVASIVE , LOCATED MAINLY IN THE CRANIAL BASE & VERTEBRAE , WITH ILL -DEFINED CLINICAL & RADIOLOGICAL FEATURES , & RESISTANT TO SURGICAL EXCISION .

IN HYDATID DISEASE THE ¹/₁₀₀ IS AFFECTED IN TWO PERCENT OF CASES & BONE LOCALISATIONS COMPRISES FOUR PERCENT . AMONG THE LATTER THE TWO LOCALITIES MOST INTERESTING TO US -THE CRANIAL & VERTEBRAL - ARE FOUND WITH A FREQUENCY OF TWO PERCENT IN THE CRANIUM & FIFTY PERCENT IN THE VERTEBRY . THUS , ONE HALF OF BONE LOCALIZATIONS ARE IN THE VERTEBRY ; CRANIAL LOCALIZATIONS ARE , ON THE CONTRARY , QUITE RARE .

DEVE (1946,1949) HAS DESCRIBED PRIMARY & SECONDARY HYDATIDOSIS . PRIMARY HYDATIDOSIS IS THE HYDATID DISEASE CAUSED BY THE LARVAL DEVELOPMENT OF THE HEXACANTH EMBRYO . THE HYDATIT CYST OF THE NURVOUS SYSTEM , AS WELL AS CRANIAL & VERTEBRAL HYDATIDOSIS , IS AN EXAMPLE OF PRIMARY HYDATIDOSIS WHICH RESULTS FROM ESCAPE OF SCOLICES INTO THE ARTERIAL CIRCULATION , USUALLY FROM THE LEFT VENTRICLE .

SECONDARY HYDATIDOSIS IS THAT FORM OF THE DISEASE WHICH RESULTS FROM THE RUPTURE OF A PRIMARY HYDATID CYST IN AN ORGANIC SURROUNDING . WHERE SEVERAL HYDATID BRAIN CYSTS ARE INCOUNTED , IT WILL BE FOUND THAT THE HEART IS INVOLVED & THAT RUPTURE OF A HYDATID CYST IN THE LEFT HEART CHAMBERS IS RESPONSIBLE FOR THE GENERAL DESSEMINATION . THE RUPTURE OF THIS CARDIAC HYDATID CYST

HYDATID CYST OF THE BRAIN IN ADULTS:

42 CASES WERE COLLECTED IN THIS 10 YEARS WHICH COMPRISES 32.8% OF HYDATID CYST OF THE NERVOUS SYSTEM & 45.3% OF HYDATID DISEASE OF THE BRAIN . 24 CASES WERE FEMALES & 18 WERE MALES WITH MALE:FEMALE RATIO OF 0.75:1 , IF WE THINK THIS FEMALE PREPONDERANCE IS DUE TO MALE IN THE MILITARY SERVICE THIS WILL NOT EXPLAIN THE SLIGHT MALE PREPONDERANCE IN HYDATID DISEASE OF THE SPINES ONLY IF WE THINK THAT HYDATID DISEASE OF THE SPINES IS A CRIPPLING DISEASE THAT KEEPS YOUNG MALES AWAY FROM THE MILITARY SERVICE .

PRESENTATION:

13 CASES (37%) PRESENTED AS ALTERED VISION WHICH WAS PRESENT IN 17M CASES (48%) . WEAKNESS WAS THE PRESENTING SYMPTOM IN 8 CASES (22.8%) & SIDED WEAKNESS WAS THR PRESENTING SYMPTOM IN 7 OUT OF THOSE 8 CASES HOWEVER 15 CASES (42%) WERE HAVING WEAKNESS HEADACHE & VOMITING WERE PRESENT IN 29 CASES (82%) HOWEVER THEY WERE THRE PRESENTING SYMPTOMS IN ONLY 5 CASES (14%) . FITS WERE PRESENTING IN 3 CASES (8.5%) & PRESENT IN 9 CASES (25.7%) . WALKING ABNORMALITIES WERE PRESENTING IN 3 CASES (8.5%) . SPEECH ABRNALITIES WERE PRESENTING IN 2 CASES (5.7%) & MENTAL ALTERATIONS WERE PRESENT IN 10 CASES (28.5%) & PRESENTING IN ONLY 10 CASE (2.8%) .

DURATION:

THE DURATION OF THOSE SYMPTOMS WAS 15 DAYS OR LESS IN 6 CASES (14.3%) , BETWEEN 16-30 DAYS IN 9 CASES (21.4%) , BETWEEN MORE THAN 1 MONTH UP TO 2 MONTHS 9 CASES (21.4%) , BETWEEN MORE THAN 2 MONTHS UP TO 6 MONTHS 6 CASES (14.3%) , ABOUT 1 YEAR 2 CASES (4.8%) & ABOUT 2 YEARS 3 CASES (7.1%) .

EXAMINATION:

EXAMINATION SHOWED PAPILLOEDEMA IN 24 CASES (68%) , MOTOR DISTURBANCES IN 21 CASES (60%) , ALTERED CONCIIOUSNESS IN 12 CASES (34.2%) , IMPAIRED VISION IN 7 CASES (20%) , FACIAL WEAKNESS IN 7 CASES (20%) , 6th NURVE PULSY IN 5 CASES (14.2%) & SPEECH DISTURBANCES IN 5 CASES (14.2%)

SITE:

THE MOST COMMON SITE FOR HYDATID CYST OF THE BRAIN IN CHILDREN WAS THE PARIETAL LOBE WHILE IN ADULTS THE PARIETO-OCCIPITAL REGION WAS THE COMMONEST SITE . THERE WAS 1 CASE HYDATID CYST IN THE THALAMIC REGION IN ADULTS & ANOTHER CASE IN THE POSTERIORFOSSA IN CHILDREN . THERE WAS NO DIFFERENCE BETWEEN RIGHT & LEFT SIDE BOTH IN CHILDREN & ADULTS .

MULTIPLICITY:

10. CASES (25%) OF HYDATID CYSTS OF THE BRAIN IN CHILDREN WERE MULTIPLE , OF THOSE 2 CASES (20%) WERE RECURRENT CASES & NONE OF THEM WERE HAVING HYDATID CYST ELSEWHERE IN THE BODY .

11 CASES (30.5%) OF HYDATID CYSTS OF THE BRAIN IN ADULTS WERE MULTIPLE , 4 CASES (36.3%) OF THEM WERE RECURRENT CASES WITH OR WITHOUT HYDATID CYST ELSEWHERE . 2 CASES (18%) OF THOSE 11 CASES WERE NOT RECURRENT BUT WERE HAVING HYDATID CYSTS IN ANOTHER SITE IN THE BODY , SO 6 CASES (54.3%) WERE RECURRENT CASES AND/OR HAVING HYDATID ELSEWHERE .

5 CASES (45.45%) OF THOSE 11 CASES DIED DURING ADMISSION .

6 CASES WERE HAVING HYDATID CYSTS ELSEWHERE IN THE BODY & 4 OF THEM (66.6%) WERE MULTIPLE .

EOSINOPHIL COUNT WAS DONE IN 45 CASES ONLY . EOSINOPHILIA (ABOVE 5%) WAS FOUND IN 18 CASES (28.57%) ONLY

+VE

BRAIN(ADULTS)	4 (17%)
BRAIN(CHILD.)	8 (32%)
SPINES	4 (36%)
ORBIT	2 (50%)

CT SCAN:

CT SCAN WAS DONE IN 75 CASES . IT GAVE CORRECT DIAGNOSIS IN 72 CASES (96%) . IT MISSED 1 CASE OUT OF 75 (1.3%) . IT GAVE FALSE NUMBER OF CYSTS IN 2 CASES (2.6%)

ANGIOGRAPHY WAS DONE IN 4 CASES

HYDATID DISEASE OF THE SPINES:

20 CASES (15.6%) BETWEEN THE AGES OF 9-55 YEARS 11 WERE MALES & 9 FEMALES WITH MALE:FEMALE RATIO OF 1.2:1.
9 CASES (15%) WERE BELOW 15 .14 CASES (70%) WERE BETWEEN 15-44.
3 CASES (15%) WERE ABOVE 45.
9 CASES (52%) WERE IN THE DORSAL SPINES ,5 CASES (29.4%) WERE IN THE LUMBAR , 1 CASE (5.8%) IN THE DORSO-LUMBAR & 2 CASES (11.7%) WERE IN THE SERVICAL SPINES.
5 CASES (29.4%) WITH HYDATID DISEASE ELSEWHERE.
11 CASES (64.7%) WERE RECURRENT OR RECURED DURING THIS 19 YEARS PERIOD.
PRESENTATION:14 (82.3%) PRESENTED WITH WEAKNESS OR COMPLETE PARALYSIS , 2 (11.7%) AS RETENSION OF URINE & 1 (5.88%) AS PAIN .
DURING EXAMINATION NOTOR WEAKNESS OR PARALYSIS WERE PRESENT IN 15 (88.8%) CASE , SENSORY LEVEL WAS PRESENT IN 12 (70.5%) & URINARY OR INCONTINENCE WERE PRESENT IN 4 (23.5%) CASES .
MYELOGRAPHY SHOWED EXTRADURAL BLOCK IN 10 (76.9%) CASES , INTRADURAL BLOCK IN 1 (7.6%) CASE & DESTRUCTIVE OR OSTEOLYTIC LESION IN 2 (15.3%) CASES.

	SITE
DORSAL	9 (52%)
LUMBAR	5 (29.4%)
DORSO-	
LUMBAR	1 (5.8%)
CERVICAL	2 (11.7%)

20
33
42
1158
23

HYDATID DISEASE OF THE ORBIT

8 (6.25%) CASES WERE COLLECTED IN THIS 10 YEARS PERIOD ALL OF THEM WERE FEMALES BETWEEN 12-45 YEARS .

1-14 Y 1 (14.2%)
15-44Y 5 (71.4%)
45 Y 1 (14.2%)

4 (66.6%) IN THE LEFT ORBIT
2 (33.3%) IN THE RIGHT ORBIT

PRESENTATION:

6 (85.9%) CASES PRESENTED AS PROTRUSION OF THE EYE BALL OF 2-6 MONTHS DURATION & 1 CASE AS PROGRESSIVE DROPPING OF THE EYELID .

EXAMINATION REVEALED PROPTOSYS IN ALL THE CASES , 3rd NERVE PULSY IN 3 CASES , PAPTILLOEDEMA IN 2 CASES , BLIND EYE IN 2 CASES , OPTICATROPHY IN OTHER 2 CASES , 6th NERVE PULSY IN 2 CASES & OPTHALMOPLERIA IN 2 CASES .

INADVERTANT RUPTURE OF THE CYST OCCURED IN 3 CASES DURING OPERATION.

INJURIES IN THE WAR ZONE

مؤتمر كلية الطب الجامعة المستنصرية 1980

Mr Chairman, Ladies and Gentlemen

Injury in the war zone is unique as it generally affects healthy young males. Head injury is rather common and comes just after limb injury incidence.

Head injury comprises two main categories

1. That caused by blunt trauma like collapse of a shelter, car accidents or other vehicle accidents.

2. Missile injury

The Blunt type of head injury includes:

CSF leak, skull fracture, Haemorrhagic contusion, cerebral damage (EDH, IDH) and primary brain damage.

Primary brain damage can be severe or less severe where the patient's consciousness is

disrupted. The main pathological features are brain oedema

brain oedema and disruption of the BBB.

Here we need to concentrate on the proper assessment and management. The patient usually have no focal signs. Features of ICP \uparrow may be seen like BPT, PRT and inadequate breathing.

The management starts with the very essential care of the respiratory system. This is very important for treatment and also prevention of brain damage. The care starts with clearing airways, intubation, tracheostomy or even putting him on ventilator depending on the degree of respiratory trouble. The latter is used to reduce PCO_2 which is the main cause of brain oedema and ICP \uparrow . Treatment of our patient basically is to keep his blood gases right. This means normal PO_2 .

which includes subdural and intracerebral
usually are of bad prognosis as they are accompanied
by brain damage and laceration.

Clinical picture is practically the same as EDH

⊖ But with one major difference in that the
EDH patient may have regained consciousness after
the insult while the IDH patient usually
is unconscious from the start and remains so.

⇒ CSF leak caused by basal skull #

⊖ Where there is tear of dura and communication
to paranasal sinuses like ethmoid, frontal
and sphenoid. This is suspected when there is clear

CSF or diluted blood running from the nose or ear.

Skull xray may show opaque sinus or air

in the cranium. Patient should be prevented
from blowing nose.

normal P_{O_2} , P_{CO_2} , Hb, blood volume, fluid balance, BP and temp.

Treatment with steroids, mannitol, urea have been applied extensively and found to be of limited benefit in management of head injury

brain oedema.

⇒ EDH commonly seen with linear skull fracture which causes tear of the middle meningeal artery.

In our type of patients, young and healthy, the bleeding can be enormous. This produces ICP,

herniation cross the midline with ipsilateral pupillary dilatation,

then trans tentorial and eventually coning if no treatment commences

The patient usually have boggy swelling

of the scalp at area of fracture. Management

is urgent evacuation of the haematoma i.e. craniotomy
Intracranial haematoma

them as they travel. The danger is of three fold namely the damage from missile and pressure wave, haematomas formation and the presence of FB and indriven bone chips in the brain.

The severity of the injury depends on many factors:

1. Type of missile: bullet or shrapnel.

2. Speed of the missile

3. Site of the missile

4. Multiplicity of missile

5. Site of entrance

Transorbital & across midline are worse.

6. Presence of intracranial haematomas

7. Whether the missile has entered and left cranium (this produces more massive damage.)



The aim is to

from blowing the nose

and never to prevent the free drainage of

CSF from nose or ear. Antibiotics better be

given to prevent ascending infection.

⇒ depressed fractures   should be treated within


24 hours if they are compound or with CNS

malfunction. The bone is removed and any dirt

or collected haemorrhage sucked out. Dura searched

for tear and should be closed properly to

prevent chances of infection and epilepsy.

⇒ Penetrating missile injuries  are serious

and can be fatal. They are inflicted by

bullet or shrapnel. Both when penetrate they

smash the skull, dura and brain tissue

by their mass and the pressure wave around

~~them~~

The aim is to treat the damage and to prevent complications.

Priorities to surgery in penetrating injuries depend on

1. Level of consciousness: whether unconscious or having deterioration of level of consciousness.
2. Significant bleeding
3. Major skull damage
4. Injuries with minimal neurological deficit

Management

1. GA

2. Plenty blood ready

3. Large scalp exposure

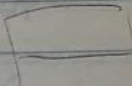
4. Craniotomy - sucking all haematoma in the extradural space.


5. Enlarge dural opening if needed

6. Suck all necrotic brain, bone chips and intra cerebral haematoma.

7. Try to

7. Don't try to remove the missile unless it is accessible.


8. Inlet graft water tight closure 

9. skin closer direct or by rotation flap. 

2. Prn op Antibiotics
Anticonvulsants.
Steroids may be given
when the patient is well few weeks

later new plain xray is taken with
various maneuvers applied to see if

the missile moves in the head in which
case it has to be removed surgically as

an abscess is developing or the missile is
in the ventricle. 

~~the~~ Dandy, Now check & shift of missile & GA

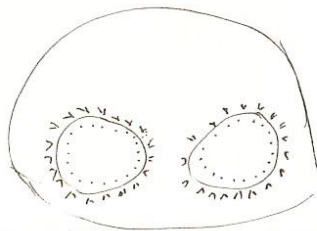
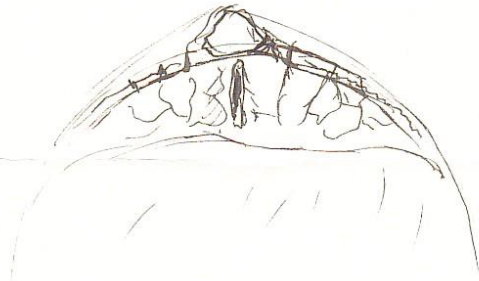
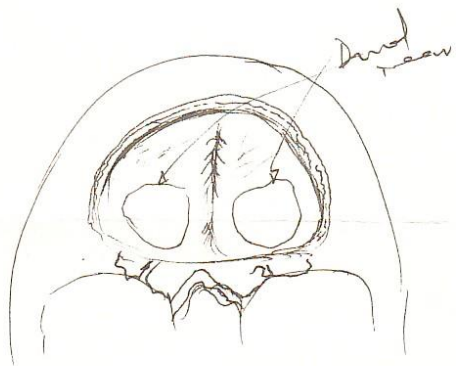
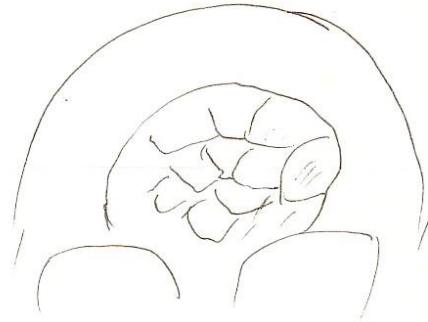
We should always remember that to
have a pure head injury is not common in
the war injuries. The patient must be
assessed

assessed thoroughly. If other injuries are present which require surgery it is better to do them all under one GA.

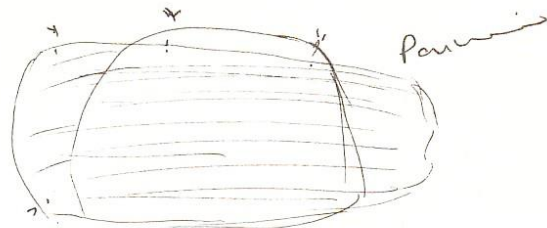
In conclusion, neurosurgery plays a vital role in the good care of the injured. Adequate and scientific management is essential. This includes proper preoperative assessment, good general anaesthesia, good blood bank facilities and proper surgery. The golden rule is that the first surgery should be the optimal when possible.

Thank you

مزرع ستون جھاد



درد دند
جھاد



SAMPLE OF OPERATING SKETCHES FOR WAR VICTIMS IN AMARA HOSPITAL DURING IRAQ IRAN WAR

IRAQI HEAD CIRCUMFERENCE CHART

1989

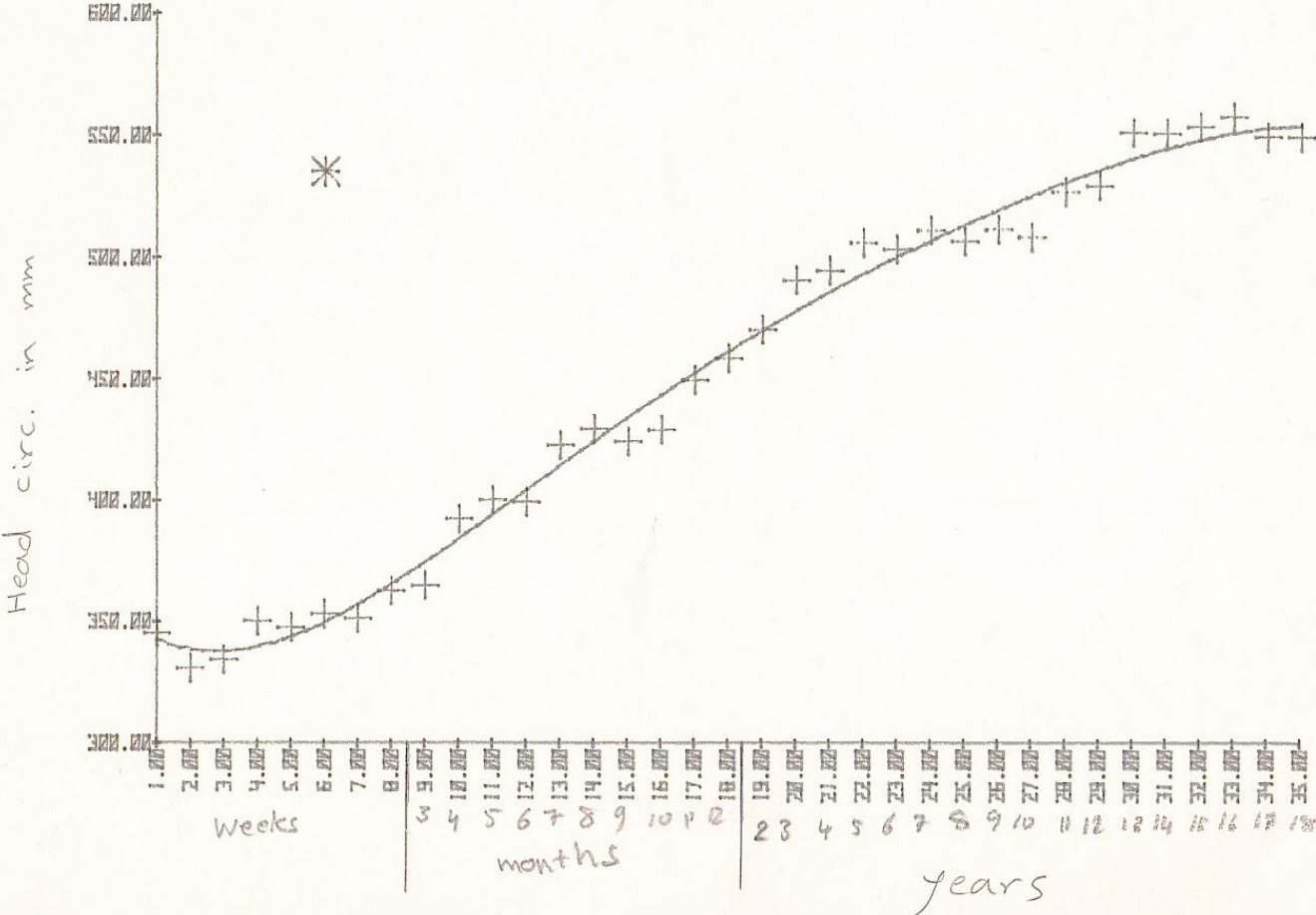
① ال Data الاصلية مخزونة بشكل System File ويمكن أخذ نسخ منها في اي وقت وبشكل مفصل .

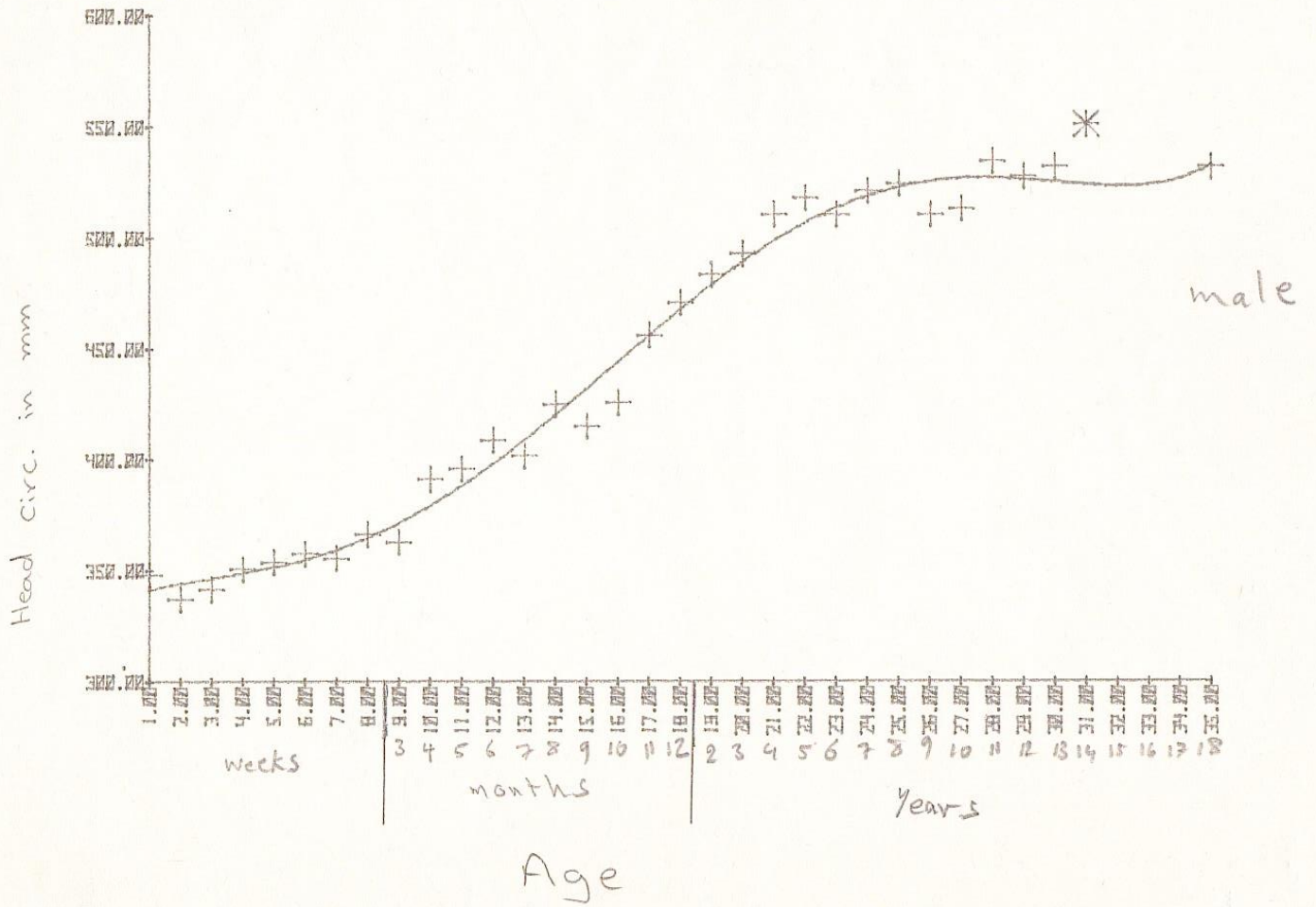
② الرسم المرفق يعتمد على قيم ال Mean لكل مرحلة من مراحل العمر لكل من الاناث والذكور (وهي قيم معدلات محيط الرأس بغض النظر عن كون الكمال من الناحية الدينية او القومية) . العلامات + على الرسم تمثل ال points في كل عمر والخط المتصل هو ال best fit line .

③ سوف يتم انتاج رسم آخر يوضح بالاضافة الى خط المعدل كل من $(+2 SD)$ و $(-2 SD)$.

④ بالامكان تحليل النتائج (عن طريق انتاج رسم) للمعدلات على + من الصفات المطلوبة (مسلم / عربي / كردي .. الخ) وليس بالضرورة على + من الجنس فقط .
ويمكن تحليل النتائج على + من المعدلات لانه من صفة (مثلاً : للذكور العرب ، أو للاناث المسلمين الاكراد مثلاً)

Famle





PT. NO.	X	Y
1	1.0000	345.4290
2	2.0000	330.8670
3	3.0000	334.4000
4	4.0000	350.4000
5	5.0000	347.5330
6	6.0000	535.2670
7	7.0000	351.5380
7	6.0000	535.2670
8	8.0000	353.2670
9	8.0000	362.6670
10	9.0000	365.0670
11	10.0000	392.4670
12	11.0000	400.2000
13	12.0000	399.5330
14	13.0000	422.6670
15	14.0000	429.4670
16	15.0000	424.2000
17	16.0000	429.0670
18	17.0000	449.6670
19	18.0000	458.5330
20	19.0000	470.2670
21	20.0000	490.8000
22	21.0000	494.6670
23	22.0000	505.9330
24	23.0000	503.4000
25	24.0000	511.1250
26	25.0000	506.5330
27	26.0000	511.4670
28	27.0000	508.2500
29	28.0000	526.8000
29	29.0000	529.4000
30	30.0000	551.3330
31	31.0000	550.8670
32	32.0000	553.6000
33	33.0000	557.6670
34	34.0000	549.4000
35	35.0000	549.4000

Family

NO. POINTS = 35

X: MEAN= 18 ST. DEV. = 10.24695077
 Y: MEAN= 451.9393714 ST. DEV. = 77.12468446

CORR. COEFF. = 0.986057115

COEFFICIENTS

NO.	X	Y
1	1.0000	347.9440
2	2.0000	337.1110
3	3.0000	341.5560
4	4.0000	350.6110
5	5.0000	353.7780
6	6.0000	357.6110
7	7.0000	355.3890
8	8.0000	366.4440
9	9.0000	362.7780
10	10.0000	391.2780
11	11.0000	395.9440
12	12.0000	409.0560
13	13.0000	401.8890
14	14.0000	425.1110
15	15.0000	415.2220
16	16.0000	425.7780
17	17.0000	456.2000
18	18.0000	470.8890
19	19.0000	483.5560
20	20.0000	493.0000
21	21.0000	510.7220
22	22.0000	518.0000
23	23.0000	510.5290
24	24.0000	521.2220
25	25.0000	524.3330
26	26.0000	510.5560
27	27.0000	513.1110
28	28.0000	534.4210
29	29.0000	527.5560
30	30.0000	532.0000
31	31.0000	550.0670
ETE	31.0000	550.0670
31	35.0000	532.0000

male

POINTS = 31

MEAN = 16.12903226 ST. DEV. = 9.337172789
 MEAN = 441.1482258 ST. DEV. = 72.28259646

DEFF. = 0.967975395

ENTS

337.1654
 1.0017

LASER IN MEDICINE

1990

محاضرة في ندوة الليزر في جامعة بغداد

بِسْمِ اللّٰهِ الرَّحْمٰنِ الرَّحِیْمِ

« مَنْ اَلِهٌ غَيْرُ اللّٰهِ يَأْتِيكُمْ بِضِيَاءٍ

اَفْلَاتَسْمَعُونَ »

” الْقَصَص: ٧١ ”

العقل سراجٌ وهماجٌ

والعلمُ منارٌ لا يُطفأ

فاستشفوا بالنور الشافي

بالمصحة والراحة حفاً

الامتاذ د. هين ينفوذ

Laser :

- Coherence
- Collimation
- Monochromatic

Spot Size

depends on :

→ Focal length

→ Mode

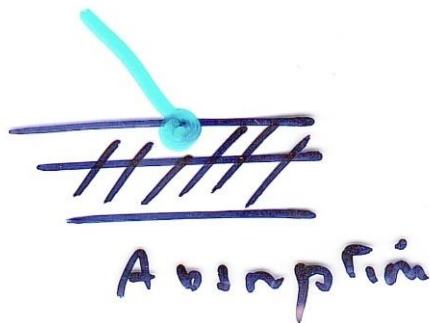
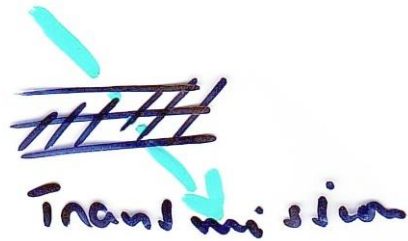
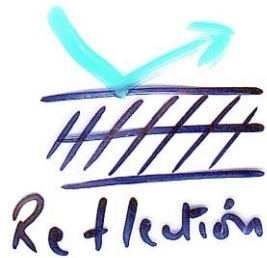
[Transverse EM
Mode]

TEM



→ Wave length

Tissue Interaction



ABSORPTION

- INCISION
- COAGULATION
- VAPORIZATION
- TISSUE WELDING

Biological effect depends on:

- Power density
- Radiant exposure
- Coefficient of ab by tissue

Cutting:

- Precise beam
- Minimal damage

Depth $\left\{ \begin{array}{l} \text{Power density} \\ \text{Time of application} \end{array} \right.$

Features:

Bloodless

Heals the same
Easier
Quicker

Vaporisation:

Focussed
defocussed

Coagulation:

Focussed 0.5mm

Defocussed: Bigger
(slow blood flow)

+welding



Advantages in Neurosurgery

- atraumatic
- reasonable haemostasis
- craniotomy made smaller
- less pulling and manipulation
- can work around delicate
- shaving tumour cells attached to major vessels

Future

- Percutaneous ablation
- Photoradiation
- Intravascular application

Common Laser in Medicine

CO₂

Argon

Nd: YAG

Others : Excimer

Helium-Neon

Ruby

Krypton

Experimental :

Copper Vapor

Gold Vapor

CO₂ Laser

10600 nm.

- High degree of absorption
- limited lateral damage

• Cutting

• Vaporisation

• Coagulation (welding)

Argon

— 488 nm - 514 nm

EFF: 0.1%

Heat up: cool down

Photo coagulation

Pigmented tissue



Eye surgery

skin basal cell ca



Nd:YAG



1064

EFF

2.6%

Heat up

Coagulation

(1320 - cutting)

Helium - Neon

633 nm

EFF 0.15%

Visible light used
with other laser

- May be used to
 - alleviate pain
 - promote healing

DYE LASER

Rhodamine (560, 575, 590
610, 640)

610 photo radiation

Hemeporphyrin derivative

↓
Superoxide radical

↓
Cytotoxic

ADVANTAGES OF LASER

Features

- No touch
- No interference with monitor
- Precision
- Sterilisation of op. site

Surgeon Immediate

- Dry field
- Reduced blood loss
- Reduced tissue oedema
- Potential limitation of residual ca cells (Metast. or rec.)

Result

- Limited fibrosis
- Reduced post op pain
- No danger of genetic transformation

General surgery

Co₂ all organ surgery
or thoracics

limited

Bone heat conduct

ophth. ophthalmology

Retinal detachment

Diabetic retinopathy

Glaucoma

Vascular surgery

Welding

LASER

SAFETY

- Eye glasses + Patients eyes
- Sponges and drapes
- Inflammables
- Instruments

Dermatology

CO₂ Nd:YAG and Argon

Teleangiectasia of skin

Tattoo removal

GIT

Nd:YAG

Bleed ulcer

angiomas

Recanalization of

obstructed tumours

GIT

UROLOGY

CO₂

Bladder tumours
condylomata

Nd:YAG

Penile Ca
urethral stricture
prostate Ca

Gynaecology

CO₂

Endometriosis

Cyst evaporation

Micro tuboplasty

uterine myomas

Cervical neoplasia

epithelial)

Genital warts

Nd: YAG

Menorrhagia

ENT

CO₂

papillomas

Laryngeal surgery

Vocal cord papilloma

Intra nasal telangiectasia

Tonsillectomy

Nd: YAG

Argon

Tumours in facial

Stapedectomy

الأضداد وحيدة النسيلة (monoclonal antibodies)

واستخدامها في أمراض الجهاز العصبي، ندوة الأضداد وحيدة النسيلة، مدينة الطب 1987

○

119

Mr Chairman Ladies & Gentlemen

It has been stated that in much the same way that computerised tomography has influenced the clinical neurology, hybridoma technology has influenced the basic neurosciences. Monoclonal antibody although still in an early stage of development has already had tremendous impact upon immunology and medicine allowing a specificity and reproducibility previously not possible with poly clonal antibodies.

Monoclonal antibodies proved valuable

①

in neuro oncology, study of normal and abnormal neurological functions and also in establishing new concepts in neuro anatomy.

9. In neurooncology it has been widely used. There is an enormous potential as yet unrealised clinically, for MCA to increase specificity in diagnosis and treatment of CNS tumours.

Scientists and clinicians have long been intrigued with the idea whether human tumours might express specific tumour antigen on their cell surface.

There is increasing evidence that this will be true in human brain tumours most specifically malignant glioblastoma tumours. Human and experimental brain tumours have been demonstrated to have

②

glioma associated antigens. When MCA technology has been applied three major antigens have been demonstrated:

1. Differentiation antigens
2. Epithelial proliferation antigens
3. oncofetal antigens.

1. Differentiation antigens are present in normal and neoplastic cells. They are either cytoplasmic like intermediate filaments protein (IFPs) cytokeratin or membrane associated which can be defined by UJ 13 A antibodies in neuroectodermal tumours.

2. Epithelial proliferation antigens present in small amounts in normal simple epithelium but strongly expressed in proliferative states. example HMFG1 and HMFG2.

3. Oncofetal antigens which are restricted to fetal tissue but re-expressed in adults by tissues that have undergone neoplastic transformation. example antigen which

Can be recognised by UJ 181.4 antibody,
MCA have the capacity to distinguish between
normal organ specific and tumour
specific antigens in most of instances.
It may also be able to determine
the cell of origin of many CNS tumours,
early identification of tumour,
possibly identifying prognostic factors
and predict responses to various therapeutic
modalities.

③ This can be carried out by
application of MCA markers and
MCA radioisotopes. Amongst the
markers is the glial fibrillary
acid protein (GFAP) & the best known
It is expressed specifically by

astroglial cells as normal cells or astroglial derived tumours. Binding to GFAP demonstrated by all types of glial tumours including ependymoma, oligodendroglioma. The other MCA marker - 4 neurofilament protein proved useful to diagnose peripheral and some CNS tumours including neuroblastoma, pinealoblastoma.

Radiouclides localisation of brain tumours may not reach the accuracy of computerised tomography or nuclear magnetic resonance. However, the biochemical information given by radiouclides localisation is unique and may ultimately allow differentiation between neoplastic and inflammatory or vascular lesions in brain.

and quantified when experiments done
on human glioma bearing athymic
mice and other primates in order
to be used on glioblastoma patients.

Eight monoclonal antibodies were
characterized that defined glioma
associated antigens. They were
specific and failed to react with
the brain. Examples are 81 C6 which
is labelled to 125 I and β coupled MCA,

By the cell marker and radio labeled
MCA it was found that certain
brain tumours have specific corresponding antigens.
Cerebral glioma have UJ 13A,

81 C6 Medullo blastoma UJ 181.4

Schwannoma, UJ 127.11 Meningeoma

UJ 13A, ch. plexus papilloma LE 61

4

In the aspect of therapy of brain tumour MCA have a major potential as a carrier of toxins and drugs.

1. Toxins : Human neoplasms transplanted in athymic mice have been successfully treated with plant toxin a-brin, Cicin or gelonin. Bacterial toxins were also used mainly diphtheria

2. Drugs conjugation with MCA included methotaxate, chlorambucil, melphalan, adriamycin, and others.

Advantages of this conjugation to MCA would be in the specificity of drug delivery with reduced systemic toxicity with the theoretical potential of maintaining therapeutic levels of

8/

dry at the tumour site over
prolonged period of time

MCA are

(5)

MCA have been applied in study of normal and abnormal CNS functions. They have been used to define receptors - an example is the acetylcholine receptor at the muscle membrane in normal state and in myasthenia gravis.

MCA was used to study the neurotransmitter. They have advantage over any other method to be of selective affinity. They also can be labelled in vivo and in tissue sections and able to detect in the same section more than one transmitter in one nerve terminal or in adjacent terminals.

An example is the MCA to Substance P (NC1/34 H2) which was used to study the distribution of substance P within the neural pathway, and anti serotonergic MCA (YC5/45) which recognises serotonin containing neurons in the nucleus pallidus.

This methodology of using MCA in the study of neurotransmitter may probably open the gate for identifying the true aetiology of many mysterious psychic and neurological disorders like schizophrenia and other types of dementia, Parkinsonism, Huntington's chorea and other genetic acquired disorders.

11

In neuroanatomy MCA have been valuable not only in identifying the different cell types but also as experimental tools for marking or deleting the progenitor cell.

They have been made to react with some of the principal cell types of retina or cerebellum. As an example is the use of MCA Car 301 which reacts with limited classes of neurons in different areas of CNS. have identified their true site in the cerebellar hemisphere.

In conclusion MCA have resulted in a new awareness of the complex relationships that exist within the CNS, their specificity and reproducibility can provide means to quantitatively and qualitatively define the ~~stress~~ malignant gliomas. The potential exist to use MCA alone or as a carrier of radioisotopic drugs or toxins for treatment of malignant brain tumours.

THERAPY WITH

MCA CARRIERS

- Toxins

- Plant abrin ricin
- Bacterial diphtheria

- Drugs

- Methotaxate
- chlorambucil

⋮

Aspects of **MCA** in Neurology :-

- Neuro-oncology
- Neurological Functions
- Neuroanatomy

MCA and CNS

Functions

- Receptors

acetylcholine

- Neurotransmitters

Substance P

NC1 34 HL

Serotonin

YC 5/45

• Aetiology of ?!

Schizophrenia

Dementia

Parkinsonism

H. Chorea

Genetic and acquired
Disorders

Brain Tumours

Antigens as detected
by **MCA**

- Diff. antigens
- Epith. Prolif. antigens
- Oncofoetal antigens

MCA MARKERS

- GFAP
- Neurofilamen pt.

MCA RADIONUCLIDES

- Glioma UJ13A
81C6
- Medulloblastoma
UJ181.4

• • • • • • •

NEUROBLASTOMA 1989

①

NEUROBLASTOMA

نوربلاستوما

Nervo - Neuron - Nerve.

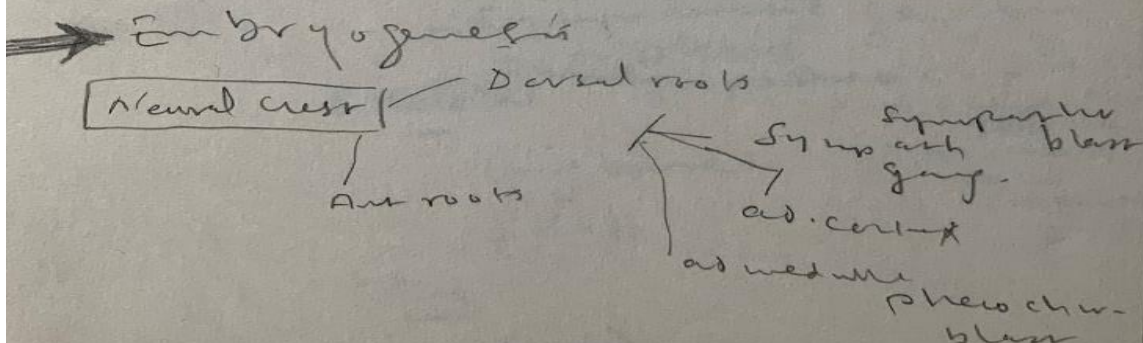
Blast - Blastus - Germ

Neuroblast

Embryonic cell which develops into a nerve cell or neuron.

Neuroblastoma

Sarcoma of nervous system origin, composed chiefly of neuroblasts and affecting mostly the autonomic nervous system & adrenal medulla.



~~Site~~
~~we face it~~

in CNS

Brain
Rare in

power
cord
cauda equina

Vanuxemian -
with some calcification
To diff from
oligodendro...

Cord

can be affected by local
expansion from vertebral

PNS

roots.

orbis

in a 17

ANS

- adrenal medulla

- sympathetic ganglia

- parasympathetic - plexus

Skeletal

- viscera: Hk
abdomen

Long bones

- Myenteric
plexus
submucosa

Skull

Skin

Nasal cavity
secondary

and sinuses

Clinical Presentation

③

Determined by $\left\{ \begin{array}{l} \text{site of primary} \\ \text{its}^{\text{a}} \text{ metastases} \\ \text{age of patient} \end{array} \right.$

1. Fetal:

The mother (pregnant):
palpitation, headaches, sweating,
and hypertension late in pregnancy

2. Congenital

like erythroblastosis fetalis:
jaundice, anaemia, oedema
& abdominal distension -
"Blueberry Muffin" under
5% -

3. Neonatal

Most common: abdomen

65% abdomen

14 chest

4.5% pelvis

3.5% neck

12 other

Types according to timing
infantile (congenital)
acquired.

Age incidence -

Mostly first decade.

7 1/2 first 5 yrs

25% before 2 yrs

Baby can be born with the
tumour

Sex equal.

associated lesions:

Congenital NB : Cardiac anomalies

Thoracic NB 2

Beckwith Wiedman Synd.

[omphalocele, macroglossia,
visceromegaly and hypoglycaemia]

Hirschsprungs Dis.

Pyloric stenosis

Von Recklinghausen

Von Hippel Lindau

We face it

- as 19 lesion of ~~24~~ side of
- Brain related to side of
- ~~Skull~~ lobe.
- Symphysis
- orbit
- Paraplegia
~~24~~ skull
- skull
- scap
- orbit

age

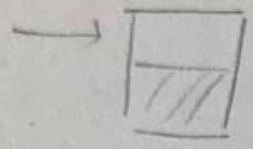
Mostly first decade

Neuroblasts

Tricle

acellular

5-6 / 52



inner layer or

Matrix
(Germinal)

7 / 52

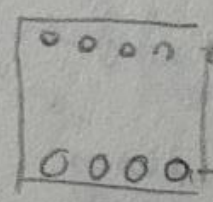
Neuroblasts migrate to the

single layer.

A layer between
cellular density

will have low

→ white matter



late migrating cells

early cells

Ruckenstein

157

Diff. Diagnosis

Oxydendroglia

unident. primary tumor

Immunological studies 29
Adenofib

Tumor specific markers

From Murray to Ben

- Eleutheria New Line

185

1) send for transportation

Russel & Rubenstein

280

1) Mostly First Decade

7 1/2 thru 5 yo

25% before 2 yo

size related to size of lobe

Frontal -> later parietal

Pons rare

Cereb rare

Cauda equina rare

Impairment cut as time calcified

Dibb -> oligodendrocytes

Associated 1 -> Van Hippiel Lindauer

50% and 50% variant

Brain features

Raised level of
catecholamines
in urine & CSF

one patient of ultra med-
uller neuroblastoma.

Bioassay of the tumour
showed ↑ level of adre-
nic - ↑ metadrenaline -
via methyl mandelic acid.

Returned to normal after removal
of growth.

Growth & Biological
Behaviour

3 yr survival, 60%

5 yr 30%

40% rec. 30% of them survived

Metastasis

(3)

Local rec.

CSF pathways rec.

Extranodal

Vertebrae / other bones

liver

can happen 6 mo years
later.

one can repeated surgery

1. nodes (vulva)

scalp

—

898

pangheral neuroblast.

origi-

||

adrenal medulla

parasympathetic sympathetic

chain &

plexus

parasympathetic plexus

- visceral afferent

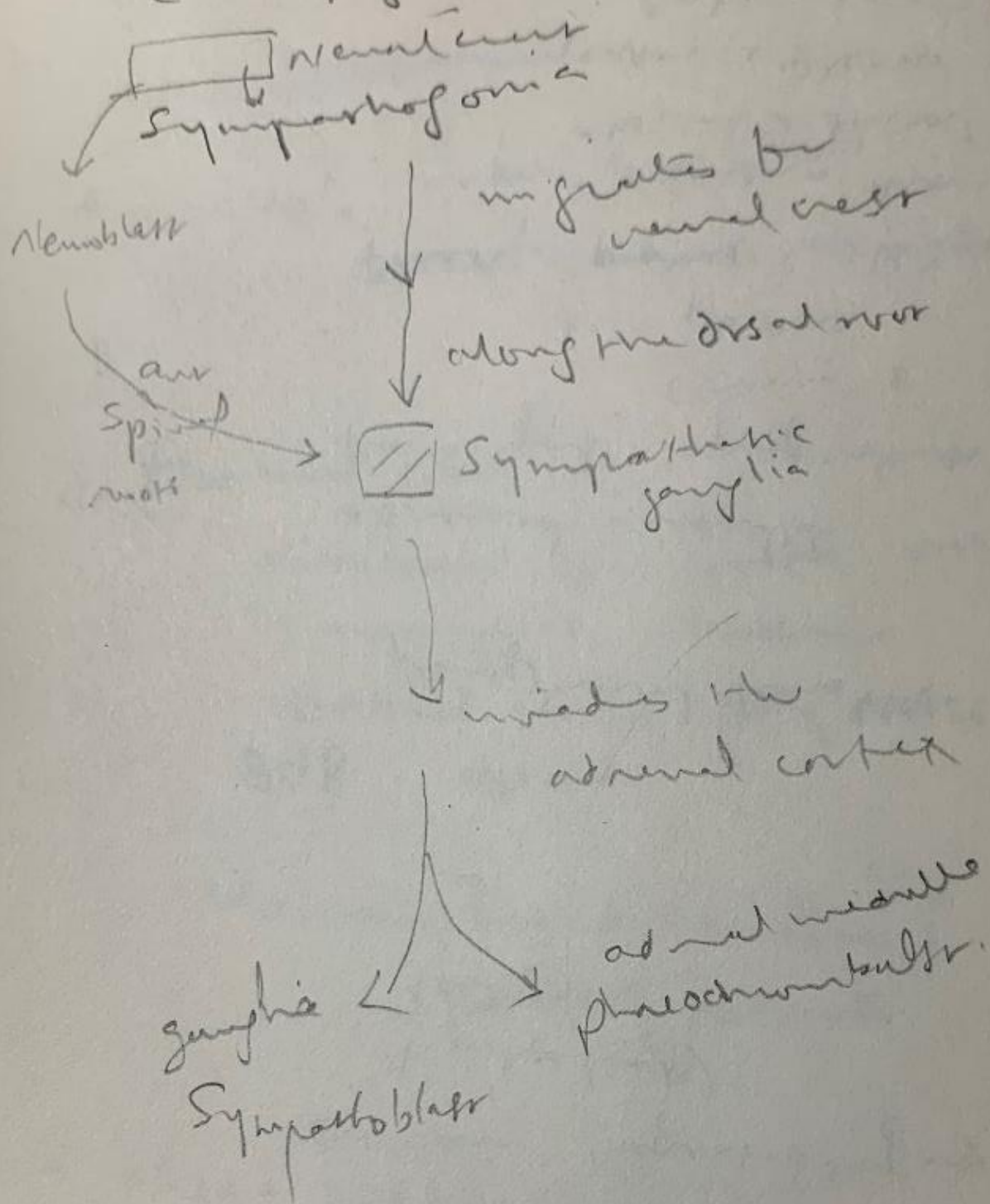
abscd dorsal -

myenteric plexus -

submucosa

outside ventral ganglion
and a v. roots

Embryogenesis



900

(4)

Neuroblastoma

- // 70% under 4 yrs of life
- common cardiac anomalies
- ++

- Familial cases -

autosomal dominant with:
incomplete penetrance.

identical twins - only one is affected ..

Urinary Catecholamines ↑
in families of patients.

- No sex predilection but

// ♀ have better prognosis

- Associated lesion

congenital NB → cardiac anomalies

thoracic NB → Beckwith Wiedemann
syndrome (omphalocele, macroglossia,
visceromegaly and hypoglycaemia)

// Hirschsprung's; pyloric stenosis,
von Recklinghausen.

- sites (common)
adrenal
Retropituitary / ventr

76% - the abdomen

//
adrenal 51% < 3 yrs of age
35% 3-14 yrs
13% adult

usually unilateral. R = L

(congenital type - Bilat)

ovary) Rarely

GIT

mediastinum

nerve

nasal cavity

A sinus

Diff.

Neurochemistry

Neurospecific enolase

Neurofilament protein

68 kD 160 kD

Growth & spread.

Metastases

adrenal -> Retro local invasion

1. node metastases

-> medial direction -

overlap of course - the node

invading the IVC & renal v.

Lumbar vertebrae &

pelvis.

Sympathetic ganglia

- local invasion

Vertebrae

Pancreas (coeliac plexus)

Thoracic vertebrae (medisternal)

Bomb-bell tumor to vertebrae

Two types of metastases

-> Repper type abdomen + liver

-> Hutchinsonian Syndrome
orbis skull

-> older group
long bones.

<6/12

liver 65%

↓
Reynold 1. wades

5 skull, Temp bone
5 skull bone

orbis

long bone asymptomatic

occasional late recurrence

5-20 yr later -

Evolution =

Differentiate &

regression

Metformin have been
used. 1927

Case of Harry Curo
2 y old boy Neurofibromatosis
histologically → 10 y later
ganglion removed

Phillips 1953 ⑥
another case of neuroblastoma
→ ganglion neuroblastoma. lived
for 6 yr.

Cushing case survived for
45 yr

Phillips survived 20 yr

Even with large resection 27
can regress.

The survival is better when this
tumor is congenital.

Regression and maturation
appears when the tumor appears
before 6/12 of age

Stain secondary may act
as a good prognostic sign

in the cores 100% survival after
2 yrs - 86% after 6 yrs

Biochemical correlates

Degradation products ...
Dopa, Dopamine, Ⓢ

5 hydroxyindolacetic acid,
homovanillic acid and VMA
(vanilmandelic acid)

⇒ high level of excretion of
arcsulic acids = slow return to normal
= poor prognosis.

⇒ if more homovanillic acid over
VAM ⇒ poor prognosis

⇒ Presence of methoxytyrosine or
vanillic acid, or of
increased level of cysta-
thyronin in urine
poor prognosis

Other factors:

raised serum ferritin

elevated serum level of
neuronal specific enolase

NGF elevated in serum

⇒ Some tumours adrenergic
others cholinergic

Prognosis factors

① - Histological evidence of neuronal maturation

② age of the patient at the time of initial diagnosis
< 2yr better

③ site of growth

adrenal
suprarenal
(Lumbar) } worse prognosis

cervical & thoracic } Better

④ stage of the disease

I tumor confined to organ

II extends in continuity but not crossing midline

III Directly beyond the midline

IV metastases skeletal

⑤ Biochemistry

poor prog ⓧ ↑ ferritin (above 150 ng/ml)

ⓧ ↑ Neuron specific enolase (above 100 ug/ml)

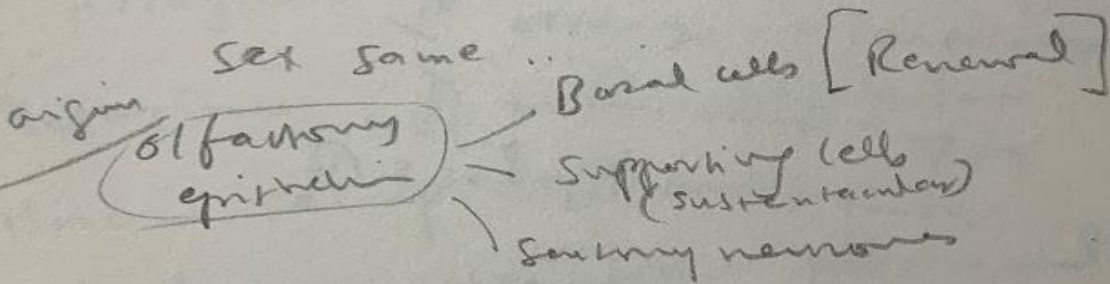
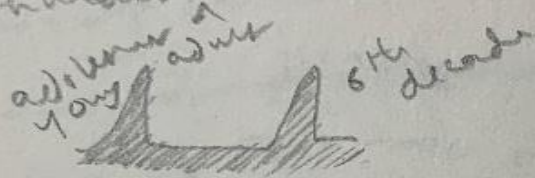
9, 5

Olfactory Nerve cells

are the same as those

originating from olfactory epithelium

From embryonic



These cells → GFA pr. glial fibrillary acidic pr

are found in the cortex

↓
neurospecific esterase

Biological Behavior of Nerve

- slow growth & Radial orientation
- local extension - all directions
- 30% survival can reach 90% depends on stage
- 50% > 5 yo
- retains by phages - long - bones

Ophthalmic Pathology

(8)

2749

Metastatic orbital tumour -
9 years old child

N.B. owing to
rapidly developing proptosis
+ ecchymosis of lids

Metastases 40%. Bilateral
There is temp + Bone lesion
Mostly coming from abdominal
medullary,
Mediastinal

orbital metastases was 11%. Proptosis.

orbis
Henderson

It was considered to be the most common infantile orbital tumor now. (Henderson's disease).

1.5% incidence

38% secondary some 16% papers

It is disease of infants & children
at birth

25% before 1 year occur 40%
75% before 5 yr

can be bilateral

♀: ♂ equal

Clinical features

Usually 2y; Mostly for retroperitoneal + Horner syndrome; when the 1y is a thickened sympathetic.

Can be very rapid; oedema, swelling or puffiness. May suggest orbital cellulitis. May resemble RMS

but RMS is firmer than NB
ecchymosis is a feature of NB
although it is not specific against
for NB but for all malignancies.
The point here is to diff for cellular

^{approx}
Diets depends on site & lesion
chemo, redness etc

like cellulitis

when $orbis$ is ++ there is an
abdominal mass

other when manifested by
convuls, headache etc

usually ^{orbis} 24 approx 3/12 after 14
2.6% only before the 14 discomd

Bilateral 7 nodes.

Ammonia & ill.

Hay

74% secondary: skull.

wide suture by destruction
and reactive changes.

absent + any soft tissue

50% calcification ^{mass} of tumor

Bone involvement ..

Prognosis

① age : More favorable
- < 1 year

② site : Better with
mediastinal
& adrenal

③ Extent of location of 2y
within first few
Bone upon prognosis

④ Degree of cytologic detail

⑤ Better means of Rx

⑥ Spontaneous regression
even with metastases

Orbit 4 categories

1. Rarely an orbital mass is the initial and only manifestation should have removed completely or excimeration.

chemotherapy but no DXR except 29 extraorbital tumor sites.

2. The orbit is either the only 29 or one of few after the 19 is removed.

You may remove the orbital tumor. By reducing the mass chT & DXR may help better.

3. Orbit is seen with - large abdominal mass both should be removed.

4. Orbit is one of many 29s pallid - DXR & chT

DXR 1000 - 1500

chT - Vincristine - -

Survival = 3 1/2 when orbital second is +.

11

3307

Yours

When: fetal life in the mother (pregnant)

palpitation, weakness, sweat, and hypertension late in pregnancy.

congenital:

like angiodysplasia fetalis

jaundice, anemia, edema & umbilical distension

"Blueberry Muffin" seen under skin.

Neonatal

Most common is abdominal (adrenal)

- 1/ 65 adrenal
- 14 chest
- 4.5 pelvis
- 3.5 neck
- 12 unknown

Abdominal mass → when
radiological manifestations →
intra-abdominal extension of tumor.
Spinal cord involvement ++.

14% intra-abdominal extension

32% where thoracic
orig.

10% where
abdominal orig.

Regions

- dist of abd. mass
- thoracic .. retroperitoneal
- abdominal .. peritoneal

- 5 cases

- Bochvarov

- urinary VMA

NEUROLOGICAL COMPLICATIONS OF AIDS

1985

في كلية الطب، جامعة بغداد

NEUROLOGICAL COMPLICATIONS OF AIDS

- — VIRAL INFECTION
- — NON VIRAL INFECTION
- — NEOPLASM
- — CEREBROVASCULAR
- — CRANIAL NERVES
- — PERIPHERAL NERVES
- — OTHERS

VIRAL INFECTIONS

- Subacute Encephalitis
- Atypical Aseptic Meningitis
- Herpes Simplex Encephalitis
- Viral Myelitis
- Prog. Multifocal Leucodystrophy
- Others

NON VIRAL INFECT ION

• Toxoplasma gondii

• Fungal

Cryptoc. neoformans

Candida albicans

Coccidioides immitis

Aspergillus

• Bacterial

• Syphilis

Subacute Encephalitis

● Incidence 25%

● Features -dementia - headache
- fever
- focal neurol. deficits
- visual problems

● Diagnosis CT scan LP
EEG MRI

● Cause CMV

● Course Progressive fatal

ATYPICAL ASEPTIC MENINGITIS

- Incidence 5 %
- Presentation headache
fever
meningial signs
- Features recurrence
chronicity
long tract signs
cranial nerves involvement
- Diagnosis CSF
- Cause CMV
- Course Selflimited recurrence

HERPES SIMPLEX ENCEPHALITIS

NERVES

- Features
 - headache
 - fever
 - seizure
 - aphasia
 - focal deficit
- Diagnosis
 - CT scan
 - MRI
 - Brain biopsy
- Treatment
 - Acyclovir

NEOPLASM

CRANIAL & PERIPH.
NERVES

Distal Symmetrical Neuropathy

Ch. Inflammatory Polyneuropathy

Herpes Zoster Radiculitis

Bell's Palsy

NEOPLASM

PRIMARY CNS LYMPHOMA

SYSTEMIC LYMPHOMA + CNS

KAPOSI SARCOMA + CNS

1985

①
MCW

In Chairman Ladies and Gentlemen

Slide ①

This poor creature the African green monkey has been accused by everybody to be the primary source of the whole AIDS trouble. In its blood scientists found

virus similar to that of HTLV virus and

This animal is a pet in the AIDS zone of Africa that is Zaire, Kinshasa, Rwanda

and Burundi. The animal lives with people

frequently bites them and even people might eat this

monkey. Recently however, in that part of Africa

similar virus was found in sheep and goat.

side ①

In 1983 Dr Luc Montagnier of Pasteur
 institute in Paris first discovered the virus
 and a year later Dr Robert Gallo of the
 National Cancer Institute Bethesda USA
 also discovered and cultured the virus

The No. of victims of AIDS is increasing.

The highest known incidence is in USA

side ②

up to 10 July 1985 the total incidence
 was about 12 250 victims. By Oct 10th

The total risen to 14 121 with 7200 already
 dead. The mortality is approaching 100%.

As we heard from our colleagues
 AIDS detrimental effect is due to the
 destruction of body immunity mechanism
 by not only destroying T cells but also
 by making them factories for virus production.
 This is called the lymphotropic
 mechanism. As a result of this marked

decrease in cell mediated immunity
 Patients with AIDS are devastated by
 multiple opportunistic infections and tumours of the
 body including CNS. Recently another mechanism
 was discovered and that is neurotropic.
 With the virus having direct effect
 on the CNS as it is found to be able to pass
 the Blood Brain Barrier.

H

It is well documented that nearly 10-15% of AIDS patients present primarily with CNS deficit. Between 40-60% of all AIDS victims have amongst other clinical features CNS involvement. In autopsy it was found that in over 70% there was CNS involvement.

The primary CNS symptoms are of dementia, depression, headache, seizures, focal neurological deficits and that of neuropathology.

~~slide 6~~ The neurological complications of AIDS are grouped in this slide

- viral infection
- Non viral infection
- Neoplasms
- Cerebrovascular disease
- cranial nerves
- peripheral nerves
- others

~~slide 7~~ Amongst the viral infections:

- Subacute encephalitis & Atypical
- Aseptic meningitis, Herpes simplex
- Encephalitis, viral myelitis
- Progressive multifocal leukoencephalopathy
- and others

~~slide 4~~

Subacute encephalitis

This is the commonest CNS manifestation in AIDS patients it makes about 27%.

The patients present with

Progressive dementia

Headache

Low fever

Partial neurological deficit

Signs of frontal lobe damage

Visual impairment

Diagnosed by

CT Scan Mild generalized atrophy

LP elevated pt. slightly low sugar
mononuclear pleocytosis

EEG diffuse non specific
slow waves

MRI very helpful.

(2)

Cause is cytomegalic virus, which is seen in both white and grey matter.

It is progressive and fatal.

~~Shd 9~~

Atypical atypical meningitis.

Its incidence is about 5%.

Patient presents with

~~10~~
Headache

Fever

Meningeal signs

Features of this meningitis

recurrence

Chronic

long track signs

Cranial nerve involvement I, II, V

Diagnosed by CSF

Pressure ↑

Placocytes ++

Sugar ↓

pH ↑

CMV was cultured from some patients.

It is self limited with spontaneous regression and recurrence.

slide

10

Herpes Simplex Encephalitis

Commonly HSV I.

Features Headache

fever

seizure

aphasia

Other focal deficits

(9)

Diagnosed by CT scan

MRI

Brain Biopsy

Some patients may be

treated by Acyclovir

~~stroke~~
~~stroke~~

Progressive Multifocal Leukoencephalopathy

show mental changes

blindness

aphasia

hemiparesis

ataxia

CT low density lesion

Viral myelitis

ascending myelitis

Myelogram normal

CSF pleocytosis

CMV and HSV II cultured

Shiba 12

Non viral infections

The commonest is Toxoplasma gondii
Usually progressive and fatal but
can be treated if diagnosed early
Presentation:

- Altered level of consciousness
- lethargy
- confusion
- Seizures
- focal deficit

CSF pr ↑
 chloride ↓
 sugar ↓
 pleocytosis

IGG titre elevated but not diagnostic

CT very helpful
Biopsy is the answer

Can be treated by Sulfadiazine and
Pyrimethamine.

Fungal

These also seen in patients who under go organ transplant and debilitated patients.

Cryptococcus

Present as meningitis with hydrocephalus

Candida albicans

Meningoencephalitis

sterile
flank

Bacteria &

Syphilis seen rarely

CEREBROVASCULAR COMPLICATIONS

Include Intracerebral haemage due to thrombocytopenia and other blood changes
Embolism from infective endocarditis.

Slide 13

Neoplasm

Primary CNS lymphoma is the commonest
also seen in patients with

compromised immunity due to other causes
i.e. organ transplant, HIV infection

The lymphoma affects brain
paraneoplastic

Presenting

Encephalopathy

Neuropathy

Brain stem dysfunction

CSF high protein Sugar normal
may see atypical cells

or

CT Scan is helpful.

2. Secondary lymphoma
affect the meninges or at extradural space.

Secondary from Kaposi Sarcoma
or other systemic tumours

Bur KHL lymphoma, Rectal carcinoma
can involve the CNS

S/S
Cranial and peripheral
nerve involvement

- Distal Symmetrical Neuropathy
- Ch. Inflammatory polyneuropathy
- Herpes zoster radiculitis
- Bells Palsy.

~~Name~~

CT scan is an important non-invasive investigation. It can delineate the presence or absence of intracerebral & focal lesions in most instances.

It can show:

- ① Presence of intracranial mass
- ② cerebral atrophy
- ③ Ventricular enlargement

~~Name~~ This shows ring enhancement.

This is seen in toxoplasma and pyogenic abscess. A course of sulphur or pyrimethamine produce resolution of the lesion.

Slide

Hypersensitivity encephalitis.

CT + MRI

A: Day 1

B: Day 2

C: Day 5

mass masses

MRI shows enhancement

Slide

Lymphoma also shows

ring enhancement - but does

respond to Rx

Slide

CT + MRI

Subacute encephalitis

CT ? normal MRI Marked bifrontal

In summary CNI involvement
in AD patients is common it is
present in 40-60% of cases

Presented as dementia, depression,
focal deficit syndromes.

Diagnosed best by CT scan or
MRI In most instances it
is fatal -

OCCULOMOTOR NERVE DAMAGE AND REGENERATION

7

Oculomotor Recovery & Regeneration

Paper given by Dr. A.Hadi Khalili in the Iraqi ophthalmic Society Dec.1977

The phenomenon of the recovery of the third nerve is very well known to you and I am sure you have met many examples of there. Its interesting note that G. Jefferson the neurosurgeon had stated in 1947 that although considerable recovery takes place in time. The nerve in my experience he said " almost nerve regains function so completely that there is perfect mobility of the globus oculi in all directions and with parallel uisual axes " .

Paterson in the year 1968 also stated although recovery further III pelly was complete from a subjective point of view on testing ocular movements, all patients had same degree of improvement of upword saze in the originally affected eye .

Nevertheless recent workers have described cases with complete recovery .

Herein I have few examples of different pathologies causing isolated III palsy .

WY is a man of fifty. History of acutionset of sudden pain over left head for 6 weeks with diplopia and ptosis of the left eye. Angeo showed PC aneurysm. He was found hypertensive of deferred by the time this was controlled his III palsy and headache disappeared and he refused the operation. The III recovery was of grade I .

MS lady of 44 presented with incidious mild weakness of the right side of the body with left side visual blurring and left side moderate III palsy . Angeo showed a giant internal carotid artery aneurysm. The carotid artery was ligated. The III has improved to grade I but with slightly large pupil.

YM is a lady of 30 presented with a classical SAH. Angeo showed a right MCA. The aneurysm at operation has suptured which required more than one clip to be used with some extra retraction of the brain . When she recovered postop. She was found to have a right III complete palsy. ~~Abgaut~~ 4 weeks later this started to improve and when she was seen 2 months after the operation she had grade I recovery neuropratia. But there was disgeneration on abduction the upper lid ptoses .

WS lady of 50 classical SAH plus sudden complete paralysis of the III . Angeo PCA . Directly attacked & clipped III recovered grade II with slight ptosis .

FS man of 30 sudden collapse with dense right hemiplygia & incomplete III palsy which was complete next day. Referred to us 10 days after the collapse. SAH diagnosed and Angeo showed an MCA with a big clot direct attack with removed of the clot with clipping the aneurysm. Recovery started immediately after the operation and almost grade I 3/12 after the operation .

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(4)

The grading of recovery has put by Cantu and modified by Reja for practical purposes .

- Gd 1 complete recovery + mild pupillary and argement .
- Gd 2 slight ptosis but didn't involve the visual axes .
- Gd 3 marked ptosis + visual axes involvement .
- Gd 4 constant ptosis or axes problem .

Pupil recovery

1. Return to normal
2. Remain large & fixed
3. Shaggy reaction
4. Smaller
5. Angyll Robenson midlinection

Bosterell

Aneurysm 40 cases

4 cons.	
8 ligation	
28 clipped	18 comp.
	8 mud.
	2 slight

conchrdded operation 10 danp direct attack only could result -
Gd 1 recovery .

Helper

25 cases carotid ligation only 4 have complete recovery
pupil 14 mild reaction to light
11 non reactive
20 cases pseudo graefe of lid

The recovery depends on the octiology of the cause in neuropraxia as a small haematoma at the S.O. Fissure or at the hila of the neuprascula bundle or haematoma of the muscle itself then recovery is likely. But it avnl serios leceration .

The sequence of recovery

1. The medial rectures shows the first recovery & it is good .
2. The inferior recturs .
3. The suprections is the slowest to recover. The pt. who didn't acheive full recovery he usually has limitation of this .
4. LPS recovers well-all pateints .
5. Some with pseudo Geefe sign .

The grading of recovery has put by cantu and modified by reja for practical purposis .

- Gd 1 complete recovery + mild pupillary and argement .
- Gd 2 slight ptosis but didn't involve the visual axes .
- Gd 3 marked ptosis + visual axes involvement .
- Gd 4 constant ptosis or axes problem .

Pupil recovery

- 1. Return to normal
- 2. Remain large & fixed
- 3. Shegkish reaction
- 4. Smaller
- 5. Angyll Robenson midlinection

Bosterell

Aneurysm 40 cases

4 cons.	
8 ligation	
28 clipped	18 comp.
	8 mud.
	2 slight

conchrded operation 10 danp direct attack only could result -
Gd 1 recovery .

Helper

25 cases carotid ligation only 4 have complete recovery
pupil 14 mild reaction to light
11 non reactive
20 cases pseudo graefe of lid

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RUCKER 335 CASES

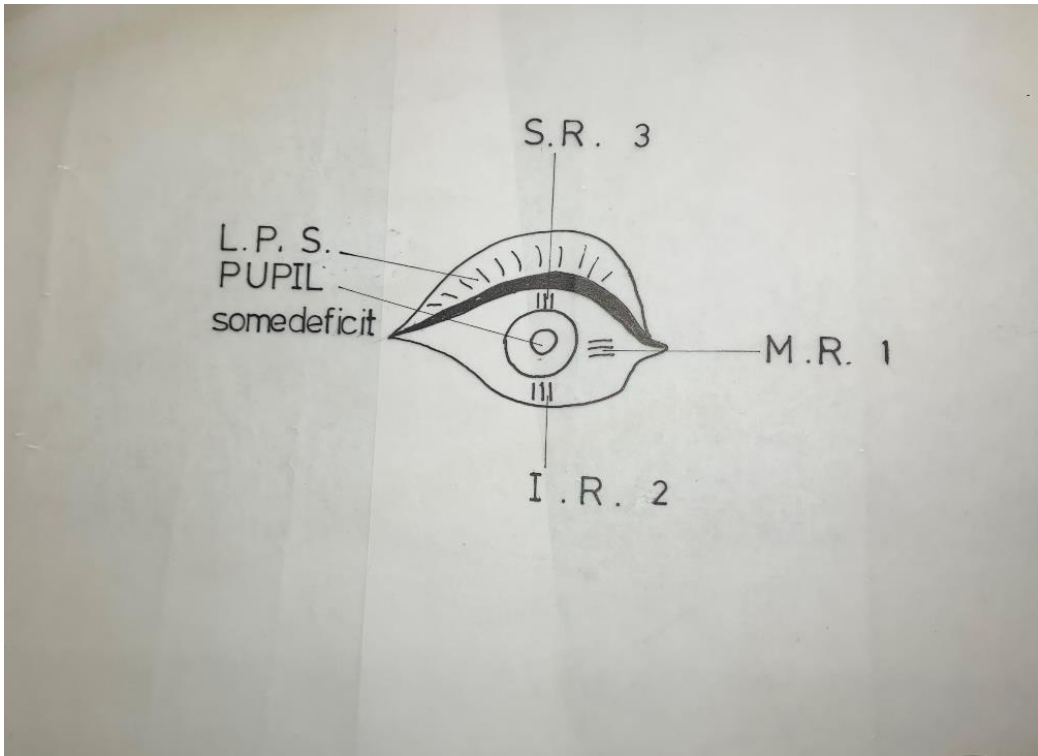
ANEURYSM	64	19.3 %
VASCULAR	63	19 %
HEAD INJURY	51	15.3 %
NEOPLASM	35	10.4 %
OTHERS	27	8 %
UNDETERMINED	95	29 %

PATHOLOGY OF III PALSY IN ANEURYSM

I SUDDEN ENLARGEMENT OF ANEURYSM SAC

- ⊙ STRETCH
- ⊙ OEDEMA
- ⊙ INTRANEURAL HAEM.

- II
- ⊙ MID BRAIN HAEM.
 - ⊙ KINKING & DISPLACEMENT OF POST. C.A.
 - ⊙ COMPRESSION BY HERNIATION.
 - ⊙ COMPRESSION OF THE BRAINSTEM.



PATIENT	AGE	SEX	DIAGNOSIS	III LESION	MANAGEMENT	RECOVERY
W.Y.	50	♂	P.C.ANEUR.	SLIGHT	CONS.	GRADE. 1
M.S.	44	♀	I.C. =	MODERETE	OP.	= 1
Y.M.	30	♀	M.C. =	COMPLETE	OP.	= 1
W.S.	50	♀	P.C. =	=	OP.	= 2
F.S.	30	♂	M.C. =	=	OP.	= 1
P.R.	15	♀	HEAD INJURY	MODERETE	CONS.	= 1
D.I.	8	♂	=	COMPLETE	CONS.	= 3
H.G.	55	♀	=	MODERETE	CONS.	= 1
S.S.	65	♀	FRONTO TEM PORAL GLIOMA	SLIGHT	OP.	= 4
J.M.	50	♂	PIT. ADENO. MA	MODERETE	OP.	= 2

BOTTERELL

DEFICIT	NO. CASES	RECOVERY				DIED
		GRD. 1	GRD. 2	GRD. 3	GRD. 4	
COMPLETE	18	3	1	11	—	3
MOD.	8	4	3	—	—	1
SLIGHT	2	—	1	—	—	1
TOTAL	28	7	5	11	—	5

○ Oculomotor Nerve

The oculomotor nerve leaves the midbrain from the medial side of the cerebral peduncle between the superior cerebellar artery ^{below} and the posterior cerebral artery ^{above}. It then ^{passes} ~~traverses~~ the cisterna ^{interpeduncularis} and the tentorial gap to reach the posterior clinoid process. In this region it is in close association with the posterior communicating artery and the internal carotid. As it crosses the tentorium it lies immediately below the uncus and the hippocampal gyms of the temporal lobe. These relationships with the arteries as well as the pressure from the temporal lobe under the nerve liable to paralytic lesions. Thereafter it curves along the roof of the cavernous sinus and then its lateral wall to enter the orbit through the sup. orbital fissure in two divisions the superior supplying the levator muscle and the sup. rectus and the inferior supplying the medial and inferior recti and the inferior oblique muscles.

The parasympathetic fibres pass ~~through~~ ^{pass} the EW and go through the ~~nerve~~ ^{sup. division} to leave it eventually with the ~~nerve~~ ^{branch} to the ciliary ganglion.

→ ~~the~~ ^{the} ~~depression~~ ^{depression}

→ ~~the~~ ^{the} ~~visceral~~ ^{visceral} ~~parasympathetic~~ ^{parasympathetic} ~~nerve~~ ^{nerve} ~~anatomy~~ ^{anatomy}.

Misdirection

Gowers in the year 1879 described several abnormal ocular movements following III recovery this was followed by Wilbrand in 1900 when they observed retraction of the upper lid ~~to~~ in patients with third nerve recovery. Bielschowsky in 1935 stated that there was evidence of regeneration but in abnormal direction. The best review in fact was of ~~Fr~~

Frank Walsh ~~in~~ his address¹⁰ to the Irish ~~of~~ ophthalmic society in Dublin when he observed ⁴⁸ ~~48~~ cases of different etiology.

- 17 aneurysm
- 14 head injury
- 4 inflammation
- 4 diabetes
- 3 tumors
- 3 Ophthalmic migraine
- 3 Unknown etiology

The classical case is ~~is~~ characterized by misdirection of regenerated fibres, the upper eyelid is elevated when the eyeball is adducted, voluntarily or involuntarily.

Disgeneration

104

pupillary phenomenon

① wide dilatation of the pupil and insensitivity to light & accommodation

② loss of reflex to light but contraction at any time either with convergence or conjugate movement

③ the pupil is larger ^{or sometimes smaller} reflexly to light.

This phenomenon can form effective synapses with post ganglionic autonomic fibres.

Pseudo Strabismus :-

On primary position there is no ptosis. On looking down there is widening rather than of the palpebral fissure. However the patient can still willfully close his eye.

Recovery

Any of several developments may occur

1. There may be complete recovery ~~presumably~~
~~with no or only slight degeneration has~~
2. Complete recovery but with some ~~per~~ persistent pupillary change.
3. ~~Only a change~~
4. The paralysis may persist unchanged
5. Incomplete recovery as regards the EOM

5. There may be misdirectional recovery

The pupil recovery will be one of the following

1. Return to normal
2. Remain dilated & fixed to light.
3. It may be smaller
4. Sluggishly reacting to light
5. May become of Argyll Robertson pupil type.
i.e. misdirection

55

Copy available

Cranial Nerve Avulsion and Other Neural Injuries in Road Accidents

Julian Heinze

The Med. J. of Australia

Dec 20 1969 1244

Good article for review

21 cases of RTA dissected at PM

<u>Nerve</u>	<u>Lesion</u>	<u># Skull</u>	<u>No#</u>	<u>Total</u>
II	haem into sheaths	10	1	11
	laceration, haem into n., oedema	1	-	1
III	partial avulsion	-	1	1
	Rootlet avulsion at b. stem	1	1	2
	14 avulsion necrosis contusion	2	-	2
	Intraneural spinal nerve in sup. orbital fissure	2	-	2
IV	Rootlet avulsion at b. stem	2	1	3
	Rootlet avulsion at b. stem	4	1	5
	Disruption at tip of pet. temp. bone	1	-	1
Trigeminal	Haem on affer towards globe	12	-	12

Fracture of optic canal

	Fracture of optic canal		Haem in optic n. sheath		Haem in central n. sheath	
	(R)	(L)	(R)	(L)	(R)	(L)
ie (1)	✓	—	No	—	—	No
nasal (2)	✓	—	Yes	—	—	Yes
nasal (3)	—	✓	—	Yes	Yes	—

- The most unexpected finding is the rosette-evulsion for the brain stem.
- Bony injury of a severe order may not result in overt damage to the nerve trunk.
- The tip of petrous temporal is not the common site for \square damage.
- E.O. Muscles may be involved selectively on the bundles or the neurovascular limb at level of the sup orbital fissure. A-les would explain the rapid recovery in some cases.

Observation :- III IV & VI are exposed.

But never the three at one time.

~~Observation~~ :

Observation : longitudinal laceration of IV at diff levels. The ipsilateral orbit & canal were free from damage.

14 contusion in the III proximal segment.

Neural haematoma :

Haem in and around nerve trunks was found in three sites in sup orbital fissure involving the III.

In neurovascular bundle like of the extraocular muscles and in the optic nerve and sheath

Optic nerve Sheath Haem

	<u>intraorbital haem</u>	<u>intraorbital and Periorbital haem</u>	<u>Orbital</u>
Site (10)	2	6	1
Site (1)	—	1	

Oculomotor palsy due to
 Supradivoid internal carotid
 artery after berry aneurysm
 (a long term study of the results of surgical
 treatments on the recovery of III function)

E. H. Bottwell et al.

Am. J. ophthalmology

1962

Vol 54 60

40 cases of int. carotid artery
 aneurysm (supradivoid) with III only. Rxd by
 ligation of carotid artery or direct attack
 or conservative. The patients followed for up to 10 years

4 cases due to their age and general conditions.

8 cases ligated.

Shifting result = 35 ♀ 5 ♂
 with = good average 55% ♀
 women

Hooper 1951 Brit J. of Surgery 39: 126
orbital complications of head injury

Hooper presented 7 cases with multiple
fracture of the orbit and in 2 complete recovery
obtained for III lesion by decompression
of the orbit.

Early pupillary signs may be
due to laceration at level of sup
orbital fissure in the absence of
orbital fracture. This may account for
sudden dilatation of pupil after
head injury.

Slight

Pupil minimal dilatation
Phos & minimal
more than 15° movement of cor.

Mod.

< 15° movement
Fully dilated pupil
or severe phos.

(severe)
complete

~~R~~
28

clipped 10 days

7 complete palsy
R with 10 days
onset of III

6/8 moderate

op (10 days)

3 complete recovery

- 3 complete recovery
- 2 slight
- 1 died

- 1 slight
- 2 moderate
- 1 died

2 slight deficit

- 1 died
- 1 remain

clipped 10-30 days

9 complete palsy
None full recovery
(7 moderate)

clipped 1-6/10

2 moderate

1 full recovery

The aneurysm was situated on
- level of post c. artery above
below it.

The nerve at operation was flattened

> The berry aneurysms usually produce
motor or palsy by hemorrhage to either
the third nerve.

acute dilatation of the aneurysm
is responsible for some cases of
III in which no evidence of bleeding.
and in some at autopsy the fibers
III were seen stretched and flattened

Onset was of III palsy was sudden in 24 hrs.
7 cases over few hrs
9 over several days.

25 it was complete
15 partial.

Absent reports only observed -
2 cases.

The full recovery could be achieved
only if the aneurysm is attacked within
10 days for onset.

Reviews of Ophthalmology

Intraocular aneurysms causing
ophthalmoplegia

David Cogan - 757

Arch. Ophth. . 1963 Vol

The third ^{cranial} nerve emerges from the central
nervous system at the anterior end of the
pons in immediate proximity to the junction
the post-communicating with the vertebral art.
They then course anteriorly to parallel the
post-communicating arteries and enter the
lateral surface of the cavernous sinus

8 light of cord - weak.

recovery was partial & moderate
- general.

4 conservative - 3 lenses → nodules
1 node. remained.



The recovery is fairly constant

the sup rectus & the lower 10 recover
and the pt who didn't achieve full
recovery usually left of with difficulty
- elevations of the globe.

the medial rectus usually shows
good recovery. The inferior rectus
recovery is to a lesser extent.

Most of pt L.P. Superior and pupil
recovered well.

recovery usually starts within
days of Rx. On most cases 100%
months for full recovery best is 3/12

1000 cases studied of paralysis.

III was 1/3 of cases.

335 cases.

51 of cases head injury

(22) due to automobile accident.

Neoplasm is rare (10%)

Head trauma 51 cases
 Neoplasm 10% 35 cases
 Vascular 63 cases
 aneurysm 64 cases
 Other 27 cases
 Undetermined 95 cases

Secondary 13 cases
 BPT
 arteriosclerosis
 21 cases diabetes

encephalitis
 H-2oster
 myelin
 rotio
 measles
 scarlet
 D.S.
 post-yp.

The pit have
 likely produce
 pure
 but found
 combi.

Pupils

	Normal	affected
Neoplasm	7	28
aneurysm	2	62
Vascular	52	11

335

just in front of the post chiasm
vess.

This isolated IV palsy could come
in p.c. eye.

~~the~~ sphenoidal ca and metastatic Ca
ca ~~in this region~~ could cause ^{IV} palsy

Diabetic ^{hypohemoglobinemia}
chorioma

, middle granular

Am. J. Ophthalmology

Vol 46 1958

palsy of III IV & V cranial ⁷⁸⁷

C. Wilber Rucker

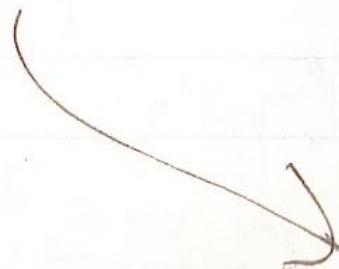
II	III	IV	V	VI	VII	VIII	IX	X
Undetermined	95	9	129	14	25	10	282	
Trauma to head	51	24	57	7	16	13	168	
Neoplasm	35	3	82	12	13	20	164	
Vascular dis	63	24	57	6	3	0	153	
Aneurysm	64	0	16	13	8	8	100	
Other	27	7	68	1	11	9	123	
	335	67	409	53	76	60	1000	

36
53
189

Evaluation of ocular signs and symptoms in cerebral aneurysms

Edward Darley et al Arch Ophthalmology
1971
1964

409
52
20
5/12



Proc. Roy. Soc. Med
1954 47
141-146
work of Hyland & Barnett

The effect of aneurysms on the vessel
is due to two categories of causes:-

① Sudden enlargement of
perigonal sac which caused half the
res and was manifested through :-

- a = stretching of the vessel
- b = occlusion
- c = increased back pressure from
venous obstruction and subsequent
fibrous infiltration profuse

② The other half cases

- a = mid brain - lesion
- b = Kinking and displacement of
the post cerebral artery
- c = compression by herniation
of hippocampal gyrus
- d = stretching or compression of
the brain stem through
sudden haem.

This is due to the somatic fibres
produce effective synapses with
the Postganglionic fibres.

Answer

Handbook of clinical
neurology Vinken & Bruyn
Brug

Vol 23

Lesions of the CN III in relation to CN VI
at the base of the skull may occur
in various manners. For most of its length
the CN III runs over the base of the skull
till it penetrates the cavernous sinus and
from there the orbital fissure. The nerve
may be injured during this long trajectory.

A study of 65 cases of
 eyes with ophthalmic complications
 42% had isolated III palsy
 In series of 106 of isolated VI
 palsy no case of anisocoria was
 reported.
 In series of 67 cases of isolated
 VII palsy no single case of
 anisocoria was found)

→ The nerve is rarely completely
 divided by pressure from the sac
 so that partial recovery of
 the nerve is the rule.

Pseudo Gaebe phenomenon in
 dysgenetion.

Pupillary changes

- wide dilatation of iris
 and inactivity to
 light & accommodation
- less of light reaction
 but contact or
 convergence
- larger than the but
 occasionally smaller &
 acts sluggishly

Rucker

1000 cases

Mechanism of head trauma
III palsy

- # sphenoid bone,
- Hinges into the sheath of the nerve
- a stretching of the nerve with post force as the brain stem is displaced at the moment of the violence.

"When ~~the~~ pit tumor caused paralysis they always affected the third nerve, most often alone but sometimes in combination with of the others"

~~Vasculer disorders~~

occurred in ~~any~~ ^{any kind of} the cases patients who have diabetes

jury may arise through ^① stretching
directly as a result of the #
desion of a the blood vessel in
proximal to the cav. sinus
rise of the ICP compressing
against the petroclinoid ligament

It is ~~very~~ important to know if
- III paralysis has occurred at
- the time of the injury or after it

Davison Neurologist

Verruken

When pain in the ~~the~~ eye or
the side of the head accompanies
III paralytic as it sometimes
does when diabetes is the cause
and nearly always does when
aneurysm is the cause the diagnosis
may be hard pressed to distinguish
one from the other. The pupillary
reactions yield valuable information.
If they are normal the
paralysis is probably due to
occlusive vascular ~~disease~~
disease, if there is iridoplegia
paralysis is more likely due
to aneurysm.

21 Cases diabetes

pupils were ~~not~~ normal
in all except 4 cases
even those ~~it was~~ iridia
artrhoplegia was incomplete

It is due to an ischaemic
infarct within the center
of the nerve trunk due to
occlusion of nutrient artery
In this location it could
readily spare the pupillary
fibres which lie along
the superior surface.

Key for diabetes
from neurology results

were noted somewhat later

Arch. op. h.

1954

Vol 51

400

Cover 1879 described

fine dysgenet.

Bender

~~D~~ Fulton (1938) produced

the aberrant regenerative movements
experimentally with chimpanzee
and the monkey. They concluded
that recovery and the phenomenon
attendant upon it are most
likely due to outbursts and
misdirection of the regenerated
axis cylinders. The abnormal
lid movements were noted as
early as one month after intraneural
section of the pupillary abnormities.

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James K Kane
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0477 Very important

Ref for III Reg

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429-440 1879

مؤسسة مدينة الطب

العيادة الاستشارية الخاصة للأطباء المتفرغين

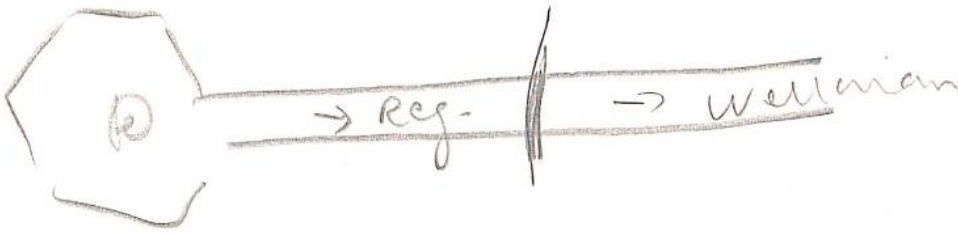
بدالة : ٨٨٨٩٠٠١

اسم المريض :

شعبة الحجز : ٤٦٥

تاريخ المراجعة :

التشخيص :



After cut of the nerve 3-5 days
the nerve distal to the cut will
still transmit impulses. 25% the
nerve will respond normally until
72 hrs. But at 12 hr 2/3 &
24 hr all nerve fibres show some
evidence of degeneration in their course.
Conduction continues if as long as the
axolemma (the axis cylinder sheath)
is intact and not damaged.

of the orbital margin. Radiographs usually give adequate information concerning the cause of the displacement and their management presents no difficulty.

These examples indicate that displacement of the globe is of considerable importance. There must



FIG. 206.—A Horner's syndrome and facial paralysis associated with a fracture of the base of the skull.

be no delay in assessing the nature of the displacement nor in arranging for early reduction of the deformity in order to prevent late complications and to diminish the cosmetic defect of the injury.

SUMMARY

Derangements of the orbit affecting visual function are a frequent sequel of the head-on injury and often present as a complication of a head injury which may be variable in severity.

The common complications affecting the visual mechanism are: deterioration of vision, double vision, and displacement of the globe.

Deterioration of vision may be due to defective accommodation or defects in the visual field subsequent to injuries to the globe or the optic pathway.

The problem of post-traumatic optic atrophy is discussed in the light of the data obtained from 21 patients, particularly in respect to the following: (1) the visual field defect; (2) the mode of onset; (3) the changes observed in the fundus oculi; (4) recovery; (5) the changes observed in the optic nerve and chiasm at operation and at autopsy; (6) radiological evidence of fracture; (7) the effects of secondary lesions in the orbit.

The aetiology and pathology of 'post-traumatic optic atrophy' is discussed and the management of the condition is considered.

The causes of diplopia are classified and the frequency of nerve involvement discussed in relation

to the nature of the impact and the situation of the lesion. Diplopia due to displacement of the globe is discussed in relation to management.

Finally, displacements of the globe itself are subject to analysis and examination in relation to diagnosis and management.

I am indebted to the members of the staffs of the Royal Melbourne Hospital and the Children's Hospital, Melbourne, for referring many of the



FIG. 207.—Unilateral exophthalmos following a head injury in which an extradural haemorrhage occurred on the opposite side.

patients whose injuries are recorded in this paper, and also for their help and advice in the management of related problems. To colleagues in country centres who have referred other cases in the series, I would also express my gratitude. Due acknowledgement is made to Miss M. Turnbull for her secretarial assistance.

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FIG. 1. Photographs of patient with oculomotor dysfunction. *Upper:* Forward gaze. *Middle:* On gaze to the right, the left palpebral fissure widens and the right narrows. *Lower:* On gaze to the left, the palpebral fissure changes reverse.

ward and medial movements were more limited in the right than in the left eye. Two years after the accident, extraocular muscle surgery on the right eye to decrease the exotropia and right hypertropia resulted in modest cosmetic improvement.

Follow-up Studies. When seen in ophthalmoneurological consultation 2½ years after trauma, the patient was well coordinated and able to participate in sports. There was an impressive decrease in mental function characterized by hyperactivity, a short attention span, poor memory, and slowness in school work. The ophthalmological findings were significant. The visual acuity was 20/20 in the right eye and 20/30 in the left, and color vision was normal in each eye when tested with Hardy-Rand-Rittler plates. Visual fields were full and the fundoscopic examination was normal except for mild bilateral optic disc pallor. Exotropia, right hypertropia, and a slight right head tilt were present, and on preferred fixation with the left eye, the right palpebral fissure was smaller than the left (Fig. 1). The pupils were

each 7 mm in diameter, fixed to light, and did not constrict with eye movement. The horizontal range of eye movements was full, elevation was mildly limited bilaterally, and downward gaze could not be elicited. No globe movement occurred on forced lid closure. Gaze to either side was accompanied by lid elevation on the side of the adducting eye and lid droop on the abducting side (Fig. 1). Upward gaze produced moderate upward-beating nystagmus with marked synchronous left upper eyelid jerks. Attempted downward gaze produced unsustained left eyelid nystagmus. A moderate upward nystagmus response accompanied by left lid nystagmus could be elicited on optokinetic stimulation, but no downward beats were evoked; horizontal optokinetic nystagmus was normal aside from minimal right medial rectus slowing. Neither convergence nor miosis occurred on near fixation with either eye.

Discussion

Misdirection has been observed following third cranial nerve injury from aneurysms, trauma (including surgical trauma), syphilis and other meningo-vascular inflammation, congenital causes, and cavernous sinus thrombosis.^{2,8-10} By far the most common association is with carotid aneurysm, with various studies disclosing an 84%,⁵ 38%,⁷ and 50%⁴ incidence of aberrant regeneration following third nerve palsy due to aneurysm. Bilateral misdirection is rare. One case following a subacute traumatic subdural hematoma with probable secondary tentorial herniation has been described briefly.⁹ Knowledge of another case following trauma is mentioned by Walsh and Hoyt.¹⁰

The specific pattern of regeneration is unpredictable in a given instance, but certain phenomena are frequently observed; these include synkinetic lid elevation and pupillary constriction when innervation of other third nerve muscles is attempted, vertical eye movement limitation (upward usually greater than downward), absent vertical optokinetic response, and medial eye deviation on attempted vertical eye movement.

In the present case, ipsilateral lid elevation on adduction of either eye indicated that some fibers normally innervating the medial recti had regenerated aberrantly to supply the levator muscles. Vertical nystagmus indicated residual brain stem dysfunction, but the syn-

Third cranial nerve regeneration

chronous left eyelid nystagmus probably represented misdirection of superior rectus fibers to the levator muscle. The inability to depress the globes, in the presence of nearly normal elevation, would be unusual in misdirection, and may represent a central palsy of downward gaze.

Differentiation between direct third nerve damage and oculomotor dysfunction from secondary tentorial herniation is a common and frequently difficult task in the patient with head trauma. Diagnostic confusion with the resulting unnecessary surgical measures in the present case might have been obviated by the observation of immediate pupillary and globe paralysis; however, the rarity of bilateral traumatic oculomotor nerve injury in patients with reasonable survival potential made this a difficult diagnosis.

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Osteopetrosis 1992

Instructions: OSTEOPETROSIS
A CLINICAL STUDY OF
Tube: OPTIC NERVE INVOLVEMENT
AM. J. OPHTHALMOLOGY
53 (1962)
943-953
ics:

The Enigma of Normal P. Hydro. / 16/31
by Lindsay Symon & T. Hingston / 1237
chap 22

Crookard HA et al

An Experimental cerebral vesicle
injury made in primates

J. Neurosurgery 46 1977 776

(Very nice references)

American Journal
of
Ophthalmology

Feb. 1980

Vol 89

No 2

Hepatoma Metastatic to the orbit
J.R. Lubin et al

PEDIATRIC HEAD INJURY

المؤتمر العربي لإصابات الاطفال 1978

PAEDIATRIC
HEAD INJURY

STUDY OF
2000 PATIENTS
OF
NEUROSURGICAL
HEAD INJURY

MODE * SEX

	♂	♀
CAR OCCUPANT	66	160
PEDESTRIAN	68	734
ASSAULT	61	13
FALL FROM HEIGHT	68	688
BICYCLE	88	32
OTHERS & UNSPECIFIED	67	373

H.I. most common cause of attendance & admission

UK 1000 000
1/3 of surgical admission
14% of paediatric admission

Almost all children suffer from accident

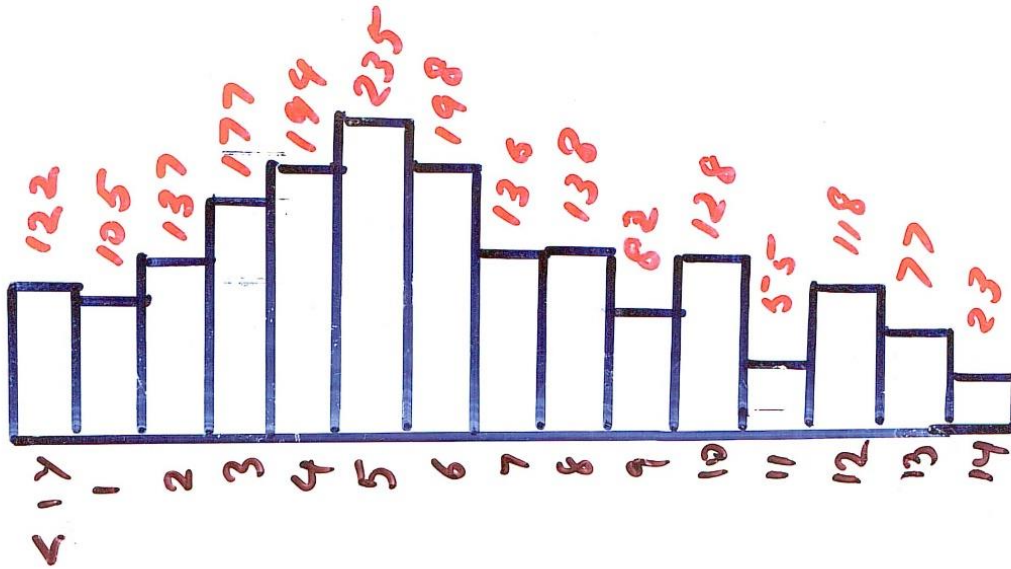
Every tenth child suffer HI with cerebral symptoms

ENGLAND 50 000 children admitted yearly

USA 200 000

Sweden 10-15%

Norway 75% of all paediatric hosp. for trauma → H.I.



68%

32%

2:1



Same as
UK
USA

Car acc.	160
Pedestrian	734
Assault	13
Fall	688
Bicycle	32
Others	373

8%
36.5%
0.7%
34.2%
1.6%
19.1%

RTA 46%

UK 15%

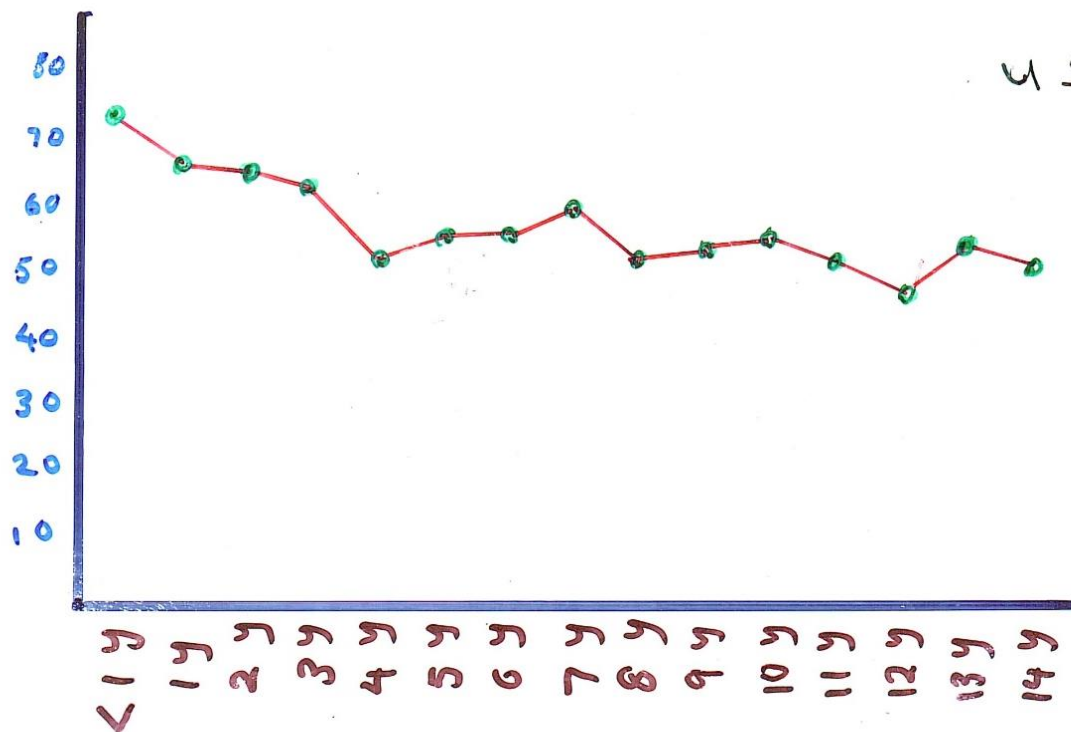
+ AGE

2000

1165 #

58%

USA 65%



	TOTAL	#	
MILD	816	426	52%
MOD.	122	69	56%
SEVERE	991	638	64%

EYE	0	10	0	9	0	6
MAX. FACIAL	6	18	0	4	0	8
CHEST	3	22	0	2	0	1
LONG BONE #	18	104	1	9	3	5
ABDOM	0	5	0	0	0	0
	160	734	13	688	32	373
	CAR occupant	Pedestrian	Assault	Fall from high hr	Bicycle	Others

317

16%
ICU

PRE-OP. ICU	11	24	1	27	4	10
POST OP. ICU < IW	10	63	7	67	7	53
POST OP. ICU > IW	6	11	0	5	0	0
	17%	13%	62%	14%	34%	17%

CSF EAR	5 9%	24 34	0	15 27	7 13	5 9
CSF NOSE	1 6%	8 44	0	7 39	0	2 11

car occupant

Pedest.

Assault

Fall

Bicycle

Others

EDH	2 18%	8 28	3 60	31 60	3 60	9 43	56 46%
IDH	9 82	21 72	2 40	20 40	2 40	12 57	66 54%

EDH ↑ MILD
IDH ↑ SEVERE

122

6.1%

HAEMATOMA

of 2000

Many series
6-8%

EYE	0	10	0	9	0	6
MAX. FACIAL	6	18	0	4	0	8
CHEST	3	22	0	2	0	1
LONG BONE #	18	104	1	9	3	5
ABDOM	0	5	0	0	0	0
	160	734	13	688	32	373
	CAR occupant	Pedestrian	Assault	Fall from highway	Bicycle	Others

317

16%
icu

PRE-OP. icu	11	24	1	27	4	10
POST OP. icu < 1w	10	63	7	67	7	53
POST OP. icu > 1w	6	11	0	5	0	0
	17%	13%	62%	14%	34%	17%

MORTALITY 17%

USA 7.3%

Ireland 25%

UK / Netherlands /

Los Angeles

52% [SEVERE]

	2000	1165	
HOME	936	621	66%
OTHER HOSP.	475	228	48%
DIED	336	197	59%
OTHERS	253	119	47%

DEATH 17% 17%

prog. PW

File Name: (Cooper) 2

Pediatric Head Injury

Cooper

Accident injury continues to be leading cause of death and disability in children. The absence of external signs of trauma may impose undesirable delay in management, although a severely contused abdominal wall may precipitate unnecessary surgical intervention.

Trivial accidents, such as falls against furniture and bicycle handlebars, will often produce serious but difficult to diagnose injuries. Child abuse is an extremely common problem and may be the etiology of many cases of pediatric trauma.

Children cannot be treated as small adults, nor evaluated as such. Normal blood pressure varies with age, it is important to be familiar with normal values. Children have a much lower margin of reserve with respect to blood loss greater than 10% is considered significant. Therefore, a rapid loss of 200 ml in a young child can produce clinical shock and acute blood loss exceeding 400 ml may cause death.

Fluid requirements are estimated using clinical criteria of blood pressure, capillary refill, extremity warmth, and so forth. A bolus of 20 ml/kg of Ringers lactate should be given by intravenous push if indicated. If no response is noted, a second 20 ml/kg bolus of Ringer lactate is given. If there is still no response the patient will probably need blood replacement, which is given in increments of 20 ml/kg of whole blood or 10 ml/kg of packed cells.

HEAD INJURY

The head as it is an exposed part of the body is liable for injury more than other parts. Old civilization have known this fact and devised some sort of head helmets to protect the head in the battle field. Perhaps the father of medicine 'Hipocrates' was the first to mention some details about head injury. The famous statement he made which says that "No head injury is so slight that it should be neglected, or so severe that life should be despaired of" is still valid.

Head injury is probably the third killing disease. It follows cancer and cardiovascular diseases. It affects all ages and nobody is immune from it. The more industrialized the society the more it is prone to head injury. It is known that over 70% of body injury is accompanied by head injury. In the war zone head injury comes after limb injury in its incidence, but is more serious and with higher morbidity and mortality rates.

Prog. PW

File Name: (Cooper) 8.

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prog. PW

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prog. PW

File Name: (Cooper) 6

Pediatric Head Injury

Cooper

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SPINAL EWING SARCOMA 1980

K.H. A boy of twelve years presented on 13.6.79 with pain in the dorsal area of 6 weeks duration. The pain ^{was} mild ache ~~at first~~ ~~severe nature~~ and persistent all the time. Could be relieved by paracetamol. One week prior to admission the pain got more severe and was not relieved by simple analgesics.

Three days prior to admission weakness of both legs developed ~~then~~ ^{which} ended up in complete paralysis of both legs one day before admission. This was accompanied by complete retention of urine.

PMH No history of trauma, fever, chest trouble, abdominal ~~complaints~~ or any previous surgery.

O/E He was found to be fully conscious and oriented but suffering from back pain while lying supine in bed.

There was marked tenderness over the middorsal area between D5 - D8.

Flexing the neck produced severe pain in the neck.

SLR was full ^{and} but kernig's sign was ~~positive~~ ^{negative}.
but both produced pain in the ~~dorsal~~ ^{dorsal} area.
Cranial nerves were normal with ~~normal~~ ^{normal} fundi.

The motor system showed normal muscle bulk
all over with no fasciculations.

The power in the upper limb was normal. The
power ^{in legs} was reduced to grade 1-2 in both
legs sides.

Reflexes were normal in upper limbs. Ankle
and knee ^{jerks} ~~jerks~~ were exaggerated in both
legs with upgoing plantar reflex on both
sides. Both upper and lower abdominal
reflexes were lost. Sensation was impaired
to touch & pin prick in the lower extremity
up to D 7/8 on both sides. Sense of
position was lost in the lower extremity.
Urine was passing through an indwelling catheter.

PR 110 / regular and BP 110/80

No abnormality in the heart, chest, abdomen
or ^{by} ~~PR~~ ^{exam}. SK letal system revealed no involvement
of any bone clinically.

ESR 15 WBC 10 000 normal differential count
FBS 90 mg B. urea 30 urine exam normal

~~WBC 10 000~~

The patient had significant early improvement⁴
post operatively.

Biopsy reported sheets of uniform cells containing PAS positive material separated by thin septa. The picture was consistent with Ewing's Sarcoma.

When the stitches were removed from his skin he could move his leg better.

He was sent to the Radiotherapy Institute^{NY}

~~At his first presentation~~ in August 1979. ^{He was started}
a radiotherapy course by ~~using~~ using the following technique

Single applied field on the tatron giving 4000 rads in 4 weeks for 12 X 6 cm field size. Following completion of radiotherapy given chemotherapy with two drugs at first starting from sept 79

endrophosphamide	300 mg
Vincristine	1 mg

Given intravenously every two weeks.

After 6 courses when the general condition of the patient improved Actinomycin - D^{150g/kg} was added to the regimen.

Chemotherapy was continued until Mar 81.

Biopsy. H.Z. 2909 June 1979

10.8.81

Re admitted to the Neuro Surgical Hospital. Five days prior to his admission he began to complain of back pain at dorsal area with weakness of both lower limbs until he became bed ridden for 2 days before admission. He also experienced some difficulty in micturition.

He was found to be fully conscious, oriented with spastic paraparesis of grade 2 power. Sensory impairment was up to D5 level. Reflexes in the lower extremity were exaggerated and both plantars were up going. Bladder was distended. Eyes clear, BP 120/80, PR 88/Reg. Cranial nerves and upper limbs were normal.

Myelography was done and complete obstruction at the same previous site was seen. No cisternal study was done.

On 20.8.81 under GA re-exploration laminectomy was carried out with removal of neural arches of D4 and D8 also. A huge extradural mass was seen. It was fleshy, soft and very vascular. All the tumour was removed until the dura and previous dural sutures were visualised. There was no evidence of intradural mass seen.

Following this chemo therapy was commenced as follows:

Methotrexate 300 mg infusion with Leucovorin factor repeated at two weekly interval.

The patient ^{made} full neurological recovery when seen in early June 1984.

At subsequent courses the dose of methotrexate was increased to 500 mg.

June 1985 He developed weakness of his legs with some pain in the dorsal spine area. There was mild increase in reflexes of the legs with upgoing toes. The chemo therapy was changed to cisplatin 50 mg intravenous infusion. ~~So far two doses were given~~ ^{treatment continued} until now. He made good recovery with normal x ray chest and no systemic manifestations. HIS CHEST X-RAY IS NORMAL.

and the normal dural pulsation seen freely.

~~Histology report~~
Biopsy report ... ASM.

(2 weeks after ^{2nd} surgery)
On 3.9.81 the patient was discharged with remarkable improvement. He was able to walk with minimal support and his bladder function was ^{almost} normal.

He was referred to the Radiotherapy Institute.

Immediately he was ~~not~~ started on a course of irradiation to the same area previously irradiated, using ~~4 tubes~~ ^{linear accelerator} two oblique fields 12x6 cm giving 4500 rads in 4 weeks. He tolerated treatment well and showed complete neurological recovery.

Chemotherapy re-started in Nov 81 giving VACA regimen.

Vincristin 1mg
Adriamycin 30mg
Cyclophosphamide 300mg
Actinomycin D 15 µg/kg

All given intravenously at day 1 and

repeated at 3 weekly interval

The patient was well and ~~disease free~~ and symptom free. His plain x-rays and bone scan proved normal.

~~The pt~~

He received further 12 courses of the above combination.
SERIAL 3 MONTHLY CHEST X-RAY ~~ARE~~ NORMAL

April 1984

The patient started to complain of vague pain in the upper dorsal area. His neurological examination and plain radiography proved normal. He refused further investigations. Prednisolone 5mg Bid was commenced for today.

May 1984

He developed signs and symptoms of cord compression at the same level. Rescreening myelography proved block at the same area. He refused re-exploration. His leg weakness got worse.

Local irradiation was given using single applied field on Theratron giving a single exposure of 1000 rad.

SURGERY IN EPILEPSY

ندوة الصرع 1987

①
17.11.87
MCH
Cant. Educ.
(Epilepsy)

Surgery of Epilepsy

In early civilisation trephinations were practiced for convulsions allegedly to release or remove supernatural or natural causes.

The real history starts on May 1886 when Victor Horsley ~~at~~ ^{at} the National Hospital for paralysed and epileptics in Queen's Square London performed his first brain-operation ^{ever} on an epileptic patient. The patient was a man of 22yrs suffered epilepsy from the age of 15 following a severe head injury received in a road traffic accident at the age of seven. He was treated then for depressed fracture which was suppurated and the brain herniated. In 1886 was suffering from prolonged episodes

(2)

of Jacksonian epilepsy status epilepticus.
That was the key to the location of
focus. Horsley operated with Huxley
Jackson nothing in the area. He removed
that abnormal brain which measured
3x2 cm with half a centimetre of
surrounding brain substance. The wound
healed and the patient had no more fits.

In 1909 he introduced the subpial
resection of the affected brain

focus.

Pentfield in Montreal pioneered the
definition of structural basis of
traumatic epilepsy and reported
his radical operation in 1930.

The first correlation of clinical
epileptic seizures and EEG study were
published in 1935 by Gibbs, Davies
and Lennox.

EEG has clearly demonstrated the
hyperirritability of focus area and the
inert activity of scar and hyperirritability around it
with

and is more widely used.

Why to consider Surgery?
unintended ~~side effects~~ medical treatment proved inadequate
reason of it to be not ideal because:

1. Control

Studies have shown on conventional drugs seizures are completely controlled in more than 50% of patients with epilepsy, and that, in another 30-40% the results are improved with additional drugs although not without some side effects. (Complete seizure control is achieved for two years in 30-37% of patients, but it drops to 20% at 5 yrs and 10% at 10 years)

2. Relapse

Following withdrawal of anti epileptic drugs after four years of complete seizure control in 148 children who were followed up for 5-12 yrs after withdrawal found a consistent relapse rate of 20-40%.

3. Side effect of drug:

- Folate deficiency in 50% of patients
- vit D deficiency in 33%
- Peripheral neuropathy in 10-20%
- changes in connective tissue
- liver, endocrine and immunological.

Surgery is a team effort which requires the cooperation of neurophysiologist, neurologist, neurosurgeon, anaesthetist and neurosurgeon. Good results depend on many factors: ~~method of case selection, impaired diagnostic procedures and improved operative techniques, working ability.~~

What are the indications :-

What are the surgical causes of epilepsy :-

1. Congenital :-

- Macrogyria
- Microgyria
- Loss of convulsions at all hemisphere or part of it
- Complete absence of a lobe

5

- Patches of congenital defects in the hemisphere.

- Gross contraction of part or all hemisphere

- Venous displacement: cluster of veins or absence of veins

The majority have some degree of mental deficiency, occasionally patients with gross abnormality of brain may be normal mentally or even brilliant.

congenital aetiology

They hardly be the cause when onset is after 25 yrs

2. Tumours

Most common between the ages of 15 - 60 yrs. One ~~10~~ third of all epilepsy after the 25 yrs of age are due to tumour.

- when condition change from generalised to focal they indicate a growing tumour

- About $\frac{1}{2}$ of brain tumour have epilepsy. There is no difference between tumours compressing or

arising from brain substance. (6)

• Poor grade tumours produce epilepsy when brain stem is involved causing tonic spasms.

3. Infection:

Cerebral abscess produce convulsion at the acute stage of inflammation and at the repair when scar develops.

4. Trauma;

Either due to intracranial haematomas

EDH, SDH or ICH. ~~The other~~
or due to ~~scar~~ produced by structural ~~change~~

brain insult & depressed fracture ^{& penetrating FIB} ~~scar~~ develops.

Adhesions are not a real cause of epilepsy.

5. Vascular malformation:

aneurysms rarely produce epilepsy except when they are large

AVM nearly always produce epilepsy. Most are Jacksonian.

6. Other causes like calcification
- stroke - etc

Operative procedures

There are few standard procedures

1. Cortical resection

About 15% of epileptic disorders were found to be due to focal brain lesion and 5% may be offered an operation. This requires the followings:

Indication:

① The clinical seizure pattern should indicate a discharging lesion in a localized operatively accessible area of brain: ~~gyrus, lobe~~ or ~~hemisphere~~.

② Serial EEG supplemented by special studies, should localise this epileptogenic area.

③ Cortical lesion should be suggested by the clinical and laboratory evidence as the cause of the seizure.

④ It must be demonstrated that intensive and methodical treatment with anti convulsants verified by adequate blood levels

(8)
of drugs ^{are} ~~are~~ inadequate to give patient normal ~~life~~ productive life.

5. Patient's condition is fit for that major surgery. The patient's An IQ of less than 60 is usually a contraindication.

6. Patients ~~over~~ ^{over} age of 10 years should be able to cooperate during surgery under local anaesthesia.

Procedure

At the beginning of the operation was primarily to remove the ^{cortical} scar. But with the use of depth ~~map~~ ^{mapping} electrocorticography the role of scar in the production of epilepsy was modified to include the adjacent cortex with epileptogenic activity.

2 Temporal lobectomy:

Mostly done for epilepsy with behavioural abnormalities. With good EEG study one can differentiate psychosis of ictal origin from non ictal.

(9)

Behavioural abnormalities associated with complex seizures particularly aggressiveness, assaultiveness and post ictal confusional state psychosis are usually benefited along with the epilepsy following appropriate operative procedure.

Procedure

Following ~~study~~ ^{investigation} electrocorticography temporal lobectomy is done as usual. 3-5 cm from the tip of the temporal lobe is resected in the non dominant hemisphere and 3-4 cm in the dominant hemisphere.

Post resection corticography done at the edge of resected area and hippocampus. If some activity seen then ~~unresected~~ some more resection is done.

Post operative manipulation hemiplegia or upper homonymous quadrantanopia, aphasia, may develop but it lasts from 6 hours - 10 days. This is due to manipulation of middle cerebral artery. ~~with upper homonymous quadrantanopia~~

Over 70% of patients have good results (10)

In general the favourable factors in the temporal lobectomy ~~and probably~~ ~~of the procedure~~ dependant are:

1. Preoperative presence of a single type of seizure
2. Duration of epilepsy less than 4 years
3. Operation is in or before adulthood
4. Anterior temporal or sphenoidal focus on EEG

Unfavourable factors:-

1. Preoperative presence of grand mal
2. Age at onset of epilepsy ^{general} or of first grand mal between 5-19 years of age
3. Preoperative duration of epilepsy of over 10y or grand mal over 1 year

Unfavourable psychiatric factors:-

1. Preoperative presence of psychosis
2. Ictal affective attacks or automatisms
3. Impairment of intellectual functions.

~~over 70% of patients have good results~~
3. Hemispherectomy

(11)

Subtotal hemispherectomy

for children who have:

1. Intractable epilepsy
2. Behavioural disturbance
3. Spastic hemiparesis
4. Hemiatrophy of brain

Electrocorticography should be done to delineate the multiple foci of epileptiform activity and also lobe by lobe. If visual fields are full the occipital lobe may be spared.

Results:

85% free from seizures.

Behaviour improvement

Motor deficit is not changed as there is deficit from before.

Other procedures:

Stereotaxy, amygdalotomy in children with medically resistant psychomotor epilepsy associated with aggressive behaviour and bilateral epileptogenic areas.

TRAUMATIC CAROTID THROMBOSIS

مؤتمر الجمعية الطبية العراقية 1978

THROMBOSIS OF THE INTERNAL CAROTID ARTERY

I Spontaneous

II Traumatic

A. Penetrating - Direct (stab)
- Indirect (Bullet)
H.V.

B. Non penetrating
- RTA
- Fighting
- Boxing
- Others

L.B. 26 ys ♀

(ON THE PILLS)

12.30 mn

- ⊙ Hit by husband on (R) side of mandible
- ⊙ Sp~~at~~ed blood
- ⊙ No Loss of consiousness
- ⊙ Slept normally

9.45 am

- ⊙ Dizzy → collapsed
- ⊙ Unconscious for few seconds
- ⊙ Recovered

L.B.

O/E

⊙ Drowsy

⊙ (L) Side weakness of body
+Face

⊙  (L) h.h.

⊙ Pupils normal

⊙ (R) Carotid pulse ↓

⊙ Tender (R) mandible

D. N. 40 ys ♂ →

12m.n.

- ⊙ Came off a bicycle hit a lamp post
- ⊙ Injured (L) side of body
- ⊙ No Loss of consciousness O/E
- ⊙ Conscious but drowsy
- ⊙ No # seen

8:30 am

- ⊙ Collapsed in bathroom
- ⊙ Unconscious for few seconds
- ⊙ Recovered

D.N.

O/E

⊙ Drowsy

⊙ ⊙ L Side weakness +Face.

⊙  ⊙ L h.h.

⊙ Pupils normal

⊙ ⊙ R Carotid pulse ↓

⊙ No sign of neck or head injury

TIME OF ONSET OF SYMPTOMS

<u>Time</u>	<u>Percent</u>
0 -10 hrs	54 %
10 -24 hrs	29 %
Over 24 hrs	17%

SIGNS OF TRAUMA TO NECK

Present	48 %
Absent	50 %
Unknown	2 %

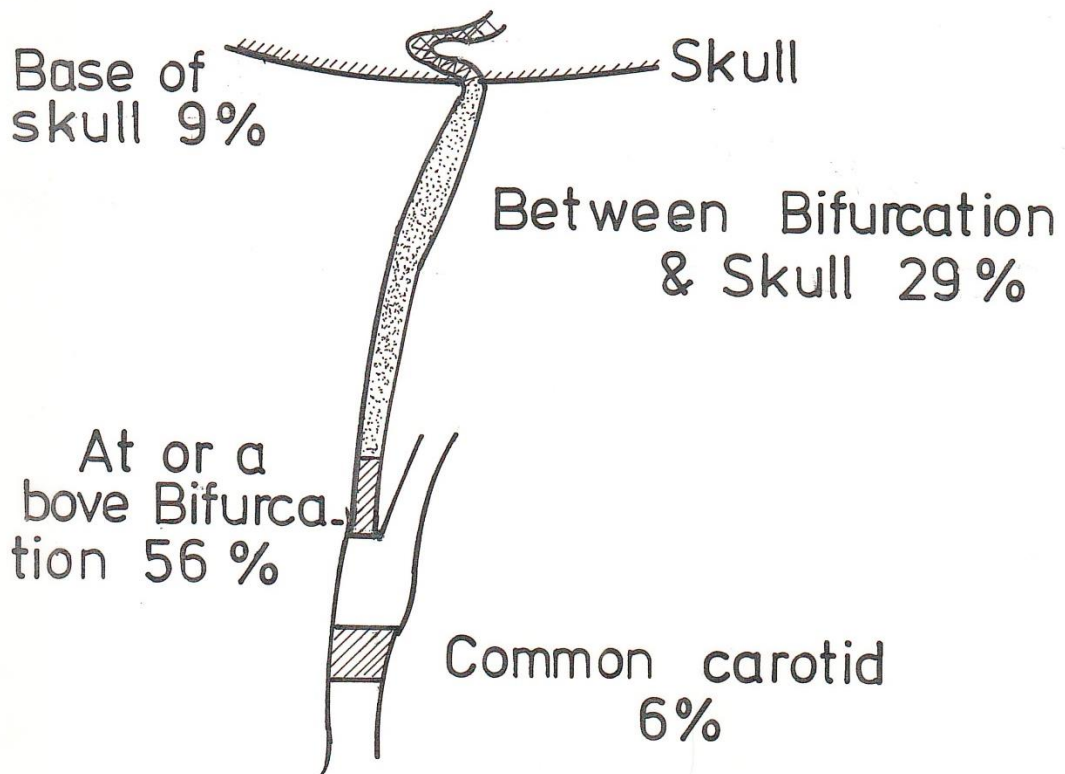
SOURCES OF TRAUMA

Vehicle accident	52 %
Fighting	15 %
Fall	15 %
Object striking neck	8 %
Boxing	4 %
Object striking head	4 %
Diagnostic carotid compression	2 %

PATHOPHYSIOLOGY

- ⊙ Tear of the intima ± media
- ⊙ Fracture of an atheromatous plaque
- ⊙ Intramural sub-intimal clot formation
- ⊙ Marked arterial spasm

SITE OF OCCLUSION



MANAGEMENT

- ⊙ Dexamethasone
- ⊙ Dextran
- ⊙ Glycerol I.V.
- ⊙ Operation - Endarterectomy

RESULT OF TREATMENT

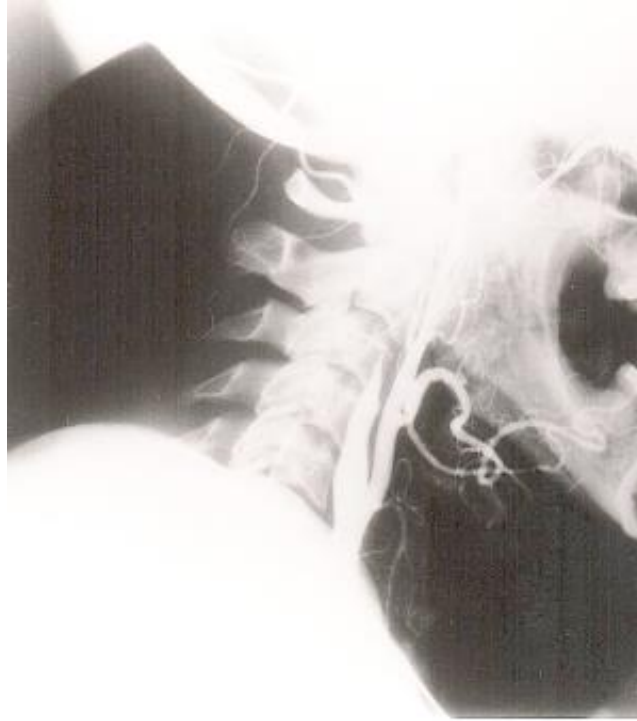
Mortality 40 %

Morbidity 52 %

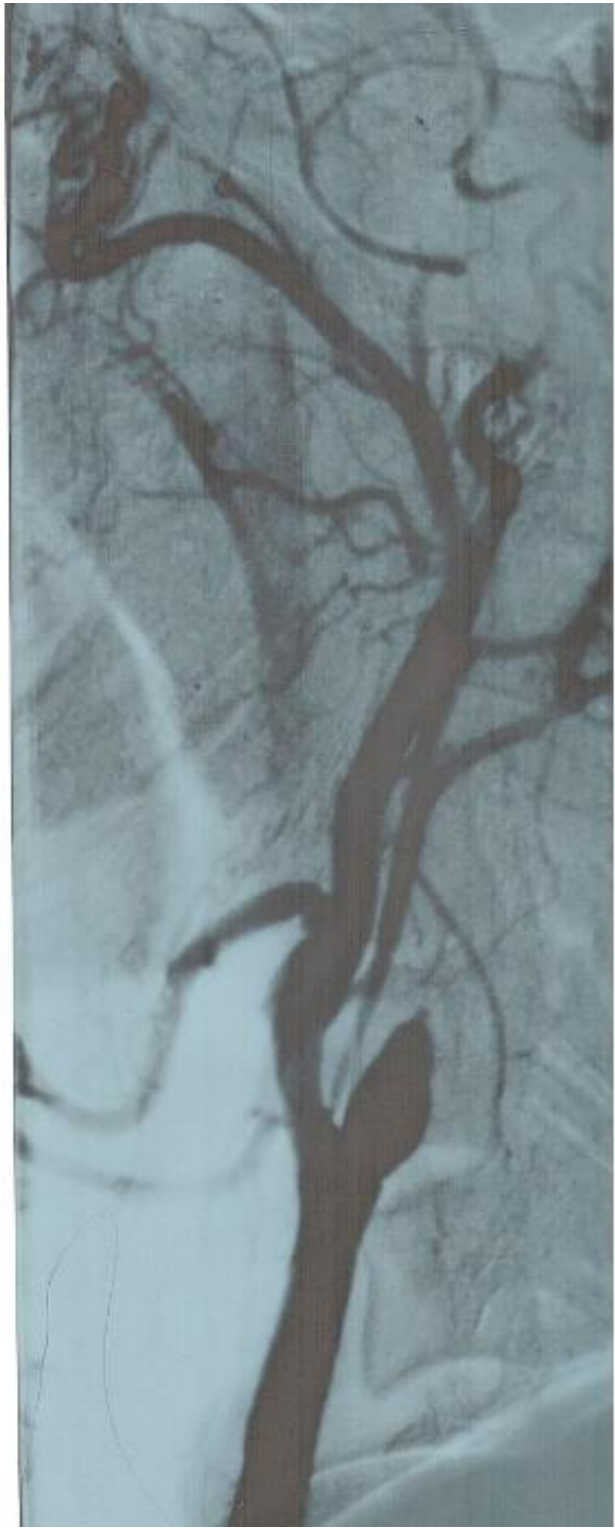
Good results 8 %

ANY PATIENT WITH HEAD INJURY
[+ NECK INJURY] WHO IN FEW HOURS
DEVELOPS LATERALIZATION BUT RATHER
CONSCIOUS SHOULD ALERT THE POSSI-
BILITY OF TRAUMATIC CAROTID
ARTERY OCCLUSION

TRAUMATIC CAROTID ARTERY THROMBOSIS



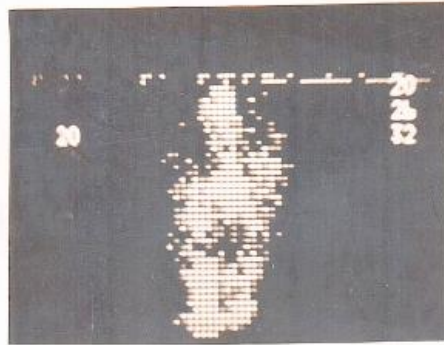




Dept. of Nuclear Medicine

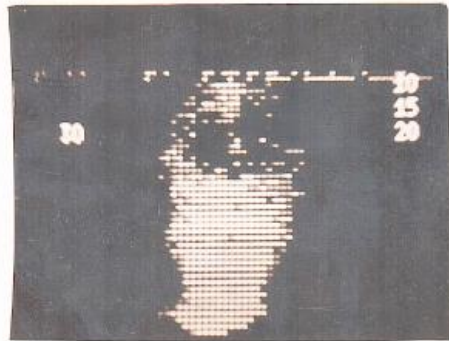
REPORT SHEET

DYNAMIC BRAIN SCAN



10-20secs.

10-20 Secs.



20-30secs.

20-30 Secs.

12

Trauma to the Carotid Artery.

Types.

- 1) Penetrating wounds; direct trauma or mainly during battles with missile injuries especially high velocity missiles which could produce thrombosis even when it is some distance from the artery in it's passage.
- 2) Non-penetrating injuries.

Non-Penetrating Injuries.

Sources; R.T.A. Fighting falls objects striking the neck boxing
occasionally diagnostic carotid compression. *safely lower*

The Injury; is not necessarily a severe one. Half of the cases only have evidence of trauma to the neck. You may see some abrasions to the face or the neck, contusion or mild swelling of the neck, fracture of the jaw, fracture of the clavicle or fracture of the first rib.

Presentation;

Age; Ranging from 16 to 60. Maximum 20 to 30 years.

Timing; The usual evolution of the signs and symptoms is slower than might be expected with a thrombosis of a major vessel due to acute trauma. The average time is as follows;

0-1	10%	
1-4	23%	
4-10	21%	Time in hours.
10-24	29%	
>24	17%	

Clinically;; the patient presents with lowered level of consciousness following head injury with or without neck injury. There maybe as in the majority of cases hemiparesis, hemiplegia, monoparesis, monoplegia, aphasia, paraesthesia or seizures. *BW*

Examination; As stated above ~~xxx~~ with regard to "The Injury".

Carotid pulsation on the side of the occlusion is usually feable compared to the other side. The patients level of consciousness is diminished hemiparesis or hemiplegia will be seen with or without hemianæsthesia homonymous hemianopia is the usual finding with facial paralysis.

Pathological Physiology:

- a) The cause of the thrombosis is usually tear of the intima on its own or accompanied with tear in the media.
- b) Fracture of an atheromatous plaque .
- c) Intramural sub-intimal clot formation causing obliteration of the lumen.

The thrombosis with extend distally from where it starts but could extend retrogradly. The site of the thrombus is usually 2 to 3 cms., above the bifurcation of the common carotid. The second common area is between the bifurcation and the skull. A small percentage is at the common carotid or at the base of the skull.

The middle cerebral artery is involed in a great number of cases. The danger is more in these cases when the thrombus is extending to the circle of Willis.

Diagnosis: Careful attention to signs of trauma to the neck and the natural history of the occlusion should be appreciated.
Angiography to be done with low puncture.
Dynamic scan is of great help.

The message is that "any patient with head injury with or without neck injury followed by development of lateralization signs several hours later, should alert to the possibility of carotid artery occlusion."

Treatment: Operate or not to operate.
Endarterectomy Anticoagulants and their danger.
Glycerol.

Prognosis: Mortality 40%
Morbidity 52%
Good results 8%



without
significant
deterioration of
level of consciousness

as the amount
of the extra deprivation
of the hemisphere
from blood during quarters
unless non established
by pass which is
itself could be
dangerous.

1/

The Syndrome of **Spontaneous thrombosis** of the int. carotid artery without preceding trauma is very well recognised and there are numerous references in the literature about it. The first of which was the report of **Willis** in the year **1664**

There have also been many cases of thrombosis of the carotid artery **secondary to penetrating injury** of the arterial wall or a thrombosis induced by **high velocity missile** as it penetrates ~~the~~ soft tissues in the vicinity of the vessel but not actually hitting it but inflicting its effect by the pressure waves it produces.

The Syndrome of thrombosis of the int. carotid artery following a **blunt injury** to the **head or neck** however, only rarely seen and it is with such cases of closed traumatic thrombosis of the int. carotid artery that this paper is concerned.

1) Gurdjian

1872 Vernier reported a case of a patient who sustained head injury and a swelling of the \odot sternocleidomastoid muscle, & \odot hemiplegia, coma, and death resulted. At Post mortem ~~there was~~ complete occlusion of the int. carotid artery caused by ~~mass~~ mural thrombus extending up to and into the middle cerebral artery and branches. The intima of the \odot carotid was torn & rolled.

He ascribed the arterial
near ~~to~~ to torsion
and bending of the neck
at the time of the head
injury.

Northcott and Morgan
1944 reported a case of
a man sustained a bruise
of the (D) side of the neck
when a rope hanging from
a passing vehicle caught
him about the neck.

He became unconscious after
a brief interval and was
paralyzed in (R) half of body
craniotomy was negative.

He died & ~~showed~~ ~~the~~ ~~bone~~ of the spine.

Gurdjian

Mechanisms of occlusion

1. Contusion of the wall of the vessel and a clinging clot which propagates.
2. # of the intimal lining with curling of the intima with eventual thrombosis and forward propagation of the clot.
3. Subintimal flap in the presence of an arteriomatous disease of the bifurcations may be sufficient for complete occlusion.
4. Flap for media in presence of arteriosclerosis

may cause dislodging away
which shuts the lumen.

→ Boldrey says that
the int carotid a. is in
close proximity of the
~~int.~~ lateral mass of the
second cervical vertebra.
The compression of the artery
against this mass could
contribute to the thrombosis.



①

David Murray

one case of carotid artery
nothing unusual.

Vertebral artery thrombosis.

boy of 16 yrs. Injury to
the (R) arm & ~~shoulder~~ by
a hand-saw. He was
shocked for blood loss.

No ~~detention~~ localizing
CNS deficit. @ Underwent
op for the limb injury.

Next morning developed one
dilated pupil hyperpyrexia
and decubitate ulcers.

post-PM Effusion of the (R)
cerebellar hemisphere and pos
a. a. medulla.

The (R) vertebral artery
was found thrombosed

→ Pathology

Contusion or stretching
of a major artery can
cause sufficient damage
to the coats of the vessel
to lead to its occlusion
by spasm or thrombosis

In some cases the intima
was curled up and acted
as a plug.

(2)

David Murray

The veins of the neck are not affected by trauma that is because the pressure in the ~~low~~ veins is ~~0-2~~ 0-2 mm Hg. whereas the mean BP in the carotid arteries is about 90 mm Hg. There is thus much greater resistance in the artery which would probably render it more vulnerable to contusion and stretching.

Widespread spasm following injury to the large arteries may play large part in the initial stages of this condition.

Ecker - 1945 had 4

Cases with ~~the~~ of the artery of ~~some~~ ~~was~~ traumatic that both accepted by ~~spas~~ at these was ~~change~~ marked improvement of the neurological deficit ~~before~~ when the spas relieved.

(1)

Hockaday

Oxford

Thousands of following injury to the neck is well recognised and was described after both world wars, but in nearly all these cases there was laceration of the neck and an open wound in relation to the artery. The youngest reported case was 16 years.

The initial injury is not usually severe and late examination shows only some abrasions of the face or neck, contusion or mild swelling of the neck. Only occasionally fracture of the ~~mandible~~ jaw, clavicle, or first rib.

② Hockaday

Le dzimin (1955) described
an interesting case. ~~from~~

thrombotic obstruction of the int
ctd artery originating from the
region where it passes upward,
for the cavernous sinus and
associated with rheumatoid
and a fracture of the cribiform
plate caused reversal of the

② exam started hours before
coma occurred and some days
before the leg was paralyzed.

TUBERCULOSIS OF THE CNS

1993

TUBERCLE

TUBERCULOSIS

PHTHIASIS STRUMA
PHYMA HECTIC FEVER
CONSUMPTION

DEFINITION

HISTORY

NEOLITHIC MESOPOTAMIA
EGYPT

HIPPOCRATES

GALEN

AL RAZI AL MAJOSI IBN SINA

SYLVIVS

MORTON - PHTHIASIOLOGY

LAENNEC

KOCH

VON PIQUET

CALMETTE GUAREN

WAKSMAN

TUBERCULOMA

Macewen
Starr

CHILE 16% RUMANIA 7%
NIGERIA 12.5% RHODESIA 19% INDIA 16-35%
IRAQ < 1%

60% CHILDREN → 60% Post-Fossa

PRESENTATION

ICP ↑
FITS 60%
HEADACHE VOMITING 50%
FEVER 25%
~~PARALYSIS~~ 25%
PAPILLOEDEMA 50%

CSF
ESR
WBC
CT ANGIOGRAPHY
MRI

TB SPONDYLITIS

POTTS

CLINICALLY PAIN

TENDERNESS

FEVER

PARAPLEGIA

ESR

RADIOLOGY 10 cases

25-55 yrs. 4 ♀ 4 ♂

2 Sudanese

ESR

WBC

Mean 7%

Mean 8.

IN CONCLUSION

DR BINGALL

THE STORY OF TUBERCULOSIS
CONTROL IN THE WORLD
IS OF TRIUMPH & TRAGEDY.
THE TRIUMPH IS THE DISCOVERY
OF ANTITUBERCULOUS DRUGS,
THE TRAGEDY IS THE FAILURE TO
USE THEM EFFECTIVELY

T B M

AURBACH 42.2% children 2.9% Abu

BOMBAY 3646 9.8% 65%

INDIA 2-5%

Senegal, Thailand, Nigeria

CHILDHOOD \Rightarrow ADULTHOOD

ESR

WBC

CSF

ARACHNOIDITIS

POORLY UNDERSTOOD

CAUSES

Tubercle : in Latin, Tuberculum
means a small swelling, bump
or protuberance.

Tuberculosis : called also by
different names : phthisis, struma
phyma, hectic fever and consumption.

It is defined by the first issue of
encyclopedia Britannica 1971 as
"tubercles are mycobacteria and develop
tumour which suppurates and
discharges pus and are often found in
lungs especially of consumptive
persons."

^{However}
It is defined by Prof Salem Al Dametiji
as a specific infectious disease caused
by mycobacterium tuberculosis and
characterised by development of
tubercles with exudation, necrosis,
fibrosis and even calcification

It is one of the oldest diseases
known to mankind. Spinal form, Potts
disease was discovered from the ancient
time of Mesopotamia and Egypt.
Hippocrates referred to its contagious-
ness. Galen noted tubercles in
lungs of various animals, and
he called a condition as hydrops
thoracis but did not understand its significance.

دار الحكمة للطباعة والنشر

بغداد

During the tenth and eleventh centuries tuberculosis was described by Al Razi in Al Hawsi, Al Majousi, in Al Kamil Fi Al Sanat Al Tibbia, and Ibn Sina in Al Canon. Their description was a classic.

Sylvius^{A Holland} in the early seventeenth century discovered that phthisis is accompanied by tubercles in lung.

Later in the century^{in 1689} Richard

Morton of London named the lesion tubercles in his book phthisiology. The name tuberculosis resulted from Morton's term.

مع اطيب تعيات

دار الحكمة للطباعة والنشر

بغداد

In 1804 Laennec the inventor of the stethoscope in a famous lecture demonstrated that phthisis was tuberculosis of the lung.

In 1882 Robert Koch discovered the tubercle bacilli. Koch also prepared tuberculin which he thought to be a cure of the disease but proved not.

However, von Pirquet in 1907 used tuberculin as a useful cutaneous diagnostic test.

In 1920 Calmette and Guérin introduced the BCG.

مع اطيب تعييات
دار الحكمة للطباعة والنشر
بفداد

In the therapy gold was used first with the sanatoria.
In 1944 Selman Waksman discovered streptomycin and in 1947 German scientists introduced PAS.

Although tuberculosis is linked to the pulmonary system, it can in fact affect any body organ including the CNS.

This is almost always secondary to a primary focus in the lung or GIT. It may affect any part of ^{CNS} either locally or diffusely and acutely or chronically.

مع اطيب تحيات

دار الحكمة للطباعة والنشر

بغداد

②
CNS tuberculosis is still
a major problem in the developing
world. For instance a study from
Bombay stated that 55% of population
in some areas have PTB. It is
therefore not surprising that significant
percentage of patients admitted to
any neurology and neurosurgery unit
in Bombay are afflicted with TB
lesions of CNS.

In USA although the incidence
has decreased sharply, yet there
were 22000 new TBM cases in 1984.

In England & Wales over 100 cases of TBM
were reported yearly in 1981

مع اطيب تعيات
دار الحكمة للطباعة والنشر
بفداد

Rarely there is some increase in its incidence in patients whose immunity is impaired by autoimmune diseases, chemotherapy and steroid therapy. Curiously it is rare in AIDS patients.

Tuberculosis can involve any part of the CNS, the brain & the spine. The clinical types are TBM, Tuberculoma, arachnoiditis, TB spondylitis, epidural and subdural tuberculosis & rarely TB of the cranium.

On reviewing the Neurological TB in our ~~country~~ I was faced with bad news and good news.

The bad news is that the total number of cases was small: 25

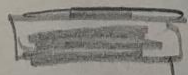
cases in all forms, from 1980 till 1991 (12 years). The good news is that this is a good

parameter to see a rate of

about 2 per year of surgical

TB. in the neurosurgical practice.

TUBERCULOMA



SLIDE

MacCewen did the first operation for tuberculoma in 1883. In 1893 Starr

reviewed 300 brain tumours and found

frequency of 52% of space occupying lesions.

مع اطيب تعيمات

Sizes: it can be either the
Smallest or largest brain SOL.
Amongst all other causes of SOL
In child it made 16% of all SOL
Rumania 7% Nigeria 12.5%
Roderia 19%. India ranges
from 16 - 35%.

In our country with relative
certainty $< 1\%$.

The cases documented were 7 from
1980 - 1987

Tuberculosis often affects
children & young people; 60%
under age of 20 yrs & 60% of
children Tuberculosis were - poor
food.

مع اطيب تحيات
دار الحكمة للطباعة والنشر

In this series The two child
under 10 yr had cerebellar tuberculoma
with all those ⁵ above ~~10 years~~ had
supratentorial. Three from Mosul,
Two from Baghdad, one Basrah
& 3 from Baghdad.

Presented a phase of ↑ ICP
Fits were seen in 60-85% of cases.
Headache, vomiting over half of cases
and fever in only one quarter
Papilloedema seen in 50%.

CSF exam is not done when there
is papilloedema. However half of those
studied were normal. ESR is not
elevated by leucocytes &
seen in the region of 11 mm.

© Fleury & Fay

Show TACP

مع اطيب تعيّنات

دار الحكمة للطباعة والنشر

بغداد

TBM

TBM said to make about 7-12% of patients with TB.

Aurbach in 1951 found in post mortem of tuberculous children 42.2%

but 2.9% in adults. In a Bombay

paediatric hospital 3646 autopsies

found TB in 9.8% and that of

CNS made 65%. It is said that

2-5% of all paediatric patients

admitted to hospitals in India suffer

from TBM. Similar figures found

in Senegal, Thailand, Nigeria &

Malaysia.

مع اطيب تعيات

دار الحكمة للطباعة والنشر

بفداد

Route is either through choroid
plexus tuberculoma or tuberculoma of
liver or cord or brain near SAS.

In developed countries it is a disease
of adults and not in childhood.

Pathologically the cisterns are filled
with a mass of gelatinous exudate. This
is also seen in the choroid plexus.

The TBM we face are those
who have been dealt with

by our physicians colleagues.

Our record ~~XXXXXX~~ includes

5 cases with an age range

14 - 25 y. Four females & one

male. ~~The main complication~~

↓

مع اطيب تعينات

دار الحكمة للطباعة والنشر

~~6 by Dr. [unclear]~~
بف [unclear]

HR & WCB values ~~normal~~
or rarely, non ~~normal~~
Blood leucocytes ~~seen~~ over 10,000
and ESR generally high ~~and~~ 50.

It is known that CSF shows
high pressure, > 300 mm water,
Clear: colourless & slightly opalescent
and outstanding a fine web with
coagulum found in it. Cell count
ranges between 50-200, chiefly
lymphocytes. Protein ~~is~~ elevated
and figures of 2000 mg were recorded.
Glucose less than 45 mg and
low chloride.

These findings were also
found in our cases pt ranged
from 70 - 275 mg with cells
from 5 - 463, and sugar 0
40 - 45 mg.

SAH AFB found + in 3 cases in
the direct smear.

Arachnoiditis

is poorly understood. It has been
reported following meningitis of
TB origin and other causes, trauma
SAH and other causes. It may
occur anywhere in the spinal canal.
It may be diffuse or localized, segmental
or continuous. CSF may be dry tap

مع اطيب تحيات

دار الحكمة للطباعة والنشر

بغداد

Nerve roots are tortuous & fixed
in position are more horizontal course
Blood is seen but no cord displacement

It is diagnosed in 4 cases. Paraplegia

3 females and one male with
age of 40 - 50 yrs. The ESR
was normal in 2 and high (42 and 50)
in two. with normal WBC count.

The site of involvement was
at lower dorsal and upper dorsal
and cervical area. With paraplegia
in 3 cases & Tetraplegia - one.

is (case)

TB

مع اطيب تعيات

دار الحكمة للطباعة والنشر

بغداد

TB Spondylitis

9) named after Sir Percival Pott
In the early 18th century.

Clinically the patient presents
with insidious back pain and
local tenderness. Fever is not
a common feature. Involvement
of spinal covering is more common
than in pyogenic infection hence
paraplegia is more common.

It most commonly involves the
thoracic and lumbar spine. Uncom-
-mon in cervical area.

In coloured people disc involvement
is more common.

مع اطيب تعيات

دار الحكمة للطباعة والنشر

بغداد

ESR is very sensitive means
of diagnosis and follow up
in the course of therapy.

Plain X-rays show the
distribution of vertebral & disc
spaces. Myelography shows the block
and clearly identified by CT & MRI.
Ten cases were reported.

age range 25 - 55 yr 4 ♀ 6 ♂

Two were from Sudan 6 Baghdad

1 Dorsalgia & 1 Sphincter

2 mid dorsal 4 lower dorsal

and 4 cervical.

ESR 42 - 106

Mean 72

WBC 3500 - 11000
مع اطياب تعينات

Mean 8.7

دار الحكمة للطباعة والنشر

بغداد

In conclusion Mr
Chairman

TB of CNS is a rare
occurrence in the neurological
practice. However it should
be considered seriously in the
differential diagnosis in our
country.

And I would like to end my
presentation by a statement by
Dr Bingall in his forward to Prof
Salem Al Dandogy Book

مع اطيب تحيات

دار الحكمة للطباعة والنشر

بغداد

The story of tuberculosis control in the world is one of triumph and tragedy. The triumph is the discovery of anti-tuberculous drugs; the tragedy is the failure to use them effectively.

CASES

Spine 99/11/11
 3/12
 24

Back ache of 3/12 Throacic spine
 mild fever Mass noticed by the patient
 at the post cervical triangle
 L. node biopsy done

Spine 99/11/11
 3/12 24

Numbness of upper → lower limbs of abdomen
 10 yr duration (chronic)

Spine 99/11/11
 3/12
 no fever but some body aches
 weak leg. Myelo Block at D11/12 ER 70
 op. 70 WPC 11,500

Spine 99/11/11
 3/12
 10 days weak legs impaired sensation back pain
 + some abdominal pain

Spine 99/11/11
 3/12 back pain history
 dura. patch removed ER 42 WPC 800

Spine 99/11/11
 6/12 weakness of legs D11-12 ER 52 WPC 908

Spine 99/11/11
 C6-7 neck pain
 weak limbs no weakness
 CSF PC 185 cells (-) 5-10-50 ER 57 WPC 708

anti TB

anatomical

10/12

also in [unclear]

50yrs

♀

10/12 history of neck pain radiating to occipital region, and upper limbs. Pain is to severe make unable to sleep at night. Unable to pass over than retention with progressive weakness of lower limbs

2/3 Tetraplegia. Increased tone all over sensory impairment up to the ER 15 was 5.2 diff normal

CBF pr 850 mg large was tested.

Myelography: block at L2

Op- anatomical

Progn dense fibrous collagenous tissue

showing congested b-ventricles

anatomical

10/6/18

18, 10/12

4/12 weak limbs for upper to lower

D11 level.

chronic nonspecific myelitis

ER 41 was 5.7

anatomical

ER 52

was 6.2

10/11/18

anti TB

2/12 history of progressive tetraplegia.

anatomical

ER 10

was 9

10/1/17

10/12/17

4/12 weak leg poor control of [unclear]

anti TB

TBM 1991

1991 10/10/91

P TB 2 yr. chem relapse recently.

CSF pr 231 sp 45 cell
ESR 68 CT marked
No hydrocephalus.

TBM

1991 10/10/91

Few tubercles and some

granuloma formation. Papilloedema.

CSF lymph 236 pr 28 sp 40

Pb 275 direct AFB seen.

CT slight hydroceph. ESR 55
wk 8

TBM

1991 10/10/91

Visual failure optic atrophy.

Tubercles in the chiasm area.

ESR 70 op. craniotomy

مع اطيب تعيات

دار الحكمة للطباعة والنشر

بغداد

TBM

2/9 Q 19/11/12
CSF 20
not for test

Header - 2/12 and high fever

Bilateral peritonsillar

CSF 46 cells lymphocytes 34 12 poly ESR 20 PR 70

AFB +. ESR 28

TBM

19/10/14
CSF 20
not for test

Conatond fever. Rest not

CT Nil. on amox

Tuberculosis

Jan 1981

Handwritten notes in Arabic script.

visual dist of one year

Bilar early paritudo.

op. Hand tumor for deep seated

Primary tuberculo

Tuberculosis

9.11.81

Handwritten notes in Arabic script.

Tuberculosis percutaneous abscesses. General
died (op) Bro & percut

Tuberculosis

Handwritten notes in Arabic script.

Fever headache .. Paritudo

op. twice.

1981/11/19

Tuberculosis (embolus)

4/12 headache. faint palsy. Bilar. paritudo

Tuberculosis

(B) Hemis 14 days. faint palsy & sweat

Handwritten notes in Arabic script.

Handwritten notes in Arabic script.

Tuberculosis

1990/7/12

ظالم ترميم - سوان - البرية

lost consciousness for one day. fever for 2/12

spastic lower limbs Bilateral papilloedema
(cerebellar)

cranialy poor fossa

thickened arachnoid matter with
multiple small loculi of CSF in the brain
stem - No tumor.

ESR 10 WBC 11.400

CT men - the poor fossa.

Tuberculosis

1982/2/17

موت - 11 - 24 - 57

Headache vomiting Bilateral papilloedema
CT enhanced \oplus peritubercular

sp. tuberculosis.

مع اطيب تعيات
دار الحكمة للطباعة والنشر
بفداد

Spine

١٠/١١/١٥

عبدالرحمن قاسم

بغداد ١٥

ER ٤٥ WAC 35

1/2 paraplegia & retent V

Spine & (exchange) C6 - D1 cord

Spine

١٤/١١/١٥

ER 90 WAC 10

Back pain 1 week legs 2yr

Hampshire 3 hrs D11 - 12

Spine

١٩/٧/١٩

مردة خلف

بغداد ١٥

ER 106

WAC 9

D6 - 8

Back pain

Tuberculosis

So directed

Header	Vanity	Pages	Fines	Fees	Payable
25	15	11	12	30	

(payable) 24

- Fees 60%
- Header 50%
- payable 50%
- Vanity 30%
- pages 22%
- Fines 24%

Spina

<u>Praxis</u>	<u>age</u>	<u>Sex</u>	<u>Site</u>	<u>Gr.</u>	<u>WPI</u>	<u>Year</u>
بفاز	25	♂	C6-D1	80	3.5	86
ديوانه	47	♂	D11-12	90	10	83
بفاز	50	♀	D6-8	106	9	83
سودان	30	♂	C6-7	-	-	90
بفاز	44	♀	C6-7	-	-	90
بفاز	55	♂	D11-12	70	11	91
سودان	30	♂	D10-4	76	6	89
بفاز	40	♂	D6-8	42	8	91
بفاز	55	♀	D11-12	52	9.8	81
م. م.	24	♀	C6-7	57	7.8	87

♂ 4
♀ 6

2 Sudan 24-55
6 Baybt
1 Dinary
1 Subman

6 ♂
4 ♀

- ② Mid Dorsal
- ④ Lower Dorsal
- ④ Cervical

ESR
mean
72

42-106

81	1
83	2
86	1
87	1
89	1
90	2
91	2

WPI
8.17
Mean

3.5-11

...
...
...

Arachnida

جنس	العمر	المنطقة	عدد	EM	WMI
♀	50	D2	92	15	7.2
♀	40	D11	85	42	5.7
♀	45	D10	85	10	9
♂	50	C4-7	85	52	8

1985 3
92 1

Tuberculosis

موزيل	♀	27	Supratentorial	81	77 1 80 1 81 1 84 1 86 1 av ±
بغداد	♀	50	Supratentorial	90 (+ Parenchymatous 4 at site)	
بغداد	♂	24	Supratentorial	77	
بغداد	♂	7y	cerebellar	81	
بغداد	♂	10	Supratentorial	86	
بغداد	♂	5y	cerebellar	90	EM 10 WMI 11.4
بغداد	♀	18y	Supratentorial	84	

TBM

بغداد	♀	14	EM 68	pr 231	cell 2 5 45	PTB+
بغداد	♀	19	WMI 8 EM 55	275	cell 463 40	AFB+
بغداد	♂	15	70	70	46 20	AFB+
بغداد	♀	24	28	70		
بغداد	♀	25				

مع اطيب تعينات

دار الحكمة للطباعة والنشر

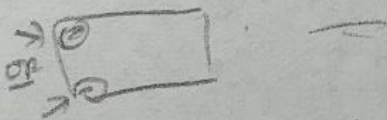
بغداد

Long TD

TB Spedylitis - or

Tx to

Tuberculous osteomyelitis of axial skeleton most commonly involves the thoracic and lumbar spine. Uncommon cervical & sacral spine. 9+ starts as the
 are part of body either superior or inferior...
 as it progresses it affects the adjacent disc & vertebrae



white people more sacral

coloured less, disc involvement

More sclerous - coloured

More C.S.F.

(1)
1/4
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@pSilverPlatter 1.6

MEDLINE (R) 1/90 - 5/90

- TI: Intracranial tuberculoma developing during therapy for tuberculous meningitis. 1 of 7
AU: Malone-JL; Paparello-S; Rickman-LS; Wagner-KF; Monahan-B; Oldfield-EC
SD: West-J-Med. 1990 Feb; 152(2): 188-90
- TI: Intracranial tuberculomas. 2 of 7
AU: Malhotra-M; Mishra-VN; Gupta-S
SD: J-Indian-Med-Assoc. 1989 Sep; 87(9): 213-6
- TI: The treatment of tuberculous meningitis. 3 of 7
AU: Parsons-M
SD: Tubercle. 1989 Jun; 70(2): 79-82
- TI: A comparison of secretory epithelioid cells and phagocytosing macrophages in experimental mycobacterial granulomas. 4 of 7
AU: Turk-JL
SD: Br-J-Exp-Pathol. 1989 Oct; 70(5): 589-96
- TI: Isolated giant tuberculomata of the liver detected by computed tomography. 5 of 7
AU: Chan-HS; Pang-J
SD: Gastrointest-Radiol. 1989 Fall; 14(4): 305-7
AB: Isolated giant tuberculomata of the liver are rare, and they are frequently misdiagnosed as primary or secondary tumors of the liver. We describe the computed tomography findings in 2 patients with giant tuberculomata of the liver. One patient had a large low-attenuation lesion with rim enhancement after contrast. The other patient had multiple calcific lesions that did not enhance but showed a rim of hypoattenuation after contrast. Biopsy established the diagnosis and both patients recovered with antituberculous chemotherapy.

SilverPlatter 1.6

MEDLINE (R) 1/90 - 5/90

- TI: Third ventricular tuberculoma: a case report. 6 of 7
AU: Singh-JP; Chandy-MJ
SD: Br-J-Neurosurg. 1988; 2(1): 93-6
AB: Tuberculomas of the brain can now be diagnosed readily with computerised axial tomography. A rare, biopsy proven case of a third ventricular tuberculoma is presented. Typical CT scan findings are discussed and management with drugs and minimal surgical intervention when necessary is stressed.
- TI: Intracranial tuberculoma: MR imaging. 7 of 7
AU: Salgado-P; Del-Brutto-OH; Talamas-O; Zenteno-MA; Rodriguez-Carbajal-J
SD: Neuroradiology. 1989; 31(4): 299-302
AB: MR studies of 6 patients with intracranial tuberculoma are reviewed. All patients also underwent CT scans which showed hypo- or isodense lesions with abnormal enhancement following contrast administration. MR showed lesions with prolongation of the T1 relaxation time in every case. On the T2-weighted sequences, the signal properties of the tuberculoma varied according to the stage of evolution of the lesion. Incipient tuberculomas appeared as scattered areas of hypointensity surrounded by edema. Mature tuberculomas were composed of a dark necrotic center surrounded by an isointense capsule which was, in turn, surrounded by edema. In one patient, the center of the lesion was hyperintense probably because of liquefaction and pus formation (tuberculous abscess). While both, CT and MR, were equally sensitive in visualizing the intracranial tuberculoma in every patient, MR was slightly superior in demonstrating the extent of the lesion, especially for brainstem tuberculomas. Nevertheless, the potential role for MR diagnosis of intracranial tuberculoma is limited by the fact that other infectious or neoplastic diseases may present similar findings. The diagnosis of intracranial tuberculoma should rest on a proper integration of data from clinical manifestations, cerebrospinal fluid analysis, and neuroimaging studies.

TI: Tuberculous arachnoiditis of the spine: findings on myelography, CT, and MR imaging.

AU: Chang-KH; Han-MH; Choi-YW; Kim-ID; Han-MC; Kim-CW

SO: AJNR. 1989 Nov-Dec; 10(6): 1255-62

AB: Tuberculosis (TB) is a rare cause of spinal arachnoiditis. It may occur primarily or secondary to intracranial or vertebral infection; unlike other types of arachnoiditis, it frequently involves the spinal cord as well as the meninges and the nerve roots. We retrospectively reviewed 13 conventional myelograms, eight CT myelograms, and five Gd-DTPA-enhanced MR images in 13 patients with spinal TB radiculomyelitis (arachnoiditis). Eleven patients had intracranial TB meningitis at the time of diagnosis or before. Ten patients were less than 30 years old. Conventional myelographic findings included a block of the CSF (11/13), most commonly at the level of the conus medullaris; irregular or indistinct thecal sac contour (9/13); multiple fine and/or coarse nodular defects (8/13); nerve-root thickening (7/13); and vertical bandlike adhesive defects (4/13). CT myelography showed intradural nodular masses suggesting tuberculomas at or just above the level of the block (4/8), irregularity of the spinal cord surface (4/8), irregular filling or obliteration of subarachnoidal space (6/8), and root thickening (5/8). Gd-DTPA-enhanced MR images revealed enhancing nodules suggesting tuberculomas (2/5); enhancement of the dura-arachnoid complex around the cord (3/5); and segmental enhancement of the thoracic cord, suggesting either infarction caused by vasculitis or TB myelitis in association with diffuse cord swelling (1/5). Plain MR findings were much less conspicuous, showing only an indistinct or irregular dura-arachnoid-cord complex (4/5). In conclusion, the conventional myelographic findings are considered to be virtually diagnostic of spinal TB radiculomyelitis in young patients with antecedent or coexisting TB meningitis. (ABSTRACT TRUNCATED AT 250 WORDS)

TI: The long-range prognosis of arachnoiditis.

AU: Guyer-DW; Wiltse-LL; Eskay-ML; Guyer-BH

SO: Spine. 1989 Dec; 14(12): 1332-41

AB: Fifty patients with arachnoiditis were studied, and long-term follow-up ranging from 10 to 21 years was obtained on 36 (72%). Prior to developing arachnoiditis, 90% originally had intervertebral disc disease, Pantopaque (Alcon Surgical, Ft. Worth, Texas) myelography, and subsequent lumbar spine surgery. Pain and functional disability tended to remain the same as at the time of diagnosis, although severity of symptoms fluctuated. Increased neurologic deficits were more frequently due to surgical intervention than to the natural course of the disease. Urinary symptoms characterized by urgency, frequency, and occasional incontinence, with no other apparent cause, developed late in 23%. Although the majority were able to walk and drive a car without limitation, ability to return to previous full-time occupations was markedly limited. The majority depended on daily narcotic analgesics; a few admitted to alcohol abuse. There were two deaths by suicide. Although other deaths were not directly related to arachnoiditis, the average lifespan was shortened by 12 years. Treatment results were disappointing. Arachnoiditis may be disabling; however, longterm follow-up indicates that progression of symptoms and functional impairment are not the natural course of the disease.

cent of patients were under five years of age. Among the infectious diseases, gastroenteritis accounted for nearly 70% of admissions. Tuberculosis, measles, diphtheria and typhoid fever were other common infectious diseases. Malnutrition of varying degree was the core problem among the hospitalised children and was seen in nearly two thirds of admissions. Twenty per cent of them had severe protein energy malnutrition which contributed for higher mortality. Gastroenteritis contributed for half (51.5%) of the mortality. Septicemia, tetanus neonatorum and central nervous system infections were associated with high mortality especially among the neonates. Deaths following 6-target preventable diseases accounted for nearly 1/4th of deaths (20.4-24.6%) over these years.

SilverPlatter 1.6

MEDLINE (R) 1/90 - 5/90

TI: Acquired immune deficiency syndrome in childhood. Neurological aspects. 7 of 9

AU: Iannetti-P; Falconieri-P; Imperato-C
SO: Childs-Nerv-Syst. 1989 Oct; 5(5): 281-7

AB: Central nervous system (CNS) involvement is very frequently observed in pediatric AIDS. Clinical manifestations include encephalopathy, cognitive deficits, acquired microcephaly, neurological signs, myelopathy, and peripheral neuropathy. Neurological complications can be related to opportunistic viral infections such as encephalitis, atypical aseptic meningitis, progressive multifocal leukoencephalopathy, and myelitis. Nonviral syndromes include: toxoplasmosis, cryptococcal meningitis, candidiasis, Mycobacterium tuberculosis meningitis, and Mycobacterium avium subacute encephalitis. Bacterial infections, tumors, cerebrovascular complications, and peripheral neuropathies are not frequently observed in pediatric AIDS. The most severe complications of HIV infection is encephalopathy resulting from HIV infection of brain tissue. Direct HIV invasion of the CNS has been demonstrated. Clinical features of HIV encephalopathy are classified into three categories: (1) normal neurological findings; (2) static encephalopathy; and (3) progressive encephalopathy. AIDS dementia complex can be differentiated from the predominance of behavioral and cognitive disabilities.

TI: Third ventricular tuberculoma: a case report. 8 of 9

AU: Singh-JP; Chandy-MJ
SO: Br-J-Neurosurg. 1988; 2(1): 93-6

AB: Tuberculomas of the brain can now be diagnosed readily with computerised axial tomography. A rare, biopsy proven case of a third ventricular tuberculoma is presented. Typical CT scan findings are discussed and management with drugs and minimal surgical intervention when necessary is stressed.

TI: Intracranial tuberculoma: MR imaging. 9 of 9

AU: Salgado-P; Del-Erutto-OH; Talamas-O; Zenteno-MA; Rodriguez-Carbajal-J
SO: Neuroradiology. 1989; 31(4): 299-302

AB: MR studies of 6 patients with intracranial tuberculoma are reviewed. All patients also underwent CT scans which showed hypo- or isodense lesions with abnormal enhancement following contrast administration. MR showed lesions with prolongation of the T1 relaxation time in every case. On the T2-weighted sequences, the signal properties of the tuberculoma varied according to the stage of evolution of the lesion. Incipient tuberculomas appeared as scattered areas of hypointensity surrounded by edema. Mature tuberculomas were composed of a dark necrotic center surrounded by an isointense capsule which was, in turn, surrounded by edema. In one patient, the center of the lesion was hyperintense probably because of liquefaction and pus formation (tuberculous abscess). While both, CT and MR, were equally sensitive in visualizing the intracranial tuberculoma in every patient, MR was slightly superior in demonstrating the extent of the lesion, especially for brainstem tuberculomas. Nevertheless, the potential role for MR diagnosis of intracranial tuberculoma is limited by the fact that other infectious or neoplastic diseases may present similar findings. The diagnosis of intracranial tuberculoma should rest on a proper integration of data from clinical manifestations, cerebrospinal fluid analysis, and neuroimaging studies.

TI: Radiological and clinical features of basal ganglia infarction in tuberculous meningitis.

AU: Tang-PS; Low-LC

SO: Aust-Paediatr-J. 1989 Dec; 25(6): 361-2

AB: A patient with choreoathetosis and dystonia who had computerized tomography evidence of basal ganglia damage resulting from tuberculous meningitis is presented. It is important to distinguish these extrapyramidal movements from fits, and the observation of such movements in a clinical setting of meningitis should alert physicians to the diagnosis of tuberculous meningitis.

TI: Neurobrucellosis--another cause of increased adenosine deaminase activity in cerebrospinal fluid [letter]

AU: da-Cunha-S; Gaspar-E; Melico-Silvestre-A; Azlvedo-Bernarda-R; da-Costa-C

SO: J-Infect-Dis. 1990 Jan; 161(1): 156-7

TI: Ofloxacin: a review.

AU: Smythe-MA; Rybak-MJ

SO: DICP. 1989 Nov; 23(11): 839-46

AB: Ofloxacin is a new fluorinated quinolone antibiotic with a broad spectrum of activity against a variety of gram-positive and -negative bacteria including Enterobacteriaceae, Pseudomonas aeruginosa, and methicillin-resistant Staphylococcus aureus. In addition, ofloxacin has significant activity against Neisseria gonorrhoeae, Chlamydia trachomatis, and Mycobacterium tuberculosis and this may give rise to new indications for the class of quinolone antibiotics. Clinical trials to date have demonstrated the efficacy of ofloxacin in the treatment of lower respiratory tract infections, urinary tract infections, and sexually transmitted diseases. Adverse effects to ofloxacin are usually mild and include gastrointestinal, central nervous system, and hypersensitivity reactions. Significant drug interactions with ofloxacin have not been reported.

TI: Pre-morbid height and weight as risk factors for development of central nervous system neoplasms.

AU: Helseth-A; Tretli-S

SO: Neuroepidemiology. 1989; 8(6): 277-82

AB: Information on pre-morbid height and weight from a national screening of tuberculosis between 1963 and 1975 was linked with the registrations in the population-based Norwegian Cancer Registry. For each case with a primary central nervous system (CNS) neoplasm, 10 matched controls were taken from the non-cases. Analyses were done by a Cox regression model for the total group of CNS neoplasms and the various histological groups. In the case of the total group, height emerged as a significant risk factor for both sexes. Within each sex, a similar trend was found for each histological group although statistical significance was retained only for glioblastoma among males and for other types of glioma (astrocytoma, oligodendroglioma, mixed glioma and ependymoma) for females. A significant negative association was revealed between Quetelet's index (weight/height squared) and 'other gliomas' in females. No association with body mass, as expressed by Quetelet's index, was found for patients with meningioma.

TI: Enzyme-linked immuno-assay for the detection of mycobacterium tuberculosis specific IgG antibody in the cerebrospinal fluid in cases of tuberculous meningitis.

AU: Dole-M; Maniar-P; Lahiri-K; Shah-MD

SO: J-Trop-Pediatr. 1989 Oct; 35(5): 218-20

AB: The efficacy of enzyme-linked immuno-assay in the detection of IgG antibody against mycobacterium tuberculosis in the cerebrospinal fluid of patients suffering from tuberculous meningitis was measured in 50 children consecutively admitted to hospital. The controls were 15 cases of tuberculosis other than of the central nervous system; 24 cases of pyogenic meningitis; 19 cases of neurologic problems but with essentially normal cerebrospinal fluid. The specificity of the test ranged from 93 to 100 per cent and the sensitivity from 82 to 95 per cent.

TI: Pattern of preventable diseases in Afghanistan: suggestions to reduce the morbidity and mortality at IGICH.

AU: Choudhry-VP; Fazal-I; Aram-G; Choudhry-M; Arya-LS; Torpeki-MS

SO: Indian-Pediatr. 1989 Jul; 24(7): 654-9

AB: Over nine years period (1354-1362), 1,39,436 children were admitted in Indira Gandhi Institute of Child Health (IGICH), Kabul. Of these 51,212 (46.8%) children were hospitalised with preventable diseases. Seventy four per

bone, resulting in a small post-debridement defect that needed only a short graft; marked intraoperative correction of the deformity; and involvement of lower lumbar segments. Fifteen patients (19 per cent) had a fair result and eighteen (22 per cent), a poor result. An increase in the deformity was common in patients who had extensive involvement of the vertebral bodies that had resulted in a large post-debridement defect necessitating a graft spanning more than two disc spaces. Lesions of the thoracic vertebrae were associated with many of the poor results, and patients who had a marked kyphosis before treatment also did not do well. A stable graft that provided structural support was observed in only thirty-three patients (41 per cent), and failure of the graft due to slippage, fracture, absorption, or subsidence was seen in forty-eight patients (59 per cent). The length of the graft also played a role: the graft failed most often in patients in whom it spanned more than two disc spaces. We concluded that it is unwise to rely solely on the graft to prevent vertebral collapse in patients in whom the length of the graft exceeds two disc spaces. These patients may benefit from additional measures, such as an extended period of non-weight-bearing, posterior arthrodesis after six to twelve weeks, and prolonged use of a brace until complete consolidation is evident.

19 of 21

TI: Pott's disease [letter]
SD: Chest. 1989 Oct; 96(4): 955-6

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MEDLINE (R) 1/90 - 5/90

TI: Pott's disease [letter]
SD: Chest. 1989 Oct; 96(4): 955-6

19 of 21

TI: Tuberculous spondylitis in adults [letter]
AU: Johnston-RA
SO: Br-J-Neurosurg. 1989; 3(3): 417

20 of 21

TI: A conus tuberculoma mimicking an intramedullary tumour: a case report and review of the literature.

21 of 21

AU: Choksey-MS; Powell-M; Gibb-WR; Casey-AT; Geddes-JF

SD: Br-J-Neurosurg. 1989; 3(1): 117-21

AB: Tuberculomas of the spinal cord are rare. They usually present as mass lesions with little evidence of systemic illness. We report a case where the diagnosis was only made histologically, emphasising the need to consider infection as a cause of neurological illness in patients from under-developed countries.

231

SilverPlatter 1.6

MEDLINE (R) 1/90 - 5/90

2 of 21
 TI: Pott's disease and extrapleural anterior decompression. Results of 108 consecutive cases.
 AU: Korkusuz-Z; Binnet-MS; Isiklar-ZU
 SD: Arch-Orthop-Trauma-Surg. 1989; 108(4): 349-52
 AB: Between 1973 and 1988, 108 patients with a preoperative diagnosis of spinal tuberculosis were treated by anterior extirpation and interbody fusion at Ankara University Medical Faculty, Orthopedic Surgery and Traumatology Department. In 96 cases the operations were performed intrapleurally, as Hogston described. For 12 patients who had spinal involvement at lower thoracic and upper lumbar segments an extrapleural and extraperitoneal approach was used. The extrapleural approach is strongly recommended for patients who have compromised pulmonary reserve. When this approach is used adequate exposure can be obtained and postoperative rehabilitation of patients is facilitated. Advantages and disadvantages of the extrapleural approach and the results obtained from 108 patients are presented.

4 of 21
 TI: Echographic evaluation of tubercular abscesses in lumbar spondylitis.
 AU: Rubaltelli-L; De-Gerone-E; Caterino-G
 SD: J-Ultrasound-Med. 1990 Feb; 9(2): 67-70
 AB: Thirty-two patients with tubercular lumbar spondylodiskitis were studied by using traditional x-rays and echography. Computed tomography (CT) scans were also employed in six patients. Ultrasound scans detected tubercular abscesses in 17 cases, whereas traditional x-rays diagnosed abscesses in only 10. Echographic patterns are reported depending on the site and contents. Besides assessing the abscess, it was possible to diagnose a case complicated with hydronephrosis due to compression of the ureter. Analysis of the results obtained indicates that the association of traditional x-rays with echography is sufficient to obtain, in most cases, complete and exact diagnoses and that using CT scans can be limited to doubtful cases or those complicated by paraplegia.

5 of 21
 TI: Harvey Cushing operates on a child with tuberculosis of the spine [letter]
 AU: Rossitch-E Jr; Moore-MR; Black-PM
 SD: Am-J-Dis-Child. 1990 Jan; 144(1): 17-9

7 of 21
 TI: A paraspinal shadow.
 AU: Kreel-L
 SD: Postgrad-Med-J. 1989 Aug; 65(766): 568-9

SilverPlatter 1.6

MEDLINE (R) 1/90 - 5/90

14 of 21
 TI: Tuberculous spondylitis in adults: diagnosis and treatment.
 AU: Azzam-NI; Tammawy-M
 SD: Br-J-Neurosurg. 1988; 2(1): 85-91
 AB: A retrospective study of 23 patients with spinal tuberculosis (TB) was conducted, with special attention to the diagnosis and method of treatment. Computerised tomography (CT) was found to be the diagnostic radiological modality of choice. Triple therapy with the new anti-tuberculous drugs and posterior or posteriolateral decompression succeeded in decompressing the cord and eliminating the tuberculous lesion in all cases. The outcome was comparable to series where anterior decompression was adopted. None of the patients required spinal fusion. Erythrocyte sedimentation rate was the most consistent blood test in suggesting the diagnosis and was the best tool for evaluating a patient's response to treatment. The average hospital stay was only 17 days, which speaks favourably for the surgical management of tuberculous spondylitis.

15 of 21
 TI: Anterior spinal tuberculosis: paraplegia following laminectomy [letter]
 AU: Grogono-JS
 SD: Ann-R-Coll-Surg-Engl. 1989 Sep; 71(5): 339

18 of 21
 TI: Progression of kyphosis in tuberculosis of the spine treated by anterior arthrodesis.
 AU: Rajasekaran-S; Soundarapandian-S
 SD: J-Bone-Joint-Surg-Am. 1989 Oct; 71(9): 1314-23
 AB: The case of eighty-one patients who had tuberculosis of the spine that was treated by debridement and anterior arthrodesis were reviewed eight years or more postoperatively. We studied the progression of the kyphosis and evaluated the function and fate of the bone grafts that were used. At eight years, the results with respect to the progression of the kyphosis were classified as excellent or good in forty-eight patients (59 per cent), all of whom had had minimum destruction of the vertebral bodies; limited surgical excision of

V.E.R. RECORDS

THE GENERAL INFIRMARY AT LEEDS

37662 (REV.)

Request/Report form for:

E.E.G.

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NAME ROBINSON Christopher AGE 4/12

PHYSICIAN Mr Gibson

INDEX No. A 420765 WARD OP

DIAGNOSIS (with summary of history and clinical findings, and a note as to the pattern of any seizures or attacks, the nature and dosage of any drugs administered, the results of any other relevant investigations, etc.)

An infant of 4 months sustained severe head injury Scalp electrodes over right and left occipital poles, with right and left ears as reference. Response to 100 light reflexes were recorded.

On July 1, 1975: No sign of primary potential

On Jan 30, 1976: Normal and asymmetrical primary and secondary potentials were recorded over both occipital areas of an amplitude at least 10 microvolts.

VISUAL EVOKED RESPONSE ASSESSMENT.

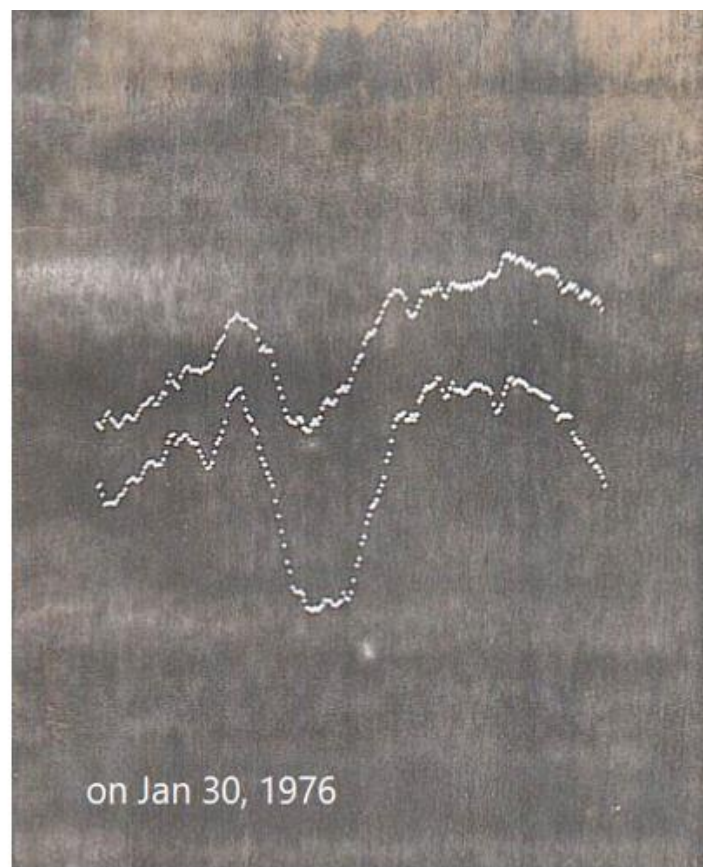
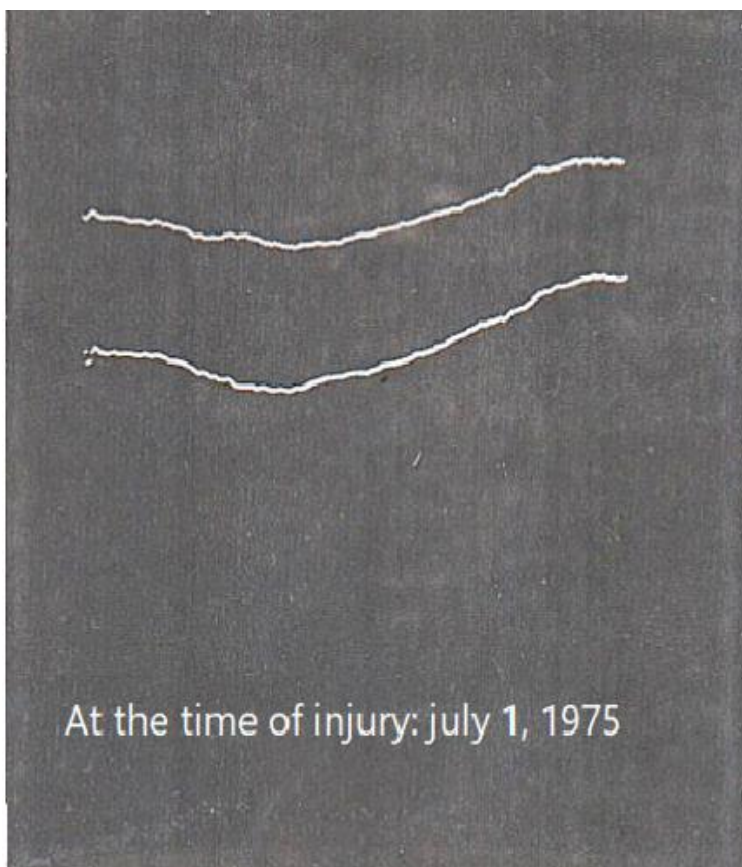
Responses averaged from 100 light-flashes.

In complete contrast with the V.E.R. assessment carried out on 1.7.75, normal and asymmetrical primary and secondary potentials were recorded over the right and left occipital areas, the former now having an amplitude of at least 10 microvolts.

K.A. HXLEY,
Consultant Clinical Neurophysiologist.

30.1.76.

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Symposium on the Cancer Cell

ندوة الخلية السرطانية

1985

اقترحت إقامة ندوة حول الخلية السرطانية دعوت للمشاركة فيها أطباء اختصاصيين وعلماء في اختصاصات علمية أساسية. تعاونت فيها كلية الطب مع جمعية مكافحة السرطان العراقية.

ندوة عن

الخلية السرطانية

تقيمها

عمادة كلية الطب / جامعة بغداد

بالاشتراك مع

جمعية مكافحة السرطان العراقية

يوم الاحد المصادف ١٠ / ١١ / ١٩٨٥

على

قاعة البكر الكهسرى

ندوة عن الخلية السرطانية

تقيمها عمادة كلية الطب / جامعة بغداد / بالاشتراك مع

جمعية مكافحة السرطان العراقي

يوم الاحد المصادف ١٠ / ١١ / ١٩٨٥ على قاعة البكر الكبرى

المقرر : الدكتور عبد الهادي الخليلي / كلية الطب / جامعة بغداد

الجلسة الاولى : (٨٣٠ - ٩٥٠)

رئيس الجلسة : الاستاذ الدكتور زهير قصير / كلية الطب / جامعة بغداد

٨٣٠ الدكتور محمود حياوي / فرع التشريح / كلية الطب / جامعة بغداد

" CARCINOGENESIS AND EMPYOLOGY OF THE CANCER CELL".

٨٥٠ الدكتور سعدى السامرائي / فرع التشريح / كلية الطب / جامعة بغداد

" SOME EM FEATURES OF THE CANCER CELL ".

٩١٠ الدكتور سلمان رشيد سلمان / قسم الكيمياء / كلية العلوم / جامعة بغداد

" MOLECULAR ASPECT OF DNA IN THE CANCER CELL".

٩٣٠ الاستاذ الدكتور سامي المظفر / قسم الكيمياء / كلية العلوم / جامعة بغداد

" BIOCHEMICAL ASPECTS OF THE CANCER CELL ".

٩٥٠ - ١٠٠٠ مناقشة

١٠٠٠ - ١٠٢٠ استراحة عشرون دقيقة

الجلسة الثانية : (١٠٢٠ - ١١٤٠)

رئيس الجلسة : الاستاذ الدكتور حنا بورزان / كلية الصيدلة / جامعة بغداد

١٠٢٠ الدكتورة نزيهة فرمان / فرع الباثولوجي / كلية الطب / جامعة بغداد

" GENETICS AND THE CANCER CELL ".

١٠٤٠ الاستاذ الدكتور مصلح المصلح / فرع الاحياء المجهرية / كلية الطب / جامعة بغداد

" ONCOGENIC VIRUS AND THE CANCER CELL ".

١١٠٠ الدكتور عبد الوهاب الشيلخي / مستشفى الرشيد العسكري

" IMMUNOLOGICAL ASPECTS OF THE CANCER CELL "

١١٢٠ الدكتور قتيبة الراوي / فرع الباثولوجي / كلية الطب / جامعة بغداد

" CYTOPATHOLOGICAL CRITERIA OF THE CANCER CELL "

١١٤٠ - ١١٥٠ مناقشة

١١٥٠ - ١١٢٠ استراحة

الجلسة الثالثة : (١٢٠٠ - ١٣٠)

رئيس الجلسة : الاستاذ الدكتور كنعان محمد جميل / كلية الطب / الجامعة المستنصرية

١٢٠٠ الدكتور تحسين السليم / فرع الباثولوجي / كلية الطب / جامعة بغداد

" PATHOBIOLOGY OF THE CANCER CELL "

١٢٢٠ الدكتور منير صالح / فرع التشريح / كلية الطب / جامعة بغداد

" KINETICS OF THE CANCER CELL BEFORE AND AFTER IRRADIATION "

١٢٤٠ الدكتور موهيـد مهدي / فرع الكيمياء / كلية الطب / جامعة بغداد

" MARKERS OF THE CANCER CELL "

١٢٠٠ الدكتور عماد فرجو / فرع الفارماكولوجي / كلية الطب / جامعة بغداد

" THERAPEUTIC BASES OF THE CANCER CELL "

١٢٠ - ١٣٠ مناقشة

تقييم البحوث التي قدمتها لدرجة الاستاذية
المقوم من جامعة عين، شمس القاهرة 1988

سمسزى
استواره تقويم الابحاث العلميه
(بمسلاهما الحكيم)

رقم البحث : ١

عنوان البحث : Reaction time measurement

اسم الباحث : Salim Nassary + A. Hadi Khaledi

رتبته العلميه : استاذ مساعد

القسم : الجراح الكليه : العلم

بعد مراجعته البحث المرفق طيا ، يرجى التفذيلا باجابته على السؤاليين

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟



٠٢ اذا كان الجواب نعم ، ماهي نقاد الاماله والابتكار فيه ؟

- استخدام وسائل و الاجهز صنعتي طيا لفرضه البحث والنظريه
- استخدام البحث بطريقه علميه ومنعالم مجال لم يطرقه احد طيا ومثل

الاسم :

اللقب العلميه :

العنوان :

١٢٧٧

صفء / ٨ / ٤

سمسرى
استناره تقويم الابحاث العلميه
(يمسلاهما الحكيم)

رقم البحث :

عنوان البحث : Spinal Cord Regeneration
New Experimental approach

اسم الباحث : A. Hade Khalili

مرتبه العلميه : استاذ

القسم : الجراح الكليه : الطبيه

بعد مراجعه البحث المرفق طيا ، يرجى التفذيلا بالا جا به على السوء اليمن

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟

لا

نعم

٠٢ اذا كان الجواب نعم ، ماهي نقاط الاصاله والابتكار فيه ؟

التجريب جديده ولم ليمنه استخرا م هذه الوسيلا من التجارب الما در
وه وبل . والموضوع جديده جدا ويبر نتائج مأموره

استشاره تقويم الابحاث العلميه
(بمسئله الحكيم)

ن

رقم البحث :

عنوان البحث : C.T values in orbital Hydrate
Cyst

اسم الباحث : A. Hadi Khalili

مؤيته العلميه : استاذ مساعد

القسم : الجراحه الكليه : الرطيم

بعد مراجعته البحث العرفق دليا ، يرجى التفدول بالا جا به على السوء اليمن

التاليين :

٠١ هل البحث المذكور اعلاه اصميلا ومبتكرا ؟

لا

نعم

٠٢ اذا كان الجواب نعم ، ماهي نقاد الاصاله والابتكار فيه ؟

عرضه لعدد كبير للمجلات
منها ايضا في امريه واستيطات واصفالات لتقييم هفتيم او سيلم
لصحت العصب الطيقه الجود من الكياس معبر القيم الجود

الاسم :

اللقب العلميه :

العنوان :

١٩٨٧/١

صفحة ٤ / ٨

سسسرى

استناره تقویم الابحاث العلمیه
(یمسلاهما النکسم)

The value of computerised
Tomography in the diagnosis
of orbital lesion
A. Hadi Khalil

رقم البحث :

عنوان البحث :

اسم الباحث :

رتبته العلمیه :

القسم :

الكلیه : الطب

الکرام

بعد مراجعته البحث المرفق طيا ، يرجى التفضل بالاجابه على السوالين

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟

لا

نعم

٠٢ اذا كان الجواب نعم ، ماهي نقاط الاماله والابتكار فيه ؟

الاسم :

اللقب العلمی :

الجنسوان :

٨٧/٨

صفحة ٤/٨

سبب
استطاره بتقويم الابحاث العلميه
(بمسلاهما المحكم)

رقم البحث :

عنوان البحث : Computer Analysis of intracranial
pressure Measurement clinical value
& hearing response

اسم الباحث : Turner, McDonald, Gibson & Khalili

مؤيته العلميه : آتار ماس

القسم : الجراح الكليه : الطيب

بعد مراجعه البحث المرفق طيا ، يرجى التفضل بالا جا به على السوالين

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟



٠٢ اذا كان الجواب نعم ، ماهي نقاد الاصله والابتكار فيه ؟
هذه المحوكم المستخرجه من الحث وفتح البركوز جليل من الورد من قياس
الصنط را حل الدماغ واستخدم اللوسيوكرو تبيسط لهندسة القوي
فيه انما اصل والاسط

الاسم :

اللقب العلميه :

المسوان :

سمسرى
استماره تقويم الابحاث العلميه
(يمسلاها المحكم)

رقم البحث : Experimental Concession in
Annual Preliminary report
عنوان البحث :
اسم الباحث : A. H. Khalili et al.
مؤيته العلميه : استاذ مساعد
القسم : الكرام الكليه : الطبيه

بعد مراجعته البحث المرفق طيا ، يرجى التفذيلا بالا جا به على السواء الين

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟



٠٢ اذا كان الجواب نعم ، ماهي نقاط الاصاله والا ابتكار فيه ؟

- التجريب جديده وجميع وسائل البحث اصيلا وتحليله على الصنع
- دراسه المتغيرات الكهربيه والمختلفه في وقت واحد في نفس الموضع
- اصول البحث وجعله مبسوطا

الاسم :

اللقب العلميه :

العنوان :

صفحة ٤ / ٨

ســـــــــــــــري
استباره تقويم الابحاث العلميه
(يمسلاهما المحكم)

رقم البحث :
عنوان البحث : موت الدماغ
اسم الباحث : د . عبدالرحمن خليل
مرتبته العلميه : استاذ مساعد
القسم : الحراس الكليه : الطبيه

بعد مراجعته البحث العرفق طليا ، يرجى التفديل بالا جابه على السوء اليمن

التاليين :

٠١ هل البحث المذكور اعلاه اصيلا ومبتكرا ؟



٠٢ اذا كان الجواب نعم ، ماهي نقاط الاصله والابتكار فيه ؟

عقال ممتاز كفضيل و در قيمه و تعليم و وطن و قانوني مع العلم الاول
الاصله هنا هو محليه التعريف و التطبيق و ما يثبت محققا و ديننا
و عليه تقديم بل تشجيع لنقل الأعضاء حيث بدأ تقسيم الموت للدماغ

الاسم :

اللقب العلميه :

العنوان :

١٩٨٧/

صفحة ٤ / ٨

السيد الأستاذ الدكتور محمد عبدالعزیز الصیامه

المساعد العلمي لرئيس جامعة بغداد

حسبه طيبه ايماءا الى ضطالكم المؤرخ ١٩٨٧/٩/١٩ بتأني
تقسيم آليات الدكتور عبدالردي خليل والموصى الى الأستاذ الدكتور

أحمد البزوري ويؤسفنا أنه أنفق اليكم نيا وفاه

فقد ثلاثة شهور وقد كلفنا مجلس القسم بتقسيم

ويصدق أنه أقر بالقيم الكليه للبرود المبدولة مع الدكتور

خليل من مجال صراع المخ والأعصاب بالفراغ التصفيه سواء بالتعليم

ومما كنه تخصصات أخرى ومجالات أخرى أما بخصوص أعماله

وأبحاثه فري من مجموع عمل توصله للدرجه المتقدمه إلى بل تفرز

من مقدمه صفوف صراع الأعصاب بالتره الأوسط

أرجو أنه تقبلوا فالص تحياتي وإيماءا وأود أنه أبلغكم

باعتقاد قسم صراع الأعصاب بكله جنب جميعه حسن النفاذ

مع جامعتكم دوما والسلام عليكم ورحمة الله وبركاته

MAJOR DISASTER TRIAGE

1992

((دوره تدريب الكوارث))

تاريخ الدورة : ١١ - ١٤ / ٤ / ١٩٩٢

المشاركين في الدورة : مدراء المستشفيات والمسؤولون عن وحدات الطوارئ في المستشفيات

مبررات الدورة وأهدافها : تقديم خدمات سريعة أفضل في حالات الكوارث من قبل العاملين في
المستشفيات

ويكسبون المشاركون في الدورة قدرات من

(١) إقامة دورات لتدريب الكوادر الطبية والنسبية في المستشفيات على كيفية التعامل مع المواقف
في حالات الكوارث الطبيعية والدموية من أجل تقليل نسبة
الوفيات الناتجة من الكوارث التي تحدث بالعراق ، الانفجارات
حوادث الطرقات ، انهيارات الأبنية ، التفجيرات ، الأمراض
الوبائية ، توارث الحروب ... الخ

(٢) كيفية التعامل الصحيح في حالات الكوارث داخل المستشفيات

مكان الدورة : مركز تطوير الكوادر

مدير الدورة : الدكتور بهاج يوسف عبد القادر

مفردات منهج دوره لعب الكوارث

المطابق للمقرر	الموضوع	اليوم والوقت
<p>المدير العام د * فارس فريد بني د * صباح يوسف ميخائيل د * فائز فتح الله عبد الرحيم = =</p>	<p>افتتاح الدورة توزيع استمارة الاستبيان الكوارث / تعريفها / انواعها كيفية التعامل مع حالات الكوارث عسر في تنظيم</p>	<p>السبت ١١ / ٤ ٩ - ١٠ ١٠ / ٣٠ - ١١ / ٣٠ ١١ / ٣٠ - ١١ / ٣٠</p>
<p>د * كمال ماضي د * منار المرصفي د * صباح يوسف</p>	<p>ملاحظات عامة عن الكوارث الالبييه التهجان المسؤوله في الكوارث / واجباتها / كيفية تنفيذ العمل مناقشه / عرض نظم</p>	<p>الاحد ١٢ / ٤ ٩ - ١٠ ١٠ - ١١ ١١ / ٣٠ - ١١ / ٣٠</p>
<p>د * خالد العبيدي د * خالد روميا</p>	<p>كيفية التعامل مع المصابين في حالات الكوارث كيفية التعامل مع المصابين في كوارث ... المعيشة</p>	<p>الاثنين ١٣ / ٤ ٩ - ١١ ١١ / ٣٠ - ١١ / ٣٠</p>
<p>د * عبد الهادي الخليلي د * نجم عطا د * منار كركابي</p>	<p>كيفية التعامل مع اصابات الرأس والرقبة كيفية التعامل مع اصابات القلب والاوعية الدمويه التعامل مع اصابات الكسور والجراحات</p>	<p>الثلاثاء ١٤ / ٤ ٩ - ١٠ ١٠ - ١١ ١١ / ٣٠ - ١١ / ٣٠</p>
<p>الدكتور المشرفه</p>	<p>مناقشه عامه وتنظيم الدورة توزيع استمارة الاستبيان اختتام الدورة</p>	<p>الاربعاء ١٥ / ٤ ٩ - ١١ ١١ - ١٢ ١٢ / ٣٠ - ١١ / ٣٠</p>

الكاشة

هي مصدر التبريد من الصباين ما أصابت به
كامة الانداع ويطلق درجاته من (سبون
انذار مبرك او بانه اقليل) الى المستقر
ما يندرق فة مرة المستقر على التفاعل معها في وقت
واحد من ما صير رصميا وكوادرها

اسبابها

- حدارة طوق المرور السريع
- حدارة الباصات (سيارات القدر) الكبيرة
- حدارة التيارات
- حدارة الطائرات
- حدارة الانفجار
- الكروم

سوطها

لندرجه كما رتبنا مما تبين
الهدف الاساس من التفاعل مع الكاشة هو
تحقيق الفائدة القصوى لا كبر لرد من الصباين

9

العوامل التي تؤثر من الكارثة

- ١. تدعيمها
- ٢. حريق
- ٣. ارتفاع
- ٤. سرعة
- ٥. المد

ان هذه العوامل تؤثر من

- ١. نسبة الوفيات
- ٢. نسبة الإصابات
- ٣. سرعة الوصول إلى نظام الكارثة
- ٤. سهولة الإخلاء
- ٥. وقت الوصول إلى المستشفى

٢

قائمة التكو

التوقف بعد فرق المتقار
نقاط السيطرة

- * اصول المصائب
- * مبادئ الارشاد في الوقع والالتفات
- * السيطرة على الكوارث ، الاجهزة ، دلائل وادوات
- المركبات و المصائب .
- * التوثيق وطرقه والسلب التقرين
- * السدج والحماية ضد الضغى
- * الفرز طرقه وتطبيقه
- * السلب وصول واصد اسبابه الاسعاف
- * التمهيد التائيه

ان مكانه ايراد الله اصل الحرام هو مني
 الله سبحانه وتعالى وليس على المؤمنين ذنب العارض

ان الاطباء يجب انهم يتوجهوا بالاصح
 الكارة بعبارة الاسعاف اذ لا يسهل
 والكيفيين بعبارة استهم

٤

في موقع الكارتة

هنا - اناس من اجتماعات ومن

متباينة

على بسببهم لا يوفوا لهم (لا)

عسر على عديري

الاصنام

تقنين الكهنة

بلا (dentification)

وهذا الهة صوية

- الاستقام

- المركبات

- نسا و السيطرة

- العدر والاصنام

٥

وبعد ذلك

الارتباطات

والتنسيق

Coordination

السفر على ...

نقاط السيرة

تجمع معلومات لفصل

١. عدد المصائب

٢. حجم الكارثة

٣. المخاطر المتوقعة

Involved

٤. المشاكل المتوقعة

من الالهة والادوار

٥. غيرها

وهذه بدورها تؤثر على الاحوارات كما :

١. مدقع الكارثة

٢. فيما يتعلق المتوقعة

①

بحسب طلبنا شسمية

الطبيب الموقر في الموضع

ولهذا يعرض بالتشريف مع / هذمات الاسعاف

الطبيب الموقر في
التشريف

الآن

وقد رخصت الوزير الطبي الى

المصالحين في موقع الكارثة

↓

فام بتقييم الاصحاب

↓

الى الاسعاف الارضية

↓

تم افراجه Trapped

↓

تصنيف الكهوية

↓

ارسل خارج منطقة الكارثة

تدريج

يجب عدم كبح
الاصحاب

الاصحاب تدون

لا تتأخر من اسلاف

المالك التسمية

ارسل الاركان من

على الصدر

9

القرينة

تعريف

كلمة قرينة معناها العدة بعد القرين
من ادع الا بها ما

اول ما استعمل الجراح لاري وهو
تاليون

تعريف هو: كلمة الاستنبات

تققن زرع الحياة لاولئك

الذين من الممكن جداً ان يبقوا
offer chance of survival to those
who most likely to
benefit.

التوثيق

في موقع الكارثة

ان المصابين الان

خارج موقع الكارثة

يجب ان يجرى عبر فترة تقدم عليهم

الفرز حسب انه المرحل لهم

تدوم في اربعة انواع

- | | | |
|---|------------------------------------|--------------|
| ١ | حالات | تحت الملاحظة |
| ٢ | آجل (عند الانتظار) | تحت الملاحظة |
| ٣ | مطلقا او موقت (اجبا عليه الانتظار) | تحت الملاحظة |
| ٤ | بيدا | تحت الملاحظة |

(5)

اسماء ردة معلومة - اسما ردة الاسما

ضيق دائمة

اسميا - المذبح صفة

حلاوة -	العموان	الاسم
آصلا -	التاريخ	العمر
ملطف -	طعامه الى وقت	الكنية
سبط -		
صوتي		

نذبح اي ردة (مورثي) وقت الارضال وقت الوصول

وضع المصاب عند شدة المرض وقتاً كان مطلقاً

صداه المريف لشمسها نال

الاصابات الاسمية (ضخامة) رأساً صدر بطن حوض عود تقريري

ذوات ارجح ذراع ايسر ساعة سا قانها

المفرد الاسماء الادي نال مناجيل

حالة	المسك البينة	التراف	فقدان الدم نال
سائلة	مصرع	قليل	درهم الدم
صافية	متوسط	متوسط	واي 1
صدوية	كثيرة	كثيرة	شعير 2
بنية	العاصبية (الذئبية) نال	البنفسج	خاوة الدم 3
لونته	البنفسج	الضفاد	تغير الى 1 - 2
وردي			الوقت
الارقي			
تصب			
دم يتراف عن الاذن			
تلا الإلتفات			
الكلم			

فقد التسنن اذا كان لها في حاله قلة الدم (اسرة مداوي) حين كان المريف والشمس جيل و صفة يمكن ان يصفه كل واحد في نفسه

Handwritten mark

العلاج

الرفق
عدد

- ارجح
- غاراة افوه
- التمس
- افطار السواكن الاربعة
- استوب القصد كهداية
- جوار السحب
- بزل الصدر
- ته ليد القتب (وقته ...)

الاوية _____
 وقت اعطائها _____
 الصبي _____
 من صان صبي في الاصحاف ن / ن

(١٠)

الأضداد يوافق

سائر الأضداد

أما ربه يكد به صان مركز الأضداد السوراني
وأنه لرب فضل توزع المصائب من سببها في مختلف

عنه وهذا المصائب إلى المسبب والسيئات
ويتر الطوارق

تَوْضِيحُ تَابِعِيٍّ XII

في مكي الطوارق

أما ربه يكد به صان مركز الأضداد

وأنه لرب فضل توزع المصائب من سببها في مختلف

عنه وهذا المصائب إلى المسبب والسيئات

ويتر الطوارق

أما ربه يكد به صان مركز الأضداد

②

خزينة الفرز
① زيتي ليعود لكل المصابين ، ويعطى العلاج الاولي
ويقرر ترتيب مرصده العلاج الكاليم ونوعها

أو
⑤ من سريع اولى من قبل طبيب ذ النخمة
ومما تم تحويلهم الى الزنا الى صفة

نصين الكهنة

ضوح لوجه صفوح من الصاب

التوصية

- ملدنا - طيبة دقيقة
- مغلف مئين كلف مديج وصابون
- الصاب

(١٢)

منطق الصواع الاولى

سبع الفون في اربعة اصناف

الصواع الالهية - يكون الريف الاعرف والاشفا

الصواع السبعين - يكون في منطق الصواع

الصواع السبعين في منطق الصواع
منطق الصواع السبعين

الصواع السبعين - يكون الريف الاعرف والاشفا

الصواع السبعين او الاماكن الاخرى
الموضحة

الموضحة - الريف الاعرف والاشفا

الكرار - فريق الاشفا

فريق ما قبل العلية الجاهل

فريق الصواع - فريق العلية الجاهل

فريق الصواع

فريق الصواع

(١٣)

منطق الصريح الالاسيم

قائمة العليات - الجراح

قوة العليات

وقد الاقامة

الجراح من قبل السيرة

على العليات

الارادات المستقل

الادوية الطبية

جماعة تكدن كقوة ومصرنة

الكوادر : من راي اين يد هب

كارتات العمل : عامة و تحفصة

سنت عمل الكارثة

سرر الشيق : عرنة مناسب ربيعة من قدراريا

الكدارر الطليه : من الحظر انه يد ص ا طهار كيون فهدوة

لا ص لا الطلاريا

المؤمنين : انظروهم كما انتم في العمل
الاطهار المسمى : ضابط الفوز
الاقتصاد المسمى : سوية فاعه العبادات
الاصحاح المسمى : اثار اهدان المكن
الاصحاح المسمى : في الراهه المستقلة

الممرحات

رابع رتبة الممرحات كهيئة وتبطين
الفاراسه في الطوائف ، الله فاعه الالايه
والاصحاح الاوس

الادارة

واجبات

- توجيه بهالة المستقر
- الاشراف على امن الصحابين وممتلكاتهم
- تنظيم المرور في المستقر
- توفير طعام الصحابي
- نقل الكرادير من السفوح الى
- كتيبة باسمه بالصحابين الاجانب ^{والاموات}
- كتيبة كهبزات عليه اهتمامه
 - ⊙ أسرة الصحابه
 - ⊙ عمارة تدن
 - ⊙ اديبين
 - ⊙ علماء آت
 - ⊙ مدرر كدير
 - ⊙ كتيبة آت اوق

(١٥)

المرحلة الأولى

من الوثائق من اسماها اوراق تقريباً ١٤٠

مرحلة صقل النسخ

مهمة جداً
تماماً ما يفضل غيرها

دراسة ما الملكة المسماة

لاستكمال المرحلة الأولى : فإضافة إلى الأوصاف
على ذلك المسماة (١٤٠) ما الوثائق ١٤٠ في الطوارى

دراسة من الدول والمجاهد

١٦٠ في الوثائق الأولى النقص

١١٠ في الطوارى

" المرصها الذي يتكلمون ثم يمدون "

١٥٤ عندهم كما يمكن انقاذهم

السياسة هو مركز الاستكشاف / نقد

الصفحة ١٥٤ / ما في الدراج

" المرصها الذي لا الوثائق التي تم نطقها "

دراسة في سادس وداكو ١٩٧٦ - ١٩٨٠

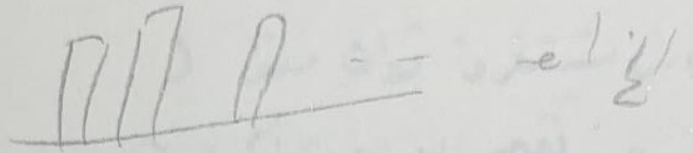
مفاتيح ١٩٨١ - ١٩٨٤ قد افضل الوثائق

معدل ١٥٤ عندهما زاد السكاه ١٠٠٠٠٠ والسبب

هو تمين صفات الطوارى الطيه

(١٦)

Graph



الأسباب المحيطة بالوقوع منها على الصعيد الاستراتيجي

معرفة الإدارة

تقسيم حالة الجهات المعنية

مزايا البرامج

ومزايا المخرجات

الهدف من البرنامج هو زيادة الكفاءة الإدارية

من حيث القدرة على تطوير المهارات القيادية

... كفاءة في إعداد التقارير

المعيار

(11)

عن الحكم صراً الجوار فمنه سريع ولكن دميون
للصحة - اللصبي

الاستيفاء فكان نطقاً

- تقويم الصدقات الكريمة

- المؤيد

- الجواهر الحكيمة والحكي

- الكفاية

الغاية بالبرزخ المسمى - لبيد 10

- أو الأدمية أي مائة

مفر الرغامي وشبهه

(في القيد الكواكب)

الزراف أي زراف

- الصفد الأصم

- العاصبة (لورينك) الكواكب

ويذكر

أخضع كل اللبس لك

المدد الخواص والشيء يكتم

مختلفة لهذا الشغل بين السهم

متركة الرأس .. تحفظ حالاً

(١٨)

هاتفه حول السنة ١٩٧٠

هاتفك تركيز ليس له غير حول

مرة قد انتم الداعي الوظيفي

الصفحة

التقديرات

بذلك لا تتركها هي

الاستراتيجية (صحة الداعي القيمة)
(صحة الودعات استقرها)

وعدد كسر الحمية

وعدد اجابته مقتوصة

الكل من الله يمد يده سعادياً

من الله يمد يده الى السعد

اصح طرق معالجة

- العلم بما يجب عمله في هذه الظروف
- تقسيم الاسباب ودراسةها
- عمل الكيماويات المناسبة
- دراسة صيد رتائج السموم
- الكاربتام و سلفا لاكس و السيفترام
- للدجاج

3/16

↓

Resume Emergency Care

DISASTER : arrival with little or no warning of many more casualties of all types and degrees of severity than a hospital is designed or staffed to handle at any one time.

①

MULTIPLE CASUALTIES

- ⊗ High ways
- ⊗ Coach
- ⊗ Rail crashes
- ⊗ Air crashes
- ⊗ Bombs
- ⊗ Others

⊗ NO TWO DISASTERS ARE ALIKE

⊗ AIM : ACHIEVE GREATEST
GOOD FOR
GREATEST NUMBER

11
Management is
divided into
3 stages

- Disaster site
- Ambulance
- At hospital

PREHOSPITAL IMPROVED
RESULTS

Death / Casualty Ratio

World War II 4.5/100

Korean war 2.5/100

Vietnam war 1/100

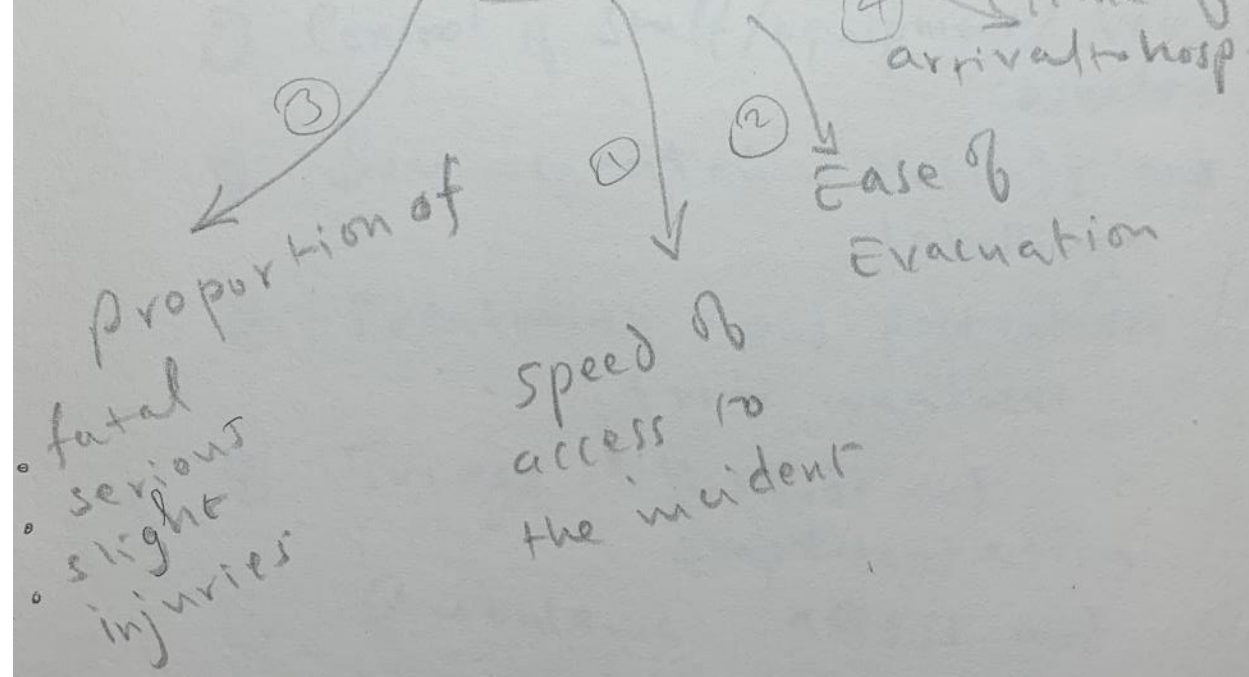
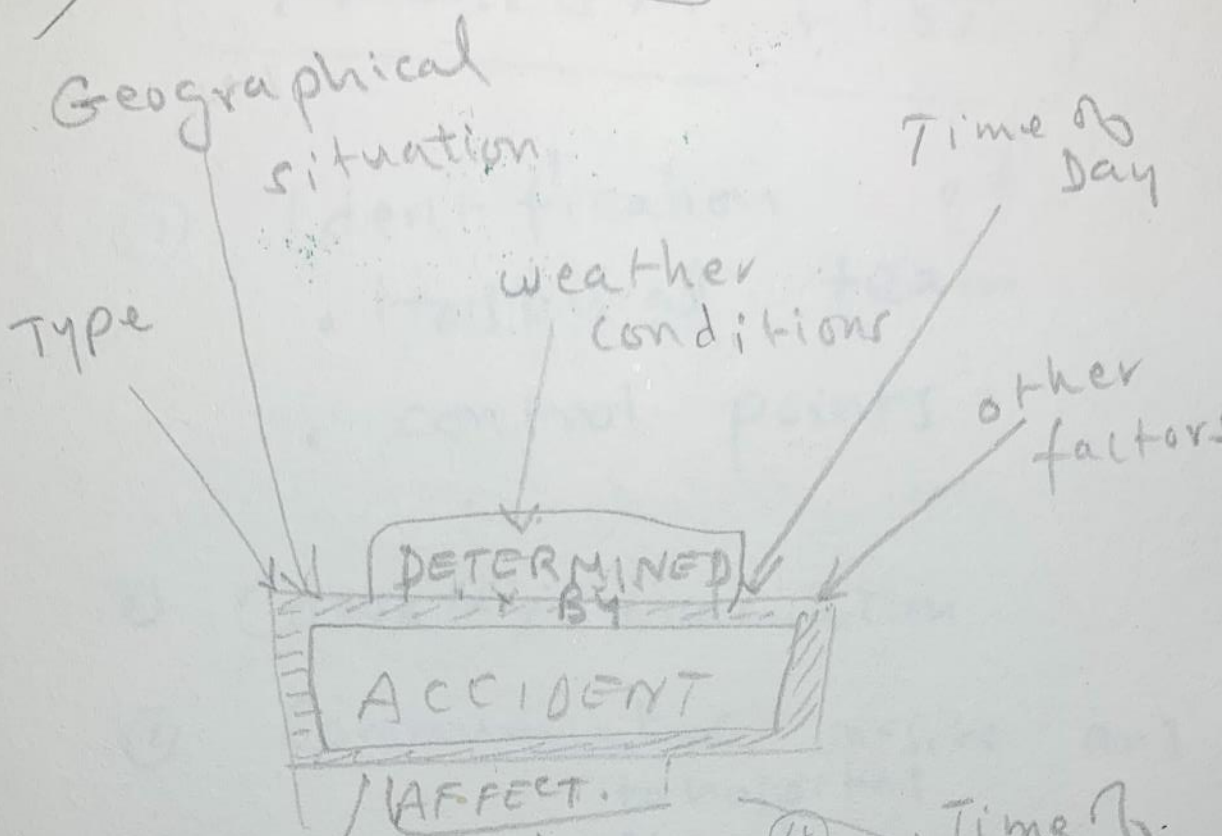
Cause: Multifactorial
Rapid Evacuation
En route Care

300 patients / 150 Helicopter
 / 150 Ambulance

Predicted death / 52% in
Helicopter

III

(2)



1/2/

3

PROBLEM LIST

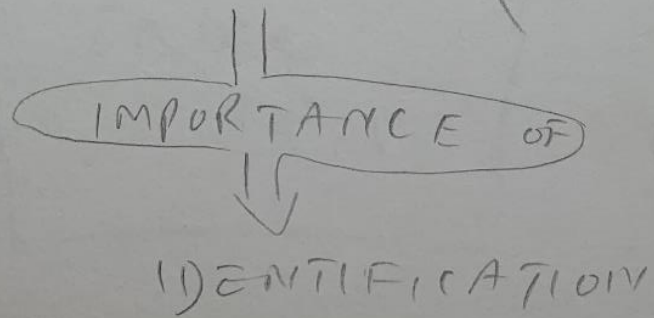
- ⊗ Identification of
 - Hospital team
 - control points
- ⊗ Casualty evacuation
- ⊗ Communication on-site and to hospital
- ⊗ Control of staff/equipment/vehicle casualties
- ⊗ Documentation - Methods and labelling
- ⊗ Treatment and protection from weather
- ⊗ Triage - Methods and Implementation
- ⊗ Ambulance access and loading
- ⊗ Night operation

1

⊗ The place of surgery is at the hospital and not at the road side

⊗ Doctors should travel by ambulance or Police Car and Not his own car

- ⊗ At site
- People of many disciplines
 - May not know each other
 - Many volunteers



VI

⑦

IDENTIFICATION

VERY ESSENTIAL

⊗ PERSONAL

⊗ VEHICLES

⊗ CONTROL POINTS

⊗ EQUIPMENTS

Table

5.1

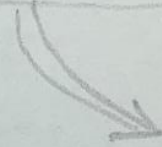
8

NEXT

COMMUNICATION



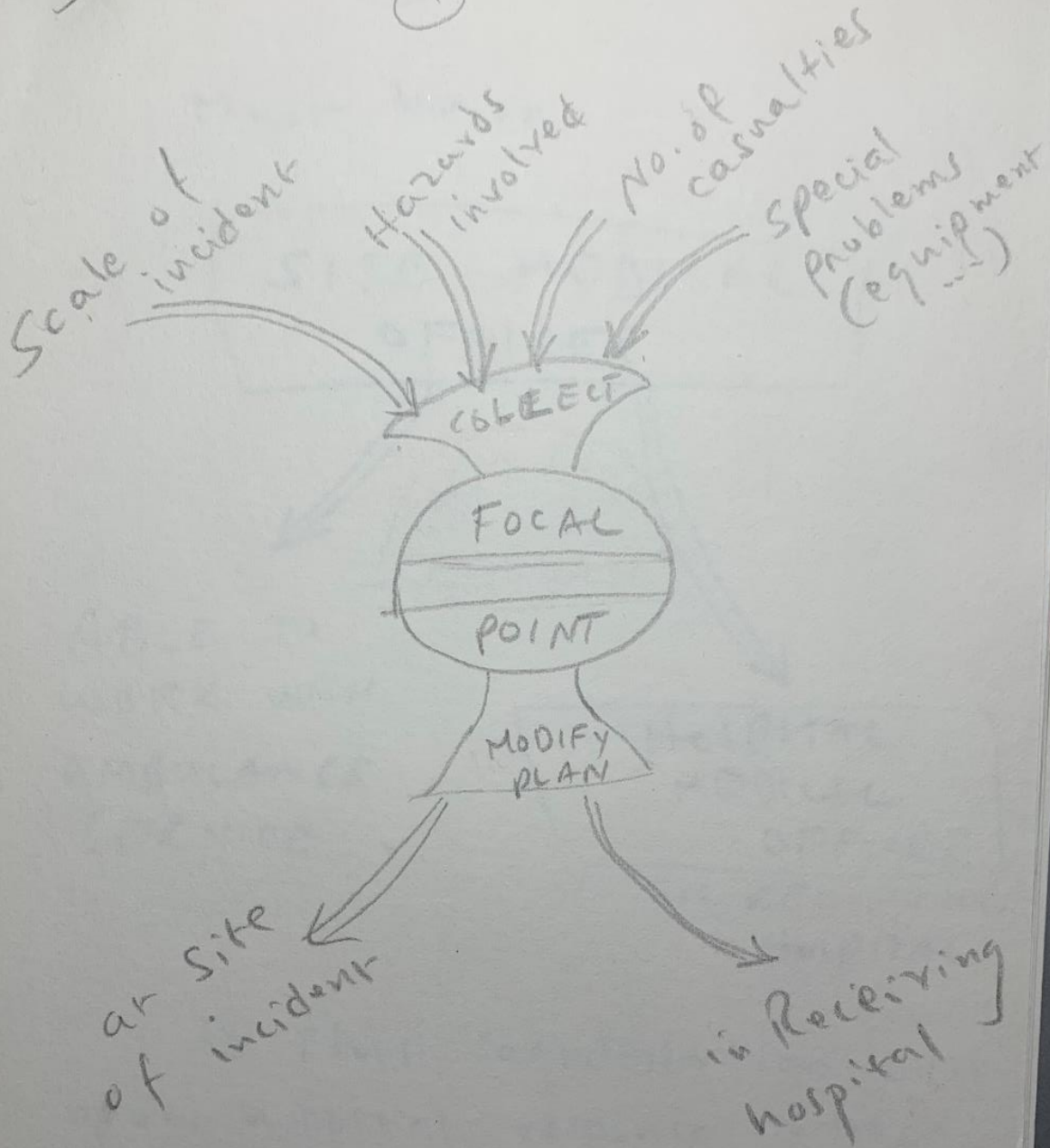
CONTROL



CO-ORDINATION

VII

9



VIII

(10)

Must have

SITE MEDICAL OFFICER

ABLE TO WORK WITH AMBULANCE SERVICE

HOSPITAL MEDICAL OFFICER

IN RECEIVING HOSPITAL

⊗ This coordination will allow hospital response to be optimal

⊗ SITE AND HOSPITAL MEDICAL OFFICERS should be experienced senior surgeons

Now

(11)

CASUALTIES HAVE BEEN

REACHED



ASSESSED



GIVEN FIRST AID



EXTRICATED

Remember ←



LABELLED as to R



OUT OF DISASTER AREA

No Pulling

Priority

Secure patient airways

Remove Debris from thorax

IX

(12)

OUT OF DISASTER / AREA

SHOULD PASS THROUGH FILTERING SYSTEM TRIAGE

TREATMENT NEEDED

"Immediate"

"Delayed"

"Palliative"

"Minor"

173

PHILOSOPHY OF
TRIAGE

ALLOCATION
OF
PRIORITY

OFFER CHANCE
OF SURVIVAL
TO THOSE WHO
MOST LIKELY
TO BENEFIT

X

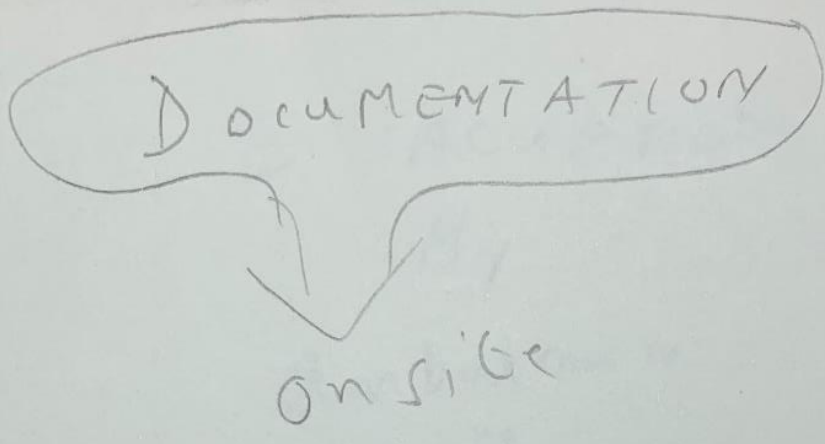


Fig 5-6 Emergency

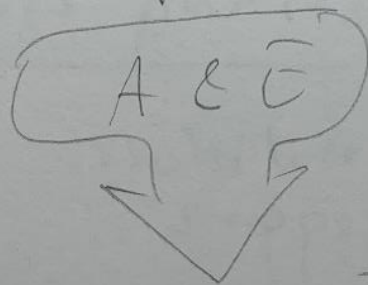
XI

E. VACUATION

By

Ambulance
to
HOSPITAL

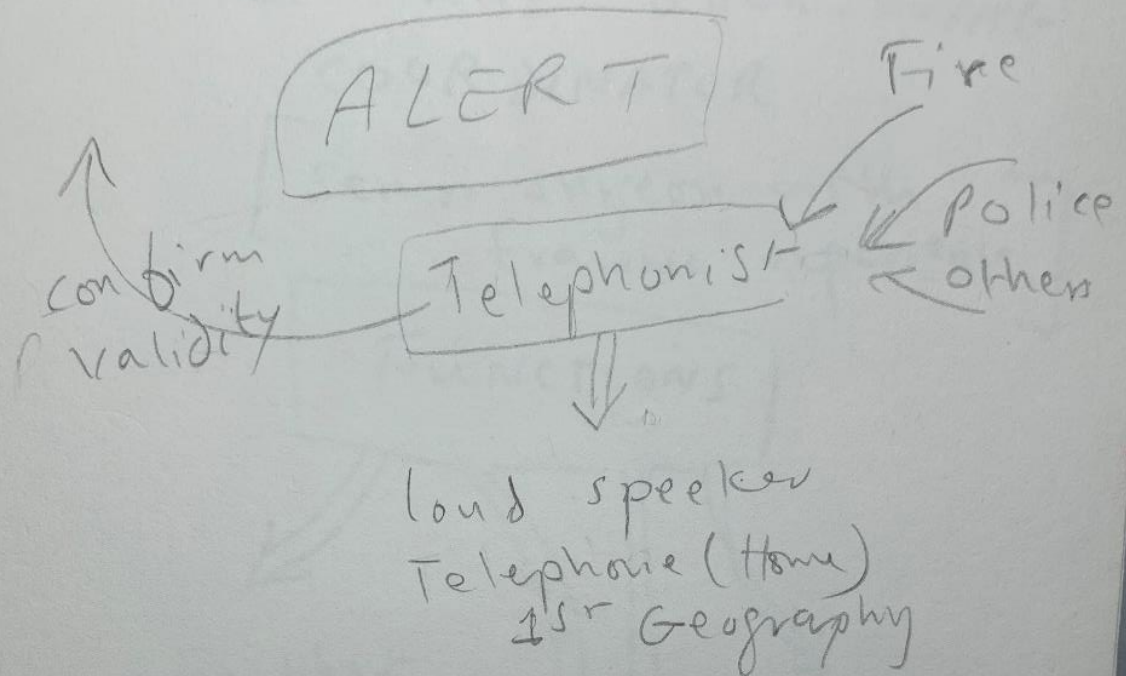
- ☑ Ambulance loading point
- ☑ Spreading load to diff. Hosps.



Further Triage
Emergency Doc
Documentation

XII
chart

HOSPITAL A & E



Three phases

- Green Mobilise staff to support A&E
- Yellow Mobilise staff for A&E & other areas
- Red Mobilise the whole hospital

(15)

HOSPITAL

MUST HAVE OVERSEEING
COORDINATOR

[Senior surgeon with
trauma experience]

FUNCTIONS

Ensures that
important details
are not overlooked

Ensures
service for
usual day-to-
day accident
cases

Advices on
difficult cases

sending
people off duty
etc

XIII

A&E

Reception Area

Better use reception areas

Casualty Flow Path

⊗ avoid confusion

⊗ Three people to be controlled

- casualties
- staff
- public

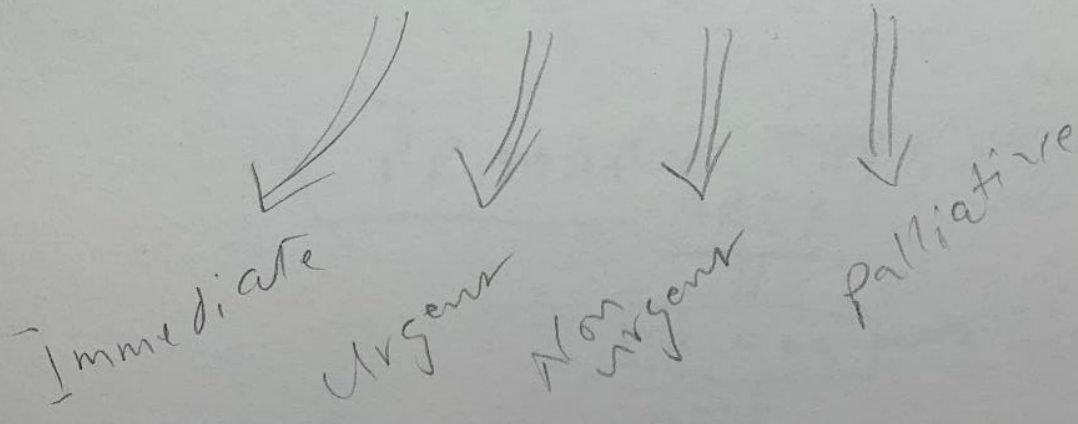
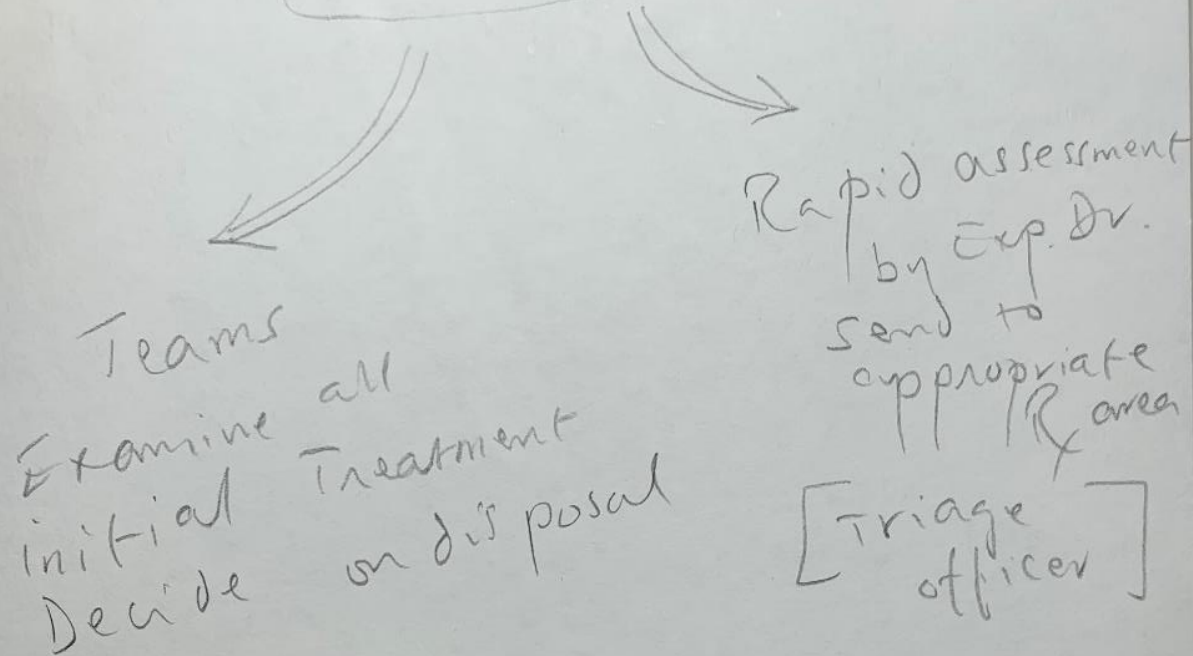
⊗ Control car movements from street

Triage

Normally: Critical first

In Disaster: Priority to the many on the expense of few

Methods



XIV

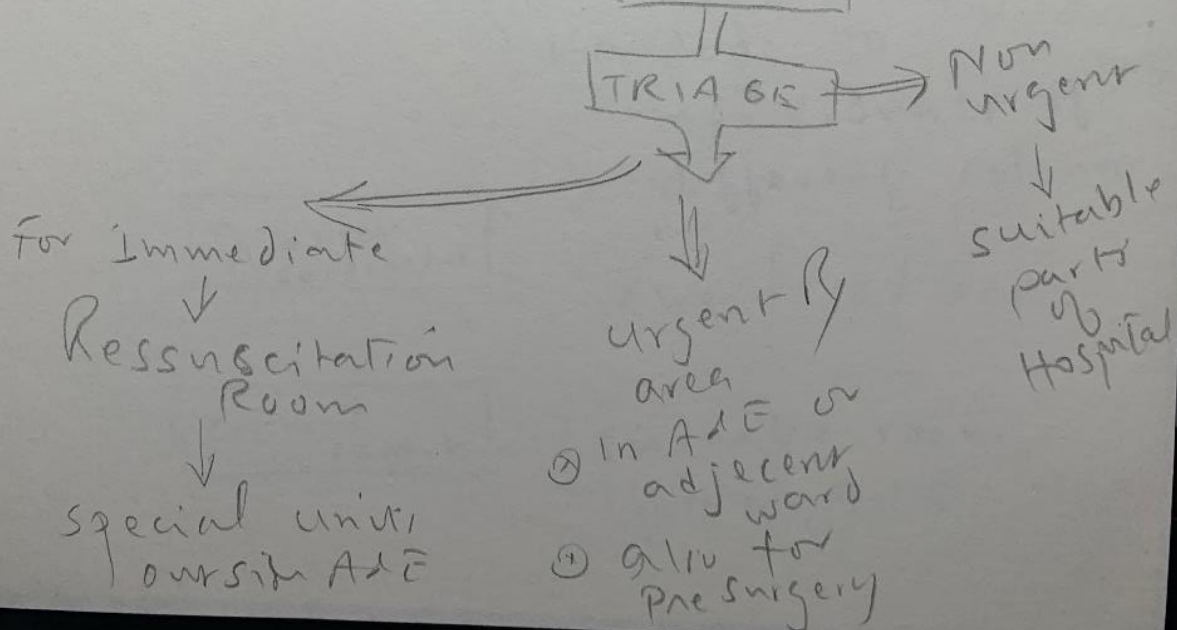
IDENTIFICATION

Immediate Tag

DOCUMENTATION

- ⊗ accurate clinical records
- ⊗ good envelope for casualty clothing and valuables

PRIMARY TREATMENT AREAS



XVII

MEDICAL MANAGEMENT OF VICTIMS

Efficient - & Flexible
for Burn disasters
crash -- etc

Personnel - need to know who & where ^{to go} for instructions

action cards - general instructions
Handed to individuals of different colours

Disaster coordinator - chief of team

Control centre - suitable room close to A&E

Medical staff

Dangerous to have too many doctors rushing to A&E

Junior - give action cards

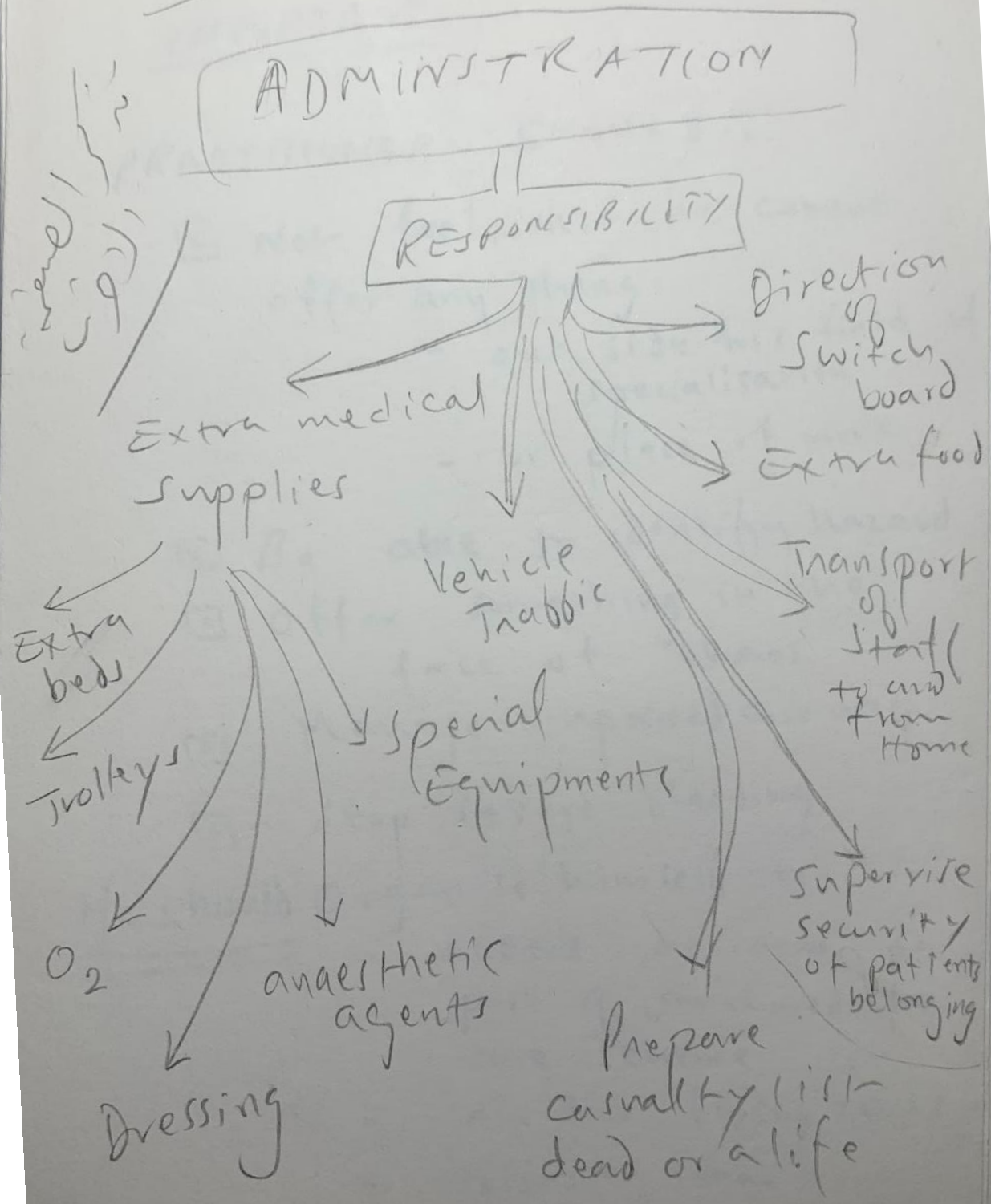
Most experience
↓
Triage officer

- On duty consultant
Take responsibility of theatre controller
- Gynae consultant
Receiving ward
- Medical
Trouble shooter

Nursing staff

- Nursing officer
Arrange for staffing
- Theatre - A&E
- other

XVIII



(16)

IMPORTANT

PRACTITIONER SHOULD...

- Not feel that he cannot offer any thing:
 - out side his field of specialisation
 - or place of work
- Be able to identify hazard
- Offer something in the face of chaos
- Manage impaired airway
- stop severe bleeding

He should Organise himself to

- attend accident as part of an immediate care scheme
- accident flying squad
- disaster team

cooper

XIX

1/4

Mortality from head injury
40%

→ The Pre Hospital Phase

Very important
overlooked

Field study UK

60% of H.I. deaths
before hospital admission

[40% at scene,
20% in emergency room]

States study

60% death < scene
& transit

11% in emergency room

3/4

Cooper

"Patients who talk and die"

54% had preventable factors

Hypoxia

Hypotension

Delay in treatment

FIG 2.1

"Patients who almost died and talked"

Study in San Diego

1976 - 1980

1981 - 1982

Death rate reduced by 24% when population increased by 100,000

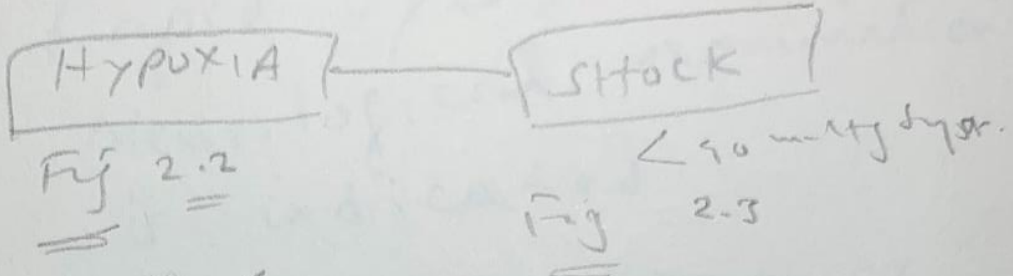
Improvement in emergency medical services

4/4

comp

+/x

PRE-HOSPITAL PREVENTABLE CAUSES



TREAT
EPILEPSY
POST-TRAUMATIC

4% do not die
up to 35% with
bacteremia
etc.

CNS ASSESSMENT

AIM OF HEAD INJURY
MANAGEMENT

PREVENT
SECONDARY
BRAIN
DAMAGE

FACILITATE
RECOVERY
PROCESS
BY PROVIDING
OPTIMAL
PHYSIOLOGICAL
ENVIRONMENT

XXI

Rapid, yet, Thorough
Neurological examination
is indicated

- 9T TAKES SECONDS
ONLY
- Evaluate vital signs
 - pupils
 - Motor & Sensory
 - Deep Tendon reflexes

RESP. Care - Not needed
↓ tracheostomy

BLEEDING (EXI)
digital pressure
pneumatic
Tourniquet

THEY

Take all clothes

o/b

- Entrance

- Exit

May be missed
in hair bearing
areas

- Scalp: immediate
suture

X XII

FACT ABOUT
HI

OVER EMPHASISED

- Brief period of unconsciousness
- Headache
- Vomiting

More Important

- Persisting (mild impaired consciousness)
- Presence of skull #
- Detection of open injury

Problems

- who to x-ray
- who to admit

1/3 The British Council
1980

A & E Dept.

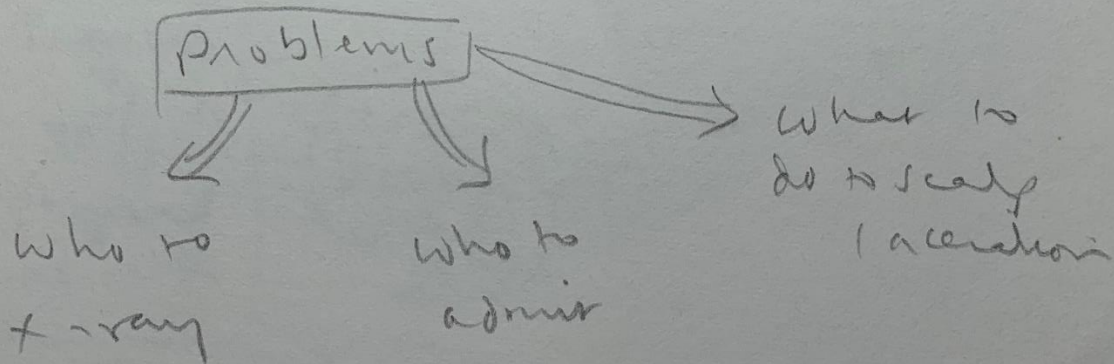
10% HI

⊗ More after 5 pm
week ends.
less staff in Hospital

⊗ Most are mild

⊗ 1/2 have scalp injury

⊗ 2% have skull #



More important
is
BRAIN DAMAGE

2/3 Bitter counsel
1980

over emphasized

- Brief period of unconscious
- Headache
- Vomiting

more important

- Persisting (Mild impairment of consciousness)
- Presence of skull #
- Detection of open injury

Trauma is 30% of surgical admission

2/3 Discharged within 48 hrs

12% stay more than one week

1/2 stay more than 2/52

15% Extracranial injuries

3/3

British Council

Who to admit and
where

UK and All over Europe ICH are
admitted under care of
general surgeons, A&E or
orthopaedic surgeons.

Traumatic ICH rarely occur

in the absence of:

- neurological symptoms
- or signs
- or skull fracture

1/16 Rescue Emergency Care

photograph
—
235

"The place for surgery is at the hospital and not at the roadside"

gr has been tried to get an operating theatre at the accident site but found to be not good.

⊗ Doctor should travel by ambulance or Police Car & not his own car

~~XXIII~~
2/16 Rescue Emergency care

Four Steps

I Knowledge of what to do
in emergency

ii Understanding of causes +
effects

iii To do the right things

iv Acquaintance with the
nature & result : lessons
for prevention.

4/6

Resume & Example

Stage

The alert

Usually by ^{tone of the} emergency services (police, fire...)
The telephonist should confirm its validity.

During working hours: alarm on loud speaker. Non working hours by telephone. Two or more lists of persons to be called in the same time.

Better to consider geographical distribution of staff

5.6 Emergency

Three phases of alert

phase I (green) alert:

Mobilises staff to support the A&E
sudden influx of small no. of
casualties of limited duration

phase II (amber) alert

mobilises personnel and resources
to support both A&E and other
areas of hosp.

phase III (red) alert

mobilises the whole hospital.

6/16

Review emergency
A&E Dept.

Reception area

Better to use the reception area than opening new areas. Everything is known to every body (place of equipments flow of patients - etc).

Casualty Flow Path

avoid confusion.

Three groups of people should be controlled

← Casualties

← Staff

members of public

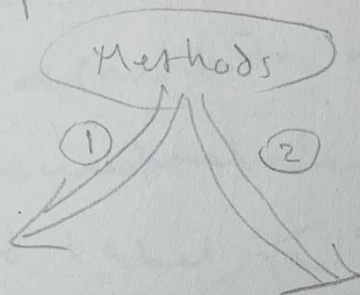
Car movements should be controlled by police from road to hospital grounds

7/16

Triage

Normally the most critical injury is treated first no matter how poor the prognosis.

In disaster priority is given to the many at the expense of the few.



Teams
(Doctors & nurses)
Examine all

casualties,
initial treatment
recording diagnosis
& instructions and
decisions on
their disposal

Rapid assessment
by experienced doctor
and assignment of
their casualty
to an appropriate
treatment area.

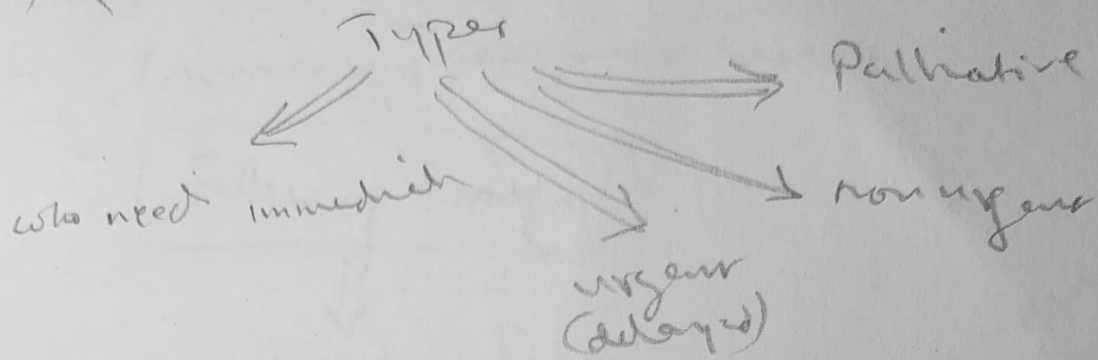
Triage officer
stationed at entrance
and does carry out
any treatment

one for
stretchers

Better two

For walking
patients

8/16



Identification

all casualties entering A&E must be immediately tagged with a numbered label

- identification of person
- medical record
- X-ray
- Blood Sample
- coron meshed

Documentation

- accurate clinical records
- Printed casualty cards (Parr)
- Cards should be kept sequentially
- pathology and radiology requests kept sequentially
- store evidence for casualty clothing and vehicle

9/10

Primary Treatment Occas

Following Injuries

Treatment needs

to need for
unstable, life
Resuscitation
may

ambulatory
as long
as possible
growth of injury
Treating / make
Supporting this

Further &
to be done
outside
A&E

non urgent
treatment
may

can be done
post
hospital

ambulance

non
ambulance

urgent treatment
may be A&E

may be
inpatient
ward

To assess
prepare for
surgery

- ① Special arrangements for those with minimal injury but emotionally disturbed
- ② with early injury & req. only palliative

10/16

XV

staffing

Resuscitation Team

- 1 doctor
- 2 nurses
- 2 aids

15 patients
each hour

Max: look
after 5 patients
at a time

2 teams with an relief team
should be available

Pre op. Team

- 1 doctor
- 2 nurses
- 1 attendant

30 patients in an hour
in urgent treatment area

Await Surgery area

1 doctor

11
16

Transport Team

Porters & domestic staff

Move furniture

Set up triage
and primary
treatment areas

unload trolleys,
supplies
& equipment

move casualties
from ambulance to
triage area and other
treatment areas

Registration Team

from medical records.

Documentation of non urgent cases,
collect money and valuables.

12/16

~~IV~~

Secondary treatment areas.

INPATIENT

OP theatre

Receiving ward

[specially arranged]

operation
Theatre
controller

- Re-assessing patients
- Treating shock etc
- Brief surgical teams
- Give advise when needed by surgeons

Surgical Team

- 1 Surgeon
- 1 assistant
- 1 nurse (scrub)
- 1 nurse (circulating)
- 1 anaesthetist

Recovery team

1 anaesthetist, 2 nurse
For post op recovery

Control room

Suitable room not necessarily
in front line. close to A&E.
adjacent rooms...

Medical Staff

Dangerous to have too many
doctors rushing to A&E

⇒ Juniors → A&E give advice

More experience one

Triage Officer

⇒ on duty
consultants → A&E →
each takes his duty

A&E direction
orthopedic consultant

~~Seedbar~~
Gynaecologist →
receiving ward
Medical →

duty
consultant surgeon
Op. theatre
counsellor
troubleshooter

14/16

Control Centre

Suitable room not necessarily
in front line. close to A&E.
adjacent rooms...

Medical Staff

Dangerous to have too many
doctors rushing to A&E

⇒ Juniors → A&E give action
cards

Most experience one

Triage Officer

⇒ on duty
consultants → A&E →
each takes his duty

A&E direction
orthopedic consultant

duty
consultant surgeon

Gynaecologist →
receiving ward
Medical →

Op. theatre
cannula
troubleshooter

15/16

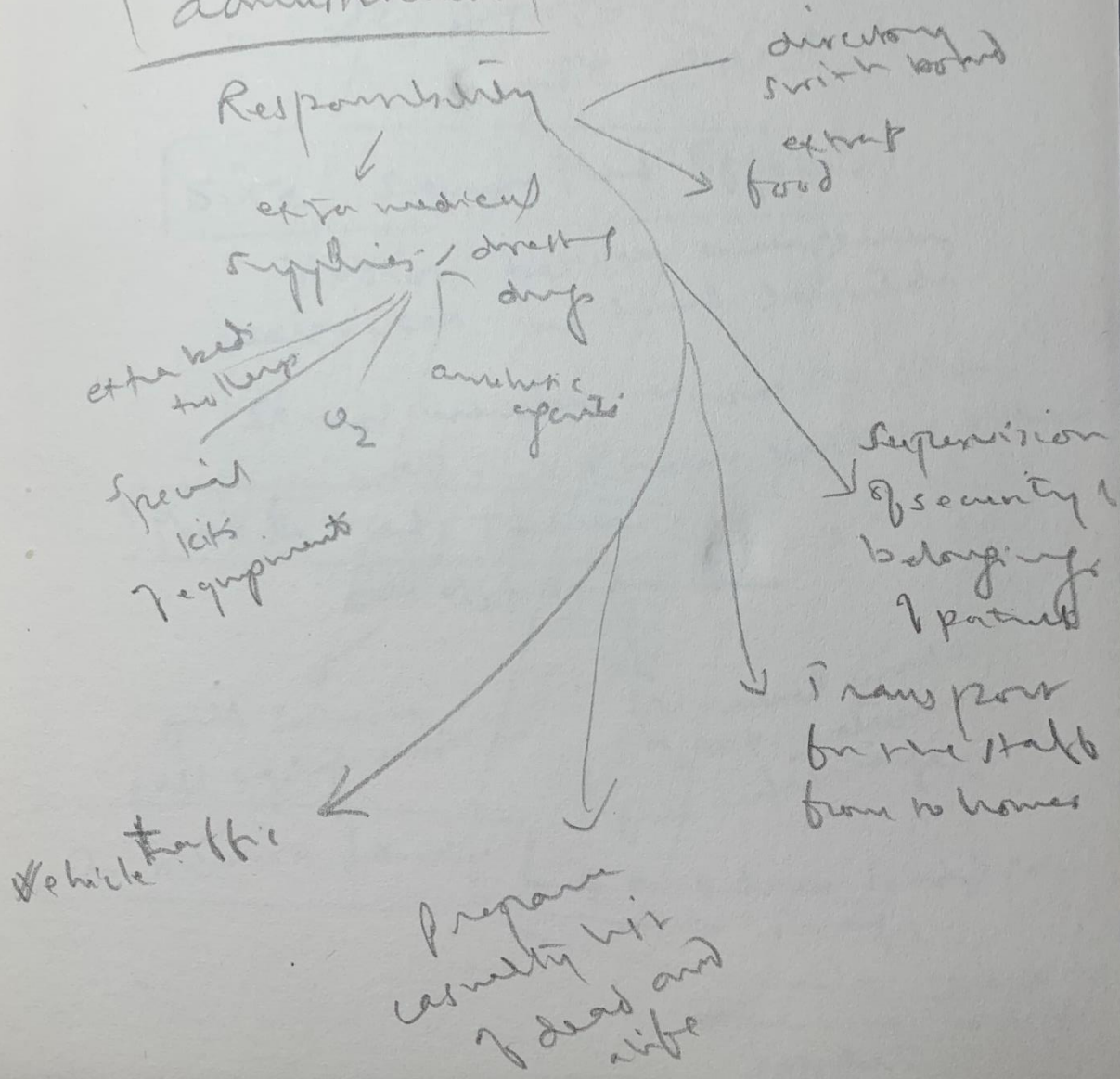
Marketing Staff

N. Officer → arrange for
theatre list

AAC
OPD

Administration

Responsibility



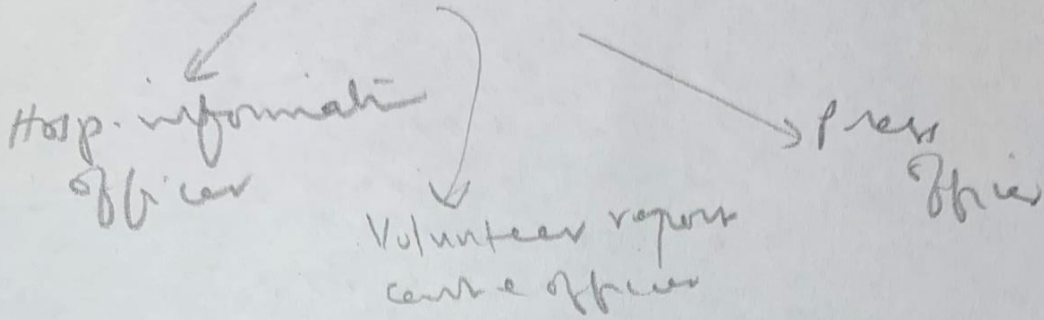
directory
switch board
extra
food

vehicle traffic

prepare
casualty list
of dead and
alive

16
/ 14

Three administrative roles are needed



DISASTER SCENE

Site Senior Med. Officer

Liaison between emergency services and local hospitals.

Senior member knows the plan well. & known well to others

Mobile Med. Teams

one or two units

full service
full equipment

minimal work
ventilation
full air & triage

Ambulance Service

ambulance load from
→ triage

→ spreading
the load to diff
hospital

Bentley Emergency Squad

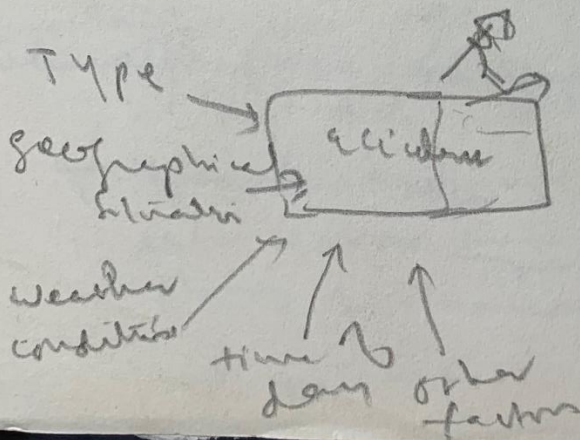
①

Multiple Casualties

- Motor ways
- coach
- rail crashes
- air crashes
- military conflict
- guerrilla conflicts

achieve greatest good
for
greatest number

- No two disasters are alike



proportion of
fatal
casualties
injury

after the details of

Speed of incident

Ease of prevention

Time arrived to help

- The problem list
includes

- Hospital team nothing and identified
- Identified & control points
- Casualty evacuation (distance & terrain)
- communication on site and to hospital
- control of staff / equipment / vehicle / casualties
- Documentation method and availability of labeling
- Treatment & protection for weather
- Triage - methods and implementation
- ambulance access and loading
- Night operations

Treatment on site

①

- Each hospital or district
Hospital must have plan

- Team for on site service

For:

⊖ Treatment of trapped
or critically ill patients

⊖ Sorting of priorities or casualty
collection point

- Patient ~~not~~ covered by dust etc
should not pulled from rubble
before resuscitation & assessment
as his injury may be worsened

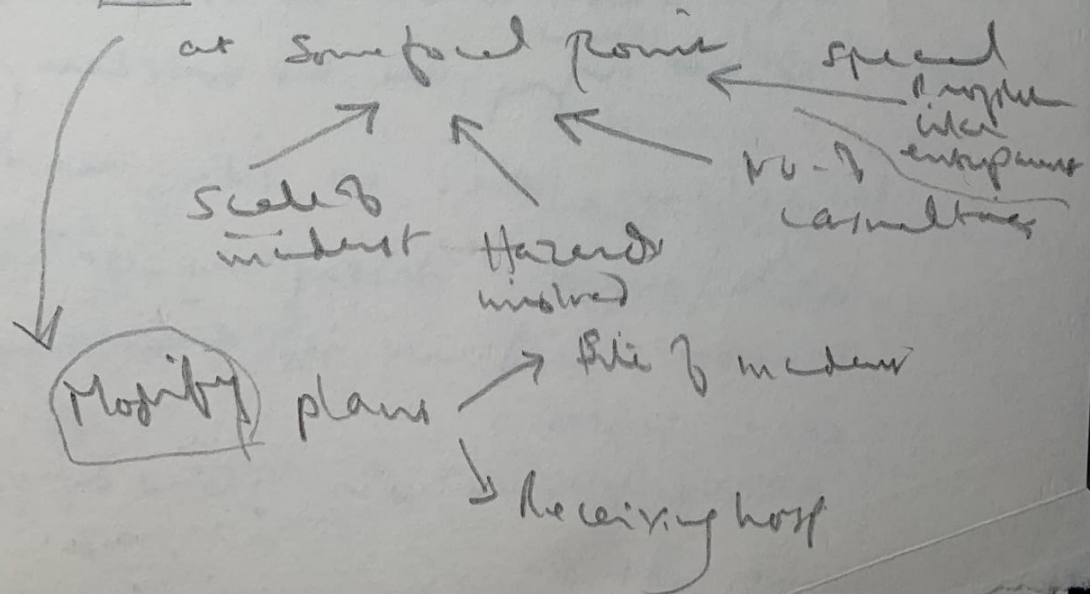
- Important note: at site there may
be ^{people of} different disciplines working
together and we not known to
each other.
Plenty of volunteers who don't know
the situation

- identification is very essential
- of - personal identification
- identification vehicle
- control points
- equipments.

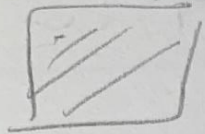
⊖ communication.

There must be a measure of control and co-ordination which is dependent on communication.

x // Information to be collected



?

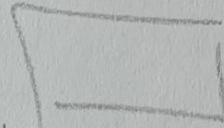


Site Medical Officer

at scene of disaster area

able to work with

ambulance
services



Hospital Med Officer
in receiving
hospitals.

This coordination
will allow hospital
response to be
matched to the needs
of particular incidents

(N.B)

Site Medical
Officer

& Hospital medical
Officer

Should be arranged
early on project

Now cosmetics ~~start~~ ^{have} been

~~write~~

received



assessed



given form and



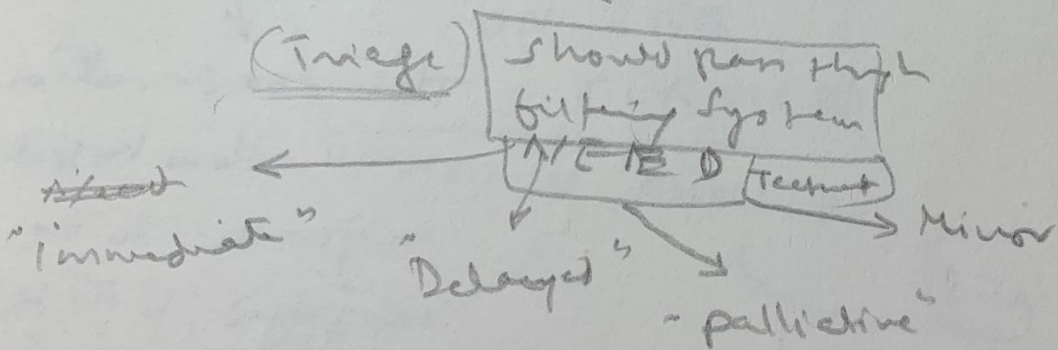
Exhibited



labelled as to R_y



out of disaster area



philosophy of Image

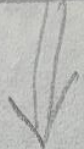
allocation & priority

off the chance of survival to the who most likely benefit

(4)

EACH HOSPITAL OR DISTRICT
HOSPITALS MUST HAVE
A PLAN FOR DISASTER

INCLUDES



TEAM FOR
ON-SITE
SERVICE

MAIN FUNCTIONS

TREATMENT OF
⊗ TRAPPED
⊗ CRITICALLY
ILL

SORTING
OF
PRIORITIES



accident

The first person to reach the victim of a serious accident may have the best chance of saving life.

steps

Remove or protect victim from further hazard

clear the mouth & pharynx

if breaths → Recovery position

if semi breath → Mouth to mouth ... etc

apply pressure on external bleeding spots

Ambulance.

2/3

Ambulance Team

↓
check Respiration

↓ Suction & airway available

↓ May need Ambu Bag

↓ $O_2 + N_2O$ mixture 50% each cylinder. (Entonox)

↓ Sterile pressure dressing to stop bleeding

↓ Spinal board for spinal injury

↓ Temporary splint for limb fracture

↓ Detailed information on accident

↓ Estimate of blood lost or scene of accident

↓ to A & E

313

A & E

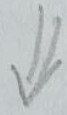
If needed ET tube



IV infusion if needed



Estimate the injuries
and alert the department



Death can be diagnosed
by any GP.

Resuscitation Room

Good light

Adequate floor space

Equipments readily available

Voice communication with
the whole A&E

Telephone communication with
the whole hospital

Team work resuscitation.



Gunshot wounds

17

Triage: (from French
+ trier - to sort)

Napoleon's surgeon

Larrey given the
credit for the
popularization of
triage.

Gunshot wound

2/7

Impairment of respiration
due to obstruction must
be distinguished
from

deranged ventilation
secondary to flail
chest

haemopneumothorax
paralytic asphyxia

ET may be needed
especially in Maxillofacial
injury (clear air passages)

Periodic re-assessment is
required.

3/7

Gunshot wounds.

External hemorrhage
control is important
priority.

Digital pressure upon actively
bleeding exposed parts.

Bleeding limb : pneumatic
tourniquet

Bleeding from maxillofacial
best explored immediately

Scalp : immediate suturing
don't care about sterility
or local anesthesia

4/7 Gunther word.

Rapid, yet, thorough neurological exam is indicated.

9r takes seconds only:

- evaluate vital signs
- pupils
- motor & sensory function
- deep tendon reflexes

case

BP ↑

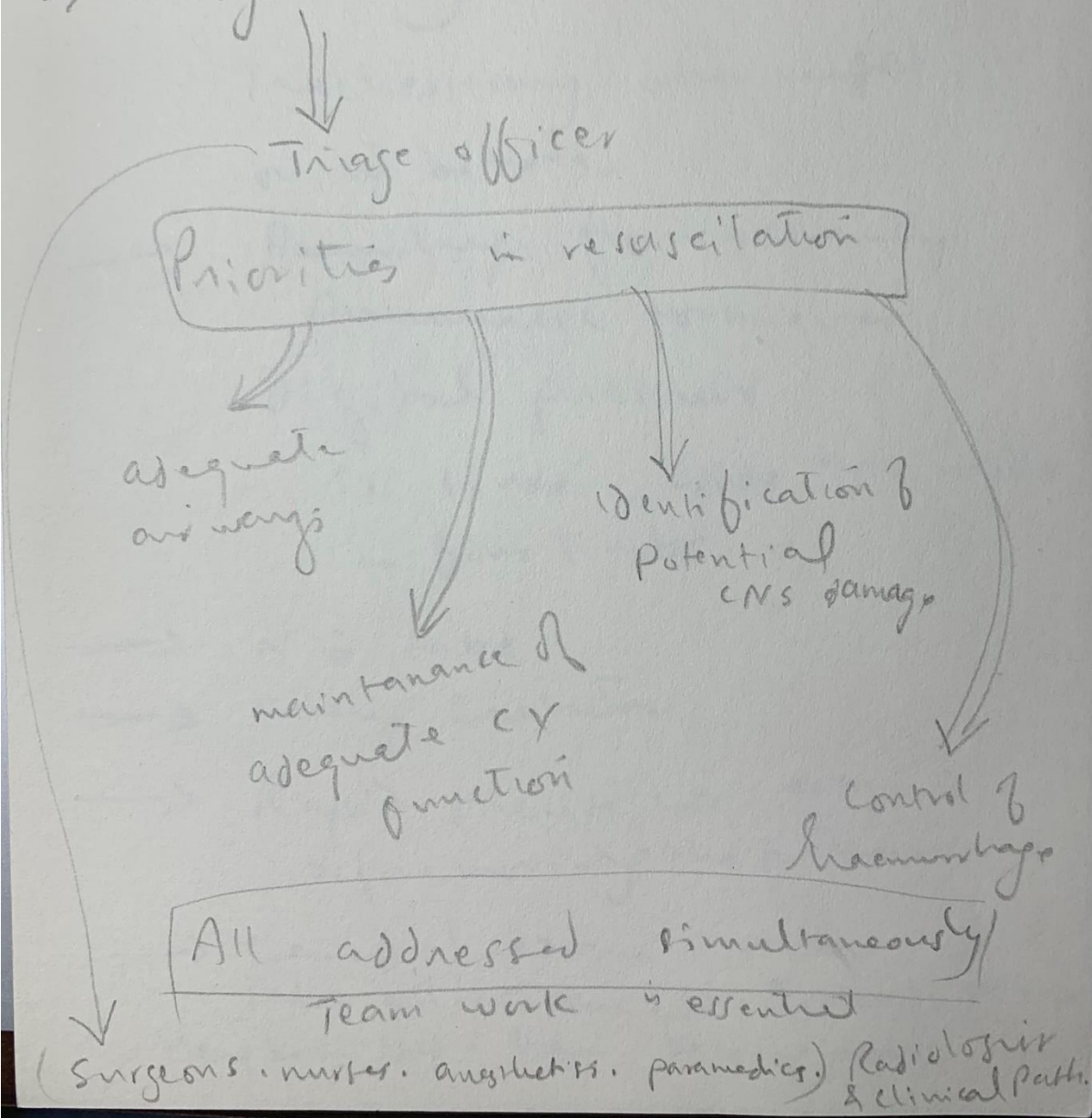
PR ↓

pupils dilated ipsilaterally

S/7 Summary Overview

⇒ Well trained, equipped and rehearsed team approach

⇒ Triage



6/7

Emergent

→ Respiratory care

Nothing when resp is normal

Tracheostomy when needed
or in between

→ Haemorrhage from extremity

- Pneumatic tourniquet

- Digital pressure

- IV lines: wide bore needles
to four limbs.

→ NG tube

→ Foley catheter

→ Rapid pre-ictal exam
before moving the patient

→ Careful exam then
Take all clothes off: Extraneous
May be missed - hair bearing areas

7/7 Guns her
→ PR important
→ x-ray

Resuscitation

blood vol replacement
↓ Ringer solution
whole blood

Prophylaxis against tetanus

antibiotics

Reassurance of patient and
consultation with relatives.

(2)

TRIAGE

French

Trier - to sort

Larrey : Napoleon's Surgeon

PHYLOSOPHY OF TRIAGE

*Allocation of
priority*

*Offer chance of
survival to
those who most
likely to benefit.*

DOCUMENTATION ON SITE

FOUR STEPS

- I. Knowledge of what to do in emergency
- II. Understanding of causes and effects
- III. To do the right thing
- IV. Study the nature, results and lessons for prevention

xxii

FACTS ABOUT H I

OVER EMPHASISED

- Brief period of unconsciousness
- Headache
- Vomiting

MORE IMPORTANT

- Persisting (mild impaired consciousness)
- Skull fracture
- Open injury

PROBLEMS

- Who to X-Ray
- Who to admit



Rapid, yet, thorough, Neurological examination is indicated

IT takes seconds only

- evaluate vital signs
- pupils
- motor and sensory
- deep tendon reflexes

Resp. care - not needed
 - Tracheostomy

Bleeding (EXT)

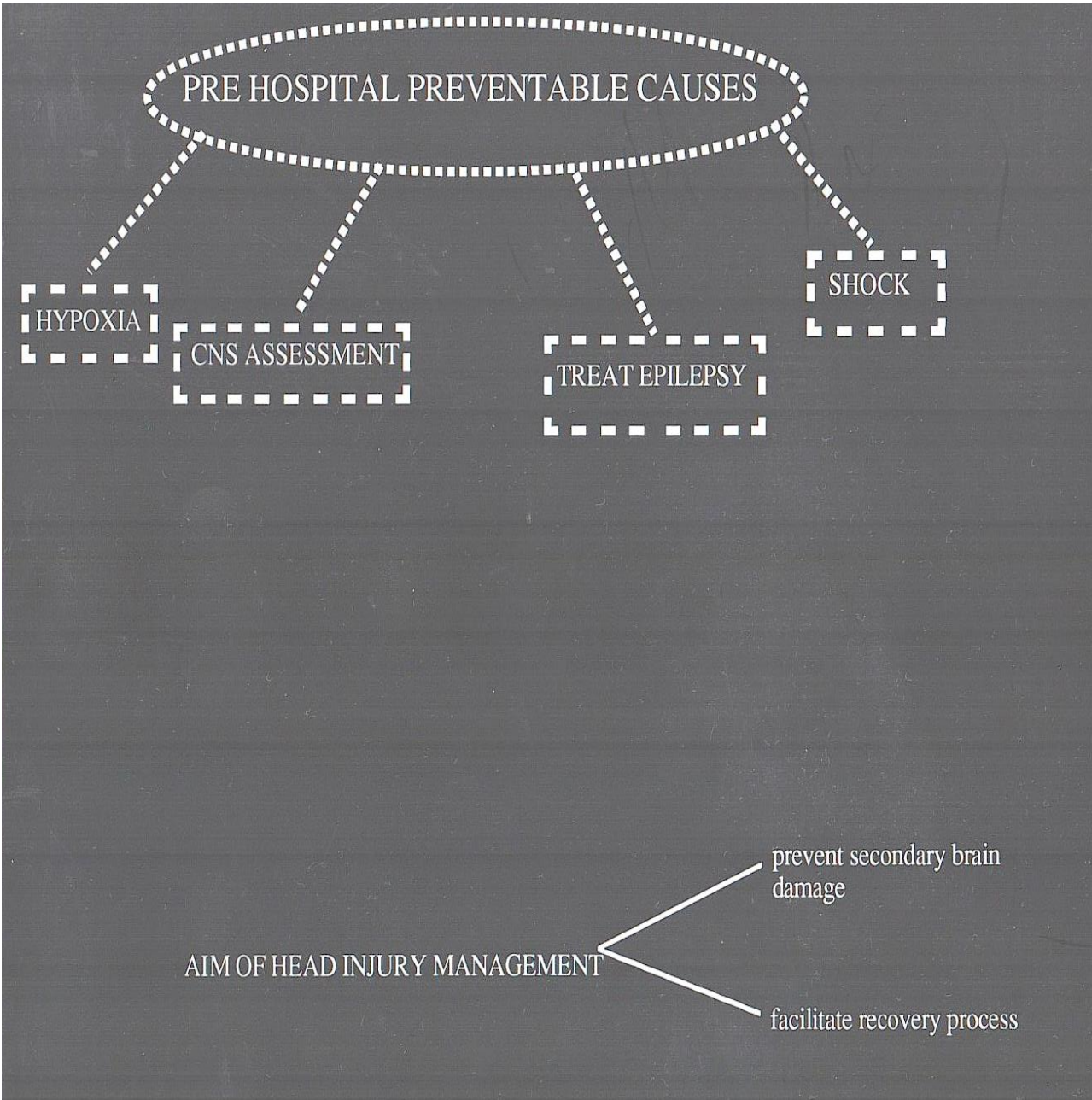
- digital pressure
- pneumatic tourniquet

Then

Take all clothes off

- entrance
- exit
- may be missed in hairy areas

Scalp: immediate suture



XIX

Mortality from head injury 40%

Pre hospital phase

very important
over looked

Field

study from UK

60% of H.I. deaths before hospital
admission [40% at scene
20% at A & E]

study from USA

60% deaths scene/transit
11% at A & E

" Patient who talk and die"

54% had preventable factors

Hypoxia/Hypotension/delay in treatment

" Patients who almost died and talked"

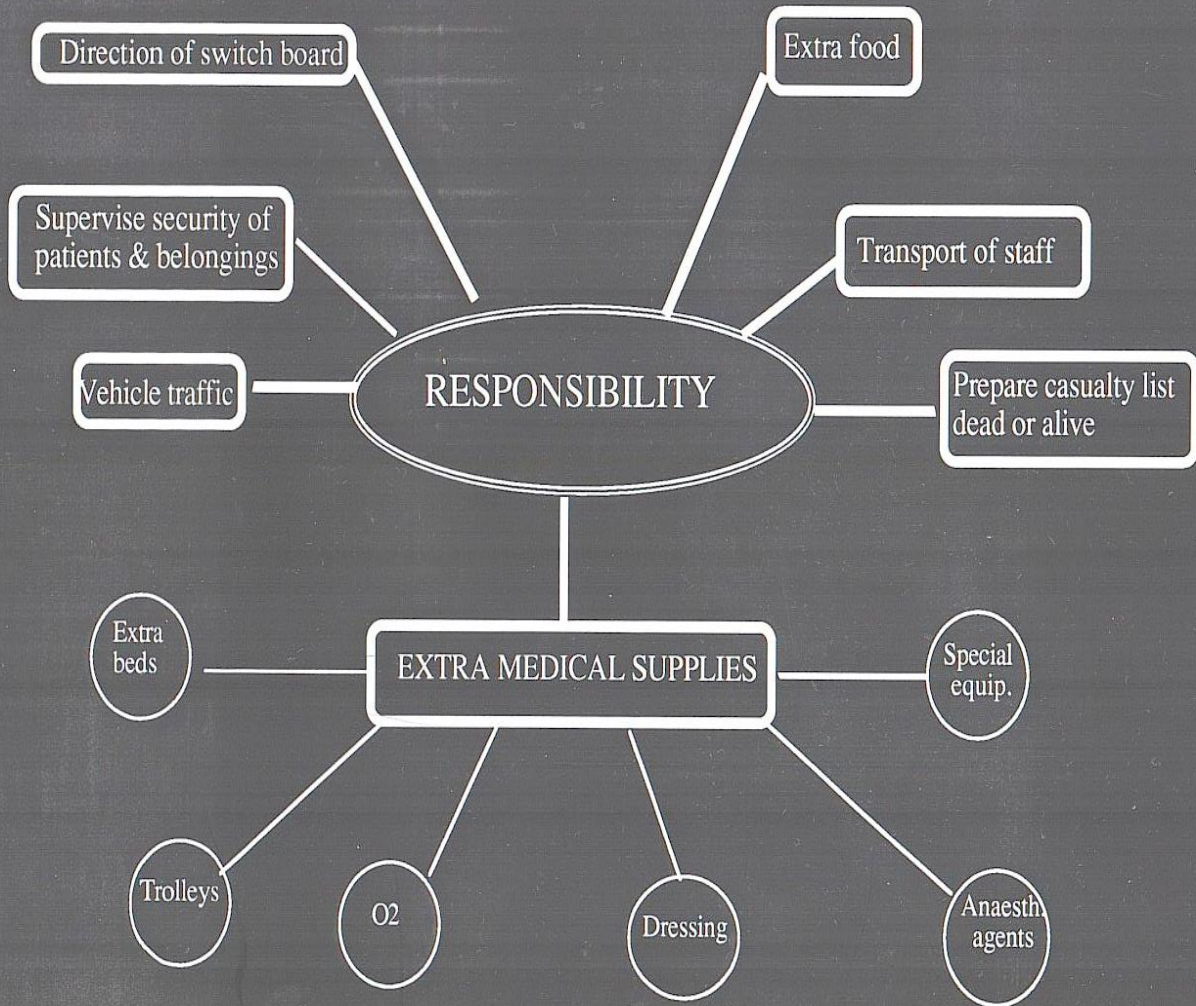
Study in San Diego

1976-1980 1981-1982

Death rate reduced by 24% when
population increased by 100,000

Improvement in emergency medical services

ADMINISTRATION



XVII

MEDICAL MANAGEMENT (EFFECIENT & FLEXIBLE)

PERSONNEL: WHO AND WHERE TO GO

ACTION CARDS: GENERAL
INDIVIDUAL

DISASTER CO-ORDINATOR

CONTROL CENTRE: SUITABLE ROOM CLOSE TO A&E

MEDICAL STAFF: DANGEROUS TO HAVE TOO MANY
DOCTORS RUSHING TO A&E

JUNIOURS--- Give action cards

MORE EXPERIENCED --- Triage officer

ON DUTY CONSULTANT --- O P theatre responsibilty

MEDICAL CONSULTANT --- Trouble shooter

GYNAE CONSULTANT --- Recieving ward

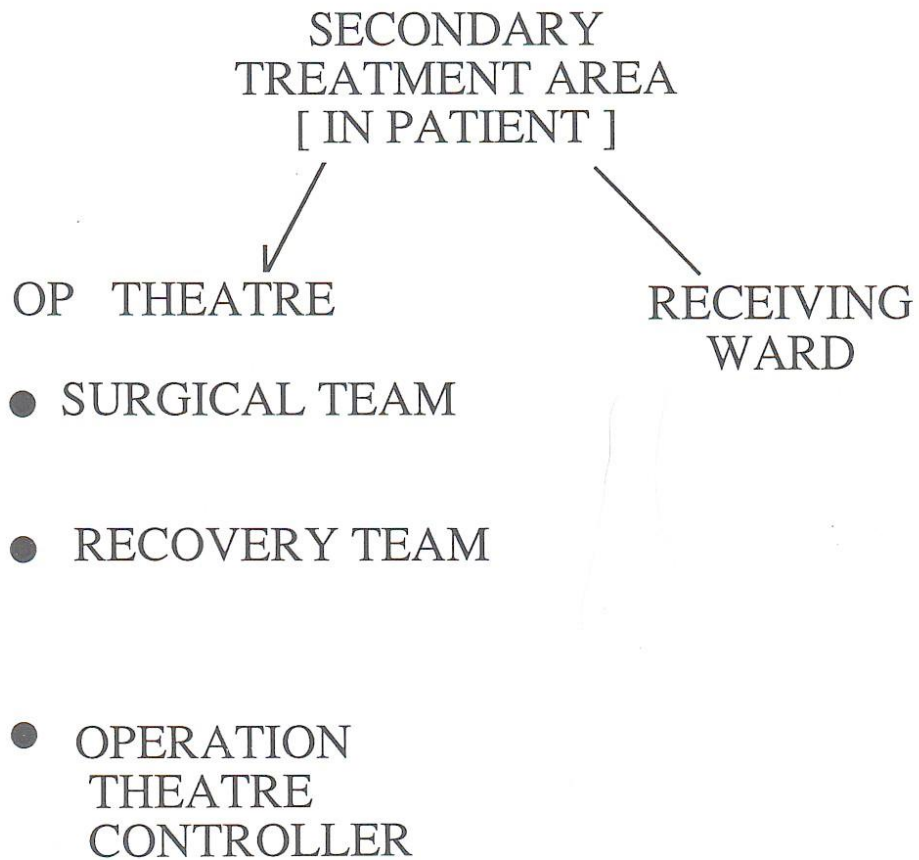
NURSING STAFF

NURSING OFFICER --- Arrange for staffing of A&E, OP,
others

1/2/21

STAFFING

- RESUSCITATION TEAM
- PRE OPERATIVE TEAM
- AWAITING SURGERY AREA TEAM
- TRANSPORT TEAM
- REGISTRATION TEAM



812

IDENTIFICATION

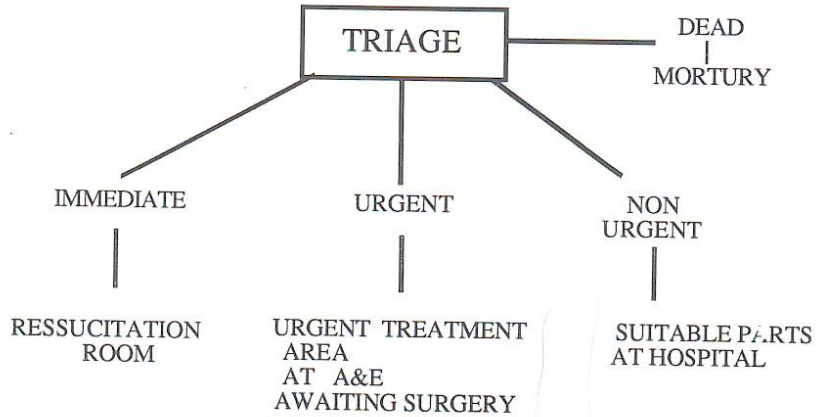


IMMEDIATE TAG

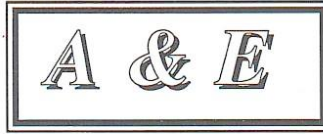
[DOCUMENTATION]

- Accurate clinical records.
- Good envelopes for casualty clothing and valuables.

PRIMARY TREATMENT AREA



Am



RECEPTION AREA CASUALTY FLOW PATH

- Avoid confusion .
- Three people to be controlled .
 - casualty .
 - staff .
 - public .
- Control car movement .

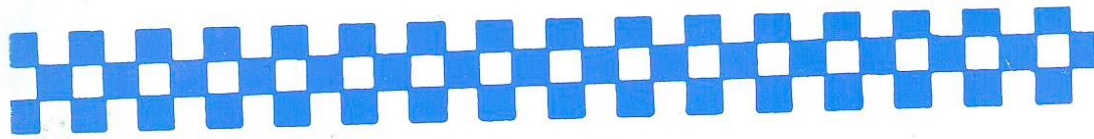
TRIAGE

- TEAMS EXAMINE **ALL** INITIAL
TREATMENT DECIDE ON DISPOSAL

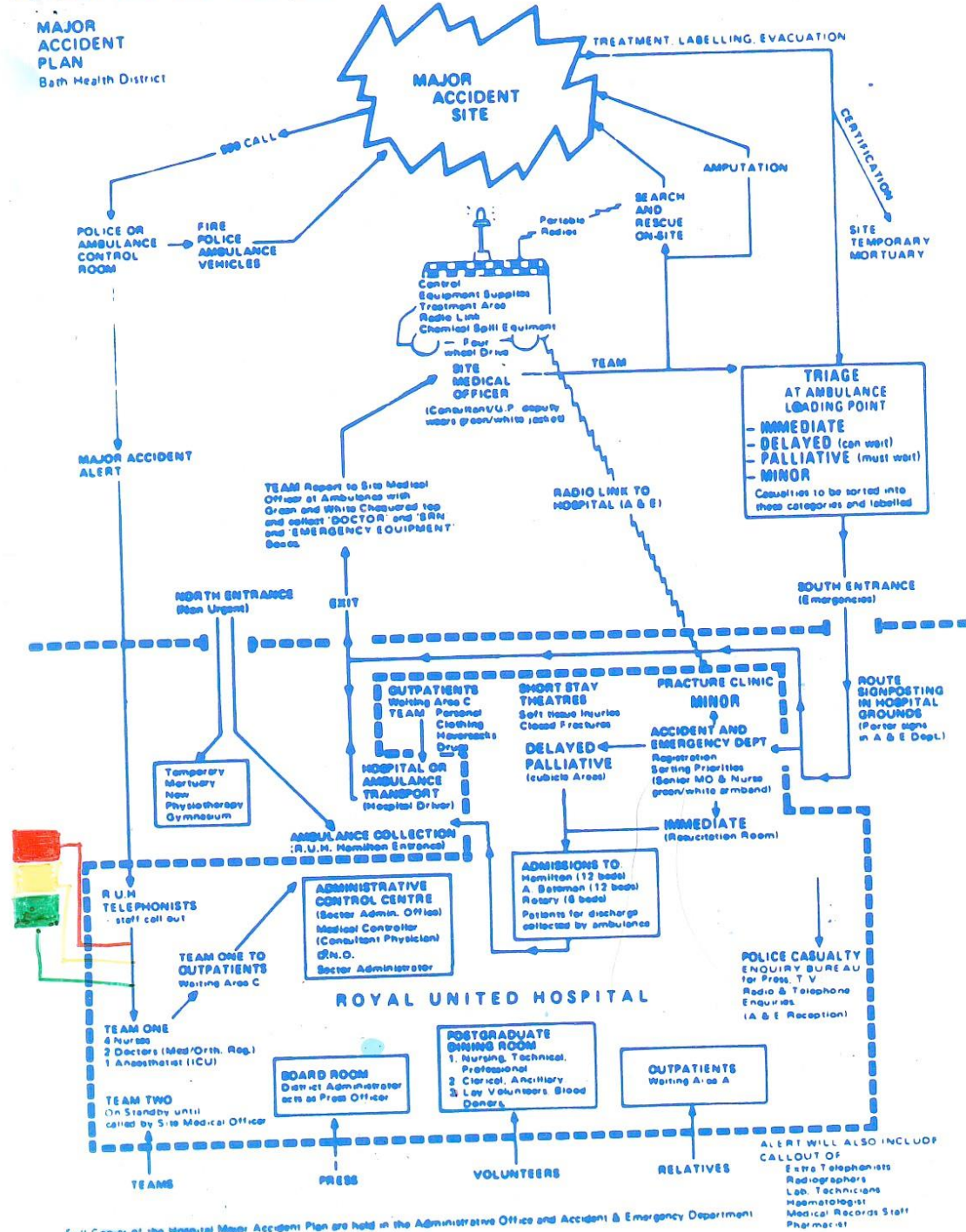
OR

- RAPID ASSESSMENT BY EXPERIENCED
Dr.
- SEND TO APPROPRIATE TREATMENT
AREAS.

7/11



MAJOR ACCIDENT PLAN
Both Health District



4/

E V A C U A T I O N B Y

A M B U L A N C E



*A M B U L A N C E
L O A D I N G P O I N T*



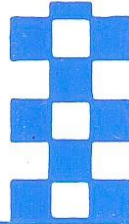
*S P R E A D I N G L O A D
T O D I F F E R E N T
H O S P I T A L S*

H O S P I T A L

*A C C I D E N T A N D E M E R G E N C Y
(A & E)*

AMBULANCE INFORMATION FORM

Bath Health District



MAJOR ACCIDENT (ring priority)

IMMEDIATE
 DELAYED (can wait)
 PALLIATIVE (must wait)
 MINOR

Certified

NAME Age Male Female

Address

Accident at Date

Type of incident (eg RTA) Time of call Amb. arrival

POSITION Standing Sitting Trapped Wearing S belt Yes/No
 FOUND Lying position duration C. helmet Yes/No

Main Injuries (ring) Head Chest Abdo Pelvis Spine L Arm R Arm L Leg R Leg
 First Aid already given by

CONDITION		HAEMORRHAGE		K O. Yes No	
AIRWAY		CONSCIOUS LEVEL			
clear	<input type="checkbox"/>	none	<input type="checkbox"/>	1 alert	<input type="checkbox"/>
noisy	<input type="checkbox"/>	slight (5 lit)	<input type="checkbox"/>	2 confused/drowsy	<input type="checkbox"/>
blocked	<input type="checkbox"/>	moderate (10 lit)	<input type="checkbox"/>	3 unconscious	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	severe (2+ lits)	<input type="checkbox"/>	4 fitting	<input type="checkbox"/>
COLOUR pink	<input type="checkbox"/>	PULSE min		CHANGED TO No. 1 2 3 4	
blue	<input type="checkbox"/>	BP time		time	
pale	<input type="checkbox"/>	TOURNIQUET	<input type="checkbox"/>	BLOOD FROM ears <input type="checkbox"/>	
RESP RATE (when relevant)	min	time applied by patient/doctor		nose <input type="checkbox"/>	
				mouth <input type="checkbox"/>	

UNCONSCIOUS HEAD INJURY
 was patient conscious before ambulance arrived? Yes No Not known
 Pupils Moving limbs R yes/no L yes/no

TREATMENT

Oxygen Ventilation Sucker Cardiac Massage
 Entonox Time of Arrest

Intubation Infusion Fluid lits

Chest drain ECG S rhythm Arrhythmia Defib

Drugs time Dr

Doctor in attendance Yes No

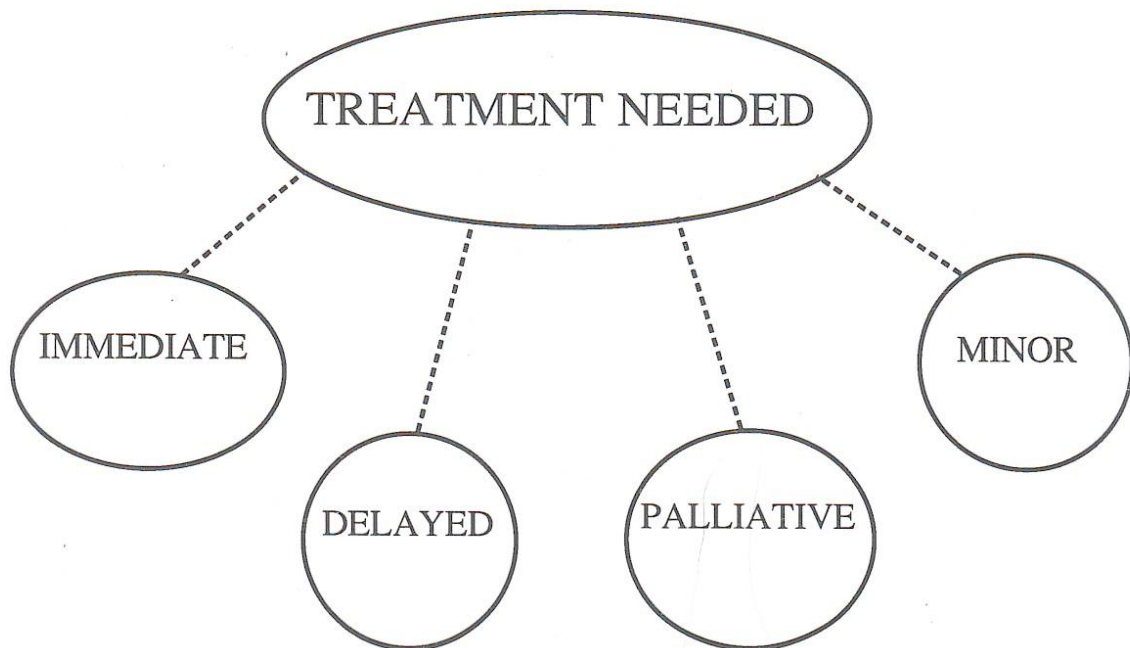
AMBULANCE CALL SIGN

CREW



OUT OF DISASTER AREA

SHOULD PASS THROUGH FILTERING
SYSTEM
TRIAGE





MUST HAVE



NOW

CASUALTIES
have been..

REACHED



ASSESSED



GIVEN FIRST AID



EXTRICATED



LABELLED



OUT OF DISASTER AREA

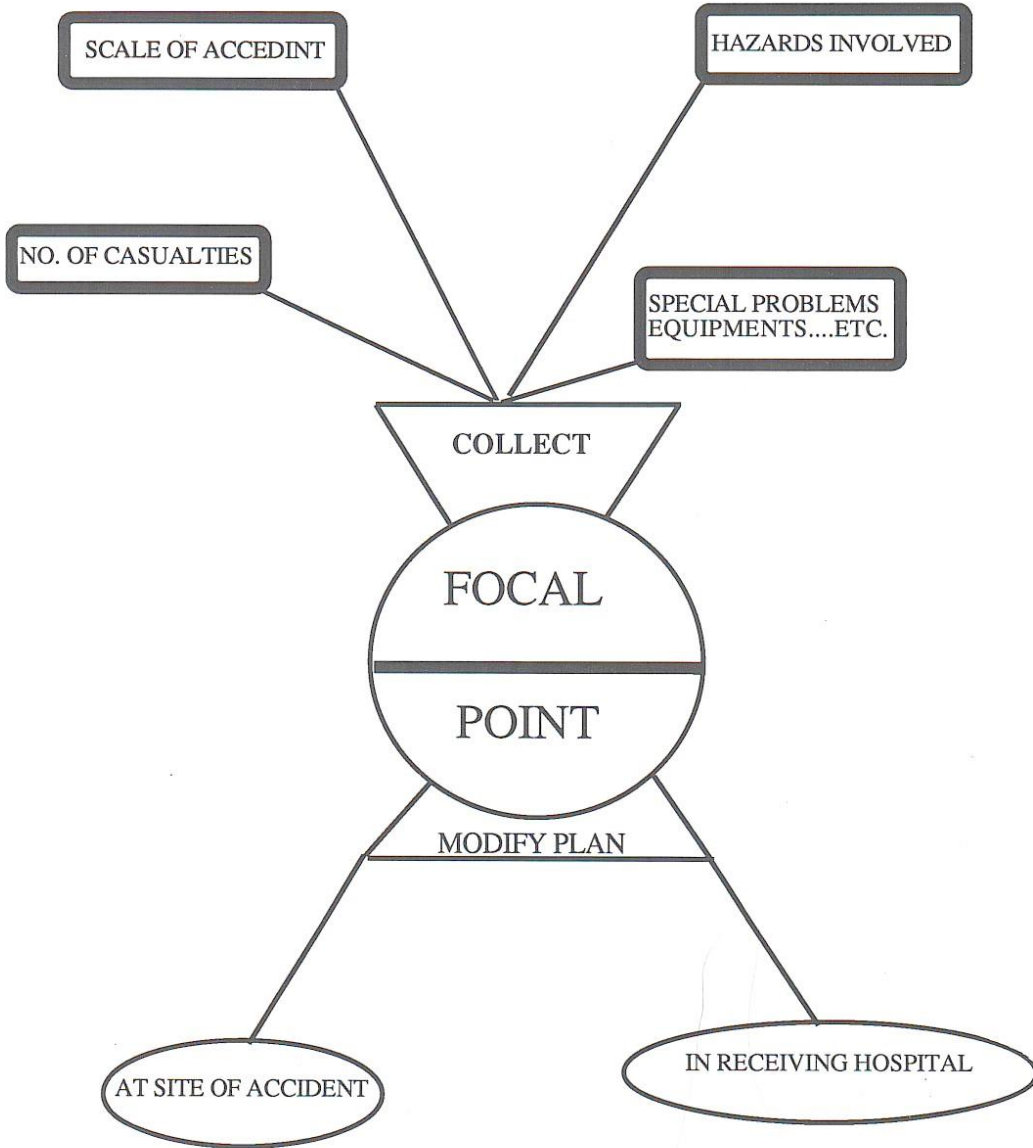
REMEMBER

No Pulling
[Priority]

SECURE
AIRWAYS

REMOVE
DEBRIS
FROM
THORAX

311



15

IDENTIFICATION

VERY ESSENTIAL

- * *PERSONAL*
- * *VEHICLES*
- * *CONTROL POINTS*
- * *EQUIPMENTS*

NEXT

COMMUNICATION

CONTROL

CO-ORDENATION

(3)

- * The place of surgery is at the **HOSPITAL** and not at the road side
- * Doctors should travel by ambulance or police car and **NOT** by their own cars
- * At site there are
 - people of many disciplines
 - may not know each other
 - many volunteers

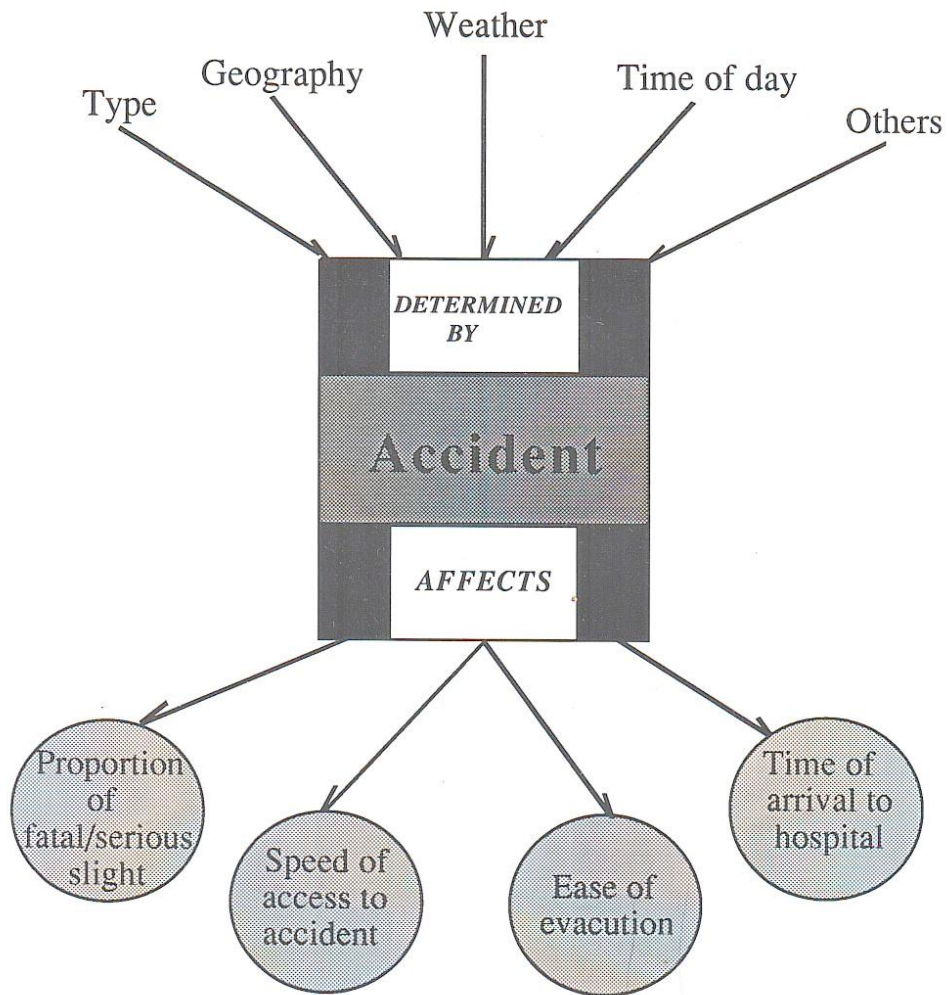
IMPORTANCE OF

IDENTIFICATION

(12)

PROBLEM LIST

- * Identification of
 - Hospital team
 - Control points
- * Casualty evacuation
- * Communication on-site and to hospital
- * Control of staff/equipment/vehicles/casualties
- * Documentation-methods and labelling
- * Treatment and protection from weather
- * Triage - methods and implementation
- * Ambulance access and loading
- * Night operation



MANAGEMENT

THREE STAGES



PREHOSPITAL improved results

WW 2	4.5 / 100	
K W	2.5	D/C
V W	1	

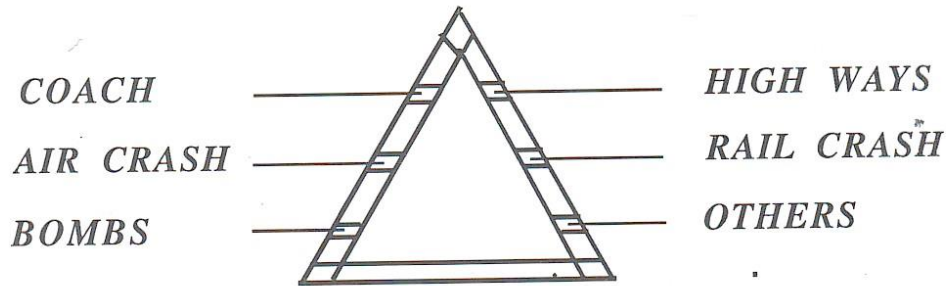
cause: Rapid evacuation
En route care

300 patients	150 helic
52% (↓) pred. death	150 amb.

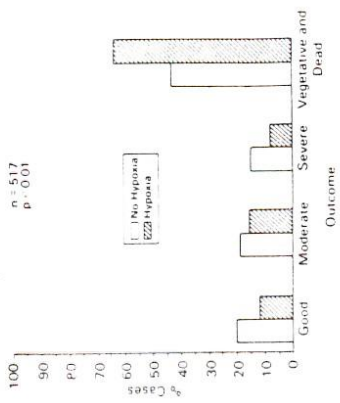
1

DISASTER

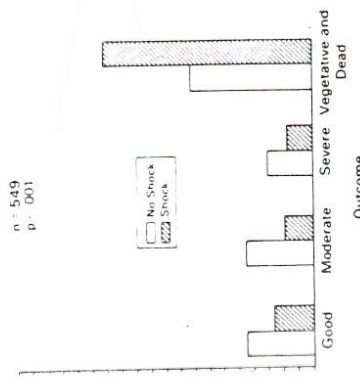
ARRIVAL WITH LITTLE OR NO WARNING OF MANY MORE CASUALTIES OF ALL TYPES AND DEGREES OF SEVERITY THAN A HOSPITAL IS DESIGNED OR STAFFED TO HANDLE AT ANY ONE TIME.



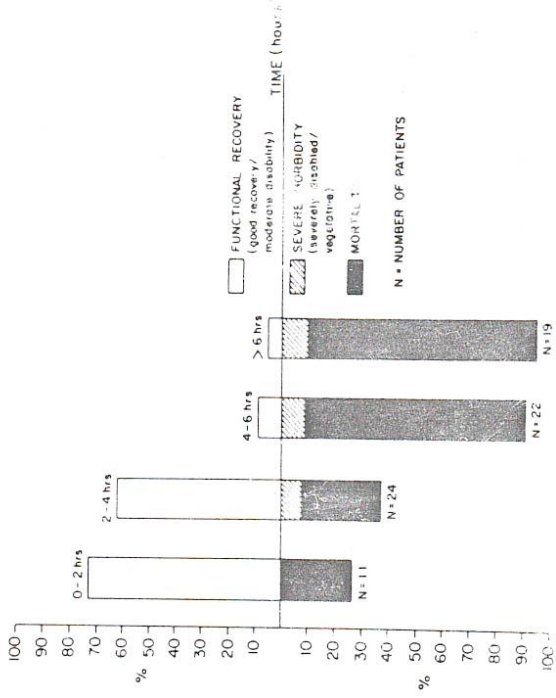
- NO TWO DISASTERS ARE ALIKE.
- ACHIEVE GREATEST GOOD FOR GREATEST NUMBER.



The relationship between prehospital hypoxia and outcome is seen in this figure. Patients who sustained hypoxia had a statistically significant poorer outcome when compared to patients who were never hypoxic. Reproduced with permission, Eisenberg et al. (14).



The relationship between prehospital shock and outcome is seen in this figure. Patients who were in shock had a statistically significant poorer outcome when compared to patients who were never hypotensive. Reproduced with permission, Eisenberg et al. (14).



Influence of time delay to surgical intervention on outcome in 76 patients with acute axonal hematoma. Reproduced with permission, Seelig et al. (48).

KASHKOOL

125

Experimental Micro Lab.

- * Micro needle holders 1 straight; 1 bayonet
- * Micro sissors
- * Micro forceps 2,
- * Artery forceps, for holding the needle to stitch the rat's skin
- * Modified paper clips, fixed on rubber bands to be used as hooks for the rat's skin
- * Small arterial clamps No. 3
- * Insulin syringe with fine needle to inject the hypnorm
- * Hypnorm which should be injected at the gluteal region of the rat
- * Two sized polythene tubing, a fine one for the vascular suturing, and a bigger one for tracheostomy
- * small pledgts for drying
- * Normal saline
- * Rubber sheets to be put under the vessels when dissected
- * A dropper
- * Bipolar
- * No. 10/0 Micro-stitch
- * Adhesive tape
- * A wooden board to lay the rat on
- * Fix the rat's tail, limbs and incisor teeth with a string for the latter and all fixed to the board by adhesive tape
- *

GOOD REFERENCES

INTRACRANIAL HYPERTENSION - CHILDREN

1. Benign Intracranial Hypertension (Pseudotumor cerebri). Review and Report of 18 Cases. B. Hagberg and G. Sillimpe. Acta paediat Scandina (1970) 58: 328-339.
2. Benign Intracranial Hypertension Following Corticosteroid withdrawal in childhood. D.G.R. Dawkins and J. Wilson. B.M.J. (1970): 3: 554-556.

Foley.

- ⊙ Vascular Malformations of the brain. an anatomical study.
J. Neurosurgery 18: 630-635 1961
- ⊙ Physiologic Study of AVM of brain
J Neurosurgery 5: 165-172 1978

→
Pulmonary Function in pts
with multiple ~~org~~ trauma
and associated severe head
injury J. Abrams
The Journal of Trauma
Vol 16. No 7 1976

Schistosomiasis of the
Spinal cord
R. Lechtenberg et al
Neurology Jan 77 55-59
PFO

~~Choroid
plexus~~

Neurochemical Research

Vol 6

"Partial Purification and
Characterization of a
Folate Binding Protein
from Human choroid plexus"

Suleiman A. Sulaiman,
Reynold Spector,
Pasquale Canicella

June 1981

333 - 338

Vol 6, No. 3

June 1981

"Accumulation of peptides
of the choroid plexus in
vitro: Tyr-D-Ala-Gly
as a Model"

J. T. Huang

Vol 6, No. 6

681-690

"Compartmentation in Amino Acid
Transport Across the Blood
Brain Barrier"

Stanley Lamerels
Stephen A. Schwartz

Vol 6, No. 7 755-766

SAMPLE OF OPERATING SKETCHES FOR WAR VICTIMS IN AMARA HOSPITAL DURING IRAQ IRAN WAR

CLINICIAN'S NAME: MR. A. H. KHALILI
 ADDRESS: DEPT. OF NEURO SURGERY THE GENERAL INFIRMARY LEEDS YORKS
 PATIENT'S NAME: IRYNE WYNN
 ADDRESS: 9 Willow Bank Todmorden

PATIENT'S REF. NO. _____ IN-PATIENT OUT-PATIENT _____
 AGE: 51 SEX: MALE WEIGHT: _____
 PRIMARY DIAGNOSIS: BRAIN STEM INFARCTION
 CONCOMITANT ILLNESSES: COMA
 PREVIOUS ANTISPASTICITY THERAPY: NIL (drug) physiotherapy ++

DANTRIUM THERAPY

TOTAL DAILY DOSAGE	DURATION OF THERAPY		PATIENT RESPONSE*	
	FROM	TO	CLINICAL IMPROVEMENT	ACTIVITIES OF DAILY LIVING

* PLEASE CODE THE PATIENT RESPONSE AS: A: WORSE
 B: NO CHANGE
 C: IMPROVEMENT OR MAINTENANCE OF IMPROVEMENT

CONCOMITANT THERAPY

TREATMENT	TOTAL DAILY DOSAGE	DURATION	
		FROM	TO

DANTRIUM MONITORING FORM—PART 2
 TO BE COMPLETED AFTER SIX WEEKS
 PLEASE USE BALL POINT PEN

PLEASE COMPLETE AND RETURN IN REPLY PAID ENVELOPE WHEN THE PATIENT HAS BEEN ON DANTRIUM FOR SIX WEEKS. OR IF PATIENT PERMANENTLY STOPS THERAPY BEFORE 6 WEEKS.

112 2021

DATE PART I	20.6.15
DATE PART II	
DATE PART III	
DATE PART IV	

ANY ADVERSE REACTIONS AND/OR SIDE EFFECTS EXPERIENCED

ADVERSE REACTION/ SIDE EFFECT	TOTAL DAILY DOSAGE	DURATION OF REACTION		REACTION (KEY I)	OUTCOME FOR PATIENT (KEY II)
		FROM	TO		

KEY I—DID REACTION:
 A: BECAME WORSE
 B: WAS BETTER BUT STILL APPARENT
 C: DISAPPEARED

KEY II—STATE EITHER:
 X: PATIENT CONTINUED THERAPY
 Y: PATIENT STOPPED THERAPY
 Z: PATIENT STOPPED THERAPY, DANTRIUM LATER RETRIED AND GIVE RELEVANT RESULTS

LIVER FUNCTION TEST RESULTS

	DATE OF TESTS	TOTAL BILIRUBIN	LDH	ALKALINE PHOSPHATASE	SGOT
BASELINE (PRE-DANTRIUM)	16.7.15	6 nmol/l	390 u/l	8 ka	20 u/l
AFTER 6 WEEKS					
AFTER 3 MONTHS					
AFTER 6 MONTHS					

COMMENTS:

GUIDELINES ON:
***HOW TO WRITE
A THESIS***

Prof. A. Hadi Khalili,
MPhil, FACS, FRCSE
Dept. Neurosurgery,
College of Medicine,
Baghdad University.

DEDICATION

This work is dedicated
to all our postgraduate students,
in appreciation of their painstaking effort and struggle to perform
scientifically respected research and writing a thesis in such
difficult and nearly impossible circumstances during sanctions.

It is hoped that these modest guidelines
would minimize their hardship.

Most academic bodies that offer postgraduate degrees require writing a thesis and defending it through an oral examination as a prerequisite. The oral examination is generally used to seek for

clarification of some aspects of the thesis. Proper and impressive oral presentation may overcome some weaknesses in the thesis.

The writing of thesis is a major task. It should follow an acceptable style not only nationally but also internationally. The scientific style is universal in whichever language it is written with. Such comprehensive style is very much needed amongst our students, as there are no accessible practical guidelines for them to follow.

The preceding guidelines give an advice about various aspects of this task in a simple applied way. The material presented here is based on the experience of many authors and my own.

I am thankful to Prof. Hani Al Azzawi, MBCHB, Ph.D. Anatomy, Dr. Saad Abdul Sattar, Ph.D. computer science and Dr Ayad Al Ramadhani FRCS, for their comments and suggestions.

AHK

I. DEFINITION:

Thesis: Is a dissertation advancing an original point of view as a result of research, especially as a requirement for an academic degree.

Dissertation: Is a formal, lengthy exposition of a topic. (American Heritage dictionary). However for the MSc or Diploma originality is not essential.

- The thesis is a highly respected scientific writing.
- The main aims of the thesis are: to build up the ability of proper reading and extracting useful information, learn how to utilize and put down all the relevant data and findings of the research, and to develop the vision of comparing one's work and results with other workers. The ultimate goal is to contribute to the advancement of knowledge.
- You should be proud of your thesis, as it is a reward of your hard and great effort. Accordingly do it properly to expose the good quality of your research.
- You should aim for completing a scientific paper from your work during the course of writing the thesis, which is to be published in a respectable journal in the area of your specialty.
- You must aim for presenting your work at a scientific conference locally or internationally.

REMEMBER that from HONESTY, FRANKNESS,
and SINCERITY in saying what you have to say,
TRUTH will eventually emerge.
The TRUTH is the
real goal of research and the thesis.

II. PLANING AND WRITING:

- ⚡ WRITING should be POSTPOND until a detailed PLAN is COMPLETED.
- ⚡ Before writing a thesis one has to be ready for this task. He must have completed his thinking as how to put his ideas.
- ⚡ During the course of your work, and definitely before you start writing, give a talk (seminar) to your colleagues who are interested in your work; collect ideas from their discussion and arguments.
- ⚡ It has been said that: “I never think when I write, No body can do two things, at the same time, and do them well.”
- ⚡ Write in a double space fashion so you allow for any possible changes without loosing your original form.
- ⚡ You may better use a pencil so you can erase any thing you wish to modify or omit.
- ⚡ Take this opportunity to learn more about the use of computer in writing.
- ⚡ Be uncompromising with your self: Write - Rewrite - Delete - Polish; until you are satisfied with the final version. Remember that many great scientists and writers were doing the same. Harvey Cushing rewrites 9 times and Somerset Maughm 6 times.

You need to get ready and prepare:

- ✓ All the Ideas
 - ✓ Your material
 - ✓ Facts
 - ✓ References
- 🕒 Be careful about spelling mistakes (Using Microsoft Word 95 or 97 would minimize that significantly).

References:

- ❖ Dig and obtain the relevant references from all sources available: books, journals, databases, supplements, conferences proceedings, personal communications or others.

- ❖ Remember that a high standard thesis should use more journals than books.
- ❖ The required information from each reference, which is in line with your objective, should be assembled on separate cards or sheets of paper. On each card or sheet you must state the details of journal; title, issue volume, pages and year. As for books put down the title of the book, name(s) of author(s), or editor(s), the title of the chapter you deal with, the author(s) of that chapter, The publishing company, The publication city, the pages and the year of publication (see pages 11&12).
- ❖ You don not need to go back to those original references gain.

III. COMPONENTS:

□ The components of the thesis are:

Title, Summary, acknowledgement, Contents, Abbreviations, Introduction, Materials and Methods, Results, Discussion, Conclusion, Recommendation, References and Appendix.
Presentation is done at the time of examination

□ Start each part of the thesis by making a table of contents in the proper sequence. This is used only for your reference and not to be put in the text.

🕒 You better START by writing the RESULTS first.

TITLE:

Short, Descriptive, no unnecessary words. The department concerned should approve it. The title may not be changed after being accepted officially.

SUMMARY:

- Is very important.
- Many may read it only.
- It will be the quick judge of your work.
- Not more than two pages.
- Should demonstrate: WHY, WHAT, WHERE, and the HOW of your work.
- It must include some important (key) findings both positive and/or negative.
- The conclusion should be clear in the last lines.

ACKNOWLEDGEMENT:

- Dignified.
- Simple sentences
- No biased compliments
- Includes supervisor, typist, and people who helped in conducting the work or in critical constructive views.

CONTENTS:

- Should be clear. Use separate headings for the text, figures, and tables.
- Use Arabic numbers (1,2,3..) for paging the thesis starting from contents page to the end, and Roman numbers (I,II.VII..) for all pages before that i.e. titles, summary and acknowledgement.

ABBREVIATIONS:

- A list of all abbreviations in alphabetical order.
- In the thesis you preferably use the original word when it appears first followed by its abbreviation in brackets then continue with the abbreviation only e.g. Central Nervous System (CNS).

INTRODUCTION:

- Should include definition, bases, history, progress, views on the current situation, and justification of the work. A clear and good opening sentence is impressive.
- You should not depart from the title.
- Start with the scientific bases of the work.
- State the major facts and means related to the subject
- What other people have discovered?
- What are your own views about their work?
- What have you planned to uncover or prove?
- What is your plan briefly?
- Aim of work clearly

MATERIALS AND METHODS:

- Where was the work conducted?

- When was it done?
- What was the source of your sample?
- How was the procedure?
- What was done?
- No statements or conclusion.
- No results tables
- No reference to any result here.
- Do not use references unless you apply a specific form or scale adopted by other workers.

RESULTS:

- Clear exposition of findings
 - No references to literature
 - No statement
 - No conclusion
 - tables: Clear, simple, proper numbering, proper title, proper legends
(Legend: is an explanatory caption accompanying an illustration).
- 🔊 Results should be verified statistically.

DISCUSSION:

- THE BACK BONE OF WORK -

- A clear and good opening sentence is impressive.
- Presentable
- Clear
- Factual
- Persuasive
- Supported by findings from results
- The sequence should take the same order as the introduction and results.
- Correlate your findings to findings of other people, positive or negative
- Present your reasons for difference in opinion. When your results are in agreement with others state that support clearly.
- Have you developed a new observation? Emphasize on it.

CONCLUSION:

- Logical argument interpreting facts as you see them.
- Should be impressive.

RECOMENDATIONS:

- Supported by facts.
- Suggestion for future work.

REFERENCES:

Use Arabic numbers sequentially as they come in the text starting from introduction through discussion e.g. (1), (3,4,5), (6-10). If a reference comes in more than one place it always keeps its original number.

•JOURNAL ARTICLE:

Author surname and initial [if more than three authors add; et al] (.) Title of article (.) Title of journal year of publication (:) Volume (:) pages 00-00 (.)

Codd MB , Kurland LT. Descriptive epidemiology of intracranial tumors. Prog Exp Tumor Research 1985; 29: 1 - 11.

•BOOK (CHAPTER):

Author of chapter (:) title of chapter (.) In (:) the book's editor(s) name(s) (.) title of book (,) edition(if applicable) (,) volume (.) publishing city (,) publisher (,) year of publication (:) pages 00- 00 (.)

Behrend RCh: Epidemiology of brain tumors. In : Vinken PJ & Bruyn GW(eds.). Handbook of Clinical Neurology, Vol. 16. Amsterdam, North Holland Publishing Company, 1974: 56 - 88.

•BOOK:

Author of the book (.) title of book (,) volume (if applicable) (.) publishing city (,) publisher(,) year of publication (:) pages 00- 00 (.)

Wade OL, Bishop JM. Cardiac Output and Regional Blood Flow. Oxford, Blackwell Scientific Publications, 1962: 30-45.

APPENDIX:

Includes all forms or questionnaires applied in the study.

PRESENTATION:

The candidate wishes to make the examination committee, and or his audiences, know of the great effort he has put in his work. This is justified but should be done in an intelligent way. Show confidence while you present and during answering. However, overconfidence can be dangerous.

- Divide your presentation into clear headings corresponding to the thesis.
It should not take more than 20 - 30 minutes (In Ph.D. it may take longer).
It should be comprehensive and brief.
Not a copy of the thesis

- Good use of visual aid:
The slide should not be crowded with words. To achieve this the writing in the projected slide should be read easily with your eye when you hold the slide up by your hand.
The transparency should contain not more than ten lines. Each line not more than few words. It should never be crowded with sentences.

- In your closing remarks:
Summarize your points.
State your conclusion.
Recommend a future strategy, plan and/or goal.
Allow time for questioning and discussing your results.

You should always remember that perfection may never be achieved by any human being. You should recall "AL- IMAD" when he says:

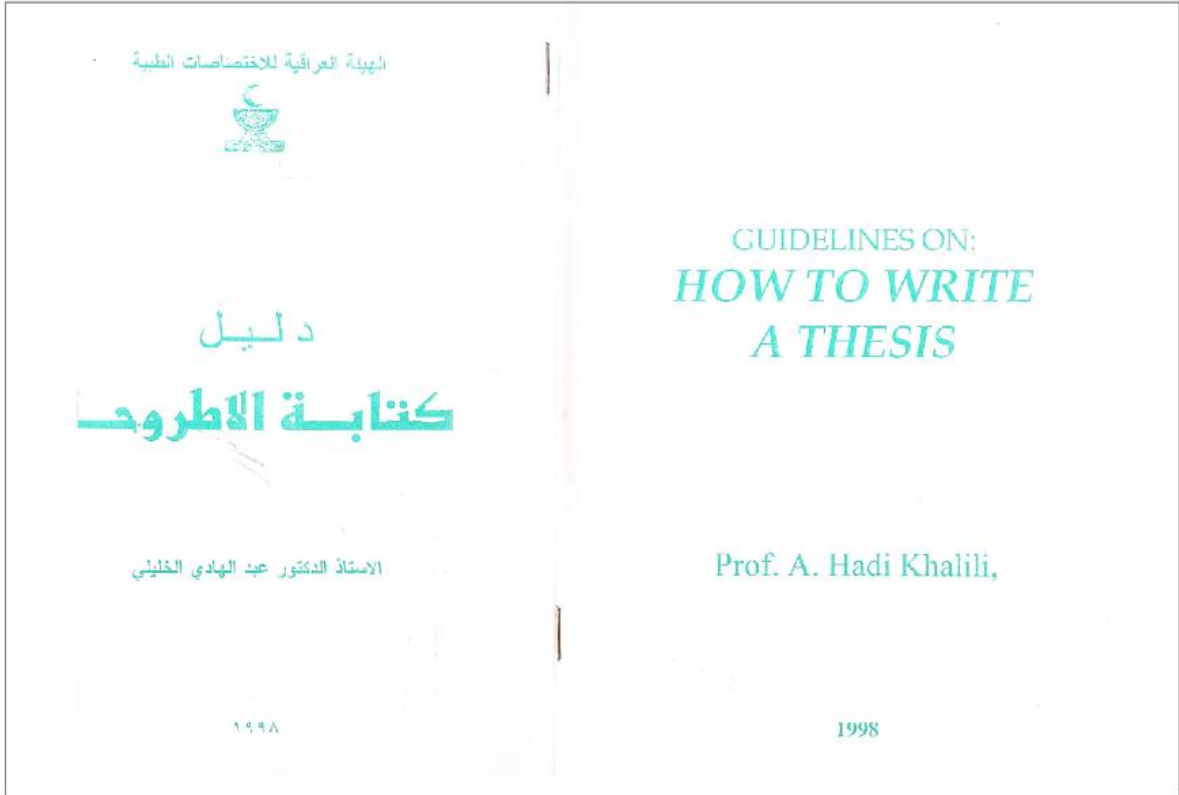
إني رأيت انه لا يكتب أحد كتابا في يومه إلا قال في غده
لو غير هذا لكان احسن
ولو قدّم هذا لكان يستحسن
ولو زيد هذا لكان افضل
ولو ترك هذا لكان اجمل

وهذا من اعظم العبر
وهو دليل على استيلاء النقص على جملة البشر.

5th. Mar 1998

دليل كتابة الاطروحة

صدر باللغة الانكليزية 1998



مرت على مسيرة التعليم العالي ظروف صعبة أثناء الحرب العراقية الايرانية وما بعدها من الحصار الجائر الذي خيم على العراق كجزء من المآسي التي عانى منها المجتمع العراقي. أهمها شمل ذلك مستوى أداء طلبة الدراسات العليا ومستوى كتابة الرسائل والأطاريح. لم يكن هناك أي تواصل مع العالم الخارجي عبر الانترنت الذي لم يدخل العراق إلا في بداية الألفينيات وكان تحت رقابة الدولة الشديدة.

أثناء تلك الفترات الصعبة حُرم الطلبة من دليل يعتمد لكتابة رسائلهم وأطاريحهم. شعرت بتلك الحاجة فقررت كتابة دليل مبسط باللغة الانكليزية يساعدهم في تخطي تلك الصعوبة اعتمادا على خبرتي في كتابة رسالتي على ماجستير فلسفة العلوم التي قدمتها في جامعة برادفورد في بريطانيا والتي قبلت كأطروحة للدكتوراه.

تولت الهيئة العراقية للاختصاصات الطبية بتكاليف طباعته وتوزيعه على كافة أقسام الكلية والطلبة المعنيين. صاحب توزيع الكتيب محاضرات عديدة ألقيتها على مجاميع الطلبة صاحبها نقاش ومدولة لتسهيل استيعاب الطلبة الأعضاء.

الهيئة العامة للأخصاصات الطبية

دليل كتاب الأشرطة .

الأستاذ الدكتور عبدالهادي الخليلي

١٩٩٨

الاهداء

تقديرًا للجهود الدؤوبة التي يبذلها جميع طلبتنا
للدراست العليا وكفاحهم من أجل إنجاز بحث تحظى
بسمة علمية محترمة وكتابة أطروحات في مثل هذه
الظروف الصعبة بل وشبه المستحيلة :

أقدم هذا العمل

آملًا أن يخفف هذا الدليل المتواضع من الصعوبات
التي تجابههم أثناء كتابته ..

عبد الرادى الخليلي

مقدمة

تتطلب معظم الرتب الأكاديمية التي تمنح درجات علمية للدراسات العليا أن يُعَمَّ طالب الدراسة العليا بكتابة أطروحة والدفاع عنها في جلسة امتحان شفوي (المناقشة) وذلك كشرط مسبق للحصول على الدرجة العلمية. والغرض من الامتحان الشفوي في العادة هو توضيح بعض جوانب الأطروحة، إن التقديم الشفوي المناسب والمؤثر قد يؤدي إلى التحول على بعض جوانب الضعف في الأطروحة.

إن كتابة أطروحة من الأطروحات هو جهد لا يحد به وينبغي أن يتبع فيه أسلوب مقبول ليس على الصعيد الوطني فحسب وإنما على الصعيد الدولي كذلك. والاسلوب العلمي هو أسلوب عام في كل لغة يكتب بها. وأنه مثل هذا الأسلوب العام والسال هو ما يحتاجه طلبتنا إلى درجة كبيرة إذ لا يتصور أمامهم دليل علمي ليتجوه. وهذا المرشد يقدم النصح حول جوانب مختلفة من هذه المهمة وبطريقة عملية بسيطة وتساعد المادة المقدمة هنا إلى تجارب كثير من المؤلفين فضلاً عن تجربتي الخاصة. وبهذه المناسبة أقدم بالشكر إلى الدكتور هاني الغزالي سناً والشيخ والدكتور سعد عبد السار سناً على إيساب والدكتور أياد الرضائي زميل كلية الجراحين الملكية للإعطاء لهم وقتاً هاماً على رأيي الخليلي.

مقدمة

تتطلب معظم الهيئات الأكاديمية التي تمنح درجات علمية للدراسات العليا أن يُعَمِّم طالب الدراسة العليا بكتابة أطروحة والدفاع عنها في جلسة امتحان شفوي (المناقشة) وذلك كشرط مسبق للحصول على الدرجة العلمية. والغرض من الامتحان الشفوي في العادة هو توضيح بعض جوانب الأطروحة، إن التقديم الشفوي المناسب والمؤثر قد يؤدي إلى التحول على بعض جوانب الضعف في الأطروحة.

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و يجب ان لا يغرب عنه بالكل وهجوب الالتزام بالأمانة والصراحة والافتقار

في أن تقول ما يجب أن يقال فان الحقيقة سوف تظهر بدهقا بكل تأكيد

والحقيقة هي الهدف الحقيقي للبحث والاطروحة .

٢- التحليل والكتابة

* ينبغي ارجاء الكتابة حين الفراغ من وضع الخطة التفصيلية .

* يجب أن يكون المرء مهيا للكتابة الاطروحة قبل قيامه بهذا العمل وبعد

أن يكون قد انتهى من قراءة كيفية تثبيت أفكاره ولبورتها .

* خلال العمل وقبل اتماع بالكتابة بكل فاعلي قم بتبادل الآراء مع

زملائك الذين يبديهم اهتماما بملك واحصل على افكار جديدة من هذه

المناسبات والآراء المتبادلة .

* لقد قال البعض : " أنتي لا افكر ابدا حينما اكتب اذ لا يمكن أن أقوم

بعلمني في وقت واحد وأدريها بصوت جيدة . "

* اكتب بين يديك وأنت لكى تكلم باعتراف آية تعديلات صحيحة وبدونه أن

تغير في الصيغة الأصلية .

* من المفضل استعمل قلم الرصاص لكونه باستطاعتك مسح أي شيء ترغب

في تعديله أو محذفه .

ويجب ان لا يغرب عنه بالك وهو ب الالتزام بالأمانة والصرامة والافتقار

في أن تقول ما يجب أن يقال فان الحقيقة سوف تظهر بدهقا بكل تأكيد

والحقيقة هي الهدف الحقيقي للبحث والاطروحة.

٢- التفريط والكاتب

* ينبغي ارجاء الكتابة حين الفراغ من وضع الحظمة التفصيلية .

* يجب أن يكون المرء مهياً للكتابة الاطروحة قبل قيامه بهذا العمل وبعد

أن يكون قد انتهى من مسألة كيفية تثبيت أفكاره وبلورتها .

* خلال العمل وقبل الروع بالكتابة بكل فغلي قم بتبادل الآراء مع

زملائك الذين يبذرون اهتماماً بعمك واهل علم افكار جديدة من هذه

المناقشات والآراء المتبادلة .

* لقد قال البعض : " أنتي لا افكر ابداً حينما اكتب اذ لا يمكن أن أتمم

بعضين في وقت واحد وأدريها بصوت جيدة ."

* اكتب بيدك وأقر لكي تكتم باعترار أية تعديلات صالحة ويبدو أن

تخيد في الصيغة الأصلية .

* من المفضل استعمال قلم الرصاص لكيه باستطاعتك مسح أي شيء ترغب

في تعديله أو محذفه .

٢
* ينبغي صبح المعلومات المطلوبة منه كل مرجع يتماشى مع الهدف عام أو خاصه أو قطع منه المحتوى

و يجب انه يبين عام كل من المعلومات الخاصة بالجملة : العنوانه (اسم الجملة) ، العدد ، الجلد ،

الصفحة أو الصفحات ، سنة الاصدار ، بالنسبة للكتب يتم بتدوين اسم الكتاب واسم

أو المؤلفين وعنوانه الفصل الذي تشير إليه مؤلف أو مؤلفين ذلك الفصل ودار

النشر والمدينة التي تقع فيها الدار والصفحات وسنة النشر (يرجى ملاحظة هفتين

١١ و ١٢) .

عناصر الاطروحة

العناصر التي تتكون من الاطروحة هي :

العنوان - الخلاصة - التبيحه الشارحة - المحتويات - الختلات - المقدمة -

المواد والطرحه - النتائج - المناقشة - الخاتمة - التوصيات للمراجع والملاحه

أما العرض (التقديم) فانه يتم يوم المناقشة (الامتحان) .

* ابدأ كل جزر من الاطروحة بعمل جدول للمحتويات وعقب التلخيص الكتاب .

ان هذا الاجراء يساعد على سهولة الرجوع للمعلومات ولا يربح ضمن نفس الاطروحة

و الأفضل ان تبدأ بكتابة النتائج قبل أي شيء آخر .

العنوان (عنوانه الاطروحة) :

يجب انه يكون مختصراً وواضحاً وغالباً من الكلمات عند الضرورة ، وينبغي أن

✓
يحفظها الصواب بموافقة الدائرة المنقصة ولا يجوز تغييره بعد حصول الموافقة الرسمية عليه.

الخلاصة :

* الخلاصة صفة هبة .

* الكثير منه يلتفتونه ببراءة الخلاصة فقط .

* هي القاطن ~~الذي~~ الذي يحكم على عملك ببرعة .

* يجب أنه تكلف الخلاصة عنه بسبب قيامك بالعمل وماهيته ومكانه وكيفية كتابته .

* عليك ان قد فعل ضمن الخلاصة بعض النتائج الراهنة التي حصلت عليها ^{أو} ايجابية أم سلبية ~~أو~~ كلها .

* يجب انه تحتّم الخلاصة بطور واضحة .

التعبير عن الفكر :

* أن يتم التعبير عن الفكر بصورة تدل على الأدب الجم .

* أن يتألف التعبير عن الفكر ^{من} بجمل بسيطة .

* أن يخلو من المساباة .

* ان يتضمن اسم الشخص على الاطروحة وجميع كتاب الطائفة - الأشخاص الذين ~~يعرفون~~

على انجاز العمل وكذلك الذين قدموا النقد والاعتراضات البناءة .

المتويات :

* ينبغي أن تكون واضحة .



* استعمل عناوين وأرقام ومبادك متعلّة للنص .

* استعمل الأرقام العربية (1, 2, 3, ...) لترقيم صفحات الاطروحة ابتداء من

صفحة المحتويات وعلى النّزاة واستعمل الأرقام ^{الرومانية} (I, II, III, IV, V) لترقيم

الصفحات التي تليه من مثل العناوين والمختصرة والتجديد عن التكرار والامتنان .

المنقّات :

* ضع قائمة بالمنقّات ورتبها حسب التّسلسل الأبجدي .

* يمتنع في الاطروحات ان تكتب الكلمة الأصلية كاملة عند ورودها لأول مرة في النص

وكتابة منقّتها بعدها مباشرة وعصره بين قوسين ثم الاكتفاء باستعمال المنقّات بعد ذلك

مثل : الجهاز العصبي المركزي (Central Nervous System) (CNS)

و (وزارة الصحة Ministry of Health) (MOH) - الترقيم))

المدّة :

* ينبغي أن تتضمن التّرينات والأسس والتاريخ والتّقديم الاصل والآثار حول

الوضع الحالي وتبويب العمل . ومنه الأمور المهمّة ان تكون صلبة الاقتناع واضحة ومفيدة .

* يجب ان لا يتخذه المدّة عن موضوع الاطروحة .

* ابدأ بالأسس العلمية للعمل .

* اذكر أهمّاته الرئيسيّة والوسائل ذات العلاقة بالموضوع .

* اذكر الاشياء التي توصل اليها الاغراض في هذا المجال .

* بين آراءك الخاصة حول ما تناول به من عمل .

* اذكر الشيء الذي حفظته لك عن ارثائه .

* اوضح غطتك باختصار .

* بين ~~الشيء~~ ^{الهدف} الذي تسعى لتحقيقه من هذا العمل وبشكل واضح .

المواد والطرق :

* اذكر الكلمة الذي عبرت فيه القيام بالعمل .

* متى تم القيام بالعمل .

* وما هو مصدر نموذجك .

* وكيف كان الاجراء .

* وما الذي أنجز .

* لا تذكر بيانات أو طائفة .

* لا تضع جداول النتائج .

* لا تشر إلى أية نتيجة هنا .

* لا تستخدم المراجع ما لم تكن بتبعية صحيحة أو مقياس ممددتها لتبعتها باهتمامه الاغراض .

* اذكر الاشارة التي توصل الى الاخرى في هذا المجال .

* بين آرائك الخاصة حول ما تناول به من عمل .

* اذكر الشيء الذي حفظته لك عن ارجائه .

* اوضح غطتك باختصار .

* بين ~~الشيء~~ ^{الهدف} الذي تسعى لتحقيقه من هذا العمل وبشكل واضح .

المواد والطرق :

* اذكر الكلمة الذي عبرت فيه القيام بالعمل .

* متى تم القيام بالعمل .

* ما هو مصدر نموذجك .

* وكيف كان الاجراء .

* ما الذي أنجز .

* لا تذكر بيانات أو فائده .

* لا تضع مبادئ النتائج .

* لا تشر الى أية نتيجة هنا .

* لا تستخدم المراجع ما لم تتم بتقييمه صحة أو مقياس صدقها استجوابها بأخرى .

* اذكر الاشياء التي توصل اليها الآخرون في هذا المجال .

* بين آرائك الخاصة حول ما اتوا به من عمل .

* اذكر الشيء الذي غلطت لك عنه أو إنباته .

* أوضي غلطك بإقتصار .

* بين ^{الهدف} الشيء الذي تسعى لتحقيقه من هذا العمل وبالحل واضح .

المواد والطرق :

* اذكر الكلمة الذي عبرت فيه القيام بالعمل .

* متى تم القيام بالعمل .

* وما هو مصدر نموذجك .

* وكيف كان الامداد .

* وما الذي أنجز .

* لا تذكر بيانات أو حاشية .

* لا تضع جداول النتائج .

* لا تشر أي نتيجة هنا .

* لا تستخدم المراجع ما لم تتم بتبعية صحيحة أو مقياس مقدر استجرا باهتمامه آخرون .

مادة المجلات :

اذكر لقب المؤلف واسمه الأول [واذا كان هناك أكثر من ٣ مؤلفين اضع عبارة (et al)

أياً (رجماعته) [اذكر اسم المؤلف الأول (٠) اذكر عنوانه المقالة (٠) اذكر اسم المجلة واسم

العدد (:) المجلة (:) الصفحات (:) ^{رقم أو أرقام} : ^٢

Codd, M.B. , Kurland L.T., Descriptive Epidemiology of Intracranial Tumors. Prog. Exp. Tumor Research 1985; 29 : 1-11.

الكتاب :

^{ان يقول خليفة} مؤلف الكتاب (:) عنوانه الكتاب (٠) الطبعة (٠) (انه كانت بين ابياء)

(٠) المجلة (٠) مدينة النشر (٠) الناشر (٠) سنة النشر (٠) الصفحات

.. - .. : ^٢

Behrend, R. Ch. : Epidemiology of Brain Tumors. In : vinken P. & Bruyn G.W. (eds). Handbook of Clinical Neurology, Vol. Amsterdam, North Holland Publishing Company, 1947 : 56-88.

الكتاب :

^{ان يقول خليفة} مؤلف الكتاب (٠) عنوانه الكتاب (٠) المجلة (٠) (انه كان بين ابياء) مدينة النشر

(٠) الناشر (٠) سنة النشر (٠) الصفحات (٠) .. - .. (٠)

مادة المجلات :

اذكر لقب المؤلف واسمه الأول [اذا كان هناك أكثر من ٣ مؤلفين اضع عبارة (et al)

أب (درجاته) [اسم المؤلف الأول (٠) اذكر عنوانه المقالة (٠) اذكر اسم المجلة والسنة

التصنيف في العدد (:) المجلة (:) الصفحات مثل :
رقم أو أرقام

Codd, M.B. , Kurland L.T., Descriptive Epidemiology of Intracranial

Tumors. Prog. Exp. Tumor Research 1985; 29 : 1-11.

الكتاب (النص) :

ان يقول خليفة

مؤلف النص (:) عنوان النص (٠) عنوان الكتاب (٠) الطبعة (انه كانت يمكن اتباعه)

(٠) المجلة (٠) مدينة النشر (٠) الناشر (٠) سنة النشر (٠) الصفحات

.. - .. مثل :

Behrend, R. Ch. : Epidemiology of Brain Tumors. In : vinken &

~~Bray~~ Bruyn G.W. (eds). Handbook of Clinical Neurology, Vol.

Amsterdam, North Holland Publishing Company, 1947 : 56-88.

الكتاب :

ان يقول خليفة

مؤلف الكتاب (٠) عنوان الكتاب (٠) المجلة (٠) كان يمكن اتباعه (٠) مدينة النشر

(٠) الناشر (٠) سنة النشر (٠) الصفحات .. - .. (٠)

عدة كلمات وأن لا تكون مقلدة جداً بل يجب أن تبدأ .

ربما لنسب للاهفائك الخاصة :-

* اختر نقاطك .

* اذكر الحاتمة .

* اقتد به سرائرية سقيلية والخطه أو الهدف أو كليهما .

x انغ وقتاً لتوجهه الاكلة اليك فلاله ومناقشة النتائج التي حصلت عليها .

وينبغي انه تذكر على الدوام أن الكمال لا يمكنه ان يتحققه أبداً لأن من ساد

وعليك أنه تذكر ما قاله " العمار " :

" اني رأيت انه لا يكتب احد كتاباً في يومه الا قال في غده

لو غدا هذا لكاه أمه

ولو قدم هذا لكاه يمين

ولو زيد هذا لكاه أفضل

ولو ترك هذا لكاه أجهل

وهذا من أعظم العبر

وهو دليل على استيلاء النفس على جلة البشر .

=====

الادراك والحاسبة

1997

أقيت في جمعية الحاسبات العراقية (ناي العلوية)

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أ. كليات ... تخصص الاتكا
ب. Clairvoyance
سنة الاصل من سنة عام مرور
في مظهره بفتن

ج. Precognition
سنة عام مرور في السنة

د. الحركة النفسية
By ...
م

تمتلكها كما ...
لها آثارها على ما دونا
التي هي من الظواهر التي لا يمكن التنبؤ بها

ESB

الاصحاح الثاني الفصول العشرة

صينا بضم سين فزنا بيا مضافا ما لنا نرهم
رأينا نجره حيث تلبس صورتها في القوف
الصغار للثنية وتوسع البؤبؤان وتسمى
الدرج اعزازها لذكر البؤبؤ باللسان
واذا لم يجد حرمته ففتح لينا
فقد اودت به وقتها كمن يراه
لولا سمي كل الصلوات بنا صلوات
وهذا ما يبعد له عن وهم الاصل
بدرج المحرف

الاصحاح في فروع الهمزة
(ادراك ما نزل الامم)

(P. 102)
هناك بركاته من الاصل والتميز
لا يصح للاصحاب الاعيان
ان افاضوا ما نزل الامم

به فو صبه الالهة الكريمة

صيات اصبنا المحقر

ابنت العبر ما انه الالهة مستلم كل شيء بحريته
عمر حاتمته من انه يملكه ومنه محمول كل المحقرات
الحاصلة ايما بقدرت به الرضا في كل كرهه بخلافه
بنا ملكه التي تتكلم المراد ان الله يملكه الصلوات
التي يقفها في محقر او مقبولة

تأثر المحقرات بالله والحق والركن

والالكران دكره في رغبتنا ونوقضاها

استقال ذلك المحقر فانعدت بها الفرس مكره

به من فيه الكفا يتكلم رتبا حميدة بالهوام

لوحيا راسيا رات بينا في آله الالهة

تكره الالهة المفردة بالاول والاطلالت اهم
في الكفا

بدر قهرها صوات الطير في صور طير

مفردا صوات صوات صوات النابغ اوماه

اللام شمع بكاد صوته في صوات صوات

طيسر الكفا

(الاصحاح والادراك)

تحت لا نستحق الا الحزنا بل للذات السما
يرى على. فمشا منها تتوقف من الرأفة
لنفسها للوقت عداها ثم رطبت بها الحزاد
ولصوت لم يسمع منه ما اسبح ووصف
المحبوب التي لم تخلد في يد. بل انما له العلم
لا يستحب كل الحزنا بل يكثر منها
المعنى و يبين في الفقه لذلك اللفظ الكبار

الاصحاح في المنحج الاختيار

ما عندك كذلك منذ ما صدر الصبر
و الكفة تترأ اصابعه قد صدرت عن
ملاها وهي الكفة صان (اصحاب تفرقة
صاحبه لا يهتم به الادراك و هذا هو
يصح اصحابه تنبيه سره فالرمان
سوايب و يعنى كل ما في العالم ولكنه لا ير تجل

وما كثر في افواه شيوخ الكنديين الذين
الذين يلبسوا من عمارت الالف - صيا الخيط
المسكينة والنوعية المصنوعة وما نوا هذه المكونة
مجموعه من الكهنة الذين يجمعون في مظهره مسيحية
يد مظهره من مظهره الخصب . مظهره ثم
اقتضاه وبقية الالف منهم كذا في الكهنة
انتم في الذين

الذين في الكهنة

عنه في الكهنة من مظهره مظهره
الذين من الالف في الكهنة الكهنة
وتمتع بها . مظهره الكهنة ولا مظهره
له . مظهره الكهنة الكهنة الكهنة
بينا الكهنة الكهنة من الكهنة والكهنة

بعض النور لكي يتم كذا صفة الخيال البصري
 اما انما وضعت نظريته كما صدره عن الشياخ
 او اللد لا لانه كما ان الحيوان لا يحيط في ادراكه
 للبرهان كما ان العقل لا يحيط بالادراك انما
 من قدرته بل ادراك الالوه والاركان
 والاعمال والكنه لا يمكن ان يكون
 معكم بعينه او يفوقها الا كان ولا
 ادراك العقل

وانما هذه التي قد تتبادر افواه
 صفة درسيه عن الامور منقولة لبقية
 عانت في محيط لم تر فيه غير النقاط الالوه
 بل علم تتعرض لها في خطوط ، صفات او احوال
 وعندها تعرضت كظلالها في علم
 الكون البصري كذا الكيفية وتبينه في
 احوالها عنما تعرضت النظم الى ظهور افقها
 او عيوبها ، وعندها في هذه الحالة تتبادر
 لم تتفر احد صلاحيه البصري

قوله من بين اللسان ان شوه الابدان بصير
من الصبر والاشعة

(الذئب البري وادخال الاطفال)

اجبت بما ربه بوضع حابر مبرور
عندنا العف القوي لتسخر البراة المزارع
فيها من الارض... وهي اذوتها مما حبايك من
ضآلة التلبه انوارها والاشارة العصبية للذئب
البري... وادخاله الامة شقيب... فالعمر
للتنق يحزن هذا بعينه... ولها لا شيب
كما بينا شيب عمره... وادخاله البري
لقد ما انفق ال عمر كما ذكرنا... وعليه ما به بعض
علا شيب تقا لتعيز فوضه بالاجامه والظلم
الذئب... وبهذا التلا المعقدة تستر بالسال العلهما
اس الحنذ منظرًا

عمل الاطفال الصغار

ضايًا صفة معده مصله كلوا (الذئب) صفة

بحا ابر الصبي ص في صحن مختلف كانه
 رادع السنن تزيين كثر شامه . له آفانه صبره
 مختلفين بالارادته سكرنا به ما ينطق العيون
 اسسه على افعى على الحمار وامر له
 الصبي وبناته يتكلموا الصبي المتعلمه و
 يفتون اصدبه الصبي . نزهه اسم اللحن على
 عنه ملكه وامر وليه الروايع .
 فكل من بعد الاضمار الصبي ليس بعد ما

دلائل السنن الاصداد

بالكنم ما اسم الصبي تطيان الاضمار بالمعنى
 والصبى ما نفا طير ملكه صبا يزداد اوقا وام
 عند اصدبه الصبي يفقد ما ينطق الحرفه وكنه الصبا
 والكنم الباقى . اسم الضائير بكنم اسم
 لرضوا لبا العن ما رسوماته بيفض اليرلاش
 ما اذا كانه صانعه تعطله وديله الله ، اذا
 كانه اصلاص بالكنم O O O O O ، اذا كانه
 اسم الصبا من نفا ، ↑↑ اذا كانه الكسوف
 صمد

عنه ما سير اعرافنا فانه اذا كنا للكرة من جهة
انه المحترق هو يعبر في الاصل كمنته الدارين
والسنة . اما اذا كانا في ارضنا فاننا
نلتحق من الكرة البرصية منسبان . فتم لنا
تأثير في هذه هي سياتيها التفرع . اجم السيرة
الغريبة اليها . وتتمت كما في هذه في الطرقات
وتصير ما في الليل لانه في النهار على اجزته وليس
على مداره

(عن الدوران)

انا سبكه في المحو . اعدنا . فلما زره التدا !

دلائل الفيزياء الرابع بالحق كبراً

انه انتم في كل يوم في كل وقت في كل مكان

وهي الايام في كل وقت كمنه . فلما هي

بوصف مدارها من حافة السطح من حافة

الارض . وقد يكون لها حافة السطح من

بجانب الارض بالليل واليوم ارضي . وعين

في هذه الساعات من وقتنا وقد يختلفان في

الصحيح

16 اذا استقلت واصفقت الاكوال للاية
حركة حو حو السابعة ما هنا تكلم وهو من وزن
وذلك في غير الازالة والاسم صائبة الى الازالة

الحركة الحسنة

ان الحركة الحسنة للفتحة كالحاوية الحركات الطاهرة
وهي ~~تسمى~~ تسمى على الوجود بين الاسماء في حين
انها المبررة وعليه التفسير التي تحدث
فقدما تحدث حركة ما هنا الازالة مع
انها تسمى ما هنا الاسماء في غير الازالة

وانه التي في حاله كون الحركات الصالحة
المسماة في لغة بعد اعتبار كل شيء
كثير من اسما في غير الازالة
تأهده في رطلية في الظاهر وذلك الاطار
تسمى في لغة التفتحة في حركة تسمى
هذا عند ما تسمى في غير الازالة
في الازالة في غير الازالة وتسمى في
تسمى في غير الازالة

مراجعة

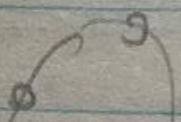
تتمتع بالوقت والمكان . وان الشغل المرصود
للدراسة أي الشغل الذي هو ادراك للمكان .
ادراكه عن أفضا مكاناً فهو وقت ضال دون

الوقت

في حركة الزمان

Autocentric effect

تتمتع بغيره وتؤثر عليه - ترى ان المرء
() وقتاً . بينما هو (أثره) الزمان وتترك
هو . وهذا ما يحدث عند الطائر في الليل
على صدى الصوت . في كاسيات نام أو



بدره قسورنا . و تفره راضيه على بما جالته الهمم
التي سيجعلنا نرى ان هذه السور الخلاله
المحسوسه والكمية

ان الادراك لا ينفك عن صفات الالهيات فهو
وكلها سجدات التي تفضل له نرى الكا صيد .

12
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14
ممن حبه الادراك الالهيات بار الهمم
منها في الهمم الهمم الهمم

و تفره ما ان الهمم الهمم الهمم
عند نرى سجدات الهمم الهمم

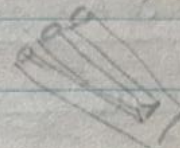
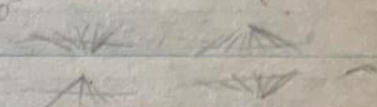
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الحذاء العربي

ان الزوايا هي الحقايق في الزوايا... ولكن الزوايا
قد تتغير احياناً...
العلم لا يدرسه...
او عند الحاجة النظر الى السهل



(نظريات الادراك)

نظريات الاختيار

البيكارا في مكتبكم...
صورة رآه لا تراها...
انقل طرية الادراك...
وعليه فانه زلا ادراك هو...
ان طلبة مات الحفرة...
ان احد التفسيرات...
نكافئاً لا نقل الا...
هالا لا يرتكها...
المبينة في...
منطقية...
وانما ان هناك...

بركات الموقع
 - بار نغم من الواقع انه الطبيب من موقع الاسكندرية
 كما هو مقرر تكملة البرهان الاصولي بالدليل .
 هذا البرهان يعتبر كأنه على الشرط الذي هو مقرر من البرهان
 عام ١٨٩٧م الذي مقرر من البرهان الذي هو مقرر من البرهان
من البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
 ان البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
 عالم مقرر من البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
من البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
من البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
 ان البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان

(التلخيص والادراك)

ان البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
 كما هو مقرر من البرهان الذي هو مقرر من البرهان

الخصبة والاسماء والخلقية

ان البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
من البرهان الذي هو مقرر من البرهان الذي هو مقرر من البرهان
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وانه جمع راء وكوا وتبعا في اذراكها من التجره والمكرم
التيهه في راء في تصلا من فرتا ال ليه فانه حرة
الطن في التام سورا في حنن من حرة البالغ في ندر
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عنه ما اتم من راء في حنن في حنن في حنن
الطن في التام سورا في حنن من حرة البالغ في ندر
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الطن في التام سورا في حنن من حرة البالغ في ندر

عنى من الالوان والاشياء كما نراها وانما نورد انما نراها

مما هي ^{الاشياء} والالوان والاشياء والاشياء والاشياء

لانها التي ^{الاشياء} منها تغيرت ودمج الالوان في كظم ما

ونرى ^{الاشياء} كما نرى منها تغيرت ^{الاشياء} من الالوان والاشياء

لها وهي ^{الاشياء} التي منها تغيرت ^{الاشياء} الكيفية

وتتغير ^{الاشياء} في الالوان والاشياء والاشياء

باللغة ^{الاشياء} التي منها تغيرت ^{الاشياء} الكيفية

التي ^{الاشياء} منها تغيرت ^{الاشياء} الكيفية

في ^{الاشياء} الكيفية

تتغير ^{الاشياء} في الكيفية اذا تغيرت كلاً مطلقاً

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

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انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

في الكيفية

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

انما ^{الاشياء} في الكيفية في الكيفية في الكيفية

مكرر

حسن نفسى واطمئنان من الاشارة الى عالم يقنعنا حواسنا
بالمخزاة في صلاتها صفاً واثباتاً في حواسنا
ويسترد من نقطه رصيدها في حروف وظلاله او لعمرة
نقته كما عرفه معزولة صديقا من حروف حواسنا
وبين تظلم وضيق ونسج مرسية وليس تظلم
ونسج بالكلية تركبه ولا يفتن في حروف حواسنا
الا قليلاً. رغبة في اجاز الصدق بالحواس والاطمئنان
المتلف نرى انه الصدق الكفيلة عن القلم الكفيلة
في الادراك بعد الاستدراك والتمسك
تنظيم وبقدر اندام المخزاة في حواسنا

ان الإدراك الاسبق والكرارة مع ما اصول اطا
الزمان والمكان والهمم يعتبر في الادراك والتمسك
لها من اعنف الكوفة وسائر الادراك. وينظر الارصاد
لانه يعطيا نظراً عاماً لا حار بالحواس وبما صاروا اليه
وهو تركه نقطتها الاضراس بالان باصفاً بالثقافت
والكرامة والتقدير. انما هي في حواسنا
بغير نظراً عاماً ولكنه اصنفه ما البرهنة في حواسنا
بما اننا نرى الصدق ما الارصاد الصفاة ما انما صلات
متمثلة. انما هو انما هو انما هو انما هو انما هو
وبينها الثقافت والتقدير والتمسك.

من بين النسل والحجم في المهر

سواءً ونسبته من النسل والحجم في المهر
في النسل (الأغلبية) من نسل الذكور (الذكور)
بأنه أدوية ومواد حيوانات مختلفة وأدوية
الذخيرة في هذه الحالة من النسل النسبية والكمية
التي يمكن التمييز

في هذه الحالة من النسل النسبية والكمية
وقد تمت الدراسة بين الفصل والمرض. وكان الهدف
منه من أجل العالم العلمي أيتها المهتمين
منه بينها.

عالم الكيمياء الحديثة من خلال معرفة عتبه من النسل
كما هو الحال في الكيمياء حيث يمكن معرفة كل من تأثير
الذخيرة والكمية. تؤثر الممارسات الكيميائية
الكيمياء المتأخرين على الكيمياء وتتميز من النسل
الكيمياء المتأخرين. وأما هذه المواد الكيميائية
لقد كانت من النسل النسبية والكمية

وانه هذه المواد الكيميائية كصودر لها صفة الالتهاب
التي قد تترجم على التهابي ولا تترك كما في التهاب الاذن
التي هي التهاب الكلى صريح ، وتذكر بالمرضى الذين
يكون لديهم توتر كذا وما وصلنا له من نتائج
انه حالة الصنطالينس تجعل الدم في ينشط عند الالتهاب
وانه الكلى التي هي توتر ~~في~~ تقاوم عند تعرضه
الى عاتق مرض او جسم غريب ، وانها هي صفة الكلى
صحة راحة في حالة الخلع ، فرائدة الكلى في الخلع
وانها تترجم في حالة التهابها

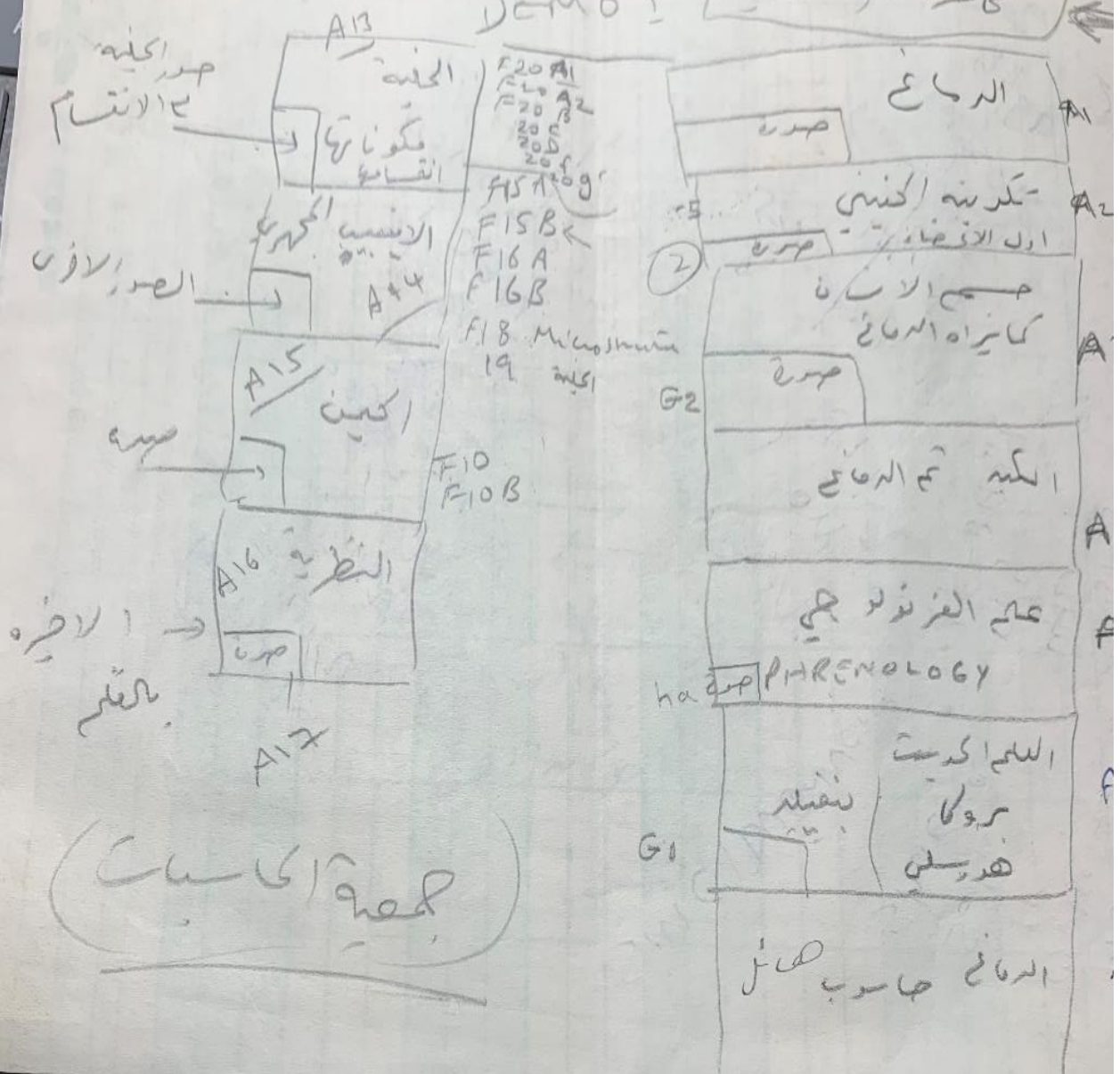
ان الالتهاب في حالات الصنطالينس كما في قشرة
الجمع والتغيرات الضمنية والحالة التي هي
قد يمكن الخلع بافضل ما يمكن للمرضى فتمت
عندما تعرض لحالة فلا يمكن انهاء
توجه الى التركيز في اهتماما والكلى وخصوصا ما هو
فرضياتي اظن بجهة او الالتهاب من هذا الموقف
وقد تترجم الدم في حالة الالتهاب في
الاطر بواكيب الدم والتي تترجم الكلى في
الدم في راحة في السكاط الدمائيا
مما تترجم في الكلى

اما الكلى التي هي فواضله ان يعرف الالتهاب الواسع

التي رصت اليه وكطيمه . وعليه كبر من مصادر
كل اسماء ، وبتعد على اعادة ثبات الكون أو
الاشياء الكونية المخرجة وتخلص ما كثر
من الطبيعة ، والاشياء التي يدرجه قوتها ونطاق
تأثيرها نظرياً لم يأتها كلها ، وإنما لا بد من الآلة
او قلة او عدم تداور اشياءها . وعند علم الفلك
المدار من تحت المرافق المائية والاشياء والرافق
المائية .

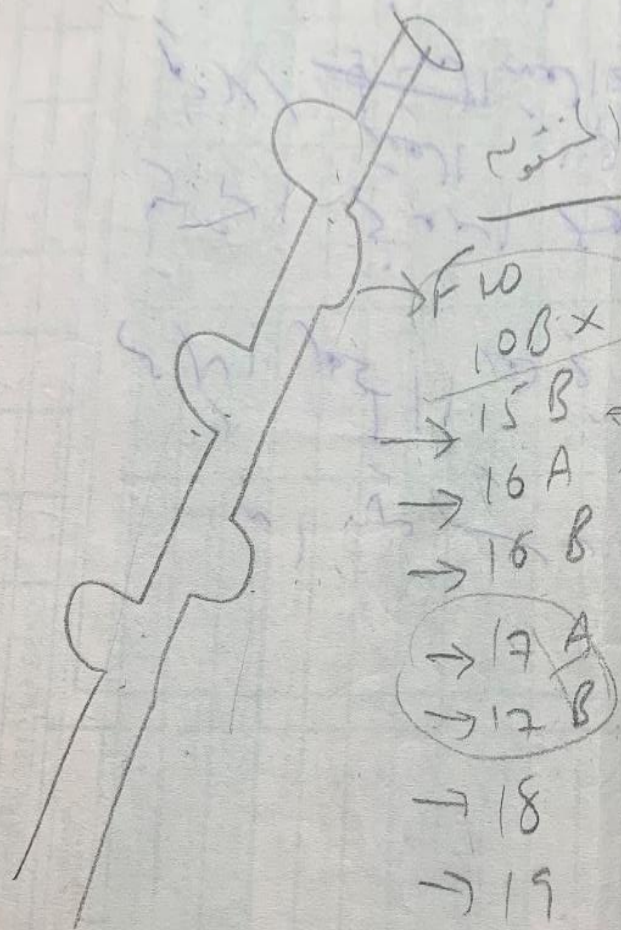
بعد الفهم الذي كتبه تفريعاتها من مصادر ثباتها
اعا الكون الذي ما جرت منه مبعثرة والاشياء يكونه من
طريق صورتها التي كالقوة بين الحركات من ركن
الاولى عن طريقها . وما القدر من هذه الاشياء
منها بين اشياءها منبها بين الاشياء
الاشياء التي في القوتها والاشياء منها وطريقها
ما جرت اشياءها . وكلاهما يتبع من اشياءها
والتي تنطق العلويات بالاشياء الخارجية والاشياء
التي الاقوى . وهي منبها منبها
التي تحمل الاشياء الى الخ .

DEMO 1 مادة تاريخ العصر



الامام سقني هجرته وقولي هي الحمر
ولا تفتي سرًا اذا ائذ الج

A9



الادراك / العلم الاتصال الاتصال بالادب والادراك الاسماء	A8
النظرية الكمية QUANTUM MECHANICS	A10
PENROSE	A11
HAMEROF	A12
الاسم الاسم	
الاسم	

مقابلة حول هروب حسين كامل

1995

حول حسين كامل

منه الناحية العلمية والرائعة، فانه اي صاحب يدوم الوراثة
تظهر عليه بعض التغييرات في الوظائف العقلية، وذلك من المحتمل انه
لقد شاهد هذه التغييرات في البداية اثناء الايام القليلة من حياته والمزمنة
للمرء. وهذه تقاضها تظهر لدى الآخرين كمن
وهذه التغييرات في عدم الكفاءة والبنام بالبراهمة الروحية
الانسانية، الصيغ المفردة، والبراهمة، العواطف غير المستقرة
والمثقلة، الحمول الفكرية، البصيرة الخاصة، الشبان
فقدان من المناورة والقدرة العقلية، عدم الاتزان واللائية
للممارسات والاصول الاصطناعية المصنوعة، فقد ان او قلدة
لقابلية على الملاحة العفوية المنطقية.

على العلوم يكون هناك تفكير في الفعول والتفكير
والتخاذ القرار . وإطالة كثير من وقت العمل على ما يحابه
من أمثلة . وقد سماها البعض بالضعف العقلي.

Mental asthenia
أو ضعف العقل الحركي
Psychomotor asthenia

وهو الضعف العصبي والكلي
Temporal and parietal lobes

عدم الاستقرار العاطفي
وهو الضعف العقلي الحركي
وهو الضعف العقلي الحركي
وهو الضعف العقلي الحركي

السر
والولع بالانقاذ لكل من حوله . وثمة من يلوته
سير السلك والاشباب بين حوله وما حوله . ولا يكمل
ايها رايا او لصغير يخالف رايه ويرد على
ذال من رويته بمر لا اقل . هذه كمثل اصل هذا
تسمى ومنه حوله لا يبيح ولا يصرماته .
كله هناك به هو من الصيرة . لقد سر الاعداد
صير من ان سرها

فتاوى موت الدماغ 1987

الرقم :
التاريخ :
المرفقات :
الموضوع :

اللائحة العامة لهيئة

كبار العلماء

قرار رقم ٦٢ في ٢٥/١٠/١٣٩٨هـ

الحمد لله ، والصلاة والسلام على رسوله وآله وصحبه / وبعد . . ففي الدورة الثالثة عشرة لمجلس هيئة كبار العلماء* المتعددة بمدينة الطائف في النصف الأخير من شهر شوال عام ١٣٩٨هـ اطلع المجلس طس ببحث القرنية من عين إنسان إلى آخر الذي أعدته اللجنة الدائمة للبحوث العلمية والأفتاء* ، بناءً على إقتراح سماحة المفتي العام لأدارات البحوث العلمية والأفتاء* والدعوة والأرشاد في كتابه رقم ٤٥٧٢ / ٢ / ١ د وأطلع على ما ذكره جماعة من المتخصصين في أمراض العميون وعلاجها عن نجاح هذه العملية ، وأن النجاح يتراوح بين ٥٠٪ و ٩٥٪ تبعاً لاختلاف الظروف والأحوال .

بعد الدراسة والمناقشة ، وتبادل وجهات النظر قرر المجلس بالإجماع ما يلي :-

أولاً : جواز نقل قرنية عين من إنسان بعد التأكد من موته وزرعها في عين إنسان مسلم مضطرب إليها وظب على الظن نجاح عملية زرعها مالم يمنع أولياؤه ذلك بناءً على قاعدة تحقيق أعلى المصلحتين وارتكاب أخف الضررين وإثارة مصلحة الحي على مصلحة الميت فانه يرجى للحي الأعمار بعد عدسه والانتفاع بذلك في نفسه ونفع الأمة به ، ولا يفتى على الميت الذي أخذت قرنية عينه شي* ، فان عينه إلى الدمار والتحول إلى رفات ، وليس في أخذ قرنية عينه مثالة طاهرة ، فان عينه قد اغضت ، وطبق جفناها أعلاهما على الأسفل .

ثانياً : جواز نقل قرنية سليمة من عين قرر طيبها نزعها من إنسان لتوقع خضوعه من بقائها ، وزرعها في عين مسلم آخر مضطرب إليها ، فإن نزعها إنما كان محافظة على صحة صاحبها أصاله ، ولا ضرر يلحقه من نقلها إلى غيره وفي زرعها في عين آخر منفعة له ، فكان ذلك مقتضى الشرع ، وبموجب الانسانية .
بإيالة التوفيق وعلى الله على نبينا محمد وآله وصحبه وسلم . . .

هيئة كبار العلماء

عبد الله بن محمد بن حميد

عبد العزيز بن صالح

محمد بن جبريل

أحمد بن محمد بن مطر

صالح بن محمد بن

عبد الله بن محمد

عبد الله بن محمد بن

عبد العزيز بن محمد

عبد العزيز بن محمد

عبد الله بن محمد بن

عبد الله بن محمد بن

رئيس الهيئة

محمد بن علي الحركان

عبد العزيز بن عبد الرحمن بن

عبد الرزاق بن عبد

ابراهيم بن محمد آل الشيخ

عبد العزيز بن محمد بن

صالح بن محمد بن

الأمانة العامة الصحفية
للدول العربية في الخليج

(بسم الله الرحمن الرحيم)

جدول أعمال مبدئي
للجنة تشريع نقل الكلى
الرياض ٢٤ - ١٢ سبتمبر ١٩٨١
١٣١ أغسطس - ١ سبتمبر ١٩٨١

- ١- عرض محضر اجتماع اللجنة الفنية التي ناقشت الجوانب التشريعية لزراعة الكلى بالرياض من ٢٤ - ٢٧ فبراير ١٩٧٩
- ٢- القرار رقم (٢) للمؤتمر السابع للوزراء
- ٣- استعراض القوانين والتشريعات والفتاوى التي صدرت ببعض الدول الاعضاء والاسلامية الاخرى التي وردت للأمانة العامة بخصوص نقل الاعضاء
- ٤- مشروع القانون الموحد لنقل الكلى الذي تقترحه اللجنة
- ٥- ما يستجد من أعمال

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

الرقم : ٢٨٤ / ٥

التاريخ : ١٩٩٥ / ١٠ / ٢٥

المرفقات : ٤

الموضوع :

المملكة العربية السعودية
بیت الإمامة والبحوث العلمیة والدعوة والارشاد

من عبد العزيز بن عبد الله بن باز الى حضرة الامين العام للامانة العامة للصحة للدول العربية في الخليج
سعادة الدكتور جلال محمد آشي

السلام عليكم ورحمة الله وبركاته . . . وبعد :

اشير الى كتابكم رقم ٢٢٧٨ في ١٣/٢/١٣٩٩ الذي جاء فيه (تتولى الامانة العامة الصحية
للدول العربية في الخليج دراسة الجانب التشريعي لزراعة الكلى ونقلها ، ويهمننا في هذا المقام معرفة
الفتاوى التي توضح رأى الاسلام في شأن نقل الاعضاء عامة والكلى خاصة ، وذلك من الحق الى الحق
أو من الميت الى الحق بوصية او بدون وصية ، وللتمشي بموجبها واستكمالاً للدراسة التي نقوم بها خدمة
للمواطن المسلم .

وان تأمل موافاتنا بما يكون قد صدر من فتاوى لديكم في هذا الشأن) .

وافيدكم انه سبق ان صدر من مجلس هيئة كبار العلماء قراران في ذلك احدهما برقم ٦٢ فـ٥

١٣/١٠/١٣٩٨ هـ والثاني برقم ٦٥ في ١٣/٢/١٣٩٩ هـ واليك صورتيهما .

اثابكم الله وورزقنا واياكم العلم النافع والعمل الصالح انه سميع مجيب .

والسلام عليكم ورحمة الله وبركاته ،،،

الرئيس العام

لادارات البحوث العلمیة والافتاء والدعوة والارشاد



الامانة العامة للصحة للدول العربية في الخليج	
رسم الوارد	٢٨٤ / ٥
التاريخ الوارد	١٣ / ٢ / ١٣٩٩
المرفقات	٤

ملف حرام على

٤

٢ / ٤



التاريخ / ٢٢ / صفر / ١٤٠٠ هـ الموافق ١٩٧٩ / ١٢ / ٣١ م الرقم أ ف / ل ف / ١٧٤ / ٧٩ /

فتوى رقم ١٣٢ / ٧٩ /

بسم الله والحمد لله والصلاة والسلام على رسول الله وطي آله وصحبه من ولاة ، أما بعد :-

فقد عرض على لجنة الفتوى في جلستها المعقدة صباح الاثنين ٥ صفر ١٤٠٠ هـ الموافق ١٩٧٩ / ١٢ / ٢٤ م السؤال المقدم من الدكتور / جلال محمد آشي - الأمين العام للأمانة العامة الصحية للدول العربية في الخليج - والذي يطلب فيه رأى الاسلام في شأن نقل الاعضاء عامة والكلية خاصة ، وذلك من الحي الى الحي ومن العيت الى الحي بوصية أو بدون وصية .

وبعد عرض الموضوع على اللجنة رأيت ما يلي :-

إذا كان المنقول منه ميتاً جاز النقل سواء أوصى أم لا ، إذا ان الضرورة في انقاذ حي تبيح المحظور وهذا النقل لا يصار اليه الا للضرورة ، ويقدم الموصى له في ذلك عن غيره كما يقدم الأخذ من جثة من أوصى أو سمحت أسرته بذلك عن غيره .

أما إذا كان المنقول منه حياً فإن كان الجزء المنقول يقضي الى موته كالقلب أو الرئتين كان النقل حراماً مطلقاً سواء اذن ام لم يأذن ، لأنه ان كان باذنه فهو انتحار وان كان بغير اذنه فهو قتل نفس بخير حق وكلاهما محرم .

وان لم يكن الجزء المنقول مفضياً الى موته على معنى انه يمكن أن يعيش الانسان بغيره ينظر : فان كان فيه تعطيل له من واجب ، أو فيه اعانة المنقول اليه على محرم كان حراماً ، وذلك كاليديين أو الرجلين مما بحيث يعجز الانسان عن كسب عيشه أو يسلك سبلاً غير شريفة ويستوى في الحرمة الاذن وعدم الاذن .

وان لم يكن فيه ذلك كاحدى الكليتين أو العينين او احدى الاسنان أو بعض السدم ... فان كان النقل بغير اذنه حرم ويجب فيه القصاص أو العوض على ما هو مفصل في باب الجنائيات والديات في كتب الفقه ،

وان كان باذنه جاز ان كان الخالب نجاح العملية ... هذا ... والله التوفيق .

نظرها
عنتها
١١/١١

مقرر لجنة الفتوى
مستشار مبارك الصباح

٧٢١
١٩٨٠ / ١ / ١٩

م / ف



بسم الله الرحمن الرحيم

الأمانة العامة للصحة للدول العربية في الخليج
رسم الوارد
التاريخ الوارد
المشروعات

مجمع البحوث الإسلامية
لجنة الفتوى

السيد الدكتور أمين عام الأمانة العامة للصحة للدول العربية في الخليج

السلام عليكم ورحمة الله وبركاته (وبعد)

فرد أعلى استفتائكم الوارد إلينا بطريق البريد في ١٦٨٠/١/١م والخاص بطلب معرفتكم الحكم الشرعي في نقل الأعضاء عامه والكلية خاصة من حي إلى حي ، ومن ميت إلى حي بوصية أو بدون وصية ؟

الجواب

الحمد لله رب العالمين والصلاة والسلام على سيد المرسلين سيدنا محمد وعلى آله وصحبه أجمعين أما بعد فنفيد : بأن نقل الكلية من الحي إلى الحي آخر تتوقف حياته على نقلها إليه فان رضى الفقول فهذا بعد أن غلب على ظنه وطن ذوى الكفاة المتأزمين من الأطباء المختصين بسلامة الفقول منه والفقول إليه بعد استئصالها ، واستمرار رسالة كل منهما في الحياة على الوجه الصحيح وأنه لا ضرر يلحق بأحد منهما **جاء ذلك .**

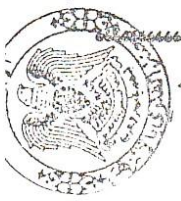
أما بالنسبة لنقل أجزاء من الميت إلى الحي ، فان نقل الكلى أو أى جزء من الميت إلى غيره من الأحياء لينتفع الحى بهذا الجزء **أسوأ جازز شـ**

نعم : للميت كرامة تراعى ولا يجوز التمرض له بما يؤذيه كما لو كان حيا ، والنبي صلى الله عليه وسلم ينهانا عن ذلك بقوله (أن الميت يتأذى ما يتأذى منه الحى) وهذا التمثيل بجثته أو الصامريتها على أى نحو يعتبر اهانة لها قال تعالى (ولقد كفرنا بنى آدم) والذي يصح القول به أن أخذ أى جزء من الميت بعد وفاته لينتفع به الحى لا يعتبر اهانة للميت ولا ساسا بكرامته إلا أنه لآن هذا مقصد لمنفعة الحى ، والحى أفضل من الميت لأنه لا يزال في مجال الانتفاع به في المجتمع فانتفاعه بجزء من الميت أولى من ترك هذا الجزء ييلس في التراب ، والإنسان لم يخلق لنفسه فقط بل خلق لنفسه ولمجتمعه ويشهد بذلك أن المرء مطالب بالجهد لعدو ديسمو وطنه ومطالب بالتضحية في سبيل الذروع من غيره من الأمة فأخذ الجزء من الميت لينتفع به الحى أسوأ **علا مع هذا الايضاح فينبغى أن يلاحظ .**

أولا : أن الحى الذى ينتفع بجزء الميت ينغى ألا يكون صدر الدم ، كالعرت عن الاسلام ، أو الزانى المحصن ، أو القاتل لغيره ظلما .

ثانيا : أن يستأذن أهل الميت ان كان له أهل ، حتى لا يوجد خلاف من جانبهم ، فربما يكون الخلاف سببا في فتنة بين الناس والله يأمرنا باجتنب الفتن كلها بقوله تعالى (واتقوا فتنة لفتنين الذين ظلموا منكم

خاصة) والنبي صلى الله عليه وسلم يقول (الفتنة نامة لعن الله من أيقظها والله تعالى أعلم رئيس لجنة الفتوى بالازهر
تحريرا في يوم ٠٢ من شهر صفر ١٤٠٠هـ
الموافق لثلاثون يوم ٨ من شهر يناير ١٩٨٠م



لجنة علماء المغرب
الامين العام
طنجة

وصلى الله على سيدنا محمد وآله

الحمد لله

تاريخ 10 صفر 1400

سيادة الدكتور جلال محمد آتش المحترم

السلام عليكم ورحمة الله

وبعد فقد تلقيت بكل سرور خطابكم الكريم المتعلق بحكم زرع الكلى ونقلها بحسب
الفتاوى التي صدرت لدينا في هذا الصدد ، ونجيب سيادتكم بأنه ليست لدينا
فتاوى من هذا القبيل ، ولكن في المؤتمر الاسلامي الدولي الذي انعقد بماليزيا
سنة 1969 كانت مسألة زرع القلب والكلى ونقل القرنية من المسائل التي بحثت فيه
وقد انفصلت اللجنة التي درستها بناء على فتوى علماء ماليزيا وتقريرين لمفتي مصر
ومفتي ليبيا على الجواز في حالتي الهبة من الحي والوصية من الميت بشرط التحقق
من الموت وانتفاع الحي وعدم تضرر الواهب الخ الاحتياطات التي يجب ان تراعى في
ذلك ، علما بان الجواز انما تقرر لانقاذ المريض ، فاذا كان هناك شك في الامر فلا
يجوز لان الحكم يدور مع العلة وجودا وعدما
وانعقد بعد ذلك في مدريد مؤتمر خاص بهذه المسألة ودعى له بعض علماء المسلمين
وقد كانت النتيجة ايجابية ايضا مع زيادة التشديد على التحرى في الامر
ومع الاسف فان قرار مؤتمر ماليزيا كانت سلّمت الى احد العلماء المشاركين في مؤتمر
مدريد وبقيت عنده ، ولذلك لم يمكنني اطلاقا علم عليها
ويعلمكم صحبته فتويين في حكم نقل الدم وهو مما له صلة بالوضع اتماما للفائدة
وتقبلوا فائق التحية والاحترام . . والسلام

عبد الله كتون

الامين العام لرابطة علماء المغرب

الأمانة العامة الصحية للمؤهل العربي في الطب	
رئيس الورد	-----
الشيخ الورود	-----
اشرفيات	-----

دخ عبد اللعنة

تمت على الموضوع لسيه درود باقو لرحمة

بسم الله الرحمن الرحيم

الحمد لله رب العالمين والصلاة والسلام على سيدنا محمد خاتم النبيين وعلى آله وصحبه

القرار رقم (٥) د ٨٦/٠٧/٣

بشأن " أجهزة الانعاش "

ان مجلس مجمع الفقه الاسلامي المنعقد في دورة مؤتمره الثالث بعمان عاصمة المملكة الاردنية الهاشمية من ٨ الى ١٣ صفر ١٤٠٧ هـ / ١١ الى ١٦ اكتوبر ١٩٨٦ م .

بعد تداوله في سائر النواحي التي اشيرت حول موضوع " أجهزة الانعاش " واستماعه الى شرح مستفيض من الاطباء المختمين ،

قرر ما يلي :

يعتبر شرعا ان الشخص قد مات وتترتب جميع الاحكام المقررة شرعا للوفاته عند ذلك اذا تبينت فيه احدى العلامتين التاليتين :

(١) اذا توقف قلبه وتنفسه توقفا تاما وحكم الاطباء بان هذا التوقف لا رجعة فيه .

(٢) اذا تعطلت جميع وظائف دماغه تعطلا نهائيا ، وحكم الاطباء الاختصاصيون الخبراء بان هذا التعطل لا رجعة فيه ، واخذ دماغه في التحلل .

وفي هذه الحالة يسوغ رفع اجهزة الانعاش المركبة على الشخص وان كان بعض الاعضاء كالقلب مثلا لا يزال يعمل آليا بفعل الاجهزة المركبة .

والله اعلم

مجمع الفقه الاسلامي
مراكش وتونس

باسم تبارك

سيارة الدفاع الأستاذ الدكتور عبد الهادي الخليلي العم

بصالحية، راجياً لك الخير والتوفيق والسلام، والاعتناء
بما تقدمه لنا من من جليل الأعمال وروغير الخدماتي.

أخي الكريم: ربيت مسألة (صيت الدفاع) على شكل أسئلة
ووجبتها أنك مرصفت من أعظم النخبة، لها: السيد الخوئي والسيد
السنوراري، وأجابته دعماً السنوراري تحت الأدبنة كالتف
ولقد يحل لك عدم الجواز وترتيباً آتياً المرفق. كل سؤال
والسيد الخوئي رتب الأدبارة، وإجابة كل سؤال
تحت لخص واحدة. وأسؤال الرابع إجابة كل فرع آتاه.
وإجابة كل من المرصفت ب(الميرالاسود).

نشتر هذه الفرصة للاعلان عن الشكر والتقدير.

الخلص

عبد الهادي الخليلي

١٤/١١/٨٧

سماحة السيد آية الله الشيرازي ادام الله ظلكم

ما هو حكم الشرع فيما وجد مات دماغه بحكم

اهل الجمة بحيث اعتبر لقطع الرأس وتز

قلبه ينفض بفعل جهاز التنفس الاصطناعي

١. هل يعتبر ميتاً شرعاً ؟

٢. هل يجوز رفع الجنازة عنه بحكم

كونه ميتاً

مع صالح الدعاء
لكم بالصحة وطول
العمر

عبدالله بن الحسين
عبدالله بن الحسين

١٢ / ٥ / ١٩٩٢

ذو القعدة ١٤١٢

بسم الله تعالى
في مفروض السؤال اذا اعتبر لقطع الرأس
يلون بحكم الميت ويجوز رفع الجنازة عنه اذا كان
ينفض القلب بفعل الجهاز والله العالم
١٤ ذو القعدة الحرام
عبدالله بن الحسين
الشيرازي



بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

سماعة سيدنا الأئمة الأعظم الأمام السيد أبو القاسم الموسوي الخوئي
دام ظله الشريف

بعد السلام عليكم ورحمة الله وبركاته

هناك حالة مرضية تسمى (موت الدماغ) وقد يعمل معها القلب بجهاز
مضاعي أو دون جهاز الى فترة بلا جدوى لأن حكمه عند علماء الأطباء
حكم مقطوع الرأس، فقد تنبض بعض الأعضاء، وتتحرك بعد القطع
وإن كان محكوماً بموت مقطوع الرأس.

المراد من سماضكم الأفاضلة ببيان الحكم الشرعي فيما يلي:

١- هل يجوز الإعلان عن موت شخص لشبوت موت الدماغ عنده،

مع أن القلب يعمل بدون جدوى، وهل تعتبر هذه الحالة وفاة شرعية؟
بسمه تعالى إن كان القلب يعمل بغيره بالجهاز فلا تعتبر هذه الحالة وفاة شرعية، وإن كان القلب لا يعمل إلا بالجهاز في الفرض فهو يعتبر ميتاً

٢- ميت الدماغ لا يمكن أن تعود له الحياة طبعاً، فإذا كان قلبه يعمل بالجهاز،
والطبيب يتحكم بأيقاف القلب لو سحب الجهاز، فهل يجوز للطبيب سحب هذا
الجهاز، إن كان بالتسم الأول أعلاه فلا يجوز سحب الجهاز إلى أن يتخلى بانها عن القلب وإن كان من التسم الثاني فلا بأس بتجديده

٣- أفخوان مصابان بموت الدماغ بوقت واحد، والطبيب يتحكم بأيقاف
قلب أحدهما - الذي يعمل بالجهاز دون جدوى - قبل الآخر فكيف يتوارثان؟
يتفرغ هذا السؤال على ما قد سألنا من الفرضين قبل الأول برت من لم يبق قلبه عن وقت قلبه قبله وعلى الثاني لا يوارث بينهما

٤- هل يجوز الانتفاضة من أعضاء ميت الدماغ - كالقلب والعين والكلية -
لأنقاذ مريض آخر في الحالات التالية:

٢- ابتداءً بتصرف من الطبيب لا يجوز

ب- بموافقة ميت الدماغ قبل موته لا يجوز ولا بأس

ج- بموافقة أهل ميت الدماغ بعد موته لا يجوز والأمر العام

٣/١٩
١٤٠٨
محمد بن محمد حسين علي الصفير
١٨/٣/١٤٠٨ هـ
١١/١١/١٤٨٧ هـ

تسهر هذه الفرصة للدعاء بكم بالعلم المبريد

SHORT PRACTICE OF NEUROSURGERY (Catechism)

HISTORY:

NEUROLOGICAL ASSESSMENT

What is the neurological assessment?

CLINICAL HISTORY

What is the clinical history?

What are the General neurological symptoms?

What are the symptoms of meningismus?

What are the symptoms related to special senses?

What are the symptoms related to speech and comprehension?

What are the motor symptoms?

What are the sensory symptoms?

What are the cognitive symptoms?

What are the symptoms related to other systems?

CLINICAL EXAMINATION

What is the mental state?

What is state of speech?

What is the cranial nerves examination?

What is the examination of the limbs and trunk?

(posture, wasting, tone, power, reflexes, sensation, coordination)

INVESTIGATIONS:

What are the means of investigating neurological disorder?

Radiological

Plain radiology

Standard Views

Normal skull

Abnormal calcification

Features of raised ICP

CT

Principle of physics

Advantages

Normal scan

Abnormal scan

Angiography and Digital subtraction angiography

Principle

Indications

MRI

Principles of physics

Advantages

Normal scan

Abnormal scan

Myelography

Procedure

Normal myelogram

Abnormal myelogram

Isotope

Brain scan

Principle

Normal scan

Abnormal scan

PET

Principles of physics

Advantages

Normal scan

Abnormal scan

SPECT

Principles of physics

Advantages

Normal scan

Abnormal scan

Monitoring

ICP

Cerebral Blood flow

CSF (LP)

Electrophysiological

EEG

Evoked potentials

Others

CSF

What is the anatomy of choroids plexus?

What is the physiology of CSF Production?

What are the constituents of CSF?

What is the CSF circulation?

ICP

What are the Components of cranial cavity?

What is the volume - ICP curve?

What is the Blood brain barrier?

What is the cerebral blood flow?

What is the clinical picture of increased ICP?

What is the management of increased ICP?

Herniation:

What is the definition of Herniation?

What are the types of Herniation?

What is the clinical picture of subfalcial Herniation?

What is the clinical picture of tentorial Herniation?

What is the clinical picture of foramen magnum Herniation?

What is the treatment of Herniation?

PSEUDOTUMOR

What is pseudotumor cerebri?

What is the etiology of pseudotumor cerebri?

What is the clinical picture of pseudotumor cerebri?

What are the investigations in pseudotumor cerebri?

What is the management of pseudotumor cerebri?

HYDROCEPHALUS

What is the anatomy of the ventricles?

What are the causes of hydrocephalus?

What is the clinical picture of adult hydrocephalus?

What is the treatment of adult hydrocephalus?

NPH

What is NPH?

What are the causes of NPH?

What is the clinical picture of NPH?

What are the investigations in NPH?

What is the management of NPH?

ARRESTED HYDROCEPHALUS

What is arrested hydrocephalus?

What are the investigations in arrested hydrocephalus?

What is the management of arrested hydrocephalus?

TRAUMA

Head

Pathology

Types

Evaluation

Investigations

Management

Complicated (Fracture, ICH, CSF leak)

Complications

Spinal

Clinical evaluation

Investigations

Management

Indications for surgery

Grafting

Complications

CONGENITAL DISEASES

Spinal dysraphism

Cranium bifidum

HYDROCEPHALUS

What is the definition of hydrocephalus?

How is it classified?

What is etiology of hydrocephalus?

What is the epidemiology of hydrocephalus?

What are the clinical features of hydrocephalus?

What is the differential diagnosis of hydrocephalus?

What are the clinical features of hydrocephalus?

How you investigate hydrocephalus?

What is the treatment of hydrocephalus?

When do you operate on hydrocephalus?

What is the prognosis of hydrocephalus?

What are the complications of surgery?
What the types of shunt complications?
What are the common shunting systems used?
What are causes of shunt complications?
What are the clinical features of shunt complications?
What are the complications of shunt operation?
How you investigate of shunt complications?
What is the management of shunt complications?
What is the prognosis of shunt complications?

CRANIOSYNOSTOSIS

What is the definition of Craniosynostosis?
What is the embryology of cranial sutures?
What is the etiology of craniosynostosis?
What are the types of craniosynostosis?
What is the sagittal synostosis?
What is the coronal synostosis?
What is the metopic synostosis?
What is the lambdoid synostosis?
What is the pan synostosis?
What is the clinical presentation of craniosynostosis?
What are the investigations in craniosynostosis?
What are the complications of craniosynostosis?
What are the indications for surgery in craniosynostosis?
What are the surgical principles in dealing with Craniosynostosis?
What are the contraindications for surgery in craniosynostosis?
What are the complications of surgery in Craniosynostosis?
What is the outcome of non operated cases?

BRAIN TUMORS

Incidence:

Site: supratentorial, infratentorial

Pathology: benign, malignant

Tumor markers

Origin:

Primary; neuroepithelial, meningeal, vascular, nerve sheath, blood vessel, maldevelopment, pituitary.
Secondary; local extension, distant metastasis

Management: investigations, surgery, radiation, chemotherapy, brachytherapy,

VASCULAR DISORDERS

Stroke

Subarachnoid bleed

AVM and fistulae

Causes

Clinical presentation

Investigations

Management

Complications

SPINAL DISORDERS

SPINA BIFIDA

What is the definition of spina bifida?

What are the types of spina bifida?

What are the causes of spina bifida?

What is the anatomy of spina bifida?

What is the presentation of spina bifida aperta?

What is the presentation of spina bifida occulta?

What are the likely findings during examination of spina bifida aperta?

What are the likely findings during examination of spina bifida occulta?

What are the investigations required in spina bifida aperta?

What are the investigations required in spina bifida occulta?

When do you decide not to operate in spina bifida aperta?
When do you decide not to operate in spina bifida occulta?
What are the indications of surgery in spina bifida aperta?
What are the indications of surgery in spina bifida occulta?
What are the surgical principles in repair of spina bifida aperta?
What are the surgical principles in repair of spina bifida occulta?
What are the complications of surgery of spina bifida aperta?
What are the complications of surgery of spina bifida occulta?
What is the prognosis of spina bifida aperta?
What is the prognosis of spina bifida occulta?
What are other possible congenital CNS abnormalities that accompany spina bifida?
What are the counseling principles to be discussed with the parents?

DISC PROTRUSION

CERVICAL SPONDYLOSIS

SPINAL STENOSIS

SPINAL CORD COMPRESSION

INFECTION

MENINGITIS

INTRACRANIAL INFECTION

SPINAL INFECTION

BRAIN ABSCESS

What is the bacteriology of brain abscess?
What is the pathology of brain abscess?
What is the pathogenesis of brain abscess?
What is the incidence of brain abscess?
What are the clinical features of brain abscess?
What is the differential diagnosis of brain abscess?
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When do you operate on brain abscess?

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STEREOTACTIC AND FUNCTIONAL

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NEURONURSING BOOK

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Preop
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Rehabilitation

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Activity exercise pattern

Sleep rest pattern

Cognitive perceptual pattern

Self-perception

Role relationship pattern

Sexuality reproductive pattern

Coping, stress tolerance pattern

هذا كتاب يحوي مجموعة من مشاريع بحثية وأفكار ومقالات

لم تسنح لي الظروف الصعبة التي عشتها أيام الحصار وما قبلها وما بعدها

أن أكملها.

أملّي أن يطلع عليه الشباب من المختصين والباحثين عسى أن

يستفيدوا من بعض ما وثقت،

ومن الله التوفيق

،

عبد الهادي الخليلي

واشنطن 2022

كتاب الأرشيف

الأستاذ الدكتور عبد الحمادي الخليفي

2022