

## Diets in Liver Diseases

Sir,

This is with reference to the article "Perception and knowledge about dietary intake in patients with liver cirrhosis and its relationship with the level of education" by Rustam Khan *et al.* JCPSP 2012; 22 (7):435-439.

It has aptly been said by Socrates that "Nutrition ends in Medicine and Medicine ends in Nutrition".

With reference to the article I would like to state that on this subject there have been many previous publications in Pakistan. A study based upon dissertation on infective hepatitis in which epidemiological, clinical and biochemical aspects of viral hepatitis for the period 1950-1958 was published in the Pakistan Armed Forces Medical Journal (PAFMJ).<sup>1</sup> About nutrition of the patient, it was concluded that there was a tendency to deprive the patients of fats, proteins etc. During the acute stage of illness when the patient is suffering from nausea/vomiting, it is rational to avoid fats but as soon as these symptoms subside, the patient should be encouraged to have palatable nutritious diet. Food cooked without fat is unpalatable and further aggravates anorexia. In the Armed Forces, the patients are placed in "C" category of diets containing carbohydrates 35 – 500 gms, fats 80 gms and proteins 120 – 150 gms. Similarly, the patients suffering from chronic liver diseases are also provided high caloric diets. Restriction on proteins is placed when there is evidence of impending hepatitis coma and these are withdrawn as soon as patient is stabilized.

During the World War II, a study was carried out on patients of acute viral hepatitis in which one group was placed on liberal diet and the other on restricted diet supplemented with vitamins. It was concluded that those who were on liberal diet recovered and resumed active duties much earlier. The recommendations of famous hepatologists like Dr. Sheila Sherlock and others have been in favour of nutritious diet. The belief and practice of subjecting the patients to malnutrition is not only confined to the patients and their families but also to family doctor and also many specialists including gastroenterologists. I have worked in Nigeria (Africa) and did not find such beliefs and practice amongst them. In our culture, there are embedded and rooted belief systems propelled by the traditional medicine systems that food like eggs, chicken, meat, fish, nuts, oils and milk etc. are hot, while cucumber and many other items of food are cold and some foods are "Badee" (local term for unsuitable foods like cauliflower etc.) and rice is unhealthy and is forbidden when a person falls ill, the combination of fish and milk causes leucoderma and many other similar beliefs.

Due to these medieval belief systems, superstitious, taboos and myths about diets is not only harming the patients but also the health of the people is adversely affected as items of nutritious food are withdrawn or restricted on arrival of summer months which form a major part of our season.

The remedy of this problem lies in proper education of doctors, nurses and paramedicals in the discipline of nutrition and dietetics. Instead of burdening the medical students with the useless knowledge of biochemistry, there should be emphasis on clinical nutrition and dietetics which have practical value in the prevention of diseases, promotion of health and treatment of diseases. The subject of clinical nutrition and dietetics should be a part of the continued medical education during the undergraduate and postgraduate levels as well as later on. Doctors should take dietetic history educate and motivate their patients about nutrition and diets.

Pakistan is a poor country, therefore, it cannot afford the services of large number of dietitians. Of course hospitals should have dietitians.

As a matter of fact, the subject of nutrition and dietetics should be taught in schools and colleges also and the public should be made aware of this subject through the media both print and electronic.

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*Mahmud Ahmad Akhtar*

*Pak Army, D.G.M.S. (Inter Services), Rawalpindi.*

*Correspondence: Lt Gen. Prof. Mahmud Ahmad Akhtar, Medical Specialist, 43 Race Course Road, Rawalpindi.*

*E-mail: mahmudahmadakhtar@hotmail.com*

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### Reply of Author

Sir,

Thank for sending comments on our study "Perception and knowledge about dietary intake in patients with liver cirrhosis and its relationship with the level of education". It is rightly said that many studies has been published on the topic of "diet in cirrhosis" both in indexed and non-indexed journals in Pakistan as well as worldwide. In current study, we highlighted that significant proportion of our population, irrespective of social status or educational level, had false perception and knowledge about diet in cirrhosis of liver. As the word "hepatitis" go, many people start avoiding meat, fish, chicken, eggs and fats in their diet as a reflex action due to various

taboos and myths about diet resulting in weight loss, low body mass index (BMI), haemoglobin and albumin level. The overall impact of this behaviour is impairment of nutritional status of the patient.

This attitude may be due to various reasons like improper advice from medical professionals, family members, friends or patients' own choices. Another important factor in this regard may be traditional methods of treatments called "HIKMAT" as in their philosophy more emphasis is given to diet restrictions and local term like "PARHAIZ" "HOT or COLD and BADEE foods" are in common use in this regard. Many people are probably influenced by this traditional medicine even if they are not being treated by "Hakeem".

Based upon the observations in this study, medical professionals are the main source of dietary information to the patients either alone or in association with family, friends and patients' own choices so, it is essential to update the knowledge of the medical professionals about nutrition in cirrhosis through electronic and print media, seminars, workshops and continuous medical education (CME).

In hospital setting, qualified dietitians had important role in screening, assessment, patient's education and nutritional support through oral, enteral and parenteral routes and this facility is underutilized in many hospital settings.

Whether nutrition topic should be added to the under graduate curriculum or not is a debatable issue and my personal view is "it should be" as biochemistry is already taught in pre-clinical phase and additional topic of nutrition principles can be added in medicine or community medicine.

In patients with cirrhosis, we can improve overall well-being and may prevent many complications through good nutrition. Secondly, hospital stay and frequency of re-admission can also be reduced by improving nutritional status by properly implementing nutrition principles in these patients.

*Rustam Khan*

*Department of Medicine and Gastroenterology, The Aga Khan University Hospital, Karachi.*

*Correspondence: Dr. Rustam Khan, Department of Medicine and Gastroenterology, The Aga Khan University Hospital, National Stadium Road, Karachi-74800.*

*E-mail: khan.rustam@aku.edu*

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## Cancer Registration in Pakistan

Sir,

The total population of Pakistan is over 180 million, with the gross national income per capita being \$2,590.<sup>1</sup> A heavily populated, resource-constrained country

like Pakistan does not have a functioning national population-based cancer registry; nor does it have an operational program for the early detection of cancer.<sup>1</sup> Further, the data on death-registration including the causes of death is limited. Although it is difficult to set-up a population-based registry and generate the crude and age-standardized rates, it is a pre-requisite for developing any cancer control programs in the region.<sup>2</sup> The only established population-based cancer registry in the country is the Karachi Cancer Registry (KCR) representing the Karachi South district and accounting for nearly 1% (1,723,617) of the total population of the country.<sup>3</sup> Since the KCR covers a fraction of the total population of Pakistan, whether the incidence, mortality, and survival reported can be extrapolated to the population of the country, is debatable. Accordingly, many more registries need to be set-up as a core component of the non-communicable disease surveillance program.

In Lahore, attempts are being made to establish a population-based registry, as per international requirements, providing coverage to the residents of Lahore district. The registry called the Punjab Cancer Registry has been in existence since 2005 and is being run by a private cancer treatment facility of the city.<sup>5</sup> Even though the efforts to collect relevant information on cancer cases from various centers of the city are ongoing, it has been estimated that a significant proportion of the cases (40%) are still not being reported to the Registry.<sup>5</sup> Therefore, the incidence, mortality, and survival estimates cannot be computed with the data available. The underreporting is attributable to a low level of awareness about the importance of disease surveillance, paucity of funds and infrastructure, and reluctance on the part of some professionals to participate in cancer reporting. Despite these hurdles, there is no doubt that efforts towards comprehensive cancer registration should continue. Further, given the scenario, it may be worthwhile considering concomitant disease-specific, population-based cancer registration. This could be initiated at a district level by making "special-interest" working groups comprising professionals who are keen about cancer reporting and could work on 1 – 2 different types of cancer of particular interest to them. The working groups could include general practitioners, oncologists, pathologists, radiologists, surgeons, statisticians, epidemiologists, and medical coders, assigned with the responsibility of capturing information initially on cancers commonly reported at a global level, following-up on them, and reporting them. The six most commonly reported cancers in Asia are: breast, lung, stomach, cervix uteri, liver, and colorectum.<sup>4</sup> By assigning each group with the task of collating information on 1 – 2 cancer type(s) diagnosed in a specified population within a geographically demarcated area over a defined time period, the quality of data collected and the number of

cases captured could improve. This could perhaps be the way forward in the area of cancer registration in Pakistan.

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*Farhana Badar*

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*Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore.*

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*Correspondence: Dr. Farhana Badar, Senior Biostatistician and Cancer Epidemiologist, Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore-54770.*

*E-mail: farhana@skm.org.pk*

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