letters

Quality of life scores should be compared before and after patients have undergone dialysis

To the Editor: We intentionally read the article "Quality of life (QoL) in hemodialysis and peritoneal dialysis patients in Saudi" written by Wakeel et al with great interest.[1] They concluded that the quality of life (QoL) was better among peritoneal dialysis (PD) than hemodialysis (HD) patients in all domains except physical domain. PD patients spent more quality time and were more satisfied than HD patients.[1]

In the last years, advances in dialysis procedures and new guidelines to treat the chronic renal failure patients have improved their treatment and prolonged their lives. At the same time, the concept of health-related quality of life (HRQoL) strengthened as a new goal to be achieved. The current dialysis guidelines enforce treatments to achieve similar outcomes in the long run, independently of the choice of dialysis treatment.[2] Manns et al. in their study concluded that there was no significant difference in HRQoL for prevalent end-stage renal disease patients treated with HD or PD.[3] In another study, Wu et al. concluded that that PD did not seem to produce a better QoL than HD for patients who imitated renal replacement therapy.[4] Ginieri-Coccossis. et al. in their study concluded that the results provided evidence that patients in HD treatment modality, particularly those with many years of treatment, experienced a more compromised QoL in comparison to PD patients.[5] The results may change due to sociodemographic characteristics of patients. We think that the comparison of the two groups could be more meaningful if the QoL is measured before and after patients are undergone dialysis. Another point of discussion could be that the variations in study results may vary upon longer follow-up durations of these patients.

Hakan Sarlak,[a] Sait Demirkol,[b] Sevket Balta,[b] Mustafa Cakar,[a] Omer Kurt,[a] Muharram Akhan[a]

From the [a]Department of Internal Medicine, Gulhane Medical Academy, Ankara, Turkey, [b]Department of Cardiology, Gulhane Medical Academy, Ankara, Turkey

Correspondence:
Dr. Sevket Balta
Department of Cardiology,
Gulhane School of Medicine,
Tevfik Saglam St., 06018
Etlik-Ankara, Turkey
T: +90-312-3044281,
F: +90-312-3044250.
drsevketb@gmail.com

DOI: 10.5144/0256-4947.2013.510a

REFERENCES

1. Jamal Al Wakeel, Ali Al Harbi, Magda Bayoumi, Karaem Al-Suwaida, Mohammed Al Ghonaim, Adel Mishkirye. Quality of life in hemodialysis and peritoneal dialysis patients in Saudi Arabia. Ann Saudi Med 2012; 32(6): 570-574.
2. Valquiria Greco Arenas, Luciene Fatima Neves Monteiro Barros, Francine Barros Lemos. Quality of Life: Comparison between patients on automated peritoneal dialysis and patients on hemodialysis. Acta Paul Enferm 2009; 22(Especial-Nefrologia): 535-9.
3. Manns B, Johnson JA, Taub K, Mortis G, Ghali WA, Donaldson C. Quality of life in patients treated with hemodialysis or peritoneal dialysis: what are the important determinants? Clin Nephrol. 2003;60(5):341-51.
4. Wu AW, Fink NE, Marsh-Manzi JV, Meyer KB, Finkelstein FO, Chapman MM, Powe NR. Changes in quality of life during hemodialysis and peritoneal dialysis treatment: generic and disease spesific measures. J Am Soc Nephrol. 2004;15(3):743-53.
5. Ginieri-Coccossis. M, Theofilou P, Synodinou C, Tomaras V, Soldatos C. Quality of life, mental health and health beliefs in hemodialysis and peritoneal dialysis patients: Investigating differences in early and later years of current treatment. BMC Nephrology. 2008 November 14;9-14.

Reply: Oxytocin ameliorates cisplatin-induced nephrotoxicity in Wistar rats

To the Editor: We read with great interest the recently published nice article in the esteemed "Ann Saudi Med", by Elberry et al entitled "Oxytocin ameliorates cisplatin-induced nephrotoxicity in Wistar rats".[1] In an experimental study on 48 male Wistar albino rats, Elberry et al. aimed to study the ameliorative effects of oxytocin against cisplatin renal toxicity.[1] They assessed the renal injury of cisplatin by performing histopathological study and by observing an increase in serum LDH activity as well as urea and creatinine levels. Furthermore, to asses renal injury, they also measured renal tissue activities of catalase, superoxide dismutase, glutathione peroxidase, and glutathione S-transferase as well as glutathione level. Also the renal tissue content of thiobarbituric acid–reactive substances, nitric oxide end-product nitrite, and the activity of myeloperoxidase were measured. They found that oxytocin protected rats from cisplatin-induced nephrotoxicity and attributedthis to the antioxidant activity of oxytocin.[1] In this letter, I would like to point out a few points about cisplatin nephrotoxicity. In a preclinical study, we observed that estrogen attenuates the defending property of erythropoietin against cisplatin-induced renal toxicity in ovariectomized Wistar rats.[2] We also observed that L-arginine had ameliorative effects against cisplatin-induced renal toxicity in male rats. Nevertheless, it intensifies the induced injury in female rats.[3] In this study, we described a sex-related difference in the rat model of cisplatin nephrotoxicity.[3] Since, the position of gender in cispla-

tin-induced renal toxicity is not reported from published reports, we conducted another preclinical study on the rat model of cisplatin nephrotoxicity. From the results of this study we found that losartan, as an angiotension receptor blocker, may prevent cisplatin nephrotoxicity in males, whereas it aggravates the cisplatin-induced tubular injury in female rats.[4] We concluded that the sex-related difference of cisplatin nephrotoxicity may be related to the renin–angiotensin system receptors in the kidneys.[4-9] In addition, we reported that, Vitamin E, Vitamin C, or losartan have not ameliorative effects against cisplatin-induced renal toxicity in the presence of estrogen in the ovariectomized rat model of cisplatin toxicity,[10] which is in agreement with our previous results. Therefore, it is well established that there is a gender difference in the cisplatin-induced renal toxicity in the rat model. However, it is well recognized that some conditions leading to chronic kidney diseases are gender related too.[5-9] Few studies published regarding gender difference in cisplatin-induced kidney toxicity. However, there still needs to more investigate mechanisms interact in cisplatin nephrotoxicity especially on gender difference.[10,11] To better find the factor of sex difference in cisplatin nephrotoxicity, further experimental rat model or clinical studies recommended.

Conflict of interest

The authors declared no competing interests.

Hamid Nasri

From the Internal Medicine, Hajar Medical, Educational and Therapeutic Center, Shahrekord University of Medical Sciences, Chaharmahal Va Bakhtiyari, Iran

Correspondence:
Dr. Hamid Nasri
Internal Medicine, Hajar Medical, Educational and Therapeutic Center, Shahrekord University of Medical Sciences, Chaharmahal Va Bakhtiyari, Iran
T: 00989121439584
F: 0098381 2243715
hamidnasri@yahoo.com
nrc@skums.ac.ir

DOI: 10.5144/0256-4947.2013.510b

REFERENCES

1. Elberry AA, Refaie SM, Kamel M, Ali T, Darwish H, Ashour O.Oxytocin ameliorates cisplatin-induced nephrotoxicity in Wistar rats. Ann Saudi Med. 2013;33(1):57-62. doi: 10.5144/0256-4947.2013.57.

2. Pezeshki Z, Nematbakhsh M, Mazaheri S, Eshraghi-Jazi F, Talebi A, Nasri H, et al. Estrogen abolishes protective effect of erythropoietin against cisplatin-induced nephrotoxicity in ovariectomized rats. ISRN Oncology. 2012, doi:10.5402/2012/890310.

3. Eshraghi-Jazi F, Nematbakhsh M, Nasri H, Talebi A, Haghighi M, Pezeshki Z, et al.The protective role of endogenous nitric oxide donor (L-arginine) in cisplatin-induced nephrotoxicity: Gender related differences in rat model.J Res Med Sci. 2011; 16(11):1389-96.

4. Haghighi M, Nematbakhsh M, Talebi A, Nasri H, Ashrafi F, Roshanaei K, et al. The role of angiotensin II receptor 1 (AT1) blockade in cisplatin-induced nephrotoxicity in rats: gender-related differences. Ren Fail. 2012; 34(8):1046-51.

5. Ghorbani A, Omidvar B, Parsi A. Protective effect of selenium on cisplatin induced nephrotoxicity: A double-blind controlled randomized clinical trial. J Nephropathology. 2013; 2(2): 129-134. DOI: 10.5812/nephropathol.10656

6. Nematbakhsh M, Ashrafi F, Pezeshki Z , Fatahi Z , Kianpoor F, Sanei MH, Talebi A: A histopathological study of nephrotoxicity, hepatoxicity or testicular toxicity: Which one is the first observation as side effect of Cisplatin-induced toxicity in animal model. JNephropathology. 2012; 1(3): 190-193. DOI: 10.5812/nephropathol.8122

7. Solati M, Mahboobi HR. Paraoxonase enzyme activity and dyslipidemia in chronic kidneydisease patients. J Nephropathology. 2012; 1(3): 123-125. DOI: 10.5812/nephropathol.8106

8. Kam-Tao Li PK, Burdmann EA, Mehta RL. Acute kidney injury: global health alert. JNephropathology. 2013; 2(2): 90-97. DOI: 10.5812/nephropathol.10449

9. Rafieian-Kopaei M, Nasri H, Nematbakhsh M, Baradaran A, Gheissari A, Rouhi H, et al. Erythropoietin ameliorates gentamycin-induced renal toxicity: A biochemical and histopathological study.J Nephropathology. 2012; 1(2): 109-116.

10. Nematbakhsh M, Pezeshki Z, Eshraghi-Jazi F, Ashrafi F, Nasri H, Talebi A, et al.Vitamin E, Vitamin C, or Losartan Is Not Nephroprotectant against Cisplatin-Induced Nephrotoxicity in Presence of Estrogen in Ovariectomized Rat Model.Int J Nephrol. 2012; 2012:284896.

11. Nematbakhsh M, Talebi A, Nasri H, Safari T, Dolatkhah S, Ashrafi F, et al. Some evidence for sex-based differences in cisplatin-induced nephrotoxicity in rats. Clinical and Experimental Medical Letters. 2012; 53(1-229):31 pages.

Fertility outcome of using intrauterine balloon stenting during resectoscopic septum division

To the Editor: With a great interest, I have read a recently published article in *Annals of Saudi Medicine* by Basim Fuad Abu Rafea et al, entitled "Fertility and pregnancy outcomes following resectoscopic septum division with and without intrauterine balloon stenting: a randomized pilot study".[1] The authors skillfully declared an interesting investigation about the benefits of intrauterine balloon splinting/Foley catheter after resectoscopic septum division on fertility, septum reformation, and pregnancy outcomes. They concluded that "Following resectoscopic septum division with monopolar knife electrode, splinting the uterine cavity with Foley catheter provided no advantage in clinical pregnancy rate, septum reformation, and pregnancy outcomes." Although this issue is a challenging topic in fertility and pregnancy, but there are some concerns in the mentioned study that undermine the reported findings to make a definite conclusion.

The number of cases included in the study is one of the most discussed queries. I can declare that if the difference between the 2 studied groups (balloon or no balloon) was not significant, it could due to the small amount of sample size that did not allow drawing any definitive conclusions. Thus, to rule out this query and to compensate any refusal of data, the authors should estimate the "power" of their study. The authors randomized the pa-

tients into the 2 studied groups, and no significant difference in terms of age, parity, and comorbidities were reported. However, menopausal status, race, age of menopause, menopausal hormone therapy, occupation, marital status, OCP use, and so on, should be distributed equally between the 2 groups before drawing any conclusion, which was not considered by the authors in this study.

The authors expertly excluded those patients who received preoperative endometrial thinning, adjunctive postoperative hormone therapy, or antibiotic prophylaxis, but they seemed to be inadequate as exclusion criteria in the clinical study. The authors did not declare if they excluded pregnant women, patients with active pelvic infection, patients allergic to radiographic contrast media, and patients with or without known endometrial or cervical cancer.[2,3] Therefore, the mentioned criteria should be considered by the authors. A participation fellow chart is mandatory for clinical studies based on the CONSORT (Consolidated Standards of Reporting Trials) statement,[4,5] but it was missing in this study. Moreover, in the "Methods" section, the statistical analysis is poorly presented and the power analysis is incomplete. Moreover, the chosen proportion for significant or not significant difference in fertility and pregnancy outcomes should be mentioned. Finally, the secondary outcomes of the resectoscopic procedure, such as fever, increasing abdominal pain, heavy vaginal bleeding, foul smelling vaginal discharge,[6] and so on, should be mentioned in the results by the authors.

We suggest that a study with accurate and powerful methods according to CONSORT statement is required for this topic. However, the authors acknowledged to the heterogeneity of their study population as a limitation. Therefore, future studies with a homogeneous sample, well-characterized controls, and cases that increase the sensitivity of detecting the associations should be considered necessary to exclude this problem.

Acknowledgments

I acknowledge the authorities of Jahrom University of Medical Sciences for financial support.

Mohamed Amin Ghobadifar

From the Department of Student Reseach Committee, Medicine School, Jahrom University of Medical Sciences, Jahrom, Iran

Correspondence:
Dr. Mohamed Amin Ghobadifar
Department of Student Reseach Committee, Medicine School, Jahrom University of Medical Sciences, Motahari Avenue, Iran, Jahrom 193, Iran
Amin_m505@yahoo.com

DOI: 10.5144/0256-4947.2013.511

REFERENCES

1. Abu BF, Vilos GA, Oraif AM, Power SG, Cains JH, Vilos AG. Fertility and pregnancy outcomes following resectoscopic septum division with and without intrauterine balloon stenting: a randomized pilot study. Ann Saudi Med. 2013;33(1):34-9.
2. Cicinelli E. Hysteroscopy without anesthesia: review of recent literature. Journal of Minimally Invasive Gynecology. 2010;17(6):703-8.
3. Palmer SN, Greenberg JA. Transcervical sterilization: a comparison of Essure® permanent birth control system and Adiana® permanent contraception system. Reviews in Obstetrics and Gynecology. 2009;2(2):84.
4. Schulz KF, Altman DG, Moher D. CONSORT 2010 Statement: Updated guidelines for reporting parallel group randomised trials. J Clin Epidemiol. 2010;63(8):834-40.
5. Begg C, Cho M, Eastwood S, Horton R, Moher D, Olkin I, et al. Improving the quality of reporting of randomized controlled trials. The CONSORT statement. Jama. 1996;276(8):637-9.
6. Garuti G, Luerti M. Hysteroscopic bipolar surgery: a valuable progress or a technique under investigation? Curr Opin Obstet Gynecol. 2009;21(4):329-34.

Prevalence of celiac disease in healthy Iranian school children

To the Editor: I have two comments on the interesting study by Dehghani et al.[1]

First, Dehghani et al[1] stated in their study that the prevalence of celiac disease (CD) based on antitissue transglutaminase antibodies (tTGA) screening test was 1:50, whereas the prevalence of biopsy-proven CD (silent celiac) was 1:167. I presume that the actual prevalence is higher. This is based on the following contributory factors: (1) The consumption of wheat as a major dietary staple is still a major custom in Iran. (2) Consanguineous marriage is a prevailing practice in Iran with the first cousin marriage being the most common type of consanguinity (69%).[2] (3) Iran is a multiethnic country and, therefore, genetic variance does exist in the Iranian population. (4) There is inadequate awareness of the referring pediatricians with regard to the uncommon manifestations of CD. (5) Underdiagnosis of CD in the primary care setting is often compounded by disease mismanagement. (6) CD is strongly associated with HLA-DQ2 in developing countries. Though recent studies are not yet present on HLA phenotypes in Iranians, the available data has pertained to the potential role of HLA-DQ2 in increasing the propensity of certain populations in Asia like Iran to have CD.[3] (7) Iranians might follow the general trend of overall worldwide increase in the CD prevalence, including silent cases.

Second, to meet the principles of screening, a disease must be common, and a significant health burden must be detectable and treatable. I presume that screening for CD in Iranian children seems justi-

fiable. This is based on the following points: (1) There is substantial prevalence of CD, in particular, silent cases in Iran.[1,4] (2) Undiagnosed CD patients have long-term serious health consequences, including malignancy, anemia, short stature, osteopenia, and infertility. Moreover, the medical costs and utilization of selected health care services over time for symptomatic CD patients during the delay between symptoms onset and diagnosis are substantial. (3) There is the presence of effective screening tool for CD in terms of measuring the serum tTGA supplemented whenever necessary by small intestinal biopsy. (4) There is the presence of effective therapy for CD in terms of gluten-free diet. The children's age range supposed to undergo screening for CD ought to be determined in Iran. However, the available evidence has advocated the age 2 to 3 years as the best time for measuring the serum tTGA due to the high detection rate.[5]

Mahmood Dhahir Al-Mendalawi

From Pediatrics, Al-Kindy College of Medicine, Baghdad University, Baghdad, Iraq

Correspondence:
Dr. Mahmood Dhahir Al-Mendalawi
Pediatrics, Al-Kindy College of Medicine, Baghdad University,
PO Box 55302,
Baghdad Post Office,
Baghdad 1111, Iraq
mdalmendalawi@yahoo.com

DOI: 10.5144/0256-4947.2013.512

REFERENCES

1. Dehghani SM, Haghighat M, Mobayen A, Rezaianzadeh A, Geramizadeh B. Prevalence of celiac disease in healthy Iranian school children. Ann Saudi Med. 2013; 33:159-61.
2. Akrami SM, Montazeri V, Shomali SR, Heshmat R, Larijani B. Is there a significant trend in prevalence of consanguineous marriage in Tehran? A review of three generations. J Genet Couns. 2009;18:82-6.
3. Cummins AG, Roberts-Thomson IC. Prevalence of celiac disease in the Asia-Pacific region. J Gastroenterol Hepatol. 2009;24: 1347-51.
4. Farahmand F, Mir-Nasseri MM, Shahraki T, Yourdkhani F, Ghotb S, Modaresi V, et al. Prevalence of occult celiac disease in healthy Iranian school age children. Arch Iran Med. 2012;15:342-5.
5. Castaño L, Blarduni E, Ortiz L, Núñez J, Bilbao JR, Rica I, et al. Prospective population screening for celiac disease: high prevalence in the first 3 years of life. Pediatr Gastroenterol Nutr. 2004;39:80-4.

The reliability of palatal rugoscopy in forensic identification

To the Editor: There is paucity of information about the reliability of palatal rugoscopy in forensic identification in Saudi Arabia. As you know, forensic dental identification plays an important role in the establishment of a person's individuality, and forensic odontology deals with the proper handling and examination of dental evidence and the proper evaluation and presentation of dental findings in the interest of justice.[1] Palatal rugoscopy is the study of palatal rugae, and their uniqueness to individuals can provide a reliable source of identification.[2] Palatal rugae are irregular, asymmetric ridges of mucous membrane extending lateral from the incisive papilla and the anterior part of the median palatal raphe.[3] Palatal rugae are well protected by the lips, cheek, and tongue and are thus protected from external insults such as fire and high-impact trauma. They do not change shape with age and reappear after trauma or surgical procedures.

From the recent studies done in the Indian population, it was postulated that palatal rugae can be used as a personal soft-tissue oral print in forensic identification.[4,5] The rugae pattern can be recorded by means of dental impressions and casts made from them. The study of maxillary dental casts is the most widely used technique due to its simplicity, cost, and reliability. The overlay print of palatal rugae in a maxillary cast can be used to perform a comparative analysis. Computerized recording of the palatal rugae pattern is also introduced in forensic identification.6 Controversy still exists about the stability of quantitative and qualitative characteristics of rugae during growth and the extent of differences between ethnic groups and sexes. Another aspect of palatoscopy that one must consider is the possibility of rugae pattern forgery and the possible distortion of the palatal rugae replica as a result of poor duplicating materials and techniques. Further studies to determine the reliability of palatal rugoscopy in forensic identification are encouraged.

Thorakkal Shamim

From the Dentistry, Government of Taluk Head Quarters Hospital, Kerala, India

Correspondence:
Dr. Thorakkal Shamim
Dentistry, Government of Taluk Head Quarters Hospital, Shangrila
Parappanangadi 676303,
Kerala, India
T: +919895447351
shamu3duad@rediffmail.com

DOI: 10.5144/0256-4947.2013.513

REFERENCES

1. Shamim T. Forensic odontology. J Coll Physicians Surg Pak. 2012 Apr; 22(4):240-5.
2. Shamim T. A new working classification proposed for forensic odontology. J Coll Physicians Surg Pak. 2011 Jan;21(1):59.
3. Paliwal A, Wanjari S, Parwani R. Palatal rugoscopy: Establishing identity. J Forensic Dent Sci. 2010 Jan;2(1):27-31.
4. Indira A, Gupta M, David MP. Usefullness of palatal rugae patterns in establishing identity: Preliminary results from Bengaluru city, India. J Forensic Dent Sci. 2012 Jan;4(1):2-5.
5. Kumar S, Vezhavendhan N, Shanthi V, Balaji N, Sumathi MK, Vendhan P. Palatal rugoscopy among Puducherry population. J Contemp Dent Pract. 2012 May 1; 13(3):401-4.
6. Limson KS, Julian R. Computerized recording of the palatal rugae pattern and an evaluation of its application in forensic identification. J Forensic Odontostomatol. 2004 Jun;22(1):1-4.