Suid-Afrikaanse Tydskrif vir Geneeskunde : South African Medical Journal

VAN DIE REDAKSIE : EDITORIAL

DIE SINDROOM VAN CHRONIESE LONGSIEKTES EN GASTRODUODENALE ULSERASIE

Oor die afgelope paar jaar het verskeie artikels die lig gesien waarin 'n verhoogde voorkoms van gastroduodenale ulserasie aangedui word by pasiënte met chroniese longsiektes, soos chroniese brongitis, asma en emfiseem, brongiëktase, en longfibrose. Die gastroduodenale patologie sluit benigne maagulkus en duodenale ulkus, asook hipertrofiese gastritis in.[1-3]

Die insidensie van peptiese ulkus by die algemene bevolking word beraam op 10 persent,[4] terwyl dit by gevalle met chroniese longsiektes deur verskillende werkers op tussen 18·8 en 33·1 persent gestel word;[1-3] en die gemiddelde van ses reekse toon 139 ulkusse in 544 chroniese longsiekte-lyers—'n insidensie van 25·6 persent.[5]

West en sy medewerkers[5] gee 'n omvattende oorsig oor die literatuur oor hierdie sindroom en vermeld ook hulle bevindings by 'n reeks van 845 pasiënte waarvan 23·1 persent chroniese longsiektes gehad het. Onder diegene sonder chroniese longsiektes was die insidensie van peptiese ulkus 10 persent, terwyl dit 25·6 persent was onder die groep met chroniese longsiekte. Hierdie skrywers vind dat in vergelyking met die gewone groep van ulkus-lyers, die geslagsinsidensie omgekeerd is, nl. mans tot vrouens (sonder chroniese longsiekte) 17 : 21, en met chroniese longsiekte 36 : 18.

Verskeie teorieë aangaande die wyse van die ontstaan van die sindroom is deur verskillende skrywers voorgestel, en waarskynlik is veelvuldige faktore daarvoor verantwoordelik.[5] Waar die presiese patogenese van peptiese ulserasie nog self onseker is,[6,7] kan daar sekerlik ook hier nie 'n enkele faktor voorgestel word nie. Dit mag slegs daarop dui dat 'n mens maag- en duodenale ulserasie moet beskou as 'n manifestasie van 'n gestelsversteuring.

By die lyer aan chroniese longsiekte is daar verskeie faktore wat verhoogde suurwaardes kan teweegbring,[5] waaronder verhoogde kortikosteroïed-aktiwiteit. Dit is welbekend dat baie van hierdie pasiënte op een of ander tyd met steroïede behandel word. Die chroniese drukte van belemmerde asemhaling en die meegaande emosionele faktore is reeds in hierdie verband deur Nestmann[8] ondersoek. Simpatomimetiese stowwe, byvoorbeeld adrenalien en efedrien, is belangrike middels teen brongospasma, wat so 'n inherente deel van hierdie pasiënte se siektebeeld uitmaak. Ander faktore wat kan bydra tot verhoogde suurwaardes sluit in die endogene histamien-produksie by asmalyers,[5] tabakverbruik, wat dikwels 'n belangrike etiologiese rol in die pasiënt se primêre siektetoestand speel[3] en, vanweë chroniese hiperkapnie, is daar ook verhoogde aktiwiteit van die koolsuur anhidrase ensiem-sisteem in die pariëtale selle van die maag.[9]

Daar is ewe-eens verskeie faktore wat lokale weerstand in die gastroduodenale gebied kan verlaag.[5] Ons is almal bekend met die menigte medisynes wat hierdie pasiënte gebruik, waaronder salisilate, ammoniumchloried en kaliumjodied, en antibiotiese middels, asook die reeds genoemde kortikosteroïede. Baie van hierdie pasiënte val in die ouderdomsgroep waar arteriosklerose feitlik inherent is. Hipoksie van lokale weefsel word deur ontoereikende ventilasie, verhoogde veneuse druk en polisitemie teweeggebring of vererger. Die tipiese emfiseem-lyer is dikwels ook in 'n negatiewe stikstofbalans en vertoon dikwels ander tekens van wanvoeding.[5]

Die belang van hierdie verband tussen chroniese longsiektes en gastroduodenale ulserasie blyk uit die feit dat die simptome van ulkus dikwels atipies is, of geheel afwesig.[2,5] Gewoonlik word die chroniese longsiekte-lyer gekenmerk deur normale of verhoogde hemoglobienwaardes. By hierdie mense moet 'n anemie 'n mens dus laat dink aan gastro-intestinale bloeding. West en sy medewerkers[5] stel dus ook voor dat 'n röntgenondersoek van die gastro-intestinale kanaal by almal gedoen behoort te word, en die stoelgange moet met die oog op okkulte bloed ondersoek word in iedere geval.

Die behandeling van gevalle met hierdie sindroom kan moeilik wees aangesien baie van hulle nie sonder hulle veelvuldige medisynes kan klaarkom nie, en die kortikosteroïde mag trouens lewensreddend wees. 'n Mens moet dus let op die voedingstoestand van hierdie pasiënte, en alkalië kan sonder gevaar vryelik toegedien word, maar anticholinergiese middels mag lei tot 'n baie ongewenste uitdroging van die trageobrongiale boom.[5]

1. Green, T. P. en Dundee, V. C. (1952): Canad. Med. Assoc. J., **67**, 438.
2. Blotkin, Z. (1957): Dis. Chest, **31**, 195.
3. Lowell, F. C., Franklik, W., Michelson, A. L. en Schuller, I. W. (1956): New Engl. J. Med., **254**, 123.
4. Cecil, R. L. en Loeb, R. F. (1954): *Text-book of Medicine*, 8ste uitgawe. Philadelphia en Londen: Saunders.
5. West, W. D., Burns, R. D., Daniel, J. M. en Jackson, H. A. (1959): A.M.A. Arch. Intern. Med., **106**, 897.
6. Marks, I. N. en Shay, H. (1959): Lancet, **1**, 1107.
7. Aagard, P., Andreassen, M. en Kurz, L. (1959): *Ibid.*, **1**, 1111.
8. Nestmann, R. (1956): West Va Med. J., **52**, 149.
9. Apperly, F. L. (1956): Amer. J. Dig. Dis., **1**, 270.

'THERAPEUTIC' SKIN DISEASES

In the days when skin diseases were classified into those cured by calamine lotion, those that needed mercury ointment, and those that were incurable, patients either became better or stayed much the same. With advances in therapy this happy state no longer obtains and, although new remedies have improved the prognosis in many dermatoses, they have brought about a broadening of the old classification to include a new group of patients who get worse before they get better. Dermatologists are constantly confronted by patients with two diseases, the original and that induced by treatment, usually topical treatment with substances which may be allergens or, simply primary irritants.

Modern topical applications are often much more effective than calamine lotion or mercury ointment, especially when used in the right case, but they carry a far greater risk of causing allergic contact dermatitis than the simpler remedies of the past.

The era of allergic contact-dermatitis medicamentosa was heralded by the sulphonamides, which are still among the most potent allergens commonly used in medicine. Dermatologists had begun to fear them by the early 1940's and were happy to abandon them with the arrival of the antibiotics. Penicillin soon proved to be just as dangerous and has also been discarded as a topical application by dermatologists, if by few others. The later antibiotics, streptomycin excepted, are much less liable to cause allergic contact dermatitis.

Lotions and ointments containing antihistaminics, paradoxically though it may seem to some, are so liable to cause sensitization that they should never be used; when antihistaminics are indicated they may be given orally or parenterally with little risk of reaction.

When the chemist is asked for something to soothe the baby's eczema or father's itching piles he is liable to provide some preparation containing a local anaesthetic which, in many cases, will eventually add fuel to the flames. Every mother knows that cuts and abrasions will lead to blood-poisoning unless liberally doused with neat antiseptics—more potential candidates for the skin department.

Only dermatologists would suffer if a law were passed banning the use of sulphonamides, penicillin, antihistaminics, local anaesthetics, and antiseptics as topical applications. These are the commonest offenders, but there are few medicaments used today which have not occasionally, or frequently, been incriminated as causes of allergic contact dermatitis or primary irritation of the skin. Even hydrocortisone has, on rare occasions, caused sensitization. Patients should be warned of the possibility of sensitization and told to discontinue treatment if their symptoms seem to be aggravated by the application of any remedy.

'Diagnosis precedes treatment' is a maxim to be heeded by those treating skin diseases. Whitfield's ointment is excellent for some ringworms, but it plays havoc with the ringed lesions of pityriasis rosea; and chrysarobin ointment often helps in psoriasis but may turn nummular eczema into exfoliative dermatitis.

If the diagnosis is in doubt, prescribe some innocuous application until there are indications for specific treatment; but, if a second opinion is likely to be required, refrain from using gentian violet or Castellani's paint which are as thwarting as they are picturesque.