Saudi Epidemiology Bulletin

Department of Preventive Medicine and Field Epidemiology Training Program
Ministry of Health / Riyadh / Jan-Jun 2000/ Volume 7, Number 1&2

ISSN 1319-3965

النشرة الوبائية السعودية

تصدرها وزارة الصحة

الوكالة المساعدة للطب الوقائي وبرنامج الوبائيات الحقلي

المجلد السابع - العدد الأول والثاني - يناير - يونيه ٢٠٠

Blood-Borne Diseases Among Barbers During Hajj, 1419 H (1999).

Head shaving is considered to be an important potential means of transmission of communicable blood-borne diseases (BBDs), such as Hepatitis B (HBV), Hepatitis C (HCV), and human immune-deficiency virus (HIV). The malpractice's of barbers can make head-shaving during Hajj an optimum focal setting for spread of serious BBDs, particularly that nationals of some Islamic countries such as Pakistan, Nigeria, and Egypt, have relatively high prevalence rates of HBV and HCV. However, previous studies have lacked laboratory components that document the prevalence of these BBD among Hajjees or barbers. The objectives of this study were to determine the prevalence of HBV, HCV and HIV among barbers during Hajj, and to study other factors associated with BBDs among them.

In a cross-sectional study, barbers working at head-shaving sites at Jamarat, where there are more than 200 barber-chairs, were recruited. The study yielded a random sample of 158 barbers, whose consent was obtained to draw their blood; 158 blood specimens were collected, sera were tested for the presence of markers for HBV, HCV, and HIV.

The mean age of the barbers was 30.9 ± 8.8 years (Range 14-65 years), they were from eight different nationalities, the majority; 72 (45.6%), were from Myanmar, 27 (17.3%) were from Egypt and 22 (14.1%) were from Bangladesh. About two-thirds of the barbers; 101 (64%) were found to work during the Hajj

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Blood-Borne diseases among barbers, Hajj 1419 H ....cont.

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season only, while professional licensed barbers were only 57 (36.1%). Most of the barbers had worked during previous Hajj seasons for a median of 2 to 5 years. More than four fifths of barbers, 128 (81%) reported that no diseases were transmittable by head shaving.

Laboratory tests revealed that 7 (4%) barbers tested positive for HbsAg, 16 (10%) for HCV, and one (0.6%) for HBeAg. None of the barbers tested positive for HIV, anti-HTLV 1&2, anti-HbsAg or Anti-HBc IgM.

There was a significant association between testing positive for HCV Antibody and nationality ($\chi 2 = 21.3$, $P<0.05$). Around one third of Egyptian barbers (9 or 32.1%), 3 Pakistani barbers (15%), and 4 barbers from Mayanmar (5.6%) tested positive for HCV, but none of those from other countries. HCV was relatively higher among barbers who had practiced head shaving at least in one previous Hajj season.

– Reported by: Dr. Abdulhafiz Turkistani, Dr. Ali Al Rumikhan and Dr. Tajammal Mustafa. Saudi Arabian Field Epidemiology Training Program.

Editorial Notes: This study reports, for the first time, the prevalence of HBV, HCV and HIV among barbers serving Hajjees during the Hajj season. Head shaving has been reported to be an occupational risk factor for BBD among barbers. Prevalence rates of HCV as high as 38% have been reported among Italian barbers (1). These results are certainly disturbing.

Barbers during Hajj are at risk to acquire a BBD from Hajjees, especially if they have a cut wound in their hand. A previous study documented that about a fourth of barbers had visible cut wounds in their hands. Conceivably, Hajjees are also at risk of being exposed to infected blood or contaminated head shaving instruments, especially if they have a cut wound on their scalps (2).

Strict supervision, screening and licensing of barbers is required to ensure that at least those working at areas supervised by the government are free from any Blood Borne Disease (see photo). Control measures have to be integrated with self-supervision by Hajjees themselves and barbers through intensified health educational programs.

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Photo showing Head-Shaving Area in Mina allocated and supervised by the Government

Glossary of terms

Hajj- Islamic pilgrimage to Makkah.

Hajjees- Muslim pilgrims.

Hijirah Calendar- The Muslim lunar year of 12 months calculated from the actual sighting of the moon.

1419 H (Hijirah) = 1999 Gregorian Calendar

Hajj season- 4-month period between Ramadan and Dhul Hijja months of the Hijirah Calendar.

Al Jamarat- Area near Makkah visited by hajjees during the hajj season.

Pulmonary Tuberculosis Outbreak in Riyadh city–center, 1999.

During the second school term (January-June) of 1999, five female secondary-school students were diagnosed with Active Pulmonary Tuberculosis (PTB). All were from Riyadh city-center. An investigation to determine the magnitude and source of this outbreak was started. A case was defined as any resident of Riyadh city-center, during the period from December 1998 to June 1999, with cough, with or without expectoration, hemoptysis, fever, anorexia, weight loss, chest pain and showing a positive tuberculin test (induration ≥ 10 mm) or a suggestive chest x-ray (CXR) or the presence of Acid Fast Bacilli in the sputum smear. A TB infection was defined as a positive tuberculin reaction.

Passive and active case finding was done in local Primary Health Care centers (PHC) and schools. Cases and contacts were interviewed using a structured questionnaire. Tuberculin skin tests and Mass Miniature Radiology (MMR) were performed. Normal CXR films were done for those with suspected MMR and/or positive tuberculin skin test. This outbreak was identified by a three-fold increase of PTB during the second school semester of 1999 as compared to the average of the previous two years within the same time period. The five cases had been attending five different schools (A, B, C, D & E). Schools A and C were at Ghubera, school B was at Shemaisy, while schools D and E were at Al-Dira and New Manfouha.

Of a total of 193 identified contacts, only 178 had had a tuberculin skin reading; 39 household and 139 school contacts. Among those 178, the infection rate was 52.2%. TB infection rate among household contacts was higher than that among school contacts (69.2% compared to 47.5%). The risk factors for positive tuberculin test included being household contacts (OR = 2.49, CI 1.09-5.74); non-Saudi nationality (OR = 2, CI 1.05-3.83); living at Al-Dira (OR = 5.57, CI 1.19-28.23) and Ghubera (OR = 3.73, CI 1.19-11.96) and father's occupation as driver (OR = 6.93, CI 1.71-30.38). The insignificant risk factors were age, no previous BCG vaccination, parents education, and crowd index. The first diagnosed case could have been the index case, whose source of infection might have been her father who had a history of incompletely treated PTB 16 years before. One of the other cases had a history of completely treated PTB three years before, which might have been reactivated.

- Reported by: Dr. Maysoon Al-Amoud, Field Epidemiology Training Program, and Dr. Ashry Gad Mohammed, Associate Professor of Epidemiology, King Saud University.

Editorial Note: Tuberculosis is a global public health problem. Although its incidence has increased among industrialised countries in recent years [1], it has however, declined in Saudi Arabia. During the second school semester of 1999, five cases of smear positive PTB cases were diagnosed among female secondary school students in Riyadh city-center. A state of anxiety and phobia spread among the students and teachers of the affected schools. No previous PTB outbreak in schools has been reported in Saudi Arabia, apart from one outbreak among students of the college of Medicine in Riyadh, 1997 [2]. The importance of this outbreak is highlighted by the fact that the affected cases were young adolescent females, whose ages ranged from 14 to 19 years, and who had no immunity impairment factors. The 5 cases were from the city-center, an overcrowded area with old, poorly ventilated houses. The diagnosis of PTB was missed by PHC centers attended by the patients at early stages of the disease. Three of the cases were Saudi unlike the usual pattern of TB in Saudi Arabia where most of the cases are non-Saudi [3,4].

In this outbreak, the TB infection rate among household contacts was higher than that among school contacts. Delayed diagnosis led to prolonged exposure to the cases, which may explain the high infection rate among contacts. Previous studies have reported that an estimated one-third to a half of smear-positive individuals close household contacts become infected. In a school outbreak in Italy, investigators reported that classroom, bus and residence contact were all independent predictors of the risk of TB infection [5]. In an outbreak at the medical college in Riyadh in 1997, the infection rate ranged from 36.8% among first year students to 45.2% among third year students. Contact may have occurred at the college's common areas, such as the cafeteria, library or mosque [2]

Although TB is a known health problem in Saudi Arabia, there was a delay in diagnosis in this outbreak, in spite of the fact that the cases had sought medical care within a short period of the onset of symptoms. This reflects a low index of suspicion for PTB of the physicians at the school health, government and private PHC centers. Physicians in all settings need to be familiar with the recently revised recommendations for the treatment of both TB infection and disease [6]. Proper screening of school contacts, management of cases and infected contacts, raising the suspicion index for TB, and promoting public health education are recommended.

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Non-Hodgkin's Lymphoma (NHL) in the Eastern Region of Saudi Arabia, 1997-1998

Non-Hodgkin's Lymphomas (NHL) are tumors of the lymphoreticular system. They represent the seventh tumor group in frequency world wide, with age-adjusted incidence rates of 7.7/100,000 among men and 5.2/100,000 among women (1).

In Saudi Arabia there were 1,197 cases of NHL diagnosed between January 1994 and December 1996 among Saudis, accounting for 7.4% of all newly diagnosed cancers. NHL ranked second for the male and fourth for the female populations (2). In the Eastern Region there were 68 cases of NHL diagnosed in the interval between January 1997 and December 1998 (3).

The aim of this study was to determine the risk factors for NHL in the Eastern Region of Saudi Arabia. A hospital-based case-control study was conducted. NHL cases for the years 1997 and 1998 were identified by reviewing the data in the National Cancer Registry and from the participating hospitals. Controls were selected among subjects who had no history of cancer, admitted as in-patients or out-patients in the same hospitals. Face-to-face interviews were conducted. Interview topics covered demographic characteristics (age, sex, and nationality), family and medical history, use of therapeutic drugs, history of viral infection, rheumatoid arthritis, blood transfusion, exposure to radiation, smoking, use of hair-colour products and occupation. Odds Ratios (OR), 95% confidence intervals (95% CI) were calculated. A P-value <0.05 was considered statistically significant.

A total of 205 subjects (41 cases and 164 controls) were included in the analysis. Out 41 cases, 27 (65.9%) were males and 33 (80.5%) were Saudis. A statistical significance of elevated risk for NHL was associated with female gender (OR=3.73, 95%CI=1.55-9, P-value=0.002), black skin (OR=4.81, 95% CI=1.33-13.1, P-value=0.008), and agricultural workers (OR=5.56, 95%CI=1.2-26.6, P-value=0.017) (Table.1) .

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Table 1. Risk factors for Non-Hodgkin's Lymphoma among cases and controls, Eastern Region, 1997-1998

Characteristic	Cases (41)		Controls (164)		OR	95% CI	P-value
	No.	%	No.	%			
Age group							
20 & under	8	19.5	35	21.3	0.89	0.34-2.3	0.49
21-40	10	24.4	68	41.5	0.46	0.19-1.1	0.03
41-60	10	34.1	40	24.4	1.61	0.72-3.6	0.14
60 & above	9	22	21	12.8	1.92	0.73-4.9	0.14
Gender							
Females	14	34.1	20	12.2	3.73	1.55-9	0.002
Skin color							
White	3	7.3	14	8.5	0.85	0.18-3.4	0.54
Black	8	19.5	9	5.5	4.81	1.33-13.1	0.008
Brown	30	72.2	141	86	0.44	0.18-1.1	0.05
Residence							
Rural	2	4.9	7	4.3	1.15	0.00-6.5	0.57
Urban	39	95.1	157	95.7	0.87	0.15-6.4	0.57
Education level							
Illiterate	12	29.3	51	31.1	0.92	0.40-2.1	0.49
less than secondary	15	36.6	76	46.3	0.67	0.37-1.8	0.37
Secondary & above	14	34.1	37	22.5	1.8	0.89-4.8	0.071
Medical conditions							
Herpes simplex virus	6	14.6	10	6.1	2.64	0.78-8.7	0.073
Hepatitis C virus	1	2.4	1	0.6	4.08	0.00-155.6	0.36
Rheumatoid arthritis	3	7.3	4	2.4	3.16	0.53-17.9	0.15
Blood transfusion	2	4.9	2	1.2	4.15	0.40-43.6	0.18
Therapeutic							
Cimitedine & other H2-receptor antagonists	2	4.9	2	1.2	4.15	0.40-43.6	0.18
Diagnostic X-ray	38	92.7	140	85.4	2.17	0.57-9.7	0.16
Smoking	9	22	41	25	0.84	0.34-2.1	0.43
Hair-color products							
Dye	4	10	7	4.3	2.49	0.57-10.3	0.15
Henna	3	7.3	12	7.3	1	0.21-4.1	0.61
Dec-oloration	1	2.4	2	1.2	2.02	0.00-30	0.49
Occupation							
Agricultural worker	5	12.2	4	2.4	5.56	1.20-26.6	0.017
Chemical industry	1	2.4	8	4.9	0.49	0.02-4.1	0.43
Textile worker	1	2.4	5	3	0.8	0.00-7.4	0.66

NHL in the Eastern Region of Saudi Arabia, 1997-1998 cont.

— Reported by: Dr. Abdulrahman Al-Khan, Dr. Nasser Al- Hamdan (Saudi Arabian Field Epidemiology Training Program), Dr. Nora Al-Nahedh (King Saud University), and Dr. Haya Al-Eid (National Cancer Registry).

Editorial note: This is the first study to determine the risk factors for NHL in the Eastern region of Saudi Arabia. Most of our results were consistent with previous sudies. A previous investigation reported a lower incidence rate of NHL for blacks than whites (4), but our results did not support this. The statistically significant elevated risk for NHL among blacks in our study may be explained by the fact that most of the residents of the Eastern region are of a brown race, and only a small proportion are of black race.

The elevated risk for NHL with living in a rural area in our results is probably due to the fact that the Eastern region is mainly an urban area with only a small number of people (Bedouins) living in rural areas.

The association between NHL and the use of drugs to treat ulcers is supportive of a previous study that suggested a link between cancer and use of cimetidine and other histamine H2-receptor antagonists used in the treatment of ulcers (5).

Experimental studies have shown that hair-colouring products contain mutagenic and carcinogenic components, which vary by hair-colour product type and colour (6). In the present study, the variation of NHL risk by product type is somewhat consistent with what would be expected based on concentration and formulation of the various hair-colour products. In this study we found that dye and decoloration types of hair-colour products, which may contain carcinogenic and amino compound, have an increased risk for NHL whereas henna, which is a natural product for hair-coloring, had no associated risk for

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Summary of Global Polio Eradication Plan of Action 2000 – 2005

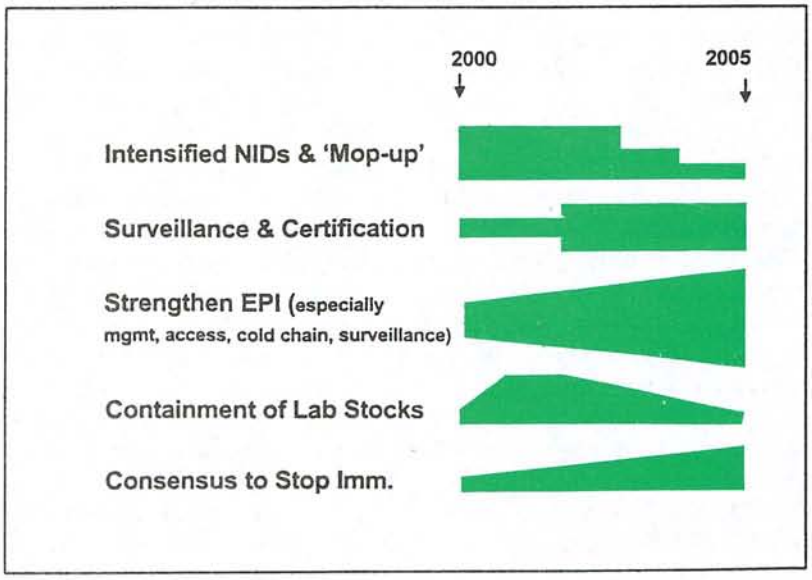
Although substantial progress towards polio eradication has been achieved during 1999, the interruption of poliovirus by 2000 or as soon as possible, will be feasible only if extraordinary efforts are taken in priority countries where polio remains endemic.

Realizing the full benefits of polio eradication will require not only stopping transmission but also a full agenda of work outlined in the strategic plan for the years 2000 – 2005 (see Figure 1).

- From 2000 – 2002, the focus will be on intensifying supplementary immunization (NIDs/mop-up) and surveillance activities to interrupt virus transmission in the 30 remaining endemic countries.
- From 2000 – 2005, surveillance and certification activities to guide intensified NIDs and to document the absence of polio in polio-free countries so that Regional and Global Certification commissions can certify eradication.
- From 2000 – 2005, a sharper focus on strengthening routine EPI, in cooperation with the Global Alliance on Vaccines and Immunization (GAVI), to secure gains and to build on lessons learned in polio eradication to date.
- From 2000 – 2005, activities to implement the Global Plan of Action for Laboratory Containment will accelerate. Laboratory containment of poliovirus is an essential part of the eradication activities in polio-free countries.

Finally, this plan of action summarizes the necessary research and policy planning required to establish an international consensus for stopping polio immunization in the post-eradication.

Figure 1. Polio Eradication Initiative Strategic Plan, 2000-2005



Source: WHO vaccine preventable diseases: monitoring system. 2000 global summary. WHO, Geneva 2000. 17-19.

Carbon monoxide poisoning: An overlooked diagnosis!

On August 28,1999, twenty females who had attended a wedding party sought medical care at two hospitals in Asir Region. They were complaining of vague symptoms comprising headache, dizziness, nausea, vomiting, drowsiness, lethargy, abdominal pain, loss of consciousness, dyspnoea, chest pain and palpitations. The diagnosis of food poisoning was made. Specimens of blood, urine, stools, and throat and rectal swabs were negative for pathogens. Carbon monoxide (CO) poisoning was not suspected and carboxyhemoglobin was not measured. All patients recovered and were discharged within 24 hours.

An epidemiological investigation was started and a case-control study conducted to determine the cause of illness. Odds Ratios (OR) along with 95 % confidence intervals (CI) were calculated for the association between the illness and potential risk factors. A case was defined as any person who had attended the wedding party on August 28,1999, between 9.00 a.m. and 3.00 p.m., and who had developed one or two of the following symptoms: headache, dizziness, nausea, vomiting, weakness, abdominal pain, loss of conscious, dyspnoea, and chest pain. Twenty cases and 39 controls were identified, all were interviewed using a standardized questionnaire.

The total number of wedding attendees was 60 females. They were divided into two groups; one group was seated inside the house, and the other in a tent built within the vicinity of the house. Investigation revealed that a fire was ignited at 9:00 a.m. using wood, and it was placed about 2 meters away from the tent outlet. At 10:00 a.m. a large bag of charcoal was added to the fire at once. It was a windy day and the wind was driving the smoke into the tent, which was about 15 x 10 meters, was closed from all sides, and had no opening except the outlet which was about 1.5 x 1.00 meters.

Cases developed symptoms after two to three hours of attending the wedding. The most common symptoms were vomiting 65%, headache 60%, drowsiness 55%, and nausea 35%, in addition to unconsciousness in one case. The median age of the victims was 28 years and all them were found to have sat in the tent. Non of those who had sat in the house became sick. Fifty-five percent of the victims had not consumed any food before onset of symptoms. However, all the non-affected attendees had eaten food. There was a strong association between the disease and the following risk factors: duration of exposure within the tent of over 1 hour (OR= 4.0), dancing (OR= undetermined), and young age group of 1 to 19 years (OR= 2.06).

– Reported by: Dr. Ahmed Al-Shihry and Dr. Tajammal Mustafa . Saudi Arabian Field Epidemiology Training Program.

Editorial Note: Carbon Monoxide is a colorless, odourless gas produced by incomplete combustion of carbon-based fuels. It has a higher affinity than oxygen to hemoglobin, forming carboxyhemoglobin which reduces the oxygen carrying capacity of hemoglobin thus depriving the tissue from oxygen and interfering with cellular respiration (1). Severe manifestations include coma, convulsions, myocardial infarction and death. Mild symptoms include vomiting, headache, nausea, and dizziness. The addition of charcoal to an already existing fire resulted in production of a large amount of CO.

The simultaneous demonstration of symptoms by all twenty cases who were inside the tent, absence of symptoms in those who were in the house, presence of a carbon monoxide source, and the strong association between risk factors and the disease suggests that this outbreak was due to carbon monoxide poisoning. Carbon Monoxide poisoning presents with vague signs and symptoms mimicking other diseases (2).

Misdiagnosis of CO poisoning as food poisoning is well known (3). This report should alert physicians to have a high index of suspicion of CO poisoning when dealing with patient(s) who present with a compatible clinical picture in the presence of risk factors.

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113 (1): 83-93.

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Notice to Contributors

The ***Saudi Epidemiology Bulletin*** is published quarterly by the Department of Preventive Medicine and the Field Epidemiology Training Program. This publication provides feedback between the Department of Preventive Medicine and medical staff in the Kingdom. The scope is public health in general and epidemiology of infectious and non-infectious diseases in particular, with emphasis on surveillance, outbreak investigation, applied research, hospital infection and innovative approaches. All medical personnel may contribute. Papers fulfilling the following requirements will be considered:

- The work should be original.
- Follow the Vancouver style [1] in preparing articles, which should be no longer than 500 words. An Arabic translation of the summary is desirable. Number references sequentially.
- The author is responsible for statements and figures, which should not have been previously published.
- Articles accepted for publication are subject to editing, including omission or amendment of material.
- Author's name, institute, full postal address, telephone and fax number should be provided.

Reference:

1. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. Saudi Med J 1991;12(6): 443-448.

NHL in Eastern Region of Saudi Arabia ..... cont.

(Continued from page 5)

NHL.

The small numbers of exposure to some variables in this study are most probably attributed to the small number of our studied cases. An additional study on a larger number of cases within more recent years would be very supportive.

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تابع ملخص اللغة العربية

أعمارهم بين ٢١-٦٠ سنة، و ٧٣٪ منهم من ذوي البشرة السمراء. ثلث الحالات كان مستواهم التعليمي فوق الثانوي.

و قد بينت هذه الدراسة أن عوامل الخطورة لسرطان الغدد الليمفاوية غير هودجكن ذات الدلالة الإحصائية هي جنس الإناث و البشرة السوداء وقد يفسر هذا بأن أغلب سكان المنطقة الشرقية ذوو بشرة سمراء اللون ونسبة ضئيلة ذوو بشرة سوداء وهم غالباً من جنسيات غير سعودية، و العمل بالزراعة ويشمل عامل رش المبيدات الحشرية. أما عوامل الخطورة المرتفعة التي ليست لها دلالة إحصائية فكانت الأعمار فوق الأربعين، العيش في المناطق الريفية، المستوى التعليمي فوق الثانوي (وهذا لا يتوافق مع دراسات سابقة)، التاريخ المرضي لكل من روماتيزم المفاصل والالتهاب الكبدي (ج) ونقل الدم و التعرض للأشعة التشخيصية و استعمال أدوية القرحة، إضافة إلى استخدام أصباغ الشعر الكيماوية و جميعها تتوافق مع دراسات أخرى سابقة.

و توصي الدراسة بتكرار عمل دراسة مشابهة على عينة أكبر و معلومات أحدث.

إعداد :

د. عبد الرحمن الخان

برنامج الوبائيات الحقلي

ملخص باللغة العربية

الأمراض المنتقلة عن طريق الدم بين الحلاقين في حج عام ١٤١٩هـ

من الأمراض المنتقلة عن طريق الدم مرضى الالتهاب الكبدي (ب ، ج) ومرض نقص المناعة المكتسبة (الإيدز). ومن طرق انتقال العدوى الغير معروفة لدى الناس الممارسات الخاطئة لبعض الحلاقين، وخصوصا في مواسم الحج والعمرة، متمثلة في عدم التزام البعض منهم بالقواعد الصحية كاستعمال شفرة حلاقة واحدة لحلاقة شخص واحد فقط. وقد لوحظ في دراسة سابقة وجود جروح في أيدي بعض الحلاقين وكذلك وجود بعض الجروح على رؤوس بعض الحجاج بعد الحلاقة. و قد أجرينا هذه الدراسة لمعرفة مدى انتشار الأمراض المنتقلة عبر الدم عند الحلاقين، و للمقارنة بين الحلاقين النظاميين والغير نظاميين من حيث خلوهم من هذه الأمراض.

تمت مقابلة ١٥٨ حلاقاً و أخذت عينة دم لكل منهم. و كان متوسط أعمارهم ما بين ١٤- ٦٤ سنة، و معظمهم من الجنسيات البورمية، المصرية، و الباكستانية. و شكل الحلاقون الذين يعملون في مواسم العمرة والحج فقط ثلثي الحلاقين، بينما شكل الثلث الآخر الذين يعملون في الحلاقة بشكل مستمر خلال السنة. وقد وجد أن اكثر من ٨٠ ٪ منهم لا يعلمون بان هنالك أمراضاً يمكن أن تنتقل بواسطة الحلاقة. و بالنسبة إلى نتائج تحاليل عينات الدم فتبين أن حوالي ٥ ٪ من الحلاقين لديهم التهاب الكبد (ب) و ١٠ ٪ لديهم التهاب الكبد (ج). ولم تظهر التحاليل وجود فيروس مرض نقص المناعة المكتسبة . و وجد أن أعلى نسبه للفيروس الكبدي (ب) بين البورميين والباكستانيين، أما أعلى نسبه للفيروس الكبدي (ج) فكان بين المصريين يشاركهم الباكستانيون. كما وجد أن من يمتهنون الحلاقة كوظيفة أساسيه هم اكثر الشرائح عرضة للإصابة بالالتهاب الكبدي (ج).

و قد تمت التوصية على وجوب فحص الحلاقين دوريا كل سنة قبل موسم الحج للتأكد من خلوهم من الأمراض المعدية وإعطائهم شهادات صحية بذلك، كما يجب عدم السماح لأي عامل من مهنة أخرى غير الحلاقة بالعمل في أماكن الحلاقة الرسمية و وضع عقوبات صارمة لمن يزاول مهنة الحلاقة بدون ترخيص صحي، إضافة إلى توعية الحجاج وتنبيههم الى عدم استعمال أي شفرة حلاقة استعملت من قبل شخص آخر وذلك عن طريق نشرات توزع على الحجاج بعدة لغات.

إعداد:

د. عبدالحفيظ تركستاني

و د. علي الرميخان.

برنامج الوبائيات الحقلي.

عوامل الخطورة لسرطان الغدد الليمفاوية غير هودجكن بالمنطقة الشرقية-محرم ١٤٢١هـ

يصنف سرطان الغدد الليمفاوية غير هودجكن سابعا على المستوى العالمي. و قد وجد أن معدل حدوث هذا النوع من السرطان خلال العشر سنوات السابقة في ازدياد ملحوظ. و قد بلغ إجمالي الحالات في المملكة العربية السعودية ١١٩٧ حالة في الأعوام ١٩٩٤ الى ١٩٩٦م. أما في المنطقة الشرقية فقد بلغ مجموع الحالات خلال عامي ١٩٩٧و ١٩٩٨م ما يقارب ٦٩ حالة. كان الهدف من هذه الدراسة التعرف على عوامل الخطورة لهذا النوع من السرطان وذلك من خلال دراسة مقارنة أجريت في المنطقة الشرقية بالمملكة العربية السعودية.

تمت معرفة حالات السرطان الليمفاوي الغير هودجكن المشخصة بالمنطقة الشرقية خلال عامي ١٩٩٧ و ١٩٩٨م عن طريق السجل الوطني للأورام بالرياض و بواسطة المستشفيات المشخصة للحالات. أخذت الحالات الضابطة من الأقسام الداخلية والعيادات الخارجية من نفس المستشفيات التي وجدت فيها الحالات المصابة.

تمت مناظرة ٤١ حالة (٣، ٦٠٪) من مجموع ٦٩ حالة مشخصة، كان من بينهم: ٢٧ ذكراً (٦، ٦٥٪) و ٣٣ (٥، ٨٠٪) سعودي. كانت أغلب الحالات (٦٠٪)

Selected notifiable diseases by region, Jan - March 2000

	Riyadh	Makkah	Jeddah	Taif	Madinah	Qassim	Eastern	Hasa	Hafr Al Batin	Asir	Bisha	Tabuk	Hail	Al Shamal	Jizan	Najran	Baha	Al Jouf	Goriat	Gonfuda	Total
Measles	21	13	38	8	10	19	4	18	7	6	5	4	6	0	20	0	1	0	0	0	180
Mumps	77	45	69	32	58	46	24	11	5	12	8	21	11	4	35	6	2	1	11	14	492
Rubella	5	13	8	2	7	5	1	0	3	6	0	0	1	0	0	0	0	0	2	0	53
Varicella	831	234	727	229	398	308	1075	210	215	374	110	153	109	33	52	92	24	50	104	55	5383
Brucellosis	107	14	6	45	29	171	19	10	52	241	34	6	185	7	67	44	20	12	4	9	1082
Meningitis mening.	3	110	20	2	15	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	151
Meningitis, other	84	2	5	12	7	8	7	9	9	9	3	4	3	0	8	1	1	2	0	0	174
Hepatitis A	32	98	56	3	42	38	15	7	14	60	1	54	6	14	19	76	0	12	12	1	560
Hepatitis B	78	59	221	1	39	28	146	7	4	32	20	6	10	0	16	2	47	0	0	5	721
Hepatitis C	17	49	186	0	25	14	53	6	3	0	3	1	4	1	0	2	25	0	0	0	389
Hepatitis, unspecified	6	47	12	0	5	0	2	5	0	32	0	22	21	0	145	2	0	2	0	0	301
Typhoid & paratyphoid	7	5	0	1	7	2	8	1	1	14	3	5	11	4	7	1	0	0	0	0	77
Amoebic dysentery	33	7	584	13	0	31	15	9	0	65	23	40	3	0	2	21	0	0	3	7	856
Shigellosis	12	0	6	0	2	2	11	0	17	0	0	13	0	0	0	7	0	0	0	2	72
Salmonellosis	28	4	21	0	3	6	132	7	15	8	0	17	0	1	0	15	9	0	0	0	266
Syphilis	2	0	5	0	0	0	9	4	0	1	2	0	4	0	0	0	0	0	1	0	28
VD, other	1	0	35	0	0	0	17	19	1	5	1	0	1	0	6	1	0	0	1	0	88

Comparisons of selected notifiable diseases, Jan-Mar 1999-2000

DISEASE	Jan-Mar 2000	Jan-Mar 1999	Change %	Jan-Mar 2000	Jan-Dec 1999
Diphtheria	0	0	0	0	0
Pertussis	2	3	-33	2	9
Tetanus, neonatal	1	1	0	1	12
Tetanus, other	3	1	200	3	7
Poliomyelitis	0	0	0	0	0
Measles	180	1173	-85	180	2815
Mumps	492	656	-25	492	2290
Rubella	53	80	-34	53	299
Varicella	5383	6705	-20	5383	23087
Brucellosis	1082	1408	-23	1082	6250
Meningitis, mening.	151	5	2920	151	20

DISEASE	Jan-Mar 2000	Jan-Mar 1999	Change %	Jan-Mar 2000	Jan -Dec 1999
Meningitis, other	174	185	-6	174	613
Hepatitis A	560	556	1	560	2365
Hepatitis B	721	616	17	721	3076
Hepatitis C	389	364	7	389	1737
Hepatitis, unspec.	301	196	54	301	960
Typhoid/paratyph.	77	75	3	77	390
Amoebic dysentery	856	1008	-15	856	3522
Shigellosis	72	174	-59	72	551
Salmonellosis	266	369	-28	266	2145
Syphilis	28	35	-20	28	220
VD, other	88	105	-16	88	460

Diseases of low frequency, January – March 2000

Yellow fever, plague, diphtheria, poliomyelitis, rabies, transverse myelitis, echinococcosis, haemolytic uraemic syndrome, puerperal sepsis: No cases

Pertussis: 2 (Makkah 1, Jeddah 1)

Tetanus neonatal: 1 (Jeddah 1)

Tetanus, other: 3 (Jeddah 3)

Guillain-Barre syndrome: 21 (Riyadh 5, Taif 1, Makkah 1, Jeddah 6, Qassim 1, Tabuk 1, Jouf 1, Goriat 1, Hassa 1, Hail 2, Gonfoda 1).

Selected notifiable diseases by region, April - Jun 2000

	Riyadh	Makkah	Jeddah	Taif	Madinah	Qassim	Eastern	Hasa	Hafr Al Batin	Asir	Bisha	Tabuk	Hail	Al Shamal	Jizan	Najran	Baha	Al Jouf	Goriat	Gonfuda	Total
Measles	19	17	30	7	16	23	23	12	6	7	5	10	8	0	1	0	3	0	0	1	188
Mumps	37	17	44	8	60	28	25	22	8	17	3	14	8	5	10	8	2	3	3	0	322
Rubella	5	3	15	0	3	11	13	1	1	5	0	0	1	0	3	0	0	0	1	0	62
Varicella	825	373	903	290	494	354	1621	453	366	391	69	225	189	151	50	75	66	45	117	43	7100
Brucellosis	172	13	6	59	39	436	91	34	105	322	114	16	315	26	45	82	11	33	6	9	1934
Meningitis, mening.	13	50	26	3	41	0	4	0	0	0	0	0	1	0	1	0	0	0	1	0	140
Meningitis, other	70	51	89	4	23	12	7	11	5	6	1	11	1	0	13	1	0	3	0	0	308
Hepatitis A	32	119	70	0	46	19	15	4	0	58	0	39	2	2	16	77	2	5	4	0	510
Hepatitis B	96	101	206	5	62	36	174	4	1	40	11	10	10	9	8	8	49	3	1	2	836
Hepatitis C	23	84	229	0	29	32	83	8	0	4	2	2	5	3	1	0	6	0	0	0	511
Hepatitis, unspecified	11	28	22	0	4	5	0	2	0	7	0	43	17	0	84	8	0	3	0	0	234
Typhoid & paratyphoid	23	26	3	0	9	1	15	1	0	21	8	14	0	6	4	0	3	0	1	0	135
Amoebic dysentery	14	3	449	9	0	27	10	5	1	82	8	32	6	0	1	30	0	0	9	1	687
Shigellosis	8	2	1	0	0	8	5	1	5	0	0	14	0	1	0	5	0	0	0	0	50
Salmonellosis	60	4	18	0	7	8	212	8	8	8	0	27	0	1	0	38	4	0	0	2	405
Syphilis	5	0	19	0	0	0	6	5	0	5	2	0	2	0	12	0	0	0	1	0	57
VD, other	2	0	35	0	0	0	16	18	0	11	0	0	0	0	0	0	0	0	4	0	86

Comparisons of selected notifiable diseases, April-Jun 1999-2000

DISEASE	Apr-Jun 2000	Apr-Jun 1999	Change %	Jan-Jun 2000	Jan-Dec 1999	DISEASE	Apr-Jun 2000	Apr-Jun 1999	Change %	Jan-Jun 2000	Jan -Dec 1999
Diphtheria	0	0	0	0	0	Meningitis, other	308	116	166	482	613
Pertussis	3	3	0	6	9	Hepatitis A	510	710	-28	1070	2365
Tetanus, neonatal	2	2	0	3	12	Hepatitis B	836	852	-2	1535	3076
Tetanus, other	3	0	300	6	7	Hepatitis C	511	381	34	900	1737
Poliomyelitis	0	0	0	0	0	Hepatitis, unspec.	234	307	-24	535	960
Measles	188	1230	-85	368	2815	Typhoid/paratyph.	135	137	-1	211	390
Mumps	322	737	-56	803	2290	Amoebic dysentery	687	783	-12	1543	3522
Rubella	62	125	-50	115	299	Shigellosis	50	121	-59	122	551
Varicella	7100	8827	-20	12483	23087	Salmonellosis	405	531	-5	671	2145
Brucellosis	1934	2244	-14	3016	6250	Syphilis	57	49	16	109	220
Meningitis, mening.	140	16	775	291	20	VD, other	86	90	-4	174	460

Diseases of low frequency, April– June 2000

Yellow fever, plague, diphtheria, poliomyelitis, rabies : No cases
Pertussis: 3 (Eastern 2, Jeddah 1)
Tetanus neonatal: 2 (Jeddah 1, Jizan 1)
Tetanus, other: 3 (Jeddah 1, Jizan 1, Assir 1),
Echinococcosis: 4 (Riyadh 2, H.Batin 2)
Guillain-Barre syndrome: 20 (Riyadh 6, Qassim 4, Jeddah 2, Assir 2, Tabuk 2, Eastern 2, H.Batin 1, Hassa 1)

Saudi Epidemiology Bulletin (SEB) is published quarterly by the Department of Preventive Medicine and the Field Epidemiology Training Program (FETP) of the Ministry of Health.

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