

Fig.1. Chest X-Ray findings

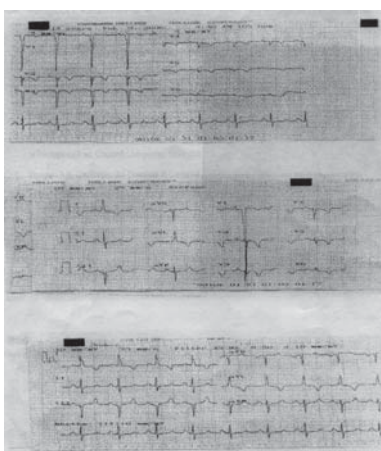


Fig.2. Electrocardiogram findings

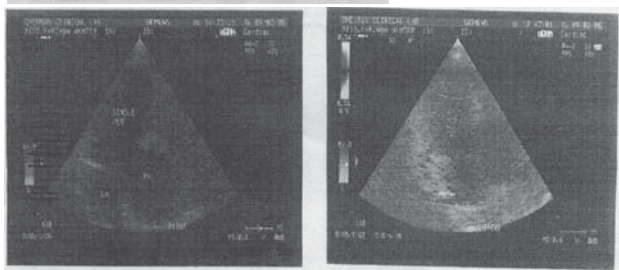


Fig.3. Echocardiography in 2D: M-Mode and Colour Doppler Study

VR, VI, all precordial leads, taller than normal in others. Echocardiography in 2D; M mode and colour doppler study (figures 3) revealed the absence of ventricular septum. The features matched with Double inlet left ventricular variety of Double inlet ventricle or single ventricle. There was a main ventricle with morphology of a normal left ventricle and two inlet valves and the right ventricle was represented by a small rudimentary outflow chamber. Aorta was arising from the rudimentary chamber and the pulmonary artery from the main chamber. Pulmonary stenosis was present.

DISCUSSION

Single ventricle combined with Dextrocardia is one of the rarest finding in clinical practice so that in standard undergraduate medical text books this findings have not been mentioned. In the developing countries, due to poor antenatal, intra natal and post natal management congenital heart disease are often missed. Asymptomatic and uncomplicated cases often go unnoticed. Double inlet (single) ventricle can account for up to 2-3% of all congenital heart disease⁵. Caregivers of the patient had been moving from pillar to post since childhood for her illness. Nobody told her the bitter truth that at the present state of development of medical science some form of palliative cardiothoracic operation is necessary for her. These costly operations will definitely improve the overall prognosis and prolongation of life by operation on pulmonic stenosis and shunt operation. But in the developing world skilled man power for this type of maneuver is still fewer than requirement. Moreover, social institutions are rarely available to the common people.

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LITERATURE REVIEW

Adult Nephritic Syndrome: Non-Specific Strategies for Treatment

Charlesworth, JA Gracey SM & Russel BA; *Nephrology* 2008; 13,45-50

Irrespective of aetiology, the nephritic syndrome presents a range of potentially serious complications. These include thrombo-embolism infection and hyperlipidaemia. Despite the prevalence of the nephrotic state among renal patients, there has been little prospective analysis of the therapeutic approach to these potentially life-threatening events even though their pathogenesis has been examined in some detail. Most of these complications are more prevent once the albumin concentration falls below 20 g/L and it is recognized that restoration of serum albumin significantly diminishes their frequency. However, this may be difficult to achieve, especially in adults. The problems of thrombo-embolism and infection are of immediate concern but, in persistent cases, the additional issues of hyperlipidaemia and loss of bone density also require consideration for therapy. Thus, in addition to specific attempts to reduce proteinuria, it is recommended that high risk nephritic patients receive anticoagulation, pneumococcal vaccination and lipid lowering therapy. Strategies for the preservation of bone density should also be considered, particularly in patients who receive high dose corticosteroids. Among a range of non-specific treatments for proteinuria, angiotensin-converting enzyme inhibitors appear best in terms of efficiency and safety. Prospective trials are required to clarify the longitudinal impact of these generic strategies on the protection of the persistently nephritic patients.

SGPGI does not possess waste treatment facilities such as microwave systems, blood bag shredders, hydroclaves, shredders, etc. The Microbiology Department has two horizontal autoclaves used to disinfect glassware, Petri dishes, test tubes etc. These are subsequently reused after disinfection. All other waste form the hospital (except sharps) is incinerated without segregation. The hospital authorities are aware that their management practices are not up to the mark and plan to give the entire waste management and disposal to an external agency are not up to the mark and plan to give the entire waste management and disposal to an external agency on lease basis. CH(CC) utilizes an autoclave and shredder for the plastic hazardous waste. This is subsequently sent for recycling. The Microbiology Department reuses its glassware after autoclaving. However, no equipment such as hydroclave, microwave or blood bag shredder is present in the hospital. Vivekanand Polyclinic has the most comprehensive treatment and disposal system for different categories of waste. There is a microwave System, autoclave, blood bag shredder and shredder. The segregated waste is treated according to the specification in the Rules. The plastic waste is recycled is sent for landfilling after proper treatment. Other hospitals should follow the example set by Vivekanand Polyclinic regarding the proper treatment and disposal of their waste. The Polyclinic has demonstrated that with effort and intention, proper management of waste in hospitals is possible. It seems that in Lucknow, bigger the hospital lesser is the concern for public health and environmental pollution.

WASTE MANAGEMENT PLAN

A comprehensive waste plan for proper treatment and disposal of different types of hospital wastes is proposed and presented., *Some recommendations for modifications in the biomedical waste (Management and Handling) rules 1998(2)*

To enable the Rules (2) to be conveniently followed by all healthcare establishment, following *recommendations* are advocated.

- ◆ For the purpose of treatment and disposal, the waste categories (2) should be reduced from 10 to 5 as detailed in Table 2
- ◆ Heavy duty coloured plastic bags according to the prescribed colour code should be provided for uniformity by the government at fixed rates.
- ◆ Costly machines for disinfection of waste and final disposal such as central incinerators, autoclaves, microwave, hydroclave, etc. must be made available centrally by the Govt. of Pollution Control Boards where the

hospital waste can be treated and disposed off, at reasonable rates on sharing basis. For this, Common Biomedical Waste Treatment, facilities need to be installed in all cities.

- ◆ The Pollution Control Board should regularly and periodically sponsor training programmes in proper management of biomedical wastes.

CONCLUSION

Bio medical waste, if not properly managed and / or treated, can lead to epidemic like situations. Large hospitals generate a lot of waste of which only about 15 percent constitute the infected biomedical waste which when mixes with the general waste, the entire waste becomes infected causing serious management and safe disposal problems. Sharp constitutes the most dangerous component of biomedical wastes because of risk and dangerous infections of Hepatitis B, C and HIV associated with needle prick injuries.

There are many technologies available for the proper treatment and disposal of biomedical waste. Incinerations which causes serious air pollution problems is gradually being replaced by other technologies such as autoclaving, microwaving, hydroclaving, chemical treatment with shredding, etc. all over the world. Waste minimization techniques and training of staff can be a very effective solution to reduce the management costs for the already cash starved hospitals. Private entrepreneurs are now taking keen interest in the field of biomedical waste management.

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LITERATURE REVIEW

Prospective Study of Progression of Kidney Dysfunction in Community – Dwelling Older Adults

Sesso RI, Prado F, Vicioso B, Ramos ER Nephology 2008, 13,93-96

Few prospective studies have assessed renal dysfunction in order persons. We sought to define kidney dysfunction among a community based cohort of elderly subjects and to determine the factors for its progression. The Epidemiologia do Idoso (EPIDSO) Study is a prospective study of individuals > 65 years old (mean 72.6+0.3) living in the community in the city of Sao Paulo. The creatinine clearance (CrCI) of 269 individuals of this cohort was estimated during 8 years of follow – up. The rate of decline in CrCI was calculated using linear regression analysis and dividing the group in to tertiles of CrCI change. Overall mean change in CrCI was -2.37 + 0.23 mL/min per year. Mean age increased with the greatest degree of decline in renal function (71.1+ 0.59, 72.5+0.59, 72.5+0.54 and 74.3+0.58, for the first, second and third CrCI change tertile, respectively, P<0.071). A higher value of baseline CrCI was associated with progressive decline in CrCI (P<0.01). Diastolic BP was greater in the second versus the first estimated glomerular filtration rate tertile (83+1 vs 80+1 mmHg, P<0.05) High density lipoprotein (HDL) cholesterol was inversely associated with CHO decline (P<0.05) Progression of kidney dysfunction occurs in most community dwelling elderly. Strategies aimed at showing the progression should be considered for possible risk factors of older age, baseline CrCI, BP and HDL