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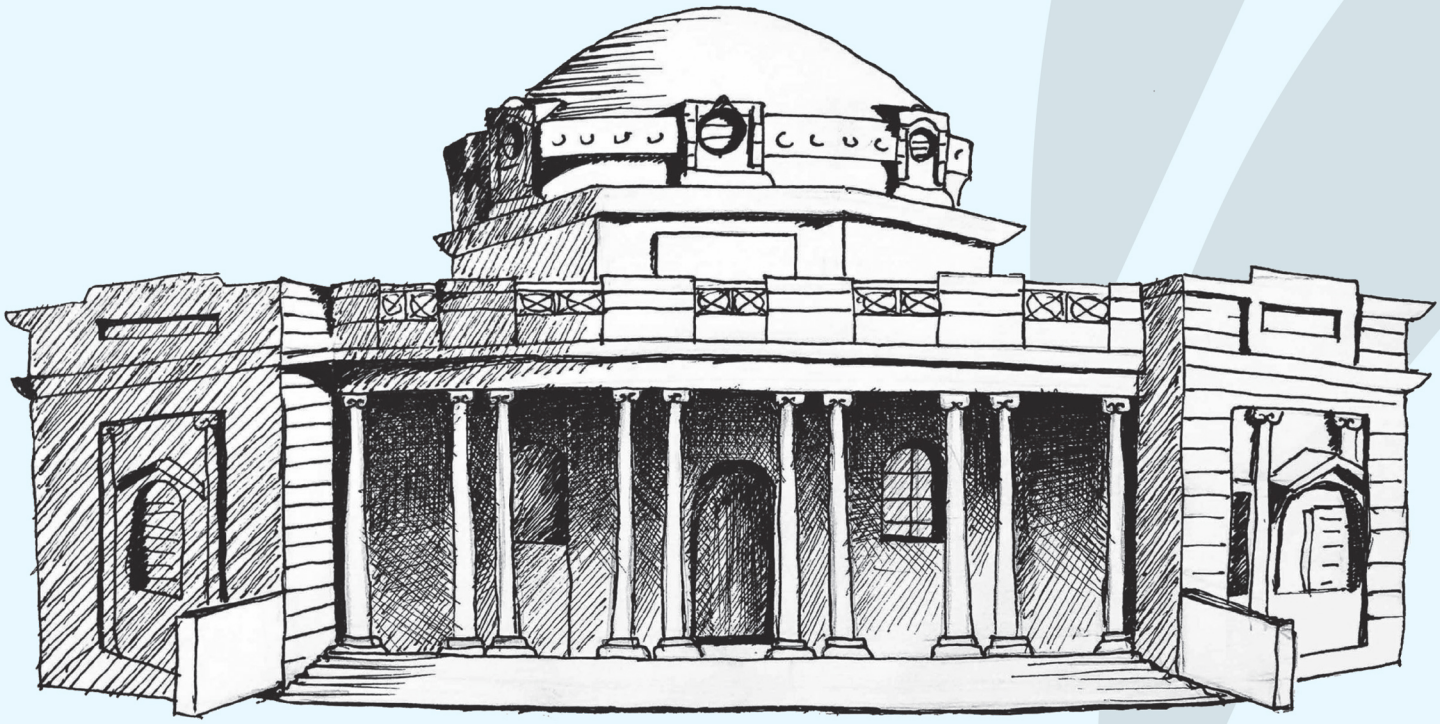

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Contents :

Dear readers,

Al-Hakeem journal's editorial team welcomes you and wishes you a pleasant journey while flipping through its pages. We sincerely hope that it meets your expectations, fulfills its goals and attains your admiration.

Al-Hakeem journal is back after decades of being unpublished. It's indeed a gratification for us to establish the vision and mission of the magazine and we would be very pleased to work as a team to get the best of it.

- Al Hakeem is a student journal that endeavors to publish research and scientific papers presented by the medical students, in addition to the research conducted during different activities , as well as publishing the latest updates related to the academic, medical, health and scientific aspects from inside and outside the faculty.

- But why Al-Hakeem?

We reckon the significance of scientific research for undergraduates, particularly medical students. The journal highlights the importance of the existence of an entity that represents students and provides them with a platform to publish their research.

- The idea of re-issuing Al-Hakeem came up not long ago. Many of those who worked to help us made a lot of effort, supported and encouraged us. They included professors, graduates and students. so, we are grateful to all of them.

We all hope this journal meets your expectations . It is always open for all those who want to publish their works. We would be delighted to listen to your opinions and suggestions.

Depression among blind people in Sudanese National Association of Blind people in Khartoum North locality in Khartoum state in 2016

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Abstract:

Background: Blindness is an overwhelming personal catastrophe. Loss of sight, accompanied with loss of occupation and mobility have profound consequences for the victim, family and society. The impact of vision loss on activities such as leisure activities, reading and driving could explain the link between vision loss and psychological stress. This research is conducted to address the psychological impact of blindness. Early treatment of depression may reduce the added disability that is associated with vision loss.

Objectives: To assess frequency and risk factors of depression among blind people in The National Association of Blind people in Khartoum North State

Methods and materials: A facility based cross sectional descriptive study was conducted at Sudanese National Association of Blind people. Systematic random sampling technique was used to select 185 of blind people including all age groups and gender. Data was collected using two questionnaires; beck depression inventory scale and another one addressing sociodemographic variables and risk factors of depression.

Results: Out of 185 respondents 84.3% were males, 42.2% were born blind, 53.5% were partially blind, and most of them 38.9% have no social support. The most impressive result was that the prevalence of depression was just 11.4%. People who were born blind and those who have been blind for long time have low level of depression.

Conclusion: The results have shown that people born blind had a lower

risk of depression in their lives. They also showed that with time, blind people accepted their disability and enjoyed their life and people who lost their sight due to trauma have high levels of depression in comparison with other causes of blindness therefore they needed more psychological support.

Recommendations: Blind people should have special educational institutions. Government are recommended to provide jobs for all blind people. There should education of family members to encourage them to be independent.

Background:

Vision is one of the most treasured senses. Most of us can hardly imagine what it will be like to lose it, to need assistance with daily activities or to have difficulty recognizing friends and family members. The diagnosis of vision loss is a traumatic event that may result in depression, People vary greatly in their reaction to the loss of vision i.e. they are likely being influenced by personal characteristics and social circumstances. Nevertheless, the experience of this case is subjective and may have different meaning for different people therefore they differ in their adjustment and rehabilitation outcome.

Loss of sight, accompanied with loss of occupation and mobility have profound consequences for the victim, family and society [1]. Attitude of society is the main difficulty in the development of people with disabilities because the society considers the person with vision loss as a burden, dependent and an object of pity, these attitudes impact negatively on their psychological well-being [2]. The impact of vision loss on daily activities could explain the link between vision loss and psychological stress.

Social support and psychosocial intervention show promise for buffering against the negative psychological impact of vision loss, also physical support helps blind patients in completions of their daily tasks which may help them in accepting their disability. Co-operation between physician and mental health professionals is key

to helping them to re-integrate in society [3]. Moreover working with groups of blind people has been helpful in adjustment to recent onset of visual impairment by integrating them into activities. [4]

Depression is not only disability in its own, but is very likely to act as a barrier to good vision rehabilitation outcomes. It is associated with problems of well-being, poor quality of life and problems in health and social participation. It also represents a secondary source of disability [5].

This study was aimed to assess frequency and risk factors of depression among blind people registered in The National Association of blind people in Khartoum North locality.

Materials and Methods: A facility based cross sectional descriptive study was conducted at Sudanese National Association of blind people in Khartoum North locality, Khartoum State.

Systematic random sampling technique was used to select 185 of blind people including all age groups and gender. Data was collected using two questionnaires; beck depression inventory scale and another one addressing sociodemographic variables and risk factors of depression.

Results: Out of 185 respondents 84.3% were males, 42.2% were born blind& 53.5% were partially blind.The prevalence of depression was just 11.4%.

Table 1. Frequency of depression in blind people

State of depression	Frequency	Percent
Normal	164	88.6%
Depressed	21	11.4%

Table 2. Association between cause of blindness and state of depression among blind people at Sudanese National Association of Blinds (n=185)

Cause of blindness	State of depression		Total
	Normal	Depressed	
Congenital	76	2	78
Glaucoma	22	4	26
Cataract	17	1	18
Trauma	16	6	22
Disease related blindness	33	8	41
Total	164	21	185

Table 3. Period of blindness and onset of depression

Time since blindness	state of depression		Total
	Normal	Depressed	
At birth	76	2	78
<16	52	12	64
>15	36	7	43
Total	164	21	185

Discussion:

The most striking finding of this study was that the prevalence of depression among blind people at Sudanese National Association of blind people was just 11.4% in comparison with other study done in Portugal which was 28%(5).This due to the social support from their families and friends. Another interesting finding is that those who had born blind experienced less depression perhaps because they were better adapted to their situation and were often more embedded in blind culture compared with others. Those who have recently lost their sight were more depressed than those who lost their eye sight for a long time. Many of those who have had a long term sight loss are properly might have attended specialist schools, and were properly given appropriate training for certain jobs. They are likely to have friends who are also blind or partially blind.

In addition, they are also likely to have been introduced to the available technology to help them cope with everyday activities. They may well have greater confidence both in using technology and in moving around their environment. Confidence is likely to increase with the length of time a person has experienced sight loss as they learn to live with their condition and become more familiar with relying on other senses. It is harder for those who have recently lost their sight because they know what they are missing and they are unhappy because they become dependent on others which is very traumatic. Those newly diagnosed need particular help as they do not have this background experience of building confidence. Agrees with the results of so many studies addressing the effect of time since blindness on the level of depression [(6)].

Conclusion: The results have shown that people who were born blind are at lower risk of

experiencing depression in their lives. They also showed that with time, blind people accept their disability and enjoy their lives and People who lost their sight due to trauma had high levels of depression, therefore they need more psychological support.

Recommendations: Blind people should have special educational institutions. Government are recommended to provide jobs for all blind people. There should education of family members to encourage them to be independent

References:

1.FtizgeraldRG,EbertJN,Chambers M. Mathenge W, Kuper H, Limburg H, Polack S, Onyango O, Nyaga G, et al. Rapid assessment of avoidable blindness in Nakuru District, Kenya. Reactions to Blindness: A Four-Year Follow-up Study. Percept Mot Skills. 1987;64(2):363–78.

2. Gronmo, S. J., & Augestad, L. B. Physical activity, self Self-concept, Adjustment to Blindness, and Quality of Friendship Among Adolescents with Visual Impairments. concepts, and global self-worth of blind youths in Norway and France,2001;40:2 15 -

3. Llb EAK, El S, Bm G, Peveler RC, Dphil MA, Bch BM. Psychosocial needs of elderly visually impaired patients .pilot study of patients ' perspective. 2007;1–14.

4. De LD, Hickey PA, Meneghel G et al. Blindness, fear of sight loss, and suicide. Psychosomatics 1999;40: 339–44.

5. Hugo senra, Elizabeth, Depression and experience of vision loss in group of adults in rehabilitation setting in faculty of psychology in Portugal, 2013;50(9):1301 1314 -.

6. Tsai SY, Cheng CY, Hsu WM, Su TP, Liu JH, Chou P. Association between visual impairment and depression in the elderly. J Formos Med Assoc. 2003;102(2):86 90 -.

Causes of long duration of medical treatment of Actinomycetoma, Mycetoma Research Center, Soba University Hospital, 2016

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Abstract:

Mycetoma is an endemic tropical disease. The cure rate of Mycetoma in Sudan is only 43.3%, the main cause of which is the long duration of treatment (mean duration of treatment is 18 months), which lead to high drop-outs of patients.

The objective of the study was to identify the causes that lead to this long duration, to help increasing the medication efficacy, and the cure rate.

A descriptive cross-sectional study was conducted. Records of all Actinomycetoma patients presented to the Mycetoma Research Center (MRC) between (2012 and 2015) were reviewed.

Data of 348 of the Actinomycetoma patients was analyzed using Pearson's Chi-square test of association.

Five factors were found to have an association with the duration of treatment: The type of treatment (95% CI, p=.003), the regularity of taking medications (95% CI, p=.02)), number of missed follow up visits (95% CI, p=.006), the occupation of the patient (95% CI, p=.009), and the radiological findings at first presentation (95% CI, p=.03).

Those findings enrich knowledge about this neglected tropical disease, and may help in planning for treatment strategies in the future.

Key Words: Actinomycetoma, Mycetoma

Introduction:

Mycetoma is a chronic specific granulomatous, progressive and disfiguring subcutaneous inflammatory disease.It's caused by true fungi or by higher bacteria and according to this it is classified into Eumycetoma or Actinomycetoma respectively [1].

The triad of painless subcutaneous mass, sinuses formation and purulent and sero-purulent discharge that contains grains is pathognomonic of Mycatoma. [1].

Actinomycetoma is amenable to medical treatment with antibiotics and other chemotherapeutic agents, however, these drugs take a long time to achieve cure, the mean duration was around 18 months and the recurrence rate was high [1].

The long duration of the treatment raise another problem which is compliance.

As the cure rate of Mycetoma in Sudan is only 43.3%, and most of the patients don ›t complete the treatment, identifying the causes of long duration of treatment, may help in changing the treatment strategies, and decreasing the duration of the treatment.

Materials and Methods:

Study design: A retrospective descriptive cross sectional study.

Study area: Mycetoma Research center, Soba university hospital, Sudan.

Study population: All of the Actinomycetoma patients presenting to MRC during the period of (2012_2015), who had complete records.

Data collection methods: Review of records and reports.

The dependent variable was the duration of treatment, while 18 other variables were the independent (Age, sex, residence, occupation, compliance (number of patients on regular treatment, and regular follow ups), the species of Actinomycetoma, site of the lesion, concomitant diseases, regimen used, surgery (previous surgery and during treatment), side effects of the drugs, family history of the disease, X-ray findings at first presentation, sinuses at first presentation, size of the lesion at first presentation, and duration of the disease before starting treatment).

Data was analysed using SPSS (statistical package for social science) software (version20)

Results:

A number of 348 patients were included, of which 72.7% were males. 49.1% age 20 to 39 years old, and 26.1% 40 to 59 years old. Workers were 24%, farmers 22% farmers, and students 17%.

Compliance assessment:

22.8% of the patients missed more than 4 follow up visits, In addition 17.1% didn ›t have regular treatment (mostly because of financial problems).

The Mean for the duration of treatment was: 18.8 months.

Table 1: Factors associated with the duration of treatment (n=348):

variables	P value	Degree of significance
Missed follow ups visits	.000	Very highly significant
Type of treatment	.001	Very highly significant
Regular treatment	.002	Highly significant
Occupation	.01	Highly significant
Radiological findings	.03	Significant

Factors that affect the duration of medical treatment among the Actinomycetoma patients were:

The type of the medication used, Compliance to the follow up visits and regular treatment, the occupation of the patient, and X-ray findings at first presentation, with different degrees of significance, see Table 1.

The sample was divided into 3 groups according to the status of treatment:

Cured patients: (21.8%), patients still on treatment (13.5%), and dropped out patients (64.7%).

Discussion:

In general Mycetoma has a poor compliance, which is the result of the long duration of treatment.

Compliance (measured by regular medications, and regular follow up visits) showed a strong correlation with the duration of treatment. Patients who keep good compliance will be cured in a shorter duration than those with poor compliance.

Type of treatment is also an important factor, as the results also showed that the mean duration of treatment among the cured patients who used Amikacin was (17.4 months), while it was (15.3 months) among the patients who used Co-Amoxiclav.

Abnormal X-ray findings mean

that the disease is severe and has bone involvement, so the duration of treatment increases in such situations.

Occupation was found to be a significant factor, but no explanation for this phenomena was found, which suggest more studies to be done in this area to find the relation between the different jobs, and the duration of treatment.

In a previous study in Sudan cure rate of Actinomycetoma patients was (19.2%) [2], which is close to our result (21.8%).

Cure rate is thought to be low because of the type of patients, as the MRC is a tertiary health care facility, so patients seen there have massive lesions of long standing disease, and have had multiple recurrences, thus they are difficult to treat.

Literature stated that (55.6%) dropped out [2], which is close to the result in this study (64.7%). This high percentage of patients drop out is alarming, and the reasons for this high drop out is that these patients are of low socioeconomic status and they come from areas quite distant from Khartoum where the MRC is situated. Another reason is the long duration of treatment, which is mostly due to the late presentation, and it became popular among the public that the treatment of Mycetoma is not effective, so they don't want to lose their time and effort and just drop out.

Those findings enrich knowledge about this neglected tropical disease, and may help in planning for treatment strategies in the future.

Lastly we recommend Health education in endemic areas to encourage early reporting and hence early treatment, to decrease the duration of treatment.

Type of treatment strongly affects the response, so further studies on the susceptibility of the organisms to different antibiotics is needed.

More centers like the MRC should be established in the endemic areas.

At the end a bizarre finding was observed which is the strong relation between the occupation and the duration of treatment, this finding could be the base for 1

more research to investigate the reason behind it.

REFERENCES:

Classes.uofk.edu.Course: Mycetoma module [Internet]. 2016 [cited 20 February 2016]. Available from: http://classes.uofk.edu/course/view.php?id=789.

Zein HA, Fahal AH, El Hassan TA, Abdel-Rahman ME. Predictors of cure, amputation and follow-up dropout among patients with mycetoma seen at the Mycetoma Research Centre, University of Khartoum, Sudan. Transactions of the Royal Society of Tropical Medicine and Hygiene. 2012 Nov 1;106(11):639- 44.

FahalA,MahgoubES,HassanAME A bdel-Rahman ME (2015) MycetomaintheSudan: AnUpdate fromtheMycetomaResearchCentre,UniversityofKhartoum,Sudan. PLoSNegl TropDis 9(3):e0003679. doi:10.1371/journal.pntd.0003679.

Welsh O, Al-Abdely HM, Salinas-Carmona MC, Fahal AH. Mycetoma medical therapy. PLoS Negl Trop Dis. 2014 Oct 16;8(10):e3218.

Zijlstra EE, van de Sande WW, Fahal AH. Mycetoma: A Long Journey from Neglect. PLoS neglected tropical diseases. 2016 Jan;10(1):e0004244-.

Welsh O, Al-Abdely HM, Salinas-Carmona MC, Fahal AH. Mycetoma medical therapy. PLoS Negl Trop Dis. 2014 Oct 16;8(10):e3218.

Fahal AH, Shaheen S, Jones DH. The orthopaedic aspects of mycetoma. Bone Joint J. 2014 Mar 1;96(3):420 5-.

GOMEZ A, SAUL A, BONIEAZ A, LOPEZ M. Amoxicillin and clavulanic acid in the treatment of actinomycetoma. International journal of dermatology. 1993 Mar 1;32(3):218 -20.

Sharma N, Mendiratta V, Sharma RC, Hemal U, Verma M. Pulse therapy with amikacin and dapsone for the treatment of actinomycotic foot: a case report. The Journal of dermatology. 2003 Oct 1;30(10):74 27-.

Mohamed HT. Mycetoma: epidemiology, treatment challenges, and progress. Res Rep Trop Med. 2015;6:31 -6.

Fahal A, Hassan AM, Abdel-Rahman ME, Alshambaty Y, Hashim A, Hago A, Zijlstra EE. A new model for management of mycetoma in the Sudan. PLoS Negl Trop Dis.

2014 Oct 30;8(10):e3271.

Zijlstra EE, van de Sande WW, Welsh O, Goodfellow M, Fahal AH. Mycetoma: a unique neglected tropical disease. The Lancet Infectious Diseases. 2016 Jan 31;16(1):100- 12.

Fahal AH. The Surgical Treatment of Mycetoma.

Zein HA, Fahal AH, El Hassan TA, Abdel-Rahman ME. Predictors of cure, amputation and follow-up dropout among patients with mycetoma seen at the Mycetoma Research Centre, University of Khartoum, Sudan. Transactions of the Royal Society of Tropical Medicine and Hygiene. 2012 Nov 1;106(11):639- 44.

Understanding Regenerative Medicine : Current practices and Future Potential

By: Alaa Abusufian ,6 th year student

Until very recent, certain diseases were labelled as incurable, every 30 seconds a patient dies from diseases which could have been treated by tissue replacement. At present, organ donation rates do not meet the demand for tissues, and with the growing diversity of populations, finding HLA matches is becoming difficult. Such constraints and more encouraged the search for an alternative potential; Regenerative medicine.

Regenerative medicine is defined as the functional restoration of a specific tissue of an organ in patients suffering from chronic disease conditions in which the body's regenerative capacity is not enough to restore the organ function. Regenerative medicine is the most recent emerging branch of medical sciences. This field utilizes the concept that our stem cells have unlimited cell division potential and can trans-differentiate into many lines of cells. Thus if adequately manipulated, the stem cells can be used in the regeneration and repair of tissues damaged by disease or congenital defects. This discovery has paved the way for discovery of treatments for diseases that for quite a time and till very recent were incurable by conventional medicines.

Stem cells are classified into Unipotent, multipotent, pluripotent and totipotent cells depending in their trans-differentiation potential. Unipotent stem cells can only differentiate into one stem cell line, for example, erythroblast gives rise to RBC's only. On the other hand multipotent cells give rise to multiple cell lines, just like erythroid progenitor cells can give rise to RBC's and platelets. Pluripotent cells can differentiate into any cell type within the 3 germ cell layers (except embryonic tissues like placenta) whereas totipotent cells can differentiate into any cell in the body. The zygote, formed immediately after feritilization comprising of morula is the only totipotent stem cell in the body and gives rise to the whole human

body tissues and placenta through the process of trans-differentiation.

Stem cell transplantation techniques can be applied to almost any organ, but the most studied and applied clinically is haematopoietic stem cell transplant used in the management of blood malignancies. 3 main forms of stem cell transplant are practised, autologous stem cell transplant, Allogenic Stem cell Transplant and Syngeneic Stem cell transplant.

Autologous Stem cells transplant is essentially the transplant of self –one's own stem cells. In stem cell therapy of blood malignancies like leukaemia's, stem cells are collected from the patient, harvested and stored and then returned after an aggressive cycle of chemotherapy to clear the malignant cells. Advantages of this technique are that, it carries minimal risk of Graft versus Host Disease, although graft failure or return of malignant cells are disadvantages that can occur. Autologous transplantation is used in stem cell therapy of conditions like leukaemia, lymphoma, testicular cancer and neuroblastoma. Science is now investigating how autologous transplants can cure other diseases, too, like systemic sclerosis, multiple sclerosis (MS), Crohn »s disease, and systemic lupus erythematosis (lupus).

Allogenic Stem cell Transplant is the transfer of stem cells from an HLA (Human Leukocyte Antigen) compatible donor to the recipient. Compatibility or matching of the donor and recipient is essential for the success of this therapy. Advantages include the fact that donor immune cells can fight against re-emerging cancer cells in the patients after treatment. This is called Graft versus Cancer effect. However there is a high risk of graft rejection - in worse cases- graft immune cells attack host tissue a condition called Graft versus Host Disease. Allogenic transplants are beneficial in treating blood conditions with primary bone marrow failure such as myelodysplastic disorders, aplastic anemia and certain leukaemia's.

Syngeneic Stem cell transplant is to transplant stem cells between identical twins. This form of transplant is only possible when the patient has a healthy donor twin. Advantages lie in the fact that grafts are almost 100% matched

and hence there is no risk of graft rejection or graft versus host disease. The graft versus cancer effect is however lost because the immune cells are similar to the immune system of the patient before emergence of cancer. If the malignant cells return, the immune system will be unable to fight or contain the cancerous growth.

In order to further understand the application of stem cells in regenerative medicine, stem cells were divided according to their regenerative applications into; embryonic stem cells(ESCs), tissue specific progenitor stem cells (TSPSCs), mesenchymal stem cells (MSCs), umbilical cord stem cells (UCSCs), bone marrow stem cells (BMSCs), and induced pluripotent stem cells (iPSCs).

Each category of cells has diverse applications within the field of regenerative medicine.

ESC's

Embryonic Stem cells were first discovered and isolated by Thompson from embryo in 1998. B3inmg pluripotent in nature they can give rise to more than 200 cells types. ESC differentiation and replication is controlled in vitro by many transcription factors. Differentiated embryonic stem cells can be sued to treat a variety of conditions such as Spinal cord injuries due to infection or trauma. ESC's transplanted to the injury sightleadtoreleaseofvasculogenic and neurogenic factors and regeneration of spinal tissue in that sight causing improved balance and sensation. Embryonic stem cell therapy can also be applied to eye conditions such as glaucoma, autosomal recessive macular regeneration causing recovery of macular defects and restoration of vision. Conditions such as diabetes, osteoarthritis, liver injuries and cardiovascular disease can all be treated by embryonic stem cell therapy causing regeneration of the damaged tissue cells. However embryonic stem cell therapy is facing limitations due to many ethical concerns. Harvesting of these cells required the destruction of human embryo and that has many ethical, religious and political constraints.

TSPC's

Tissue specific progenitor stem cell transplant offers a good alternative to ESC therapy.

However, as its name indicates, TSPC's are tissue specific, and can only differentiate into a single line. The number of TSPC's eg: Intestinal progenitor cells compared to the total number of intestinal cells population is really low, making their harvesting from blood very difficult and tricky. Nonetheless some applications of TSPC therapy are found in treating diseases such as diabetes, acoustic problems, intestinal degeneration, corneal diseases, muscular deformities, eye diseases and cardiac dysfunctions by transplanting stem cells specific to the damaged tissue. These stem cells regenerate and restore function to the damaged organ. For example in diabetes, differentiation of pancreatic progenitor stem cells in mice embryo can successfully lead to formation of functioning B cells producing insulin for insulin therapy.

MSC's

Mesenchmyal stem cells only give rise to tissues of mesodermal origin eg: tendons, cartilage, ligaments, muscles and bone. MSC's transplant and Infusion is useful in regeneration of tissue after bone or muscle degeneration conditions like infections, tumors, genetic diseases or aging. Transplanted cells are seeded in the damaged/ defective tissue area and within 4 weeks, regeneration of tissue begins, lasting up to 32 weeks for complete regeneration.

UCSC's

Umbilical cord, generally thrown at the time of child birth, is the best known source for stem cells, procured in non-invasive manner, having lesser ethical constraints than ESCs. Umbilical cord is rich source of both hematopoietic stem cells (HSCs) and Mesenchymal tissue stem cells, which possess enormous regeneration potential. The HSCs of cord blood are responsible for constant renewal of all types of blood cells and protective immune cells. Compared to HSCs from bone marrow donors, transplants of HSCs from cord blood appear to lead to fewer immune system incompatibilities, such as graft-versus-host disease. However a limitation of cord blood is that it contains fewer HSCs than a bone marrow donation does, meaning adult patients often require two volumes of cord blood for treatments. Researchers

are studying ways to expand the number of HSCs from cord blood in labs so that a single cord blood donation could supply enough cells for one or more HSC transplants.

Apart from its applications in curing of blood malignancies, UCSC's are being investigated for their role in tissue regeneration in conditions such as congenital heart defects, neurodegenerative conditions and damaged organs in autoimmune diseases like SLE. UCSC's have pronounced regenerative effects and hence public donation banks are now accepting umbilical cord blood donations.

BMSC's

Bone marrow stem cell transplant is by far the most common stem cell transplant therapy at the moment. Since 1980, bone marrow transplantation is widely accepted for cancer therapeutics. Bone marrow found in cancellus spongy bones comprises of hematopoietic stem cells (producing blood cells) and stromal cells (producing fat, cartilage and bones) that can be harvested for the curing of many diseases. However in order to avoid graft rejection, HLA matching of donors and recipients is a must (most of the time limited to family members) which hampers allogenic transplantation applications. Bone marrow stem cells transfusion is used in the curing of blood malignancies like leukaemia's and clotting disorders.

iPSC's

Induced pluripotent stem cells (iPSCs) are pluripotent stem cells generated from adult cells by reprogramming. iPSCs have the same properties as embryonic stem cells, and therefore self-renew and can differentiate into all cell types of the body except for cells in extra-embryonic tissues such as the placenta. This field is the most recent discovery in the science of regenerative medicine. Using advanced technology, skin stem cells can be reprogrammed into embryonic-like stem cells that different into different organ tissue cells for example kidney cells, photoreceptor cells, immune cells etc. Although iPSC's are a safe alternative to embryonic stem cells, science is still investigating using these cells to develop fully functioning organs.

In summary, there is spectacular

progress in the field of stem cell research and regenerative medicine. It is anticipated that within the next decade, there will be breakthroughs in the field of regenerative medicine and production of tissues, organs from adult stem cells changing the prognosis of many diseases. In the near future, the advancements of medical science presume using stem cells to treat cancer, muscles damage, autoimmune disease, and spinal cord injuries among a number of other impairments and diseases. It is expected that stem cells therapy will bring considerable benefits to the patients suffering from wide range of injuries and disease. However, the existing stem cell therapeutic approaches are of very high cost and there is much concern around the feasibility of applying such therapeutic measures at a broad scale.

References:

1. Sampogna G, Guraya SY, Forgione A. Regenerative medicine: His-torical roots and potential strategies in modern medicine. JMAUSeptember 2015;Volume 3(Issue 3):101–7.

2. Takahashi K, Yamanaka S. Induction of pluripotent stem cells from
mouse embryonic and adult fibroblast cultures by defined factors.
Cell 2006;126:663–676.

3. Ben-David U, Benvenisty N. The tumorigenicity of human embryonic
and induced pluripotent stem cells.
Nat Rev Cancer 2011;11: 268–277.

4. Song L, Young NJ, Webb NE et al. Origin and characterization of multipotential mesenchymal stem cells derived from adult human trabecular
bone. Stem Cells Dev 2005;14:712–721.

AHMED BEK HASHIM BAGHDADI

El Tigani Adam Hammad

4th .Year, Medicine

The late Ahmed Bek Hashim Baghdadi was a close friend Of the School of Medicine ever since it was established in 1924. His name has been associated with the history of medical education in the Sudan from the beginning. Besides the substantial financial help to maintain the School, he gave the students such a fatherly attention and took such interest in their welfare that the graduates still remember it. He was indeed a great benefactor to the School.

Hashim Bek was Persian by birth, born in 1875. He was brought up in Baghdad; and in 1900 he came to the Sudan, a poor single man destined to spend the rest of his life away from home. During his stay in the Sudan he became a merchant trading mainly in ornaments. He soon amassed a fortune and possessed lands, houses and shops in Khartoum and Omdurman.

Very little is known about his early days in Khartoum. He was a reserved man, of solitary habits none the less he was endowed with an attractive and endearing personality to those who knew him.

Hashim Bek , though rich and successful, had no children not any relatives during his life in the Sudan. He was married to a Sudanese girl from one of Omdurman families but by the time the medical students knew him he' was living as a bachelor, keeping only some servants from Baghdad. Once he was visited by a nephew who did not stay with him in the Sudan.

Hashim Bek was a man of liberal Views, something was scarcely accepted at that time. .He was a man of culture and intelligence and also an enthusiastic student of the Persianpoets. He spoke Arabic in a foreign accent but knew no English.

Though he was a man of solitary habits, his life was better conprehended and in fact more appreciated when he became a benefactor and real friend of the School of Medicine. It all started 1917 when a fund was raised to find a medical school at Khartoum a memorial to Lord Kitchener.

Most of the fund was collected subscriptions from the Sudanese. Hashim Bek responded generously it and that started his intimacy with the School.

By a Deed dated the 25th. of September 1917 "he transferred ain lands and buildings in Khartoum and Omdurman to the actor of Education (as he then was) as a free and irrecoverable " The "Declaration of Trust was signed on the 27th. of september 1917 in the presence of Wasy Sterry the Legal Secretary that time. The parts that signed the Declaration of Trust were

I. John Winter Crowfoot, Director of Education.

2. Lee Oliver Fitmaurice Stack, Governor General.

3. Ahmed Mohamed Hashim Baghdadi, settler

The Director of Education with the full consent and approval of the Governor General and Settler determined to constitute out he said gift a trust to be called the Sayed Ahmed Mohamed him Baghdadi Trust for the benefit, maintenance and tuition ot)013 in the said School of Medicine of which the Governor General Director of Education were the Trustees. Hashim Bek served only a life interest in the property for himself and from this allotted a sum of £ 300 to the maintenance of the students

1 the School was established.

The Declaration stated that after the death of Settler the one of the trust should be applied among other things as follows:-

(a) One_third of the net annual income to be allocated for keeping roperty in. good condition and repair so as to obtain the best rentable from It and to cover any extra-ordinary expenses.

b) To accumulate any sums remaining out of the said third to purchase other property to be held on the same trust as the other arty.

c) The remainder of the two thirds to be applied and paid for the benefit, maintenance and tuition of such poor and deserving students as may be selected forthe study of medicine in the Kitchener School of Medicine by the Director.

The Declaration goes on to say that a sum of three Egyptian pounds should be paid monthly to Ahmed Mahdi Kazwini of Cairo during his life time. Nothing is known of

this Kazwini nor of his relation to Hashim Bek but it is thought that he was his servant.

Moreover, the Declaration stated that in the selection of the students for the School of Medicine it should be always provided that poverty and merit were alone to be regarded without respect to the race, nationality, creed or religion of such students or their parents."

It goes on to state that if other trustees or trustee is to be appointed in place of or in addition to the original turstees only

the latter could do this and on conditio that the appointed turstee or trustees must be of British nationality by birth.

The Trust was made fifty one years ago in accordance with English law. After the office of Governor General became defunct on the Independence of the Sudan, a trustee was appointed in his place, this was a British national by birth in accordance with the conditions of the Trust". He was Mr. Walker, the Manager General of Mitchel Cotts Company.

The Declaration of Trust contained a schedule enumerating the transferred property as follows:

(a) Six plots in Khartoum.

(b) One club, fourteen shops, three houses and one half of a (Wakala) in Omdurman in addition to one third of five shops held in partnership with Abdel Massih Tadros and Bolus Girgis Suleiman.

The property in Khartoum Comprises shops in " All soque El Arabi and some houses south of it. The sh0p managed hy Hashim Bek himself lies in this area and is now hired to a tailor named Shebergella.

The present annual income from the rent of the properties is just over £ 4000. The rent could not be increased because of the provisions of the Rent Restriction Ordinance. Thus, all property is now hired by prices fixed in the thirties or pre-War expenses.

If a loan is granted to develop the properties, their value will be

nearly £ 300,000 and also if the properties were demolished and rebuilt the annual income will rise to £ 30,000. It is suggested that

the Trust be varied to allow for borrowing powers to demolish and rebuild the properties which are in very poor condition nowadays".

On the 20th of February 1924 the

opening of the Kitchner School of Medicine was celebrated. Hashim Bek was one of the first notables to sign his name in the Visting Book of the School, He signed his name in Arabic as Ahmed Mohamed Hashim Baghdadi.

In the Inaugral Address of Sir Lee Stack the name of Hashim Bek was recapitulated amongst subscribers to be known and acknowledged with graditude. Moreover, when a General Board was formed to look after the interests of the School and grant diploma to graduates, Hashim Bek, M.B.E., was selected as member of the Board. Besideshe was also chosen for the membership of an Executive Committee to partake in the management of the School.

From the very beginning Hashim Bek was keen to know the students very well. He took the greatest interest in the progress of the School and in particular in the feeding, comfort and general welfare of the students. He provided their food generously. In addition he gave them a monthly closing allowance of one pound each. He visited them in the hostel and the students visited him at his home which was not far away.

When the number of students rose he offered his house with its two storeys to become a hostel. Up to now the graduates remember their visits to his house and they recall how he was fond of reading Persian poetry. His house was open for them to the extent that they issued orders to the servants or even joked at the food they ate there. Hashim Bek only smiled and he sometimes joked at them. He often quoted from the Koran the verse or aya we feed you for God's sake only: we desire no recompense from you, nor any thanks. Every now and again he gave them pocket money, twenty or thirty piasters for those who asked for it.

One day some criminals violated his house and he received a stab wound in the abdomen. The students referred the accident to the police. When Hashim Bek heard of that he thanked them for their interest in the accident but he was reluctant to have it taken to the police.

The School of Medicine responded very well to the nobility and benefaction of Hashim Bey.

He was appointed as member of the General Board and Executive Committee. He was always photographed with the graduates till 1932 just before his death.

Moreover, King George the Fifth Granted Hashim Bek the' dignity of an Honorary Member of the Civil Division of the Order of the British Empire" as they thought it fitted to nominate and appoint him there.

The Egyptian Government as well grantal him the Nile Medal in admiration of his noble characters. All these certificates now hang with the big photograph of Hashim Bek in the Faculty of Medicine.

It remains almost a mystery why Hashim Bek had chosen to bequeath his property for the School of Medicine. Of course he had no children nor relatives when he died. However, it has been said that when the Khartoum Mosque was being repaired Hashim Bek visited the Grand Judge with the intention to offer his property as trust for (Al Awkaf,) but he was not well met and was treated like a poor grocer. It was an unpleasant attitude; and Hashim Bek gave up the idea of giving his property to the Mosque. But, he felt that the money he gained in the Sudan could be Spent test in the Sudan He chose to employ it in furthering medical education in the Sudan, the country of his adoption.

Hashim Bek had the desire to die and be burried in the Sudan. He prepared himself a tomb in the now called Faroah grave yards and was very interested in this tomb that he visited it every now and again. It was more akin to Egyptian tombs.

In january he was attacked by acute double pneumonia and he developed jaundice as well. He was admitted to hospital at a time when unfortunately neither antibiotics nor sulfonamides were introduced in treatment. However, the graduates doctors took in hand his nursing and attended to him to the extent that they spent the night in front of his bed. Dr.Ali Badri and Dr. Hadi El Nagar remember this very well.

On the night of January 22nd he opened his eyes from within that characteristic pain and complexion of pneumonia. It was 2 or 3 pm. Hashim Bek was very much relieved and content to see Dr. Ali Badri beside his bed. He smiled and whiSpered, "are you here ? And he

closed his eyes and never opened them again. His soul went home in peace.

The graduates and students of the School took in hand the arrangement of the funeral. The funeralwasattendedbythenotables of Khartoum and Omdurman, by the graduates, students and many others. The burial rites and ceremonies were well conducted by the graduates and students. Of the present members of the Faucty Staff Professor El Tigani El Mahi and Professor Mansour Ali Hasseeb, the Dean, were students at that time.

A few years ago the graduates visited his tomb in memory, and they built over it a model of the School of Medicine. It now stands out in the yard a symbol of sincerity and rememberance of a man worth of study if not for himself for the members of the medical profession.

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REFERENCES

(I) Baghdadi Trust.

(2) Biographical Dictionary of the Anglo-Egyptian Sudan 1951 Richard Hill.

(3) The Lord Kitchners School of Medicine Visiting Book 1924.

(4) Sudan Kitchners School of Medicine Reports 1924- 1935.

ndexing of Al Hakeem medical students Journal

As many of you already know,Alhakeem used to be bublished by the university of Khartoum faculty of medicine students ,it was the first of this kind in reserch field in Sudan as it buplished many of the amazing and valiable articles .

But due to time and copyright issues many didn't get the chance to see this great legacy.

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5.The problem of pregnancy in diabetics

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Kammal Mekki El Manna

Miscellaneous

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General/Misce

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Miscellaneous

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Dr. El Fadil Shadad . OBS&GYN

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Dr. Anis Mohammed Ali
Pediatrics

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Khadiga Ahmed Gasmalla
OBS &GYN

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Dr. Taha Bashar Psychiatry

10-Child – Mother Relationship .

Elzein Abbas Omara
Miscellaneous

11-The Seminar, A General Review .

1980:

Yousif A. Kordofani&
Salah Eldin Mohd Omer.
Maternal Health

3-Review of the Literature on Maternity Health in Sudan

Dr. Mahmoud Mohamed Hassan
Statistics

4-Historical Survey in Pediatrics and Child Care in the Sudan .

Dr. Akec, KhocAciew
Child Health

5-Review of Literature on the Scope of Child Health services in Sudan

Prof. Hassan Hag Ali Pediatrics

6-Emotional Problems of Children in Sudan .

Hafiz El Shazali Child Health

7-The Future of Child Care in Sudan .

1981:

Dr. M. E. Balla Social Aspects

3-Health Information System in P. H. C .

Ali Karrar Osman Nutrition

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Mr. Mahgoub Abdalla.
Maternal Health

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Mr. Ibrahim Taha Abu Samra
International Health

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Dr. Abdel Hamid El Sayed
International Health

-Expanded Program of Immunization (E. P. I.)

Dr. A/Wahab El Khidir.
International Health

8-Evaluation of Primary Health Care Program. Implemental in Rural Area. Khartoum Province. By.

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Mr. Nathaiel S. Bartee.
Epidemics

10-Thr Epidemiology and control of Hookworms Infestation .

Dr. J. O. Obi. Miscellaneous

11- Keynote Address

El ShafieEltayeb A/Alla
International Health

12-Material and Children Health in Primary Health Care Program

Alawad Osman Abu Shaiba
Miscellaneous

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Mr. EisaBushery Mohamed.
Gastroenterology

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Miss Georgette Aziz
Gastroenterology

4-Management of Diarrheal Disease in Childhood By.

Dr. A. R. H. El Mufti.
Ga stroenterology

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Mr. Abbas A/Rahman. Pediatrics

6-Complication of Diarrheal Infection in Children in Childhood .

Mr. AdilMahgoub Musa.
Pediatrics

7-Intestinal parasites Among School Children in Hag Yousif Area.

SawsanSalih, Nour Eldayem El Sidig, Elbadri Ahmed Hassan, Raymond Monier, A/ El Rahim Osman Mohd., A/El Karim Ibrahim, &Imad Salah.
Bacteriology

8-Leprosy .

Mr. Imad Salah Pharmacology

9-A Guide to the use of Antimalarial Drugs in Sudan By

Mr. Gamal El Din H. El Shalally
Anatomy

10-New Approach to Human Histology .

Dr. M. H. Badi Miscellaneous

11-On Pre-clinical Curriculum for Dental students

اعتماد كلية الطب جامعة الخرطوم : الأهمية والخطوات

د.خالد الأمين

رئيس قسم التشريح بكلية الطب - جامعة الخرطوم

عايش الجميع في الفترة الماضية زيارة فريق إعتماد كلية الطب – جامعة الخرطوم وطلب منى فريق محررى مجلة الحكيم أن اكتب عن ماهو الاعتماد؟ و ما هي فوائده؟ وماهى معاييره؟ و بالطبع ما تم من خطوات في اعتماد كلية الطب – جامعة الخرطوم.

يعرف الاعتماد بانه «شهادة مناسبة المناهج التعليمية وقدرة كليات الطب على تدريس هذه المناهج لضمان سلامة المرضى بتخريج اطباء اكفاء للممارسة الطبية. يتم الاعتماد بواسطة الاتحاد العالمى للتعليم الطبى وشركاؤه عبر الحكومات الوطنية او جهات تسميها هذه الحكومات شريطة ان تكون هيئات مستقلة.

لماذا الاعتماد؟

فى ظل تلاشى الحواجز بين الدول و تحول العالم لقرية واحدة يهدف الاعتماد لوضع معايير واسس موحدة للممارسة الطبية مع الاحتفاظ بخصوصية كل دولة او منطقة جغرافية. عليه فإن الاعتماد يؤهل خريجى كليات الطب المعتمدة من ممارسة الطب فى كل دول العالم المشاركة فووضع معاييىر الاتحاد العالمى للتعليم الطبى. ولا يفوت علينا هنا اعلان الولايات المتحدة الامريكية بانها لن تسمح لاى طبيب بالعمل فى مستشفياتها ما لم يكن من خريجى الكليات المعتمدة بحلول العام الفين وثلاثة وعشرين.

معايير الاعتماد:

حدد الاتحاد العالمى للتعليم الطبى وشركاؤه (ومن أبرزهم منظمة الصحة العالمية والاتحاد العالمى لطلاب الطب) تسع معايير يتم على اساسها اعتماد كليات الطب. هذه المعايير يمكن مؤامتها على حسب تقاليد وأعراف وثقافة كل بلد. تشمل هذه المعايير: رسالة واهداف الكلية، البرنامج التعليمي، تقييم الطلاب، شؤون الطلاب، هيئة التدريس، الامكانات و الموارد التعليمية، اليات تقويم البرنامج التعليمى، ادارة الكلية ونظامها المالى والادارى ورؤية التطوير. داخل هذه المعايير توجد معايير محددة تنقسم لقسمين:معايير اساسية لابد من توفرها و معايير جودة من المستحسن توفرها.

ما هى الهيئة المناط بها اعتماد كليات الطب في السودان؟

أختير المجلس الطبى السودانى ليكون الجهة المستقلة لاعتماد كليات الطب فى العام ٢٠٠٦. وشرع المجلس فى وضع معايير مستقاة من معايير الاتحاد العالمى للتعليم الطبى تتوافق مع خصوصية التعليم الطبى والممارسة الطبية فى السودان. كما قام المجلس بنشر ثقافة الاعتماد، تدريب مجموعة من المقيمين، تكوين لجنة الاعتماد، وطبع كتيبات تساعد كليات الطب فى اجراء خطوات الاعتماد. مما يجدر ذكره ان المجلس الطبى نفسه لابد ان يكون معتمدا من الاتحاد العالمى للتعليم الطبى ليعتمد كليات الطب فى السودان وهو ايضا من السباقين فى هذا الخصوص على مستوى العالم.

اجراءات وخطوات الاعتماد:

يمكن تلخيص الخطوات الواجب على كليات الطب اتباعها لتعتمد في الخطوات التالية:

بناء على الوثائق المقدمة من الكلية يأتي قرار لجنة الاعتماد في باعتماد الكلية أو الاعتماد المشروط أو عدم الاعتماد.

اعتماد كلية الطب – جامعة الخرطوم:

كلية الطب – جامعة الخرطوم لكونها أعرق كلية طب فى السودان، كانت سباقة ايضا فى الاعتماد حيث

محبى الكلية وخريجيها، ممثلى المجتمع وحتى اصحاب المحلات والكافتريات ... باختصار الجميع تعاون من اجل الكلية ورفعتها.

الزيارة الميدانية بالنسبة لفريق التقييم كانت بغرض الوقوف على محتوى تقرير الدراسة الذاتية و فى نفس الوقت كانت الزيارة لاعتماد المجلس الطبى السودانى من قبل الاتحاد العالمى للتعليم الطبى الذى اوفد فريقا لذلك الغرض. ضم ثلاثة من مشاهير التعليم الطبي من جنسيات مختلفة. احتوى برنامج الزيارة على مقابلات مع ادارة الكلية، لجان الدراسة الذاتية، رؤساء الاقسام، الاساتذة، الادارة المساعدة فى الكلية، الطلاب والخريجين بالاضافة للممثلى المجتمع والمستفيدين من خدمات الكلية. جزء اخر من برنامج فريق التقييم كان الزيارات الميدانية للموارد التعليمية للكلية من قاعات ومعامل، المكتبة، الاقسام، المراكز الصحية الاولية والمستشفيات التابعة للكلية.

ما اثار دهشتى ودهشة فريق التقييم المحلى والعالمى هو المقابلات التى كان طرفها الطلاب، فقد عكس طلاب الكلية صورة جميلة وزاهية عن الكلية والبيئة التعليمية فيها، مدى حبهم وتعلقهم بكليتهم، الثقة بالنفس وبما يقدمونه بالاضافة للوعى بما يتم فى الكلية ومشاركة الطلاب الفاعلة فى كل مفاصل العملية التعليمية. لذلك لابد من الوقوف احتراما وتقديرا لطلاب الكلية افرادا وجماعات و لرابطتهم الفتية و ممثلى الفصول المختلفة.

ماذا بعد الزيارة الميدانية؟

تم رفع تقرير مبدئى من فريق التقييم للمجلس الطبى الذى بدوره قام بمشاركته مع لجنة الدراسة الذاتية بالكلية للوقوف على جوانبه والرد على نقاطه اذا لزم الامر. وقد قامت اللجنة بذلك بعد دراسة النقاط الواردة فيه كل على حده وتم صياغة الرد ومراجعته وارساله للمجلس الطبى السودانى.

وهذه اخر خطوة من طرف الكلية اذ ما تبقى من بدأت فى العام ٢٠١٥ بزيارة من فريق من المجلس الطبى السودانى للتعريف بالاعتماد. تبع ذلك اصدار قرار ادارى بتكوين لجنة للدراسة الذاتية برئاسة البروفسور محمد احمد على الشيخ الاستاذ بقسم النساء والتوليد والمدير الأسبق لجامعة الخرطوم. كما تم تعيين البروفسور سمير شاهين المدير السابق لمركز التطوير الطبى (أمين الشؤون العلمية الحالى) مقررا للجنة وضمت العضوية كبار الاساتذة، رؤساء الاقسام، ادارة الكلية، الطلاب وممثلين من المجتمع وكل من يهمه امر الكلية. وتم تقسيم اللجنة للجان اصغر عددها تسع لتقوم كل لجنة بمهمة احد معايير الاعتماد.

باشرت اللجان عملها وحددت اهدافها وماهو مطلوب منها، وزعت المهام، جمعت المعلومات المطلوبة، بعد ذلك قامت كل لجنة بكتابة تقرير شامل لنقاط القوة والضعف، المهددات والفرص المتاحة للتطوير. لابد لنا فى هذا السياق من الاشادة بدور الطلاب فى عمل هذه اللجان اذ كانو أهم الأعضاء واكثرهم حماسا وهذا هو ديدن طلاب هذه الكلية دائما هم عند الموعد.

رفعت اللجان أعمالها للجنة العليا التى قامت بصياغة التقرير النهائى بعد عمل مضنى ومراجعات متكررة ودقيقة. أوجه القصور التى ظهرت تمت معالجتها مباشرة من قبل ادارة الكلية التى وضعت الاعتماد على اعلى سلم اولياتها.

سلم التقرير بصورته النهائية ومعه المستندات المطلوبة كمرفقات للمجلس الطبى الذى بدوره سلمه للجنة من المقيمين تم اختيارها بواسطة المجلس ووافقت الكلية على اعضاءها كما هو منصوص عليه في كتيبات المجلس الطبى. درست لجنة التقييم الدراسة الذاتية ووقفت على كل جوانبها استعدادا للزيارة الميدانية.

الزيارة الميدانية مثلت حدثا اتحدت فيه كل الاطراف التى تهمها كلية الطب – جامعة الخرطوم واظهرت المعادن الحقيقية للاساتذة، الاداريين، الطلاب، العمال،

للمصادر المشار اليها ادناه والتى اعتمدت عليها فى كتابة هذا المقال. ولابد لى من توجيه الشكر لمحررى المجلة واهتماهم باعادة الحياة لمجلة الحكيم التى كانت احد منابر طلاب كلية الطب ومتنفسهم من الحياة الاكاديمية الضاغطة.

المصادر:

١.الموقع الرسمى للمجلس الطبى السودانى

http://www.sudmc.org

٢.الموقع الرسمى للاتحاد العالمى للتعليم الطبى

/http://wfme.org/accreditation

٣.دليل الاعتماد للكليات الطبية – المجلس الطبى السودانى ٢٠١٧

خطوات تم من قبل المجلس الطبى السوداني والذي تم اعتماده من قبل الاتحاد العالمي للتعليم الطبي ، وكانت هذه الخطوات :

الاولى: رفع تقرير نهائى من قبل لجنة التقييم

الثانية: اجتماع لجنة الاعتماد على ضوء تقرير لجنة التقييم لاتخاذ القرار بشان اعتماد الكلية.

الثالثة: اعتماد القرار بواسطة المجلس الطبى.

وجاء القرار المنتظر باعتماد كلية الطب جامعة الخرطوم بتاريخ ٢٠١٨/٥/٢٩ ،واتمنى ايضا ان لا اكون قد اطلت عليكم فقد حاولت ان اكون مهنيا قدر الامكان لاعكس ما جرى وما تبقي فيما يخص اعتماد كليتنا او بيتنا الذى ننتمى اليه. وكل من لديه الرغبة فى زيادة الاطلاع والتبحر فى هذا الموضوع يمكنكم الرجوع

حول أهمية تاريخ الطب

الحارث عبدالله

يقول الفيلسوف الوجودي مارتن هيدغر :»إن العلم لا يفكّر في ذاته»[١]، بمعنى أن العلم دومًا يجنح لتجاوز التفكير عن نفسه ومناهجه وتاريخه ومستقبله ، إذ هو يركز على الآن والآن فقط ، فالفيزياء اليوم –مثلًا– لا تفكر كثيرًا في نظرية أرسطو لسقوط الأجسام ، ولا نموذج جاليليو أو كوبرنيقس ، والكيمياء لا تفكّر في تحويل المعادن ذهبًا ، ولا الطب يفكّر في الأشكال المحلية للعلاج سواء الوخز بالإبَر أو العلاج بعشبة المورنيجا، فالعلم دومًا يفكّر في لحظته الحالية ويمارس قطيعة مع الأشكال القديمة منه.

ولكن هذه القطيعة ليست جيدة دائما، لأنها تخفي على الباحث معرفة الأسباب الّتي أدت لتطور هذا العلم وازدهاره في سياق اجتماعي معين، فمن المعروف في العلوم الإنسانية المختلفة أن العلوم –خلافًا للنظرة السائدة لها– لا تزدهر بوجود أفراد مجتهدين فيها فقط، وليس فقط بوجود المعامل المجهزة والمهيأة، بل التطور والازدهار غالبًا ما يرتبط بظروف اجتماعية سياسية اقتصادية أمنية جغرافية بيئية ...إلخ معينة هي ما تدفع بالعلم للتقدم، عبر وجود التركيز الاجتماعي وعليه الدعم المالي والاقتصاديّ ، ووجود الدوافع السياسية له والمحفزات لتطوره، وعبر التوقعات المختلفة لنتائجه وغير ذلك من العوامل.[٢]

ويمكن أن نكتفي هنا بنقل ما قاله جورج سارتون (أحد المؤسسين لمبحث تاريخ العلوم كمبحث أكاديمي يُدرس في الجامعات): «إن دراسة التاريخ –وبخاصة تاريخ العلم– يمكن ألا نقصر اعتبارها على أنها نبع الحكمة والإنسية، بل نتخذها هاديًا ومرشدًا ومقومًا لضمائرنا. إنها تساعدنا على أن نكون متواضعين غير مغالين ولا متجانفين لكبرياء تلقاء انتصاراتنا، وأن نظل شاكرين آملين عاملين بهدوء ولا هوادة في سبيل إنجاز واجبنا»[٣] . «ولا ريب أن الطريق الأمثل لتأنيس العلم هو بالنظر إلى تاريخه تمامًا كما ننظر في كل المنتوجات الإنسانية الأخرى. أن ندرس نشأته وتطوره وشُعَبه وقضاياه عبر العصور. أن نحلل دوراته ومراحله ، تراكماته وانقلاباته ، انتصاراته وهزائمه، أن نعرف الأسباب التي أدت لبطء تقدم العلم وتلك التي أدت لازدهاره..»[٤] [٥]

تبدَأ قصة الطب الحديث –إذا تجاوزنا الطبّ القديم– في القرن التاسع عشر والعشرين، في فترة الاستعمار الأوربي للعالم، وهذا التزامن ليس وليد الصدفة بالطبع ، فالكثير من الباحثين يرون أنّ الاستعمار هو سبب تقدم الطب، فكما يقول دافيد أرنولد:» تزامن توسع الإمبراطوريات الاستعمارية في القرن التاسع عشر مع ما حدث من تقدم علمي كبير في الطب»[٦]. وإن كان الكثيرون تنتشر عندهم فكرة أنّ دوافع هذا التقدم كانت إنسانية لرفع المرض، كما ترى فلورانس نايتينجيل –أحد الشخصيات المهمة في تاريخ السياسة الطبية

١- ذكر هذه الجملة في محاضرة جامعية بفرايبورج، انظُر يمنى طريف الخولي «فلسفة العلم في القرن العشرين» ، مؤسسة هنداوي للتعليم والثقافة ، ص١٣.

٢- مستفاد من يمنى طريف الخولي ، «فلسفة العلم في القرن العشرين» ، مؤسسة هنداوي للتعليم والثقافة.

٣- جورج سارتون، تاريخ العلم والإنسية الجديدة ، دار النهضة العربية ، ص٩.

٤- جورج سارتون ، المرجع السابق ، ص٨٧

٥- مستفاد من مقال «في تاريخ العلم وفلسفته» للأستاذ معاوية مأمون أحمد الشريف ، في كتاب «الدليل الإرشادي لطلاب وطالبات البكالوريوس والدراسات العليا في السودان ، شركة مطابع السودان للعمالة المحدودة.

٦- ديفيد أرنولد ، مقال «الجدري وطب المستعمرات في الهند في القرن التاسع عشر» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية» ، تحرير ديفيد أرنولد ، ضمن سلسلة ترجمات «عالم المعرفة».

للمستعمرات البريطانية- «إنّ إدخال الرعاية الطبية في شبه القارة الهندية ليس فحسب مهمة نبيلة، بل أنه أمر لا يقلّ عن خلق الهند خلقًا جديدًا»[٧]، فكثيرون آخرون يرون الأمر أكثر دناءة من ذلك، مثل ديفيد أرنولد أيضًا حين قال:» إن الطب نفسه كان وسيلة رئيسية لنقل الأفكار الإمبريالية (الاستعمارية) وتطبيقاتها طارحًا تبصرات مليئة بالإيحاءات فيما يتعلق بالصفة العامة للتوسع الأوروبي. فالإمبريالية تضفي ضوءًا كاشفا على حقيقة أن الطب أيديولوجية بقدر ما هو تطبيق».

فمثلًا في قصة دراسة البلهارسيا ودورة حياتها وطريقة التعامل معها، نجد أنها ليست من الأمراض الأوروبية وإنما «مرض خاص بالأهالي»، ففي مصر مثلًا كان ٤٧٪ من سكان مصر كانوا مصابين بها حسب تقدير ج. آلن سكوت في ١٩٣٧م، وتصل الإصابة إلى ما بين ١٦ و ٢٠ مليونًا في رأي باحثين مصريين في سبعينات القرن. لكن رغم ذلك مرض الأهالي في البداية لم يكن في حد ذاته مبررًا لدعم دراستها ، ، وإنما بدأت دراستها في مصر كما يذكر جون فارلي «ثار اهتمام البريطانيين بالبلهارسيا لأول مرة قبل الحرب العالمية الأولى مباشرة وكان سبب ذلك هو الاعتقاد بأن المرض يشكل تهديدا خطيرا لحمايتهم في مصر»، فتمركز القوات البريطانية أثناء الحرب في مناطق المياه كمصاف الأنهار والبحيرات وغير ذلك يعرض جنودهم للخطر ، فلذلك شرعوا في دراسته حفاظًا على مصالحهم. وحين استنتجوا أنّ «البلهارسيا لم يعد فيها بعد أي تهديد للقوات التي لها كيانها المنضبط» أصبح «من الممكن على نحو آمن تجاهل المرض». وفي المقابل لم يكن للرجل الأبيض أي اهتمام بدراسة الملاريا رغم أنه كان مؤثرًا أكبر في صحة الأهالي مما يؤكد أنّ دافع الدراسة كان نفعيًا بدرجة كبيرة. ولذا قال جون فارلي: «فطب المستعمرات إنما وُجِد أساسًا لجعل المناطق الحارة مناسبة لإقامة الرجل الأبيض».[٨]

ثمّ استؤنفت عملية دراسة البلهارسيا بعد ذلك في أماكن مختلفة من البلاد المستعمَرَة مثل جنوب إفريقيا وروديسيا الجنوبية بدوافع مختلفة ارتكزت بشكل أساسيّ على اعتبار أنّ صحة الأهالي تضمن صحة الرجل الأبيض بسبب العدوى التي تحرِّك المرض ، فكما قال ويليام بلاكي مدير معهد الصحة العامة مبيِّنًا الأساس المنطقيّ للاهتمام بصحة الأفريقيين بأفضل تلخيص :» لست من محبي الزنوج العاطفيين... على أنه مهما كان نفورنا من الأمر، فإن الأهالي لن يسمحوا لنا بتجاهلهم أو نسيانهم إلا في مقابل عقاب يصيبنا ،وهو تعرضنا نحن أنفسنا لأقصى الخطر ذلك أن الأهالي بالنسبة لعدد كبير من الأمراض التي تثير قلقنا يوفرون مستودعا للعدوى بهذه الأمراض»[٩]، والدافع الآخر كان تأثّر النشاط الاقتصادي للرجل الأبيض بسبب مرض وموت الأهالي العاملين ، فكتب عن هذا كاترابت في عموده مثنيًا على أطباء المناجم في جنوب أفريقيا: «أصبحت صحة عامل المناجم من أفراد البانتو تكاد تكون وسواسا قهريا عند شركات التعدين»، فكان الاهتمام بأمراض الجهاز التنفسي وكيفية الوقاية منها لضمان استمرار إنتاجية العامل هو ما أدّى لعدد كبير من الفتوحات العلمية في الطب في هذا الباب.[١٠]

ومن المواضيع المهمة الّتي لها حضور عالي في الوعي الطبي والصحي المعاصر قضية «سوء التغذية»، يقول مايكل ووربويز :» لقد تمّ [اكتشاف] مشكلة سوء التغذية لأول مرة في بلاد العالم الثالث فيما بين الحربين وكانت بلاد العالم الثالث وقتها مناطق مستعمرات.»، فنشأ لذلك سؤال «لماذا في هذا الوقت بالذات؟!»[١١]،

٧- ديفيد أرنولد ، مقال «المرض والطب والإمبراطورية» ، من ضمن «الطب الإمبريالي والمجتمعات المحلية».
٨- مستفاد من مقال جون فارلي «البلهارسيا: مشكلة لصحة الأهالي ١٩٠٠-١٩٥٠» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية».
٩- جون فارلي «البلهارسيا: مشكلة لصحة الأهالي ١٩٠٠-١٩٥٠» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية».
١٠- جون فارلي «البلهارسيا: مشكلة لصحة الأهالي ١٩٠٠-١٩٥٠» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية».

فكانت العوامل الاقتصادية من نقص للإنتاجية في المستعمرات نتيجة للحرب العالمية الأولى تحتلّ مركزًا متقدمًا في التنبيه لهذه الأزمة ، ونالت في ذلك تفسيرات مختلفة تتنوع من «جهل وتخلف الدول المستعمَرة» ، لـ«زيادة عدد السكان العالي في مقابل الزيادة الأقل للإنتاج»، وكان هنالك تجنب للسبب الّذي ذكره عدد كبير من الخبراء المرتبط بأن «المذهب الاستعماري وخاصة ما يحدثه من تدمير لإنتاج الطعام محليا بأن يزيد من تحول شعوب المستعمرات إلى إنتاج المحاصيل النقدية لتصديرها» هو السبب في هذه المشكلة ، فجاء في تقرير غرب أفريقيا عن المشكلة في تلك الحقبة :« »كُرس الكثير من الاهتمام للكاكاو وصناعات التعدين بحيث تعرضت إحدى الحقائق للإهمال، وهي أن معظم السكان مزارعون بسطاء في القرى يعيشون أساسا على الطعام الذي يتم إنتاجه في مزارعهم..»، فهذ التحول في النمط الاقتصادي للسكان كان أحد أهم العوامل المؤثرة في إنتاج سوء التغذية في كثير من البلدان.

فكان لهذه العوامل الاقتصادية المرتبطة بالاستعمار وأغراضه نفسه انعكاس كبير على الاستراتيجيات المراد تطبيقها ضد هذه الظاهرة، فكان اتجاهها ليس في محاربة الفقر في حد ذاته ولا لتغيير الإنتاج بشكل جذريّ، وإنما حاولت عمل إصلاحات غذائية و تحديد للنسل و غير ذلك مما لا يؤثر على أهداف الاستعمار، ولمّا صدر التقرير النهائي لسكرتارية لجنة المجلس الاستشاري الاقتصادي لشؤون التغذية والّتي اعتمدت على تقارير وأدلة تجمعت عبر ثمانية عشر شهر، والّذي شدد في جزءٍ منه «ينبغي تنمية محاصيل الطعام على حساب المحاصيل النقدية وغيرها من الصادرات»، فكان نتيجة ذلك وغيره أن «لم يجذب التقرير إلا أقل الانتباه مهنيا أو جماهيريا أو سياسيا». وكان –كما هو المتوقع- في الإدارة البريطانية مثلًا:» و تمت إعادة تركيب مشكلة سوء التغذية في المستعمرات تركيبا سريعا سهلا، بأن تحول النظر إليها من مشكلة وبائية إلى مشكلة متوطنة، حيث المذهب الاستعماري غير مسؤول عنها إلا أقل مسؤولية، ولا يمكنه أن يمارس تجاهها إلا أقل تحكم».[١٢]

فالنتيجة الّتي يحاول المقال أن يصل إليها عبر الرحلة خلال هذين النموذجين للطب هو تغيير النظرة الساذجة المنتشرة للعلوم عمومًا والطب خصوصًا باعتبارها منتجات علمية محايدة تنتج بشكل عفوي من المجتهدين الذين يحبون العلوم والحقيقة في معاملهم الاستكشافية، ففي تاريخ أكثر العلماء دوافع أخرى –بعضها أخلاقية نعم، لكن الغالب عليها النفعية- هي المحفز لها، وترتبط ارتباطًا وثيقًا بشكل النظام والمؤسسة السياسية وعلاقات الإنتاج وشكل المجتمع سواء كان زراعي أو صناعي، وعلاقة النظام السياسي بالاقتصاد ووعيه بكيفية السيطرة على المحكومين وصولًا حتى للرؤية الوجودية والدينية للشعوب المختلفة وغير ذلك.

زائدًا لفت النظر أن تاريخ العلوم يمثل مصدرًا غزيرًا للتجارب المختلفة الناجحة والفاشلة لازدهار العلوم وانحطاطها ، مما يساعد في استنتاج ظروف جيدة قد تساعد على ازدهار العلوم في سياقنا الاجتماعي المعاصر.

١١- مايكل ووربويز ، «اكتشاف سوء التغذية بالمستعمرات في ما بين الحربين» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية».
١٢- مستفاد من مايكل ووربويز ، «اكتشاف سوء التغذية بالمستعمرات في ما بين الحربين» ، من ضمن كتاب «الطب الإمبريالي والمجتمعات المحلية».

CLINICAL QUIZ

Let's have fun

FIRST: Fun for seniors

Buzzwords

What is the disease or condition associated with the following statements:

1. Monoclonal spike on serum electrophoresis (M-protein)
2. 'Bag of worms' in the scrotum
3. Currant jelly sputum
4. Hot potato voice
5. Beefy red tongue
6. Reed-Sternberg cells on lymph node biopsy
7. Bence Jones proteins in urine
8. 'Parrot-beaked' esophagus (dilated esophagus tapered to the distal obstruction) on barium swallow

ANSWERS:

1.Multiple myeloma
2.Varicocele
3.Klebsiella pneumoniae
4.Peritonsillar abscess
5.Pronounced anemia
6.Hodgkin's lymphoma
7.Multiple myeloma
8.Achalasia

TIME FOR SOME CASES!

1. A 45-year-old man presented to the physician complaining of progressive difficulty in breathing through his left nostril. He notices blood stained secretions when he blows his nose, but denies headaches or any changes in hearing. He immigrated from China 15 years ago. He smoked 1 pack of cigarettes per day for the past 16 years. Physical examination showed a mass located in the posteromedial aspect of the nasopharynx and two enlarged, cervical lymph nodes which were not tender. Head CT scan confirms a mass in the left nasopharynx with extension into the adjacent soft tissue. A biopsy is performed. Histologically, the neoplasm is composed of large anaplastic cells admixed with abundant normal-appearing lymphocytes. The anaplastic cells are positive for cytokeratin and negative for leukocyte common antigen (LCA) on immunohistochemical stain.

Which of the following is the most likely cause of this patient's condition?

A. Cigarette smoking

B. Epstein-Barr virus infection

C. Human papilloma virus infection

D. Ionizing radiation

E. Overexpression of the bcl - 2 gene

2.A 21-year-old man is brought to the emergency department by the police after he was found sitting in the middle of traffic on a busy street. When asked to explain what happened, the patient states: "The voice told me to do it". The patient says that for the past year he had felt that people are not who they say they are. He began to isolate himself in his room and dropped out of school. He claims that he hears voices telling him to do 'bad things'. There are often two or three voices talking, and they often comment to each other on his behavior. He denies that he currently uses drugs or alcohol, although he reports that he occasionally smoked marijuana in the past. He says that he has discontinued this practice over the past 6 months because he can no longer afford it, and claims that marijuana helped with the voices. He denies any medical problems and is taking no medication.

On a mental status examination, the patient is noted to be dirty and disheveled, with poor hygiene. He appears somewhat nervous in his surroundings and paces around the examination room, always with his back to the wall. He states that his mood is "okay". His affect is congruent, although flat. His speech is of the normal rate, rhythm, and tone. His thought processes are tangential, and loose associations are occasionally noted. His thought content is positive for delusions and auditory hallucinations. He denies any suicidal or homicidal ideation.

A. What is the differential diagnosis?

B. What is the most likely diagnosis of this patient?

C. What is the treatment?

ANSWERS:

1. B

2. A (Deliria, dementia, severe hypothyroidism and hypercalcemia.

B (Schizophrenia, paranoid.

C (Atypical antipsychotic medications