



## Letter to the Editor AMJ 2011, 4, 5.

### Hypertension among children and adolescents in Iran

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Dear Editor,

In Volume 3, No. 11 (2010) of the *Australasian Medical Journal* (AMJ), Kamath et al. published a paper entitled "Prevalence of Hypertension in the Paediatric Population in Coastal South India".<sup>1</sup> The authors raised a number of issues regarding paediatric hypertension in India, which may also be applicable to other developing countries. In this cross-sectional study, a total of 2,067 students between the ages of 5–16 years from rural schools in Udupi taluk, Karnataka were studied as part of school health services. In Kamath and colleagues' study, the total prevalence of hypertension was 2.2%. Prevalence of hypertension among females was 2.4% and 2.1% in males. There was no significant difference between the prevalence of hypertension between males and females. In the paper, the prevalence of hypertension was seen to increase with an increase in body mass index (BMI). Of the total study population, 2.0% girls and 1.6% boys were found to have systolic hypertension. The diastolic hypertension was similar in both girls and boys with a prevalence of 0.8%.<sup>1</sup> Due to the nutritional transition and lifestyle changes in developing countries, hypertension epidemia is repeatedly reported in paediatrics. Considering the racial, geographical, and nutritional differences between the Iranian people and Indian society and influential effects of these risk factors on blood pressure (BP), this study aimed to notify the hypertension among children and adolescents in Iran. However in Iran, and to our knowledge in Asian countries, only a few precise studies have been conducted about this issue. Ashrafi et al.<sup>2</sup> in their study conducted from 1998 to 2000; on 10,288 students (from 125 schools) aged 6-13 in Tehran, Iran reported the prevalence of systolic

hypertension in 4.9% of boys and 3.5% of girls, whereas diastolic hypertension was reported in 10.1% boys and 3.3% girls. Furthermore, mean systolic and diastolic blood pressure showed incremental increase with age, weight and height in both sexes.<sup>2</sup> The noted systolic and diastolic hypertension prevalence rates were more than that reported by Kamath et al. In a multicentre national cross-sectional survey by Kelishadi et al.<sup>3</sup> on 21,111 students aged 6–18 in 23 (out of 28) provinces of Iran, the reported systolic and diastolic hypertension rates were more than the findings reported by Kamath et al. Kelishadi et al. selected the samples as a representative sample of nearly 16 million Iranian school students with different ethnicities. However, in both the studies, prevalence of hypertension was seen to increase with weight and height. On the other hand, the overall prevalence of systolic, diastolic as well as systolic or diastolic hypertension was 4.2%, 5.4% and 7.7%, respectively in Kelishadi and colleagues' study.<sup>3</sup> In the other cross-sectional research, Mirhosseini et al. studied a total of 622 adolescent girls (15–17 years old) in Mashhad, the second biggest city in Iran.<sup>4</sup> They reported the prevalence of combined hypertension at 6.1%, which increased with the severity of obesity. Furthermore, approximately 24.1% and 7.2% of subjects suffered from isolated diastolic and systolic hypertension, respectively.<sup>4</sup> The noted prevalence rates were not consistent with the study by Kamath et al. A thorough analysis of these studies shows that BP is not distributed similarly between the different districts of Iran and India. However, this non-communicable disease should be strictly followed as a medical problem. Moreover, monitoring of BP among children and adolescents is important for preventing hypertension in adults. According to the scientific researches, BP measurements should be incorporated into the routine paediatric examination of children aged three years or more.

Sincerely,

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## Letter to the Editor AMJ 2011, 4,5.

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### From correct English to appropriate English

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Dear Editor,

I would like to take issue with a number of points raised by Dr. Gillian Hanson when she says that:<sup>1</sup>

“The sometimes confusing and less than interesting rules of grammar can be quite daunting and often tedious, and even the best writers make errors—omit an essential word or add a word when it might not be necessary. Whether you need precise guidelines that cover the basics of grammar, mechanics, usage, and punctuation or more general advice, seeking the help of a professional proof reader and editor will help you identify grammatical and stylistic problems and revise your work for publication.”

1. This confuses the role of the proof reader, who works on a finished text to correct surface errors and generally make it fit for its intended purpose, with that of the writing teacher, who seeks to develop better writing skills in her students and make them have less need for a proof reader.

2. While a sound grasp of grammar is certainly necessary to be a skilled writer it will not suffice on its own, nor even when combined with a rich vocabulary. A text may be entirely free of grammatical or lexical errors and yet still be entirely inappropriate for the purpose for which it is intended, and a person with an excellent knowledge of grammar may still be a very poor writer.

3. Dr. Hanson’s statement gives the impression that there is a single set of grammar and other rules that define correct English and this is not the case. Of course there is a core set of grammatical intuitions that would be shared by all native speakers – “My name are Eamonn”, for example, would be wrong in any context – but this fact is not much help to *writers* of academic English. English is a multi-polar language with significant grammatical and lexical differences among varieties and writers who are encouraged to learn grammar

rules that are “correct” in some intrinsic, universal, almost metaphysical sense are likely to be poorly rewarded for their efforts.

4. A further problem with this view of “correct” English is that it tends to encourage the false belief that all native speakers of English have especially valuable knowledge about how to write academic English. The only thing that a native speaker of English has that a non-native speaker does not have is a little piece of software in her head that allows her to formulate phrases in her variety of spoken English. This may be of some advantage when it comes to writing in English but on its own it is pretty useless. There is no more perverse ambition than wanting to write like a native speaker. There is no such thing as a native speaker of written academic English.

5. “But aren’t there more unified conventions for writing academic English?” Yes, there are but the term “academic English” still encompasses an incredibly broad range of intellectual activities. I doubt very much if the kind of writing that is necessary to get published in some journals of social and cultural theory would prove acceptable to the editors of the *Australasian Medical Journal*.

6. So what should academics who want to improve their English writing skills do? They should certainly improve their knowledge of English grammar (an activity distinct from simply hunting for supposedly infallible rules) and they should not hesitate to hire a proof reader if they need one. However, given the vastness and multiplicity of English, there is not much point wondering whether their writing is correct in some abstract, universal sense; much better for them to focus on whether it is appropriate for its intended purpose. In practical terms that means that they ought to steep themselves in the English used in their writing by academics in their area of expertise (many of whom will not be native speakers of English) and, more specifically, if they want to submit a paper to a particular journal then they should make sure they are entirely familiar with the guidelines for contributors and follow them to the letter. Finally, they should read as broadly and deeply as they can in English and, if they are not satisfied with their existing writing skills they should consider seeking the assistance of someone with the appropriate training and experience in helping to improve them.



Sincerely,

Eamonn McDonagh  
Independent Academic Writing Consultant.

### **Reference**

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## Letter to the Editor AMJ 2011, 4,5

### Disaster preparedness of hospitals in a coastal city of south India

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Dear Editor,

Disasters, whether man-made or natural, may occur at any place or time. India is more prone to disasters due to its geographical characteristics, vast network of railway services, population growth and laxity in safety procedures.<sup>1</sup> The 2004 tsunami that hit countries in the Indian Ocean killed over 180,000 people, left some 50,000 others missing and presumed dead, and displaced more than 1.6 million survivors. Dakshina Kannada District is located on the Western coast of Karnataka and was thus more vulnerable to the tsunami disaster. The district falls just outside the earthquake fault line under the zone 1 of earthquake classification as per the Indian Standard.<sup>1</sup> The district is important for industry and, over recent years, increasing numbers of major companies have settled in the area. Subsequently it now has good facilities, such as a port, to support this advancing industrial infrastructure. Therefore, any disaster occurring in this area would have significant consequences and would affect a large number of people and businesses.<sup>1</sup>

This study was undertaken to establish the preparedness of local hospitals in handling emergencies according to the District Disaster Management Plan (DDMP) in the coastal city of Mangalore.

A cross-sectional study was conducted in 12 hospitals of Mangalore city, located at the south-western coast of India in April 2009. Data was collected by interviewing an administrator at each hospital using a semi-structured proforma. The proforma was developed to relate directly to the DDMP. All 12 hospitals chosen to be included in this study are covered by the DDMP. The 12 hospitals comprised of one

government district hospital, four teaching hospitals attached to four Medical Colleges and seven private hospitals in Mangalore city. Data was analysed and expressed in terms of percentages.

All the hospital administrators in the 12 hospitals surveyed were aware of the existence of a DDMP in the resident district of Dakshina Kannada. However, six (50%) were unaware that their hospitals were included in the DDMP. Four hospitals (33.3%) had received a letter relating to the DDMP that outlined their responsibilities and eight hospitals (66.6%) denied having received any letter/document from DDMP but were aware of their hospital being included under the DDMP of Mangalore. Only six (50%) hospitals had a contingency plan for handling emergencies (Table 1).

**Table 1: Disaster preparedness of hospitals**

	Government hospitals		Medical college teaching hospitals		Private hospitals		Total (%)	
	N=1		N= 4		N=7		N=12	
	Yes	No	Yes	No	Yes	No	Yes	No
Awareness regarding District plan	1	0	4	0	7	0	12 (100)	0
Awareness regarding inclusion of their hospital in District plan	1	0	4	0	1	6	6 (50)	6 (50)
No.of hospitals received letter from district authority	1	0	3	1	0	7	4 (33.3)	8 (66.7)
No.of hospitals having contingency plan	1	0	3	1	2	5	6 (50)	6 (50)

Of the 12 hospitals, mock emergency drills were conducted in six (50%) hospitals and the average



frequency of mock drills among the hospitals was once a year. Six (50%) hospitals had a blood bank, five (41.6%) had a trauma centre and eight (66.6%) had a burns ward available for emergency use. Half of them had more than two ambulances and 10 (83.3%) had sufficient stock of essential and life-saving medicines. Extra beds for emergencies were available in 11 (91.7%) hospitals with a maximum number of 42 beds in one hospital (Table 2).

**Table 2: Facilities available for emergency management**

	Government hospitals		Medical college teaching hospitals		Private hospitals		Total (%)	
	N=1		N=4		N=7		N=12	
	Yes	No	Yes	No	Yes	No	Yes	No
Blood bank	1	0	4	0	1	6	6 (50)	6 (50)
Trauma centre	1	0	4	0	0	7	5 (41.7)	7 (58.3)
Burns ward	1	0	4	0	3	4	8 (66.7)	4 (33.3)
Laboratory services	1	0	4	0	7	0	12 (100)	0
Ambulance service	1	0	3	1	2	5	6 (50)	6 (50)
Sufficient stock of medicines	1	0	4	0	5	2	10 (83.3)	2 (16.6)
Availability of Extra beds	1	0	4	0	6	1	11 (91.7)	1 (8.3)

All 12 (100%) hospital administrators included in this survey were aware of the DDMP for Mangalore district. This result compares favourably with a previous study from the USA that showed that only 33.3% respondents were aware about such plans.<sup>2</sup> However, a study conducted in China, reported that 85.2% hospitals had an active contingency plan in contrast to 50% found in this study.<sup>3</sup>

This study revealed that 10 (83.3%) hospitals had a sufficient stock of medicines. A similar study conducted in China showed that 53.1% hospitals evaluated their drug stock for emergency and found sufficient stock.<sup>3</sup> The same study showed that 49.8% hospitals had evaluated their ability to increase beds and equipment for emergency management.<sup>3</sup>

Our study revealed that mock drills were conducted only by six (50%) hospitals in contrast to the above study which showed that 22.9% of respondents reported that they

performed emergency preparedness drills along with relevant organisations.<sup>3</sup>

The study results can not be generalised to other settings because it only investigated 12 hospitals. However, it provides valuable information about the likely preparedness for disasters in the Mangalore district.

To conclude, most hospitals in Mangalore city were not well-prepared to manage emergencies in disasters. Facilities like burns wards, blood banks and ambulance services need to be enhanced. For a hospital to mobilise all health emergency resources in a short period of time, contingency plans must be issued in advance. In addition, periodic review and updating of emergency plans enhance an institution's emergency response capacity.

Sincerely,

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