

Article: Understanding Traditional Chinese Medicine – A Doctor’s Viewpoint (N K Ho)
(SMJ Vol 42 Issue 10 October 2001)

Dear Sir,

Dr Ho Nai Kiong in his review article on “Understanding Traditional Chinese Medicine – A Doctor’s Viewpoint”, has given a balanced view on the pros and cons of traditional Chinese medicine (TCM). This is not at all surprising as he is a very experienced Paediatrician well versed in Chinese culture and TCM.

It was thus most interesting to note that his paper seemed to support and explain the reservation of many western trained doctors to TCM being a readily available alternative to western medicine as practised in Singapore.

He discussed the significant differences in the way of thinking between those who practise the use of TCM and the western trained doctor (WTD) with regards to effectiveness of treatment. While the WTD relies on evidence based medicine in the form of valid statistics and scientific proof, those who believe in TCM dismiss these methods as pro-Western ways unacceptable to them. Their argument on the effectiveness of treatment hinges on the basis that TCM has been around for centuries with little or no side effects to show for it, and is largely non-invasive.

Another argument often used is that TCM helps boost the immune system unlike western medicine, especially drugs such as immunosuppressive and cytotoxic agents, which damage the immune system instead. Alas we know only too well that at times, practitioners of TCM use herbal medicines to which western medicine has been added as the active ingredient, and that at other times, toxic substances such as heavy metals (lead, mercury, arsenic) are found in TCM, whereupon the health authorities confiscate that batch of medicine for disposal.

Moreover, there are enough examples of so called medicinal plants which have been found to be toxic to mankind.

The statement that the FDA (US Food and Drugs Administration) considers that no herbal medicines have been of proven efficacy and that most benefits are likely to be placebo effects is a cause of concern.

As western trained doctors, we have a responsibility to gain knowledge of TCM and not claim total ignorance. This is because TCM is officially sanctioned in Singapore, and we have a part to play in influencing the practice of TCM and its effect on our patients. We need to know which herbs are harmful and which are harmless, and which can cause drug interactions to our patients taking both western and traditional medicine together, knowing that many patients are not forthcoming in revealing to us when they are combining both types of medicine.

Dr Ho highlighted the problem of potency differences of herbal medicines arising simply because of non-standardisation in their preparation. Another problem discussed was that herbs, unlike most purified western medicines, often have multiple effects such as diuretic, sedative, hypotensive or anti-microbial actions. Some of these effects, can be beneficial, but others undesirable or even harmful.

Dr Ho also discussed the potential danger of mistakes and changes in meaning being made upon translation of TCM literature written in classical Chinese, into the English language, and even differences in the terminology of herbs which may actually not be identical.

It is thus obvious that if we are to accept TCM into our armamentarium of medicines to be used for the good of our patients, we urgently need to redefine its role and hope that practitioners of TCM will accept a more scientific approach to it for its further advancement in hand with western medicine.

Yours sincerely,

Clin A/Prof Tan Cheng Lim
Chairman, Division of Paediatric Medicine
KKH

Article: Characteristics of Patients Referred to an Insomnia Clinic (R Mahendran)
(SMJ Vol 42 Issue 2 February 2001)

Dear Sir,

I read with interest the paper by Mahendran⁽¹⁾ on socio-demographic and clinical features of 85 consecutive cases referred to an insomnia clinic. Insomnia indeed is one of the most frequent health complaints brought to the attention of health care practitioners. It is worthwhile pointing out that sleep-related breathing and movement disorders can cause insomnia complaint. The concern is that symptoms of apnea, restless legs and periodic leg movements may not have included in the assessment of insomnia. Polysomnography may be indicated in the evaluation of insomnia when sleep-related breathing disorders and periodic leg movement disorder are suspected, when the initial diagnosis is uncertain, or when the treatment, either behavioral or pharmacologic, is unsuccessful⁽²⁾.

Yours sincerely,

K F Chung
Department of Psychiatry
University of Hong Kong
Pokfulam, Hong Kong

REFERENCES

1. Mahendran R. Characteristics of patients referred to an insomnia clinic. Singapore Med J 2001; 42:64-7.
2. Standards of practice committee of the American sleep disorders association. Practice parameters for the use of polysomnography in the evaluation of insomnia. Sleep 1995; 18:55-7.

Reply From Author

Dear Editor,

Dr K F Chung has highlighted the often overlooked yet tractable causes of insomnia such as Restless Legs Syndrome, periodic Limb Movement Disorder and Obstructive Sleep Apnea Syndrome. The evaluation of sleep complaints involved a detailed sleep history and included questions to elicit signs and symptoms of these disorders. The characteristic features of these disorders are well known; the diagnosis of RLS is based upon the history while PLMD requires polysomnographic confirmation⁽¹⁾.

In terms of treatment response, almost half (48.2%) had improved and ended treatment and 15.3% were still on follow-up. However, 36.5% had defaulted treatment – they may have recovered, remain untreated or may have sought treatment elsewhere. We are now planning a follow-up study to look at these defaulters particularly to address the risk that untreated insomnia is associated with a high risk of psychiatric morbidity.

Yours sincerely,

R Mahendran
Woodbridge Hospital
10 Buangkok View
Singapore 539747

REFERENCES

1. Chesson Jr AL, Wise M, Davila D, Johnson S, Littner M, Anderson WM, et al. Practice parameters for the treatment of restless legs syndrome and periodic limb movement disorder. Sleep 1999; Vol 22(7):961-7.

Article: Paradoxical Enlargement of Tuberculous Brain Abscess during Drug Treatment: A Case Report (S K Ng, et al)

(SMJ Vol 42 Issue 7 July 2001)

Dear Sir,

We have been interested in the case reported by Ng et al, on the paradoxical enlargement of tuberculous brain abscess during treatment⁽¹⁾. Although intriguing, especially if culture and susceptibility results are not known, this phenomenon is not specific for cerebral abscess. Paradoxical enlargement of tuberculoma during antituberculous treatment has been previously reported⁽²⁾. Some of the patients treated for tuberculous meningitis have clinically worsened days or even weeks after introduction of antituberculous treatment⁽³⁾. CT scan of the brain contrast did not reveal tuberculomas nor hydrocephalus. Addition of steroids always improved the patients' neurological status⁽³⁾.

The development of Adult Respiratory Distress Syndrome during appropriate treatment of miliary tuberculosis is also an intriguing feature^(4,5). Early diagnosis and associated steroid therapy generally improve survival⁽⁵⁾.

Transient worsening of tuberculous lymphadenitis after introduction of antituberculous treatment has been described in AIDS-patients as well as in immunocompetent patients⁽⁶⁾. Clinical deterioration and worsening of pancytopenia associated with miliary tuberculosis during treatment has also been observed⁽⁷⁾. We have recently described the development of pleurisy after seven weeks of antituberculous treatment for miliary tuberculosis in an HIV-infected patient⁽⁸⁾.

Though the explanation of worsening during antituberculous treatment remains unclear, in most of the cases this phenomenon occurs only when tuberculosis is disseminated^(2-5,7,8). Dissemination leads to massive release of mycobacterial products inducing a production of high levels of inflammatory mediators after monocyte activation⁽⁸⁾. Introduction of lytic antituberculous therapy may sometimes initiate this process⁽⁵⁾. In most of the reported cases, the addition of steroid therapy has improved the patient's outcome. So, we speculate that inflammatory mediators as well as mycobacterial products may have a central role in the pathogenesis of paradoxical worsening of tuberculosis during therapy. Thus, early adjunction of steroids to antituberculous treatment may be beneficial in the setting of acute disseminated tuberculosis.

Yours sincerely,

Ali Mofredj, Redouane Habki, Hedia Belhadj, Brahim Beldjoudi
Service de Réanimation, Hôpital Laennec
60100 CREIL, France

REFERENCES

1. Ng SK, Zhu XL, Poon WS. Paradoxical enlargement of tuberculous brain abscess during treatment: A case report. *Singapore Med J* 2001; 42:325-7.
2. Afghani B, Liebermann JM. Paradoxical enlargement or development of intracranial tuberculomas during therapy: case report and review. *Clin Infect Dis* 1994; 19:1092-9.
3. Berenguer J, Moreno S, Laguna F, Vicente T, Adrados M, Ortega A, Gonzalez-La Hoz A, Bouza E. Tuberculous meningitis in patients infected with the Human Immunodeficiency Virus. *N Engl J Med* 1992; 326:668-72.
4. Onwubalili JK, Scott GM, Smith H. Acute respiratory distress related to chemotherapy of advanced pulmonary tuberculosis: A study of two cases and review of the literature. *Quat J Med* 1989; 59:599-610.
5. Skurnik Y, Zhornicky T, Schattner A. Survival in miliary tuberculosis complicated by respiratory distress. *Presse Med* 1994; 23:979-81.
6. Hill AR, Matteo F, Hudak A. Transient exacerbation of tuberculous lymphadenitis during chemotherapy in patients with AIDS. *Clin Infect Dis* 1994; 19:774-6.
7. Rosenberg MJ, Rumans LW. Survival of a patient with pancytopenia and disseminated coagulation associated with miliary tuberculosis. *Chest* 1978; 73:536-9.
8. Mofredj A, Guerin JM, Leibinger F, Masmoudi R. Paradoxical worsening in tuberculosis during therapy in a HIV-infected patient. *Infection* 1996; 24:390-1.

Dear Editor,

The interesting phenomenon of paradoxical enlargement of tuberculoma during adequate antituberculous chemotherapy has been recognised since the 1980s⁽¹⁻⁵⁾. The majority of these tuberculoma will respond to standard steroid therapy⁽⁵⁾. However, when life or function are endangered as the result of these paradoxical enlargement of intracranial tuberculous lesions, surgery^(6,7) and prolonged high dose steroid⁽⁸⁾ have been reported.

In tuberculous meningitis (TBM) a number of randomised studies have shown that adjunctive steroid improves survival and neurological outcome^(9,10). There is also evidence that children with TBM treated with steroid and anti-TB chemotherapy were less likely to develop new tuberculomas than those treated with anti-TB drugs alone⁽¹¹⁾.

Tuberculous brain abscess is rare. The role of adjunctive steroid in treating this condition is unclear although most neurosurgeons will prescribe high dose steroid at the time of surgery and clinical deterioration. In our case, the clinical deterioration was associated with an increase in size of the abscess as well as peri-lesional oedema. It was possible that steroid might help to reduce the brain oedema, but it was against the surgical principle to be treating an expanding brain abscess in the presence of clinical deterioration medically without surgical drainage.

Yours sincerely,

S K Ng, X L Zhu, W S Poon
Division of Neurosurgery
Prince of Wales Hospital
The Chinese University of Hong Kong

REFERENCES

1. Lee AJ, Macleod AF, Marshall J. Cerebral tuberculomas developing during treatment of tuberculous meningitis. *Lancet* 1980; 1:1208-11.
2. Lebas J, Malkin JE, Coquin Y. Cerebral tuberculomas developing during treatment of tuberculous meningitis. *Lancet* 1980; 2:84.
3. Loizou LA, Anderson M. Intracranial tuberculomas: correlation of CT with clinico-pathological findings. *Q J Med* 1982; 201:104-14.
4. Chambers ST, Hendrickse WA, Record C. Paradoxical expansion of intracranial tuberculomas during chemotherapy. *Lancet* 1984; 2:181-3.
5. Teoh R, Humphries MJ, O'Mahony G. Symptomatic intracranial tuberculoma developing during treatment of tuberculosis: a report of 10 patients and review of the literature. *Q J Med* 1987; 241:449-60.
6. Eckland DJA, O'Neill JH, Lightman SL. A pituitary tuberculoma. *J Neurol Neurosurg Psychiatry* 1987; 50:310-1.
7. Teoh R, Poon W, Humphries MJ, O'Mahony G. Suprasellar tuberculoma developing during treatment of tuberculous meningitis requiring urgent surgical decompression. *J Neurol* 1988; 235:321-2.
8. Poon WS, Ahuja A, Li AKC. Optochiasmatic tuberculoma causing progressive visual failure: when has medical treatment failed? *Postgrad Med J* 1993; 69:147-9.
9. Kumarvelu S, Parsad K, Khosla A, Behari M, Ahuja GK. Randomised controlled trial of dexamethasone in tuberculous meningitis. *Tuber Lung Dis* 1994; 75(3): 203-7.
10. Girgis NI, Farid Z, Kilpatrick ME, Sultan Y, Mikhail IA. Dexamethasone adjunctive treatment for tuberculous meningitis. *Pediatr Infect Dis J* 1991; 10(3): 179-83.
11. Schoeman JF, Van Zyl LE, Laubscher JA, Donald PR. Effect of corticosteroids on intracranial pressure, CT findings and clinical outcome in young children with tuberculous meningitis. *Pediatrics* 1997; 99(2):226-31.