

formation is unclear; it perhaps results from an arrest in the maturation process of middle turbinate⁴. It is our conjecture that this present anomaly results because, besides the normal third ridge, part of the second one (which forms bulla ethmoidalis) may also have contributed to its formation; it is the non-fusion of the second and third ridge which has resulted in the splitting. This assumption is supported by the fact that the bulla ethmoidalis was inconspicuous and non-pneumatized in both cases.

Yanagisawa and Weaver³ found on endoscopy longitudinally clefted clinically asymptomatic middle turbinate. Rossiter⁴ found a sagittally clefted anteriorly fused middle turbinate on endoscopy in an adult male patient with recurrent sinusitis. This was associated with concha bullosa of the larger medial segment. Interestingly in the two cadavers, we observed a bilateral linear sagittal split in the middle two thirds of the middle turbinates. Similar to the above mentioned endoscopic finding we observed concha bullosa of upper segment of the left middle turbinate.

Clinically the middle turbinate can present with an abnormal shape, pneumatization, polypoid mucosa or, rarely a split. Such turbinates can disrupt mucus flow, block sinus ostia or can even restrict endoscopy. A split turbinate may remain silent or be a cause of sinusitis. It can easily be missed during standard anterior rhinoscopy, or mistaken for a polyp, a tumor or enlargement of normal structures such as superior turbinate, bulla ethmoidalis or uncinate process, and may prove to be a potential factor for ostiomeatal unit obstruction⁴. Diagnosis is made by endoscopy,

CT scan or MRI and operative intervention alleviates suffering.

Knowledge of a split middle turbinate enables the endoscopic sinus surgeon to anticipate and treat such condition in an effective way and avoid recurrence of sinusitis. Association of clefted middle turbinates with concha bullosa and infundibular blockade leading to the formation of accessory maxillary ostia needs further study.

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Check-List

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| <p>(i) Copyright statement/declaration (not submitted or published elsewhere) signed by all the authors.</p> <p>(ii) Three hard copies of manuscript with illustrations attached to each; floppy in addition will be desirable.</p> <p>(iii) Title page : Title of manuscript, Name(s) and affiliation of author(s); institution(s) and city(ies) address of corresponding author (Tel; Fax; e-mail).</p> <p>(iv) Abstract should highlight objectives, methods, results, conclusions.</p> <p>(v) Article (double-spaced on A/4 size paper) : material & methods,</p> | <p>results, discussions ; Indian literature must be referred, references numbered in text as they appear.</p> <p>(vi) References maximum number of references for update-20, original-10, Case reports-6.</p> <p>(vii) Each table on separate sheet; maximum number=4 in original article.</p> <p>(viii) Photographs/Figures in envelope, each marked figure number on reverse with legends on separate sheet. Number not to exceed 3, preferably.</p> <p>(ix) Statement regarding adherence to standard ethical guidelines prescribed by ICMR 2000. (see page 43)</p> |
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Literature Review

Compiled by Dr. SNA Rizvi

Effect of blood pressure on early decline in kidney function among hypertensive men. Hypertension. 2003 Dec;42(6):1144-9. Epub 2003 Nov. 03.

Few Cohort studies have examined the longitudinal association between change in blood pressure and decline in kidney function among treated hypertensive patients without chronic kidney disease. We conducted a nonconcurrent cohort study to examine the effects of blood pressure on estimated glomerular filtration rate and early kidney function decline (rise in serum creatinine > or = 0.6mg/dL during follow-up) among 504 African-American and 218 white hypertensive patients. Our results showed that each standard deviation higher treated systolic (18mm Hg) and diastolic (10mm Hg) blood pressure was associated with an average annual decline (95% confidence interval [CI] in estimated glomerular filtration rate of -0.92 ([-1.49 to -0.36] P<0.001) and -0.83 ([-1.38 to -0.28] P=0.003) mLxmin (-1) x 1.73m (-2), respectively, after adjustment for race, age, education, income, use of anti-hypertensive drugs, body mass index, and history of diabetes and dyslipidemia. Likewise, each standard deviation higher systolic and diastolic blood pressure was associated with relative risks (95% CIs) of 1.81 ([1.29 to 2.55] P<0.001) and 1.55 ([1.08 to 2.22] P=0.046), respectively, for early kidney function decline. Compared with patients with a blood pressure level <140/90mmHg, those with a blood pressure level >or = 160/95mmHg had a -2.67 ([-4.01 to -1.32] P<0.001) mL x min (-1)x 1.73m (-2) greater annual decline in estimated glomerular filtration rate and a 5.21 - fold ([2.06 to 13.21] P<0.001) greater risk of early kidney function decline. Our study found that higher levels of treated blood pressure were positively and significantly related to early decline in kidney function among hypertensive men. These results

indicate that better blood pressure control might prevent the onset of chronic kidney disease among hypertensives.

Characteristics of treated hypertension in incident hemodialysis and peritoneal dialysis patients. Am J Kidney Dis. 2003 Dec;42(6):1260-9.

The US Renal Data System (USRDS) Dialysis Morbidity and Mortality Study Wave II cohort was analyzed. A total of 2,877 patients initiating hemodialysis or peritoneal dialysis in 1996 or 1997 and treated with antihypertensives were included in this analysis. Vital status was followed until November 2000. RESULTS: Calcium channel blockers were prescribed to 70.3% of patients. Only 31.5% and 27.0% of patients with cardiovascular disease were prescribed angiotensin-converting enzyme inhibitors and beta-blockers, respectively. Mono-double-triple and more than triple therapy were reported in 48.0%, 36.1%, 13.2% and 2.7% of the cohort, respectively. In multivariable, fully adjusted models, no individual class of antihypertensives was associated with changes in all-cause mortality. In all patients, nondihydropyridine CCBs (non-DHP CCBs) were associated with a reduced risk of cardiovascular death (hazard ratio, 0.78; 95% confidence interval, 0.62 to 0.97) and among end-stage renal disease patients with preexisting cardiovascular disease, dihydropyridine CCBs (DHP CCBs) and non-DHP CCBs were associated with reduced risk of all-cause and cardiovascular mortality. CONCLUSION : Calcium channel blocker use is widespread among hypertensive dialysis patients. Antihypertensive prescription patterns suggest a lack of consensus regarding treatment of hypertension. Multivariable analysis of associations between antihypertensive class and mortality reveals results of uncertain clinical significance. Hypertension treatment trials in dialysis patients should be performed to appropriately inform treatment decisions.