

Letters to the Editor

Influenza Vaccination

To the Editor: Influenza is an emerging disease which is a major threat to public health worldwide.¹ In this context, we thank Drs. Frayha and Alrajhi for providing an educative and thought-provoking editorial.² With the excellent health facilities in the Kingdom of Saudi Arabia, it is possible to develop a national influenza surveillance system (NISS). From the isolates of influenza virus, the antigenic and genetic characterization can be carried out in order to find out their drift/shift, as well as the strains imported into the Kingdom (in view of the enormous number of visitors, as the authors stated).² An effective NISS is essential in a program for the control of influenza.¹ Moreover, it also helps to measure influenza activity³ and the ongoing antigenic variation of the virus resulting in outbreaks. In view of the antigenic drifts of the vaccine strain, the formula of the vaccine should be reviewed annually.⁴

In the editorial, children with cyanotic heart disease were included in the vulnerable group for vaccination. In addition to that, the National Health and Medical Research Council considers annual vaccination to be important for staff who care for immunocompressed patients, as well as those caring for patients in nursing homes and other chronic care facilities.

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Reply

To the Editor: We appreciate the thoughtful comments of Drs. Uma and Thirumalaikolundusubramanian. We certainly agree with the importance and necessity of monitoring influenza activity, as well as the antigenic

variation of influenza viruses in the Kingdom. The antigenic characteristics of circulating strains provide the basis for selecting the virus strains included in each year's vaccine. As vaccine efficacy is significantly influenced by the homology between the vaccine strains and the circulating strains, knowledge of antigenic variation of influenza viruses in a particular geographic location is an important requisite for recommendations on vaccine utilization.^{1,2}

The World Health Organization (WHO) and its collaborating laboratories and the Centers for Disease Control and Prevention (CDC) conduct surveillance to monitor influenza activity and to detect antigenic changes in the circulating strains of influenza viruses on a regular basis.³ From our experience, the WHO provides encouragement and support to laboratories that have facilities for influenza isolation to determine the antigenic characteristics of the isolates. Our laboratory has benefited from such collaboration over the past two years. Isolates from respiratory specimens of patients with fever and respiratory infections attending KFSH&RC during the 1996-1997 and 1997-1998 influenza seasons were antigenically characterized by the National Institute for Medical Research, London, UK, a collaborating laboratory of the WHO. Our results indicate that the types and subtypes of circulating influenza virus strains in our patient population were similar to what has been reported worldwide for those particular seasons. This included the isolation of a recent variant A/SYDNEY/5/97, which was in circulation in many parts of the world, and which has been recommended for inclusion in the vaccine for the 1998-1999 season. While this data supports the use of influenza vaccine in our patient population, a larger amount of epidemiological data is needed from other parts of the Kingdom to support more widespread influenza vaccination. This could be achieved by having a central virology laboratory which could collaborate with the WHO or CDC to provide regular surveillance of influenza activity and strains in all parts of the Kingdom.

We also concur with the recommendation to offer influenza vaccine to persons who work or live with high-risk individuals, such as immunocompromised patients, residents of nursing homes and other chronic care facilities.² Indeed, Potter et al.⁴ documented that vaccination of health care workers was associated with reductions in total patient mortality and in influenza-like illness in elderly patients in a long-term care facility. Additionally, as some persons at high risk may not mount an antibody response to influenza vaccine, their protection would be improved by reducing the likelihood of influenza exposure from their caregivers and other close contacts.²

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An Age- and Gender-Specific Analysis of *H. Pylori* Infection

To the Editor: We read with great interest the article by A.R. Khan,¹ which did not find any relationship between *H. pylori* infection and age or sex of the individuals studied. Our experience with a significant number of patients at a major teaching hospital in Srinagar, Kashmir, endorses the author's view. The prevalence of peptic ulcer disease (PUD) and gastric cancer is very high in Kashmir.^{2,3} The association of *H. pylori* infection with PUD and antral gastritis has also been found to be highly significant.^{4,5}

We studied 160 individuals, comprising 50 PUD patients, 50 NSAID users and 60 asymptomatic healthy volunteers. In all, there were 118 males and 42 females in the 15-75 years' age group. *H. pylori* was diagnosed by rapid urease test and histology, using Giemsa stain. The result from a combination of these two test methods was considered the gold standard for the presence of *H. pylori*. Our study did not find any gender-specific difference in *H. pylori* prevalence. In the PUD group, *H. pylori* positivity was 77% in males, compared to 75% in females, and in the NSAID users it was 35% and 41%, respectively, whereas in the asymptomatic healthy volunteers group, it was 35% and 32%, respectively (statistically not significant). Though *H. pylori* positivity increased with advancing age, it did not reach statistical significance. The prevalence of *H. pylori* among various age groups was as follows: <15 years, 61%; 15-30, 64%; 31-45, 72%; 46-60, 76%; and >60 years, 79%.

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Reply

To the Editor: Most of the results noted by Malik et al. are consistent with ours. In their study, they also compared those patients who had used nonsteroidal anti-inflammatory drugs (chemical gastritis), as well as an asymptomatic group. The study was also conducted in a geographic area with a high incidence of gastric cancer, as cited by the authors.

The conclusion of Malik et al., in keeping with our findings,¹ is that they did not observe statistically significant differences in the incidence of *H. pylori* in patients of different age groups. Both findings reinforce the view that *H. pylori* infection is acquired early in life in those areas of the world where gastric cancer is more common. The childhood infection and the development of multifocal atrophic gastritis as a sequelae might be playing an important role in gastric carcinogenesis.

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Surgeons and the Operating Theater: Past, Present and Future

To the Editor: I read with interest the historical account of the development of the operating theater.¹ However, there were some aspects which I felt were not covered in this short account. I think it is important to include an historical account of the Arabic surgical scene. The authors mention only one Arabic surgeon, Abu Al-Kassim Khalaf

Ibn Abbas Al-Zahrawi (Albucassis), who lived from 325-404H (936-1013 AD).² His name was wrongly given in the text as Abdul Qassim Al-Zahrawi. Another Arabic surgeon from a later period was Ibn Alkoff (1232-1286 AD), who performed surgery on soldiers at Ajloun Castle. The layout of the castle allowed him a surgical corner where extensive care of the wounded could take place, using an anesthetic sponge with special preparation. There is a famous Arabic artist's illustration of surgery, showing the use of such a device in a place which looks very similar to the 1920s operating theater.

In the middle of the 19th century Mohammed Ali Al Bakli was performing surgery in Egypt. Surgery was only performed if the surgeon's skill and the patient's endurance permitted it. Surgery on children was not allowed until it was determined that the child was old enough. If a patient lost consciousness, cold water or ammonia was used to wake them up. There was an amphitheater where anatomy and surgical sessions were conducted in Kasr Al Aini Hospital in Cairo.

With advances in anesthesia and understanding of the mechanism of infection, as well as the development of blood transfusion techniques, etc., the operating theater has developed gradually into a physiological laboratory, rather than a stage with an actor. An important aspect in the care of the anesthetized patient is the monitoring of oxygen delivery to the patient and maintaining of proper ventilation and circulation, especially in the cardiac surgery theater. Surgery and anesthetic care do not end at the close of surgery in many patients, but extend to the intensive care unit, so a biased view of a theater building may hinder the safety of the patient. It is my view that the maestro theory of theater practice has been replaced by the surgical team concept.

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Reply

To the Editor: Our purpose in writing a short history-based article on the operating theater was to create interest in the subject. Takrouri's letter confirms that we succeeded in doing that. It was neither our intention, nor was it possible,

to cover all aspects of the subject. We are grateful to Dr. Takrouri for adding to our manuscript. We hope that others will read the article with the same amount of interest and add to it from their knowledge and experience.

I have also received many comments on the part of my article which addressed the use of music in the operating theater. What I mentioned was the scientific studies done in different places to show the importance of the work environment in helping to decrease the rate of infection (e.g., shouting surgeons, unnecessary chat, or an increase in tension in the theater atmosphere, may all increase the rate of infection). I am not advocating the use of music in the operation theater, instead I believe using recitations from the Holy Quran may provide mental relaxation in the work environment.

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