C U R R I C U L U M V I T A E A S O F MARCH 2013.

PROF. S. O. MCLIGEYO

DEPARTMENT OF MEDICINE

UNIVERSITY OF NAIROBI

P. O. BOX 19676

NAIROBI.

A. PERSONAL DATA

1. Date of Birth: 28th August 1956

2. Marital Status: Married with four children

(a) Martin Otieno Mcligeyo

D.O.B 25th August 1986

(b) Brian Odhiambo Mcligeyo

D.O.B 10th November 1987

(c) Diana Adhiambo Mcligeyo

D.O.B 15th June 1992

(d) David Ochieng Mcligeyo

D.O.B 18th August 1994

WIFE - SUSAN AYUKO MCLIGEYO

B. SECONDARY SCHOOL

1. AQUINAS HIGH SCHOOL 1970 - 1973

(a) Activities: Chairman - Geography Club

Member - Photography Club

(b) Examinations: East African Certificate of Education in 1973 - Division One. Passed with distinctions in Mathematics, Physical Science, Biology, Health Science, Geography and Religious Knowledge and a credit in English.

2. ST. MARY'S HIGH SCHOOL, YALA 1974 - 1975

(a) Activities: Football, Athletics, Hockey and Drama

(b) Examinations: East African Advanced Certificate of Education - 1975.

Subjects entered for and grades obtained:

Biology - Principal A

Mathematics - Principal A

Chemistry - Principal A

Physics - Principal B

General Subjects - Subsidiary Pass.

C. HIGHER EDUCATION

1. University of Nairobi Medical School, 1976 - 1981: MB.Ch.B - 1981. Awarded prize by the Kenya Medical Association as the best qualifying undergraduate student.

2. University of Nairobi, Department of Medicine: Certificate of Tropical Medicine - 1985.

3. University of Nairobi Medical School 1983 - 1986: Masters of Medicine (Internal Medicine) - 1986
   Awarded a prize by the Kenya Medical Women Association as the best qualifying Postgraduate student in Internal Medicine.

4. Royal College of Physicians, Edinburgh - Accreditation following a one year training in Nephrology and Hypertension - 1989.

5. International Society of Nephrology fellowship training in Nephrology at the United Medical and Dental School, Guy's Hospital, London. April 1989 to April 1990.

6. Postgraduate training course in Nephrology (7th January 1992 to 7th April 1992). Tel Aviv University. Sackler Faculty of Medicine. School of Continuing Medical Education.

D. PRESENT EMPLOYMENT

Associate professor in Internal Medicine, Department of Medicine, College of Health Sciences. Appointed on promotion in December, 1999.

E. PROFESSIONAL EXPERIENCE AND POSTGRADUATE TRAINING

1. Medical Internship (House Officer), October 1981 - October 1982

   Nyanza Provincial Hospital - Three months rotation in the following specialities: Surgery, Medicine, Obstetrics & Gynaecology and Paediatrics. In that period, I was under supervision by the various provincial consultants.

2. Medical Officer in Surgery at Nyanza Provincial Hospital - November 1982 - April 1983.

3. Medical Officer in Charge of Medical and Surgical Wards at Kapenguria District Hospital - West Pokot District - May 1983 - August 1983.

4. Medical Registrar/Senior House Officer in Internal Medicine at the Kenyatta National Hospital, September 1983 to July 1986. During the same period, I worked almost full time as a Registrar in Renal Medicine.

5. From July, 1986:

   (a) Specialist Physician attached to Ward 23 at the Kenyatta national Hospital. I acted as the head of the ward for 2 months.

(b) Senior Registrar in Renal Medicine at the Kenyatta National Hospital, Renal Unit.

(c) Medical and Renal Outpatient Clinics at the Kenyatta National Hospital - 1983 to date

6. From April, 1990, Consultant Pysician and Nephrologist at Kenyatta National Hospital.

7. Training at Edinburgh, Scotland, Britain in April 1988 - April 1989.

i. Posts held:

(a) Honorary Registrar in Internal Medicine and Renal Medicine - western General Hospital.

(b) Research Registrar in Nephrology - Western General Hospital.

ii. Experience Obtained:

(a) As Honorary registrar in Internal Medicine, I was involved in admission of patients from the Accident & Emergency Department and their management in the ward thereafter. I attended the medical rounds, the

once weekly clinical meetings and the weekly medical out-patient clinics.

(b) As Honorary Registrar in Nephrology, I had an Intensive attachment course in the following areas:

i. Renal Transplant Medicine - This involved preparation of patients for renal transplants, their management in the immediate post-operative days and their follow-up at the weekly renal transplant clinics. I attended the weekly renal transplant meetings and participated in a weeks's course on tissue typing.

ii. Haemodialysis - I learnt the operation of the various haemodialysis machines at both the Western General Hospital and the Royal Infirmary, Edinburgh. I furthered my knowledge in principles and practice of maintenance dialysis. I was involved in the management of patients with acut renal failure commenced on haemodialysis. I also attended the weekly haemodialysis clinics at the Royal Infirmary, Edinburgh for 3 months.

iii. Peritoneal Dialysis - I had training in Chronic Ambulatory Peritoneal Dialysis (CAPD) at the Royal Infirmary, Edinburgh.

This involved:

- Learning the principles and practice of CAPD.

- Attending weekly CAPD clinics for 3 months.

- Training CAPD patients.

- Management of CAPD patients admitted with complications.

- Insertion of CAPD catheters.

At both the Royal Infirmary and the Western General Hospital in Edinburgh, I had exposure to acute peritoneal dialysis and continous cycling peritoneal dialysis (CCPD.

iv. General Nephrology

- Involved in the day-to-day managment of nephrology patients.

- Attended weekly general nephrology clinics at the Western General Hospital for 9 months and at the Royal Infirmary for 3 months.

- Did several renal biopsies.

- Attended weekly seminars in Nephrology.

v. Continous Arteriovenous Haemofiltration and Related Modes of Therapy

I learnt the principles and practice of Slow Continous Ultrafiltration (SCUF), Continous Arteriovenous Haemofiltration and Continous Arteriovenous Haemodialysis (CAVHD) at the Royal Infirmary, Edinburgh.

vi. Renal Pathology

- I attended the fortnightly renal pathology meetings at the Edinburgh University Department of Pathology.

- Learnt how to interprete renal biopsy material by light microscopy, electron microscopy and immunofluorescence by attending twice weekly sessions at the University Department of Pathology.

NB: Training at the Western General Hospital was under Dr. J. L. Anderson, Consultant Physician and Nephrologist, while at the Royal Infirmary it was under Dr. C. P. Swainson and Dr. R. J. Winney, both Consultant Nephrologists. Guidance in interpretation of renal biopsy material was by Dr. D. Goudesborough, Lecturer, Department of Pathology, Edinburgh University.

(c) As a Research Registrar in Nephrology, I was involved in the following research projects:

i. Use of fine needle aspiration biopsy in the diagnosis of acute rejection in renal transplant patients.

ii. Determination of the Role of Angiotensin Converting Enzyme inhibitors in the Retardation of Progression of chronic renal failure.

iii. Pharmakokinetics of xamoterol (a B_1 - partial agonist) in renal failure.

iv. Assay of Interleukin 2 receptor levels in transplant patients.

CERTIFICATES OBTAINED.

a) CERTIFICATION BY THE ROYAL COLLEGE OF PHYSICIANS AS HAVING TRAINED IN NEPHROLOGY AND HYPERTENSION

8. Training at Guy's Hospital in London, England, Britain. April 1989 to April 1990.

Supervisor: Prof. J. S. Cameron

i. Posts held:

(a) International Society of Nephrology Fellow.

(b) Honorary Senior Registrar in Nephrology.

(c) Research Fellow in Clinical Nephrology.

ii. Experience Obtained:

(a) At a clinical level I was involved in the management of patients with all kinds of renal diseases. This added to the experience I already obtained from Edinburgh in:-

- General Nephrology
- Dialysis
- Transplantation
- renal Pathology and Immunology

(b) In the same period I was involved in two research projects viz:

= Lupus Nephritis - Treatment and factors affecting long term prognosis.

= Recurrent Glomerulonephritis in renal transplant patients.

CERTIFICATES OBTAINED:

a) FELLOW OF THE INTERNATIONAL SOCIETY OF NEPHROLOGY

b) LETTER OF COMMENDATION FROM PROFESSOR JOHN STEWART CAMEROON, PRESIDENT OF THE INTERNATIONAL SOCIETY OF NEPHROLOGY

9. Training at Meir Hospital, Kfar Saba, Isreal under the auspices of Tel Aviv University, Faculty of Medicine. 8th January 1992 to 7th April 1992.

Supervisor: Prof. J. Bernheim

i. Post held: Visiting Nephrologist

ii. Experience Obtained:

Involved in the daily management of renal patients in the hospital. Worked at the major renal transplant centre in Israel, at Beilinson Hospital, for three weeks as part of the course. Spent a week visiting smaller renal units in Israel (vix. Ben Gurion University Renal Unit, Ramala Renal Unit, Paediatric Renal Unit in Jerusalem, Hebron Renal Unit) as part of familiarisation with the functioning of renal services in Israel.

CERTIFICATE OBTAINED:

(a) CERTIFICATE OF POSTGRADUATE COURSE IN NEPHROLOGY, UNIVERSITY OF TEL AVIV, FACULTY OF MEDICINE.

(b) CERTIFICATE OF TRAINING IN EMERGENCY MEDICINE,

MAGEN DAVID IN ISRAEL, CENTRAL FIRST AID TRAINING SCHOOL.

(c) LETTER OF RECOMMENDATION FROM PROF. J, BERNHEIM, MY SUPERVISOR AT MEIR HOSPITAL, KFAR SABA, ISRAEL.

F. TEACHING EXPERIENCE

1. Taught secondary school students in 1975 - 1976 (for one year)

2. Taught anatomy to Physiotherapy and Clinical Officer students (from College of Health Professionals, Nairobi), 1977 - 1978. At this time I was undergoing my first two years training for Bachelor of Medicine and Surgery (MB.Ch.B). In the same time period I carried out some research on the anatomy of the vervet monkey under Prof. J. Mungai and Dr. Kimani of the department of Anatomy, University of Nairobi.

3. Teaching community nurses (in training) some aspects of general medicine at the Nyanza Provincial Hospital, 1981 - 1982.

4. Tutorial Fellow - Department of Medicine, University of Nairobi, 1983 - 1986. During this period I took part in: -

   (a) Bedside teaching of 3rd and final year MB.Ch.B students.

   (b) Teaching intensive care nurses some aspects of renal medicine.

   (c) Teaching casualty nurses some aspects of emergency medicine.

5. Taught phase 2 and phase 3 medical students at the Western General Hospital, Edinburgh between April 1988 and April 1989 and at Guy's Hospital, London between April 1989 and April 1990.

6. Lecturer in Internal Medicine, University of Nairobi from October 1986. Since that time I have been involved in:

(a) Formal and bedside teaching of third year, final year and postgraduate students some aspects of Internal Medicine.

(b) Teaching first year postgraduate students (Paediatrics and Internal Medicine) and Intensive Care Nurses some aspects of renal medicine.

(c) Teaching final year MB.Ch.B and postgraduate students at the medical and renal out-patient's clinics.

7. Senior Lecturer in Internal Medicine, University of Nairobi from November 1990 to December 1999. Involved in the teaching listed under 6 and supervision of postgraduate students.

8. Associate Professor in internal medicine from December 1999 to date.

9. Examiner for the College of Health Sciences (University of Nairobi) and College of Health Professionals (Ministry of Health).

G. SUPERVISION OF POSTGRADUATE DISSERTATIONS

1. 1987: Dr. Kayima J: Coagulation abnormalities in patients with Nephrotic Syndrome as seen at Kenyatta National Hospital.
2. 1987: Dr. Otieno M.R.B.: Menstrual functions in patients with chronic renal failure at Kenyatta National Hospital - A clinical and Hormonal Evaluation.
3. 1990: Dr. Mathenge R.M.: Assessment of cardiac function in patients with stable chronic renal failure and end stage renal disease at Kenyatta National Hospital.
4. 1990: Dr. Chamba G.G.: Cardiovascular functions and complications of angioacess in haemodialysis patients.
5. 1992: Dr. Sindani I.S.: Coagulation study in cerebral malaria.
6. 1992: Dr. Lodenyo H.A.: Cardiovascular problems in the elderly at Kenyatta National Hospital.
7. 1992: Dr. Kairu S.M.: Peritonitis in peritoneal dialysis at Kenyatta National Hospital.
8. 1992: Dr. Ouko A.O.: Renal functional derangements in patients with symptomatic HIV infection.
9. 1992: Dr. Maimba J.M.: Protein loss during peritoneal dialysis and its effect on the occurence of peritonitis.

10. 1993: Dr. Odongo I.A.: Spirometic Indices and morbid events in chronic stable Bronchial Asthma.

11. 1993: Dr. Owino E.A.: The effect of HIV infection on exudative pleural effusions at the Kenyatta National Hospital.

12. 1993: Dr. Wanyoike M.N.: Bacteriology and sensitivity patterns of pyogenic meningitis in adult patients at Kenyatta National Hospital.

13. 1994: Dr. Kiyiapi, L.J.: Evaluation of Heterosexual spouses/partners of HIV infected of AIDS patients.

14. 1995: Dr. Mheta: Urinary tract infections in catherised patients at Kenyatta National Hospital.

15. 1996: Dr.Ngungi N.K.: The emergency treatment of hyperkalaemi in patients with renal failure at Kenyatta National Hospital.

16. 1996: Dr. Muraguri P.W: The prevalence of Proternuria and Hypertention in adolescent Kenyans.

17. 1996: Dr.Gogo K.O.: Comparative analysis of CD4, CD8 cell count and serum levels of 1gG, 1gA and 1gM in patients with chronic renal failure and end stage renal disease on and out of haemodialysis.

18. 1997: Dr.Musibi A.: A case-control study of hyperlipidaemia in diabetics without overt nephropathy and those with end stage renal disease due to diabetic nephropathy.

19. 1997: Gatuma: Pre-renal acute renal failure in predisposed patients in the medical wards at the Kenyatta National Hospital.

20. 1997: Dr.Otedo A.E.O: Hepatitis B and C virus markers in patients undergoing renal

replacement therapy at Kenyatta National hospital.

21. 1998: Dr.Hoooker J.A.G: Tuberculor meniningitis as seen at Kenyatta National hospital.
22. 1998: Dr.Karari E.M.: Prevalence of Helicobacter pylori in chronic renal failure.
23. 1998: Dr. Nyamu P.M: Diabetic foot ulcers at Kenyatta National Hospital.
24. 2002: Dr.Mbugua P: Diabetic ketoacidosis at the Kenyatta National Hospital.
25. 2002: Dr.Rishad J: Dialysis adequacy at the Keyatta National Hospital.
26. 2004: Ms.Omosa Bosibori Esther: Dertermining dietary compliance of renal patients at Kenyatta National Hospital.
27. 2004: Dr. Koech Emily: Clinicopathological manifestations of kidney disease in HIV/AIDS patients with proteinuria at Kenyatta NationalHospital.
28. 2004: Dr. Awiki Chalopa: Intradialysis hypotension in patients with end-stage renal disease on chronic haemodialysis.
29. 2004: Dr Mbogo: A Study to determine the prevalence of modifiable risk factor for progression in diabetics with chronic renal insufficiency.
30. 2004: Dr. Ngingi: Haemodialysis catheter related infections among patients on maintenance haemodialysis in the renal unit at the KNH
31. 2005: Ms.Kariuki Wanjiku Anastacia (University of Witwatersrand): Investigation of hypoglycaemia in patients with end-stage renal failure on maintenance haemodialysis at Kenyatta National Hospital Renal Unit
32. 2005: Mrs Bosibori E (KU): Dietary intakes in patients undergoing haemodialysis at the Kenyatta National Hospital

33. 2006: Dr. Mungai J: The changing clinical spectrum of HIV/AIDS at The Kenyatta National Hospital.

34. 2006: Mr. Muturi J (KU): Serum trace element levels in industrial workers

35. 2007: Dr.Kahura J: Contrast associated Nephropathy: Prevalence and risk factors at The Kenyatta National Hospital.

36. 2007: Dr. Ochieng P: Amphotericin associated nephrotoxicity in patients with HIV/AIDS undergoing treatment for cryptocoocal meningitis.

37. 2008: Dr. Mugeria: Mineral bone disease in patients with chronic kidney disease at Kenyatta National Hospital.

38. 2008: Dr. Muthui B: Glomerular diseases at the Kenyatta Hospital, Nairobi.

39. 2009: Mr. Gatua W.K: Early markers of tubular dysfunction in patients with diabetes mellitus at The Kenyatta National Hospital

40. 2010: Dr. Wagude A. A: Cardiovascular risk factors in renal transplant recipients at Kenyatta National Hospital.

41. 2011: Dr. Oktech N.A: Renal function in kidney transplant recipients at The Kenyatta National Hospital

42. 2011: Dr. Ochwilla B. A: Renal function of living kidney donors at The Kenyatta National Hospital

43. 2011: Dr.Njuguna P.K: Haematological profiles among kidney transplant recipients on follow up at The Kenyatta National Hospital.

44. 2011: Dr.Kimama: Prevalence of hypertension among high school students attending public day schools in Nairobi, Kenya.

45. 2011: Gatua W.K: Comparison of Venous and Arterial blood acid base analysis at the intensive care unit at The Kenyatta National hospital.

H. ADDITIONAL ASSISTANCE WITH POSTGRADUATE DISSERTATIONS

1. 1987, Dr. Patel A.K.: Bone metabolism and parathyroid function in chronic renal failure.

2. 1993, Dr. Ilako F.: Hepatitis C Virus antibodies in patients with chronic liver disease at the Kenyatta National Hospital.

3. 1993, Dr. Muhindi: The efficacy of Halofantrine in the treatment of malaria.

4. 1994, Dr. Thinwa J: Diagnostic value of ultrasound in renal disease in adult patients at the Kenyatta National Hospital.

5. 1994, Dr. Oyoo G.O.: Pattern of heart disease in adult patients admitted in congestive heart failure at Kenyatta National Hospital.

I. EDITORIAL EXPERIENCE

1. Editor, Nairobi Medical Journal 1978 to 1979.

2. Assistant Editor, African Journal of Hospital Medicine (MEDICOM) - October 1987 to date.

3. Member, Editorial Panel, East African Medical Journal, January 1992 to May 1995.

4. Editor, East African Medical Journal, May 1995 to date.

5. Editor, MEDICUS, May 1995 to 1998.

J. ADMINISTRATIVE EXPERIENCE

1. Acting Head, Ward 23, at the Kenyatta National Hospital(KNH): July to October, 1986.
2. Acting Head, Ward 28 (KNH): October to December, 1991.
3. Acting Chairman, Renal Unit(KNH) one month every year since 1990.
4. Secretary-General, Kenyan Chapter of Hypertension League, 1994 to date.
5. Treasurer, Kenya Association of Physicians, 1990 to 1994.
6. Chairman, Renal Unit (KNH), September 1994 to June 2002
7. Head, Ward 23 (KNH), September 1994 to 1997.
8. Chairman, Kenya Renal Association, May 2002 to date.
9. Chairman, East African Medical Journal Standing Committee, May 2002 to date.
10. Chairman, Faculty postgraduate studies committee, Faculty of Medicine June 2002 to date.
11. Acting Dean, Faculty of Medicine, 5th to 12th July 2002 and severally thereafter.
12. College Representative, Board of Postgraduate Studies, University Of Nairobi, August 2002 to January 2006.
13. Deputy Director, Board of Postgraduate Studies, University Of Nairobi, January 2006 to date.

K. OTHER ADMINISTRATIVE DUTIES.

1. Member of The University of Nairobi Biosafety Committee.
2. Member of The Ministry of Health Task Force on upscaling Renal Services in Kenya.
3. Member of The Ministry of Health Task Force on rationalization of Human Resources and Personnel Training

L. HELPING IN PERSONAL DEVELOPMENT

1. Dr. M. O. Luta: International Society of Nephrology Scholarships - Guy's Hospital, London - under Prof. George B. Haycock. Training in Paediatric Nephrology 1991.

2. Dr. Nyakundi P.: International Society of Nephrology Scholarship - Manchester Hospital. Training in Paediatric Nephrology 1992.

3. Dr. Patel A.K.: International Society of Nephrology Scholarship - Denver, Colorado - under Prof. Robert W. Schrier. Training in adult and experimental Nephrology 1995.

4. Dr. Twahir Ahmed: International Society of Nephrology scholarship – Guy's Hospital, London. – Under Prof. Steve sacks. Training in adult Nephrology 1998.

5. Dr. Twahir Majid: International Society Nephrology scholarship – Renal Unit Groote

Schuur Hospital, Cape Town, South Africa – Under Prof. Pascoe. Training In Adult Nephrology. 1999.

6. Dr. Sayed. S.M: International Society Nephrology scholarship – Department of Pathology. Me, bergdreef, Amsterdam , Netherlands. Under Prof. Jan. Weening-Training in Renal Pathology.1999.

7. Dr. Kiyiapi J.L: International Society of Nephrology scholarship – Renal Unit Groote Schuur Hospital, Cape Town, South Africa – Under Prof. Pascoe. Training in Adult Nephrology.2002.

8. Irimu Grace: Fellowship in Nephrology. Under Prof. Robert Haws. U.S.A. 2002.

9. Dr. Mbugua P: International Society of Nephrology Scholarship – Renal Unit, Groote Schuur Hospital, Cape Town South Africa – Under Prof. Pascoe. Trainining in Adult Nephrology.2004

10. Dr. Rishad: International Society of Nephrology Scholarship -Renal Unit,Groote Schuur Hospital,Cape Town, South Africa – Under Prof.Pascoe.Training in Adult Nephrology. 2005

11. Dr. Owiti: International Society of Nephrology Scholarship – Renal Unit, Witwatersrand, Johannesburg – Under Prof. Saraalar Neicker, 2008. Training in Adult Nephrology.

12. Dr. Ngigi J: International Society of Nephrology Scholarship – Renal Unit, Groote Schuur Hospital, Cape Town, South Africa – Under Prof. Pascoe,2009. Training in Adult Nephrology.

13. Dr. Moturi G: Cape Town, South Africa – Under Prof. Rafiq Moousa,2009 Training in Adult Nephrology

14. Dr. Walla H: Cape Town, South Africa – Under Prof. Saralah Naicker,2011, Training in Adult Nephrology

M. DEPARTMENTAL DUTIES

1. Member, Departmental Curriculum Committee, 1990 - 1991.

2. Member, Editorial Committee for Examinations of MB.Ch.B and M.Med, 1990 - 1991.

3. In-charge, Departmental Library, 1990 - 1991.

4. Topic Chairman, Nephrology Lectures to postgraduate students, 1990 to date.

5. In-charge, end of term clinical examinations MB.Ch.B, 1992 to 1995.

6. Member, Text Book Committee.

7. Co-ordinator Mini Rounds, Radiology meetings and Postmortem Conferences.

8. Topic Chairman, Rheumatology lectures to postgraduate and undergraduate students, 1996 to date.

N. MEMBERSHIP OF ASSOCIATION

1. Member of Kenya Medical Association.
2. Member of the Association of Physicians of East and Central Africa.
3. Member of the Kenya Association of Physicians.
4. Member of the African Association of Nephrologists.
5. Member of Kenya Renal Association.
6. Member of the Scottish Renal Association.
7. Member of the Kenya Kidney Patients and Friends Association.
8. Member of the International Society of Nephrology.
9 Member of the Hypertension League of Kenya.
10. Member of the New York Academy of Sciences.
11. Member of the Kenya National Academy of Sciences

O. CONFERENCES ATTENDED

1. European Dialysis and Transplantation Association Conference, West Berlin - October 1987.

2. European Dialysis and Transplantation Association Conference, Madrid - September 1988.

3. Scottish Renal Association Meeting Dundee - October 7th and 8th, 1988.

4. British Renal Association Conference, London - October 18th and 19th 1988.

5. International Conference on Lupus Nephritis, London - October 20th, 1988.

6. Scottish Renal Association Meeting, Glasgow - March 17th and 18th 1989.

7. Royal Society of Physicians Meeting, London - July 13th to 15th 1989.

8. Scottish Renal Association Meeting, Aberdeen - October 23rd and 24th 1989.

9. Conference on Recent Advances in the use of Cyclosporin in Transplantation, Jersey - November 5th to 7th, 1989.

10. Conference on Autoimmune diseases, royal Society of Physicians, London - February 8th and 9th, 1990.

11. Conference on Diabetic Nephropathy, Guy's Hospital London - March 24th to 29th, 1990.

12. Association of Physicians of East and Central Africa Conference, April, 1990.

13. Annual Scientific Conference, Aga Khan Hospital, Nairobi - October 1990.

14. International Society of Paediatric Nephrology Meeting, Jerusalem - March 1992.

15. Annual Scientific Conference, Aga Khan Hospital, Nairobi - 16th and 17th October, 1992.

16. Inaugaral Symposium for the launching of the Kenya Association of Physicians - October 24th 1992.

17. 14th Annual Medical Scientific Conference of Kenya Medical Research Institute and Kenya Trypanosomiasis Research Institute - February 1st to 5th, 1993.

18. Kenya Association of Clinical Patholigists Conference September 15th to 18th, 1993.

19. Medical Practitioners and Dentists Board Conference on Health, Lae and Ethics - Aga Khan Hospital, 23rd and 24th September, 1993.

20. Kenya Association of Physicians Conference, Nairobi, Kenya - 23rd and 24th October, 1993.

21. 15th African Health Sciences Congress, Nairobi - 17th to 21st February, 1994.

22. 3rd International Congress of Clyclosporine, seville, spain 29th to 31st March, 1994.

23. 16th African Health Sciences Congress, Nairobi - February, 1995.

24. Combined IVth African Association of Nephrology and Arab Society of Nephrology and Transplantation, Tunis - 26th to 29th April, 1995.

25. XIIIth International Congress of Hephrology, Madrid, Spain - 2nd to 8th July, 1995.

26. First Annual Conference of the Kenya Association of Physicians, Grand Regency Hotel, Nairobi - 2nd to 4th November, 1995.

27. International Society of Transplantation meeting - Barcelona - Spain - 23rd to 30th August, 1996.

28. Pan-African course on renal failure - Grand Regency Hotel - Nairobi, Kenya - 24th to 27th September, 1996.

29. Workshop for editors, authors and reviewers of medical literature, Nairobi, Kenya - 5th October, 1996.

30. Kenya Association of Physicians workshop on diabetes mellitus. Nairobi Safari Club, 22nd March, 1997.

31. International Workshop for authors, Peer reviewers and editors of Science and Medicine, African Academy of Sciences, Nairobi, 19th to 21st March, 1997.

32. X1Vth International Congress of Nephrology, Sydney,

Australia 25th to 29th May, 1997.

33. Vth African Association of Nephrology Congress, Durban,South

Africa, 7th to 10th September, 1997.

34. 30th American Society of Nephrology Annual Congress, San Antonio Texas, U.S.A, 2nd to 5th November 1997.

35. European Renal Association – EDTA congress, Rimini, Italy 6th to 10th June, 1998.

36. African Course In Nephrology- ISN, SARS, AFRAN,Cape Town South Africa, 5th to 8th February 1999.

37. African Renal Pathology workshop,30th October to 2nd November 2001,Nairobi, Kenya.

38. European Renal Association XXXVII Congress – Vienna, Austria, 24th to 27th June 2001.

39. European Renal Association XXXVIII Congress – Copenhagen, Denmark,14th to 17th July 2002.

40. International Society Of Nephrology/ Arican Association of Nephrology/ TheSudaneseSociety of Kidney Diseases and Transplantation congress. 2nd to 5th February, 2007, Khartoum, Sudan.

P. PAPERS READ AT CONFERENCES:

1. Annual General Meeting and Scientific Conference of the Kenya Medical Association, April, 1985 - Eldoret, Kenya. Pulmonary Oedema as seen in Intermittent Haemodialysis patients at the Kenyatta National Hospital.

2. International Workshop on Renal Disease and Electrolyte Disorders organised by International Society of Nephrology, June 1986, Nairobi, Kenya. Acute Renal failure of Obstetric origin at the Kenyatta National Hospital.

3. Annual General Meeting of the Association of Obstetrics and Gynaecologists of East and Central Africa, February 1987 - same paper as above (updated).

4. African Kidney and Electolytes Conference (organised by the International Society of Nephrology), February, 1987. Acute Renal Failure of Malarial Origin in Adult Patients seen at Kenyatta National Hospital.

5. 33rd Annual General Meeting of the Association of Physicians of East and Central Africa, November, 1987 - Lusaka, Zambia. Ascites in Patients undergoing Intermittent Haemodialysis at Kenyatta National Hospital. Treatment of Systemic Lupus rythematosus.

6. Annual General Meeting of the Kenya Medical Association, April, 1988 - Nairobi, Kenya - Continuing Medical Education in the Management of Renal Failure.

7. The Scottish Renal Association Meeting, Glasgow. 17th and 18th March, 1989.

   - Renal Transplant Aspiration Cytology in Edinburgh

   - Orthoclonal Anti-T3 Cell Antibody (OKT3) as Rescue Therapy in Renal Allograft Rejection.

   - Hypertension in Renal Transplant: Effects of Treatment on Graft function.

8. International Conference on Lupus Nephritis, London, 1989. October 20th - Improved Survival in Lupus Nephritis using prednisolone and azathioprine.

9. Association of Physicians of East and Central Africa Conference - April, 1991. Estimation of creatinine clearance from serum creatinine.

10. Annual Scientific Conference, Aga Khan Hospital, October, 1990 - Pathology and Management of Lupus Nephritis.

11. Annual Scientific Conference, Aga Khan Hospital, Nairobi - 17th October 1992 - Pattern of disease in genetic patients at the Kenyatta National Hospital.

12. Inaugaral Symposium for the launching of the Kenya Association of Physicians, 24th October, 1992. Dilemas in the management of End stage renal Failure in Kenya.

13. 14th Annual Medical and Scientific Conference of Kenya Medical Research Institute and Kenya Trypanosomiasis Research Institute 1st to 5th February., 1993. Bacteriology and Sensitivity Patterns of Pyogenic Menengitis at Kenyatta National Hospital, Kenya (AB 17/93).

14. Kenya Association of Clinical Pathologists Conference (15th to 18th Septemebr, 1993). Glomerular disease in Kenya - another look.

15. African Health Sciences Congress, Nairobi (17th - 21st February, 1994). Current status of immunosuppression in renal transplantation and its application in developing countries.

16. 22nd Annual General Meeting of the Kenya Medical Association 28th March to 1st April, 1994. Organs transplantation and human rights.

17. Commonwealth Medical Association. Regional Seminar and Workshop on Medical

Ethics (25th to 29th May, 1994). Ethical, Legal, Religious and Cultural issues in organ transplantations.

18. MEDIC AFRICA and Medical Association and Societies Conference (27th to 29th September, 1994). HIV/AIDS and Renal disease.

19. 4th Congress of African Association of Nephrology and Arab Society of Nephrology and Transplantation (26th to 29th April, 1995). Glomerular disease in Kenya - Another look at diseases characterised by Nephrotic range proteinuria.

20. First Annual Conference of the Kenya Association of Physicians, Nairobi - 2nd to 4th November, 1995. Renal Vein and Intracava invasion by an adrenal phactiromocytoms with extension into the right atrium.

21. Pan-African course on renal failure - Nairobi, Kenya - 24th to 27th September, 1996: Prevention of progression of chronic renal failure.

22. Workshop for editors, authors and reviewers of medical literature - 5th October, 1996.

(i) Formats of publishing in medical journals.

(ii) Ethical issues relating to medical publications.

23. Kenya Association of Physicians Workshop on diabetes mellitus, 22nd March, 1997.
Prevention of progression of diabetic nephropathy.

24. African Renal Pathology Workshop, 30th October – 2nd November,2000, Nairobi, Kenya.
Glomerular diseases in Kenya.

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R. **CHAPTERS IN TEXT BOOKS**

a) Chapter 15 : The evolution of nephrology in East Africa pp 230-240, In "A TEXT BOOK OF UROLOGY AND NEPHROLOGY IN AFRICA" By J.Lester Eshelman

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T. RESEARCH INTERESTS:

a) Pregnancy in patients with renal disease

b) Pregnancy induced hypertension

c) Glomerulopathies in the tropics

d) Prevention of progression of renal failure

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g) Endothelial damage in glomerular disease.

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i) Renin - Angiotensin System

j) HIV/AIDS and non-infectious complications.

h) Hypertension and renal disease in black Africans.

U. RESEARCH IN PROGRESS:

a) Lupus Nephritis - prevalence, clinical manifestations, pathology, treatment and longterm outcome in the indegenous Kenya population.

b) Pathology of glomerular disease in Kenya, relationship to parasitic disease and response to therapeutic manouvers.

c) Calcium, sodium and potassium homeostasis in diabetic nephropathy.

d) Pathogenesis of pruritis in chronic renal failure

f) Epidemiology of chronic renal failure in Kenya.

g) The epidemiology of hypertension in first degree relatives of patients suffering from hypertension.

h) Determinants of the occurence of hypertension in patients with Diabetes Mellitus

(types 1 and 11).

i) Hypertension, Renal disease and Keloids in the Kenyan population.

V. REFEREES:

(A) LOCAL

1) PROF. S.M. BHATT
DEPARTMENT OF MEDICINE
UNIVERSITY OF NAIROBI
P.O. BOX 19676
NAIROBI.
E-mail : shrikanti@yahoo.com

2) PROF. W. LORE
P.O. BOX 46132
NAIROBI
E-mail : lorebill@hotmail.com

3) PROFESSOR DOMINIC MAKAWITI
VICE CHANCELLOR
MASENO UNIVRSITY
PRIVATE BAG
MASENO – KENYA
E-mail : dmakawiti@maseno.ac.ke

(B) INTERNATIONAL

1) PROFESSOR SARALADEVI NAICKER
UNVERSITY OF WITWATERSRAND
PRIVATE BAG 3
WITS JOHANNESBURG, 2050 GAUTENG
SOUTH AFRICA
E-mail: Saraladevi.Naicker@wits.ac.ze

2) PROFESSOR ADU DWAMOA
DEPARTMENT OF MEDICINE AND THERAPEUTICS
UNIVERSITY OF GHANA COLLEGE OF HEALTH SCIENCES
P.O. BOX 4236
ACCRA – GHANA
Email: Dwoms@blueyonder.co.uk

DOCUMENT B

PROFESSOR S.O. MCLIGEYO

PUBLICATIONS INDEXED IN PubMed

Evaluation of Urinary Tubular Enzymes as Screening Markers of Renal Dysfunction in Patients Suffering from Diabetes Mellitus

Author(s): Wilfred. K. Gatua | Joseph N. Makumi | Eliud M. Njagi | Christine S. Kigondu | Seth O. Mcligeyo | Stanley K. Waithaka

Journal: Asian Journal of Medical Sciences ISSN 2040-8765
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Keywords: Diabetes mellitus | glomerular function | kidney failure | tubular integrity | urinary tubular enzymes

ABSTRACT
To determine the relationship between sub clinical kidney injury caused by diabetes mellitus and the levels of urinary enzymes; N-acetyl-$-D-glucosaminidase, lactate dehydrogenase, alkaline phosphatase and gamma glutamyl transferase in relation to urinary concentration of microprotein, serum urea and creatinine. The study subjects comprised 251 patients with Diabetes Mellitus (cases), and 73 healthy individuals (control group). The cases were further subdivided into those with normoproteinuria, microproteinuria and kidney failure. Glomerular function was studied by urinary levels of protein (U.mp), serum urea and creatinine while proximal tubular structural integrity was studied by determining the activities of the enzymes U.ALP, U.NAG, U.γ-GT, and U.LDH. Compared with healthy individuals, diabetic patients with normoproteinuria excreted significantly high levels of U.ALP, U.LDH, U.γ-GT, and U.NAG (p

1: Afr J Health Sci. 1998 Jul-Dec;5(3-4):114-7.Links

Autosomal dominant polycystic kidney disease - a systemic disorder.

McLigeyo SO.

Department of Medicine, University of Nairobi, P.O. Box 19676, Nairobi.

Autosomal dominant polycystic kidney disease [ADPKB] is one of the commonest genetic diseases. Apart from the involvement of the kidneys, several other organs, viz. the liver, the central nervous system, the pancreas, the spleen, the ovaries and the gut, amongst others, are also sometimes involved. This makes ADFKD more of a systemic rather than an isolated renal disorder. This becomes more so considering that the involvement of the other organs contribute

significantly to the morbidity and mortality of ADPKD. This review looks at the pattern and prevalence of involvement of other organs, apart from the kidney in ADPKD.

PMID: 17581009 [PubMed - in process]

Related Links

Autosomal dominant polycystic kidney disease - clinical and genetic aspects. [Kidney Blood Press Res. 2002]

[Seminal vesicle cysts and infertility in autosomal dominant polycystic kidney disease] [Nefrologia. 2005]

Recurrent pancreatitis in a patient with autosomal-dominant polycystic kidney disease. [Pancreatology. 2006]

Cardiovascular polycystins: insights from autosomal dominant polycystic kidney disease and transgenic animal models. [Trends Cardiovasc Med. 2006]

[Polycystic kidney diseases: molecular genetics and counselling] [Nephrol Ther. 2006]

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Diabetic ketoacidosis: clinical presentation and precipitating factors at Kenyatta National Hospital, Nairobi.

Mbugua PK, **Otieno CF**, **Kayima JK**, **Amayo AA**, **McLigeyo SO**.

Kenyatta National Hospital, P. O. Box 20723-00202, Nairobi, Kenya.

OBJECTIVE: To determine the clinico-laboratory features and precipitating factors of diabetic ketoacidosis (DKA) at Kenyatta National Hospital (KNH). DESIGN: Prospective cross-sectional study. SETTING: Inpatient medical and surgical wards of KNH. SUBJECTS: Adult patients aged 12 years and above with known or previously unknown diabetes hospitalised with a diagnosis of diabetic ketoacidosis. RESULTS: Over a nine month period, 48 patients had DKA out of 648 diabetic patients hospitalised within the period, one died before full evaluation. Mean (SD) age was 37 (18.12) years for males, 29.9 (14.3) for females, range of 12 to 77 years. Half of the patients were newly diagnosed. More than 90% had HbA1c > 8%, only three patients had HbA1c of 7-8.0%. More than 90% had altered level of consciousness, with almost quarter in coma, 36% had systolic hypotension, almost 75% had moderate to severe dehydration. Blunted level of consciousness was significantly associated with severe dehydration and metabolic acidosis. Over 65% patients had leucocytosis but most (55%) of them did not have overt infection. Amongst the precipitating factors, 34% had missed insulin, 23.4% had overt infection and only 6.4% had both infection and missed insulin injections. Infection sites included respiratory, genito-urinary and septicaemia. Almost thirty (29.8%) percent of the study subjects died within 48 hours of hospitalisation. CONCLUSION:

Diabetic ketoacidosis occurred in about 8% of the hospitalised diabetic patients. It was a major cause of morbidity and mortality. The main precipitant factors of DKA were infections and missed insulin injections. These factors are preventable in order to improve outcomes in the diabetic patients who complicate to DKA.

PMID: 16619732 [PubMed - indexed for MEDLINE]

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Cardiovascular risk factors in patients with type 2 diabetes mellitus in Kenya: levels of control attained at the Outpatient Diabetic Clinic of Kenyatta National Hospital, Nairobi. [East Afr Med J. 2005]

Quality of glycaemic control in ambulatory diabetics at the out-patient clinic of Kenyatta National Hospital, Nairobi. [East Afr Med J. 2003]

Influence of age on the presentation and outcome of acidotic and hyperosmolar diabetic emergencies. [Intern Med J. 2002]

Diabetic ketoacidosis: risk factors, mechanisms and management strategies in sub-Saharan Africa: a review. [East Afr Med J. 2005]

Hyperosmolarity and acidosis in diabetes mellitus: a three-year experience in Rhode Island. [J Gen Intern Med. 1991]

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Endoscopic findings and the prevalence of Helicobacter pylori in chronic renal failure patients with dyspepsia.

Karari EM, **Lule GN**, **McLigeyo SO**, **Amayo EO**.

Department of Clinical Pharmacology, College of Health Sciences, University of Nairobi, P.O. Box 19676, Nairobi.

BACKGROUND: Peptic ulcer disease (PUD) occurs in up to one fourth of patients with chronic renal failure (CRF). Some of the factors implicated in its causation include hypergastrinaemia, secondary hyperparathyroidism, drugs and, recently, Helicobacter pylori infection. Studies on the latter have been few, with none having been carried out in Kenya. OBJECTIVE: To evaluate the upper gastrointestinal tract endoscopic findings and to determine the prevalence of H. pylori in CRF patients with dyspepsia. STUDY DESIGN AND POPULATION: A prospective study of seventy seven consecutive patients with CRF and dyspepsia compared with consecutive age, sex and socio-economically matched seventy seven controls (no CRF) with dyspepsia. SETTING: Kenyatta National Hospital (KNH), the major referral and teaching hospital, Nairobi, Kenya. METHODS: In both the study population and the controls, upper gastrointestinal endoscopy was carried out. H.

pylori was tested for using the biopsy urease test and histology. Patients were considered to have H. pylori if they tested positive on both tests. OUTCOME MEASURES: Findings at endoscopy and presence of H. pylori. RESULTS: Inflammatory lesions (gastritis, duodenitis) (42%) and duodenal ulcers (18.4%) were the commonest findings in the two groups combined. The prevalence of H. pylori in the 154 subjects studied was 54.5%. There was no statistically significant difference between the prevalence of H. pylori in CRF patients (53.2%) and the controls (55.8%) ($p = 0.746$). Patients with endoscopically proven PUD had a very high prevalence of H. pylori (87.3%) regardless of their renal function status. CONCLUSION: Dyspepsia in patients with or without CRF was due to multiple causes and over 50% were attributable to H. pylori. The prevalence of H. pylon in dyspeptic CRF patients was similar to that in dyspeptic patients with normal renal function.

PMID: 12862061 [PubMed - indexed for MEDLINE]

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H pylori infection among 1000 southern Iranian dyspeptic patients. [World J Gastroenterol. 2006]

Endoscopic findings and prevalence of Helicobacter pylori in Kenyan patients with dyspepsia. [East Afr Med J. 1998]

Prevalence of Helicobacter pylori and endoscopic findings in HIV seropositive patients with upper gastrointestinal tract symptoms at Kenyatta National Hospital, Nairobi. [East Afr Med J. 2002]

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Polycystic kidney disease in a patient with achondroplasia: case report.

McLigeyo SO, **Kisiangani GS**.

Department of Medicine, College of Health Sciences, University of Nairobi, P.O. Box 19676, Nairobi, Kenya.

Autosomal dominant polycystic kidney disease is a multisystem disease involving many organs. An association with other diseases such as tuberous sclerosis, von Hippel-Lindau disease and Marfan syndrome have been previously described. We describe a 35 year old female with achondroplasia who developed polycystic kidney disease involving both kidneys and progressing to end-stage renal disease. To the best of our knowledge this is the first such case described in the literature. We also delve, briefly, into the possibility of the genes and chromosomes involved in Marfan syndrome,

polycystic kidney disease, tuberous sclerosis and achondroplasia playing a role in the co-occurrence of these entities.

PMID: 12755243 [PubMed - indexed for MEDLINE]

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Successful live related renal transplant in a case of tuberous sclerosis. [J Assoc Physicians India. 2005]

Von Hippel-Lindau disease simulating polycystic kidney disease. [Urology. 1980]

Tuberous sclerosis and polycystic kidney disease. A case report. [J Korean Med Sci. 1996]

End stage renal disease in tuberous sclerosis: a case report and review of the literature. [East Afr Med J. 1988]

Renal cystic disease in multisystem conditions. [Urol Radiol. 1992]

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Risk factors and prevalence of diabetic foot ulcers at Kenyatta National Hospital, Nairobi.

Nyamu PN, **Otieno CF**, **Amayo EO**, **McLigeyo SO**.

Department of Medicine, College of Health Sciences, University of Nairobi, PO. Box 19676, Nairobi, Kenya.

BACKGROUND: Diabetic foot ulcers contribute significantly to the morbidity and mortality of patients with diabetes mellitus. The diabetic patients with foot ulcers require long hospitalisation and carry risk of limb amputation. The risk factors for developing diabetic foot ulcers are manageable. In Kenya there is paucity of data on such risk factors. OBJECTIVE: To determine the prevalence of diabetic foot ulcers and the risk factors in a clinic-based setting. DESIGN: Cross-sectional study. SETTING: Kenyatta National Hospital, Kenya. SUBJECTS: Patients with both type 1 and 2 diabetes mellitus who had active foot ulcers in both outpatient and inpatient units. MAIN OUTCOME MEASURES: Diabetic foot ulcers glycated haemoglobin, neuropathy, peripheral vascular disease and fasting lipid profile. RESULTS: One thousand seven hundred and eighty eight patients with diabetes mellitus were screened and 82 (4.6%) were found to have foot ulcers. The males and females with diabetic foot ulcers were compared in age, duration of foot ulcers, blood pressure, glycaemic control, neurological disability score and their proportion. Diabetic foot ulcers occurred mostly in patients who had had diabetes for a long duration. The types of (occurence) ulcers were neuropathic (47.5%), neuroischaemic (30.5%) and ischaemic (18%). The neuropathic ulcers had significantly poorer glycaemic control compared to other types and the longest duration (23.3 weeks). Ischaemic ulcers had significantly higher total cholesterol and diastolic blood pressure

compared to other ulcer types. Wagner stage 2 ulcers were the commonest (49.4%) but stage 4 ulcers had their highest neuropathic score (7.8/10) and longest duration (23.6 weeks). Aerobic infective pathogens were isolated from 73.2% of the ulcers. CONCLUSION: The prevalence of diabetic foot ulcers was 4.6% in this tertiary clinic. The risk factors of diabetic foot ulcers in the study were poor glycaemic control, diastolic hypertension, dyslipidaemia, infection and poor self-care. These findings are similar to studies done in other environments and they are modifiable to achieve prevention, delay in formation or improved healing of foot ulcers in patients with diabetes. Therefore, specific attention should be paid to the management of these risk factors in patients with or without diabetes foot ulcers in this clinic.

PMID: 12755240 [PubMed - indexed for MEDLINE]

Related Links

Diabetic neuropathy, foot ulceration, peripheral vascular disease and potential risk factors among patients with diabetes in Bahrain: a nationwide primary care diabetes clinic-based study. [Ann Saudi Med. 2007]

Risk factor profile and the occurrence of microvascular complications in short-term type 2 diabetes mellitus at Kenyatta National Hospital, Nairobi. [East Afr Med J. 2005]

Cardiovascular risk factors in patients with type 2 diabetes mellitus in Kenya: levels of control attained at the Outpatient Diabetic Clinic of Kenyatta National Hospital, Nairobi. [East Afr Med J. 2005]

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Comment on:

East Afr Med J. 2002 Jun;79(6):284-90.

East Afr Med J. 2002 Jun;79(6):291-8.

Ageing population in Africa and other developing communities: a public health challenge calling for urgent solutions.

McLigeyo SO.

PMID: 12638817 [PubMed - indexed for MEDLINE]

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Violence against elderly people: a neglected problem. [Lancet. 2002]

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Ageing in the developing countries of Asia and the Pacific--implications for health care. [Ann Acad Med Singapore. 1987]

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7: East Afr Med J. 2002 Nov;79(11):614-7.Links

Neurofibromatosis type 1: report of two contrasting cases.

Sheikh N, **McLigeyo SO**.

Department of Medicine, College of Health Sciences, University of Nairobi, PO Box 19676, Nairobi, Kenya.

We present two cases of neurofibromatosis type 1 (NF-1), one a 35 year old male who first recognised his problem at the age of fifteen years and at the time of assessment, satisfied the National Institute of Health (NIH) diagnostic criteria for NF-1 and had a nodular plexiform neurofibroma involving the left fifth dorsal nerve root and a diffuse plexiform neurofibroma involving the left lower limb. The second patient, a 45 year old female recognised her problem at the age of 39 years, did not quite satisfy the NIH diagnostic criteria for NF 1 and had diffuse plexiform neurofibroma involving both lower limbs and buttocks almost symmetrically, a finding which has not previously been described to the best of our knowledge. The scarcity of management options are briefly outlined.

PMID: 12630497 [PubMed - indexed for MEDLINE]

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Segmental neurofibromatosis in childhood. [Am J Med Genet A. 2003]

Jaw malformations plus displacement and numerical aberrations of teeth in neurofibromatosis type 1: a descriptive analysis of 48 patients based on panoramic radiographs and oral findings. [J Craniomaxillofac Surg. 2003]

Facial plexiform neurofibroma in a child with neurofibromatosis type I: a case report. [J Indian Soc Pedod Prev Dent. 2007]

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Curtailing maternal to child transmission of HIV.

McLigeyo SO.

PMID: 12630487 [PubMed - indexed for MEDLINE]

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Emerging alternatives to allogeneic blood transfusions.

McLigeyo SO.

PMID: 12219959 [PubMed - indexed for MEDLINE]

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Alternatives to allogeneic blood transfusions. [Acta Anaesthesiol Belg. 2002]

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Low birthweight: more than a single hit malady of the first months of life.

McLigeyo SO.

PMID: 10442122 [PubMed - indexed for MEDLINE]

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First-year blood pressure increase steepest in low birthweight newborns. [J Hypertens. 2007]

Very low birthweight survivors: illness and readmission to hospital in the first 15 months of life. [Br Med J (Clin Res Ed). 1987]

The association of low birthweight and chronic renal failure among Medicaid young adults with diabetes and/or hypertension. [Public Health Rep. 2006]

Growth and survival of low birthweight infants from 0 to 9 years in a rural area of Ghana. Comparison of moderately low (1,501-2,000 g) and very low birthweight (1,000-1,500 g) infants and a local reference population. [Trop Med Int Health. 2000]

Nutritional status of low-birthweight ethnic minority infants in Backan province, Vietnam. [Pediatr Int. 2007]

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11: East Afr Med J. 1999 Mar;76(3):148-53.Links

Haemolytic uraemic syndrome: a review.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi.

OBJECTIVES: To provide an overview of the current understanding of the classification of haemolytic uraemic syndrome (HUS) and to describe the epidemiology, pathogenesis, clinical picture, renal histopathological findings, treatment and prevention of shiga toxin (Stx)-associated HUS, the most common type of HUS and; to compare and contrast features of idiopathic (atypical) HUS and inherited HUS with those of Stx-associated HUS. DATA SOURCE: A literature review was performed of major published series between 1989 and 1998 inclusive, using the Index Medicus and MEDLINE search. Some earlier published series were also reviewed in instances where they indirectly led to the current studies or reported on rarer organ involvements in HUS. STUDY SELECTION: Data and opinions from twelve general reviews of HUS, twelve on aetiology and classification, twelve on clinical features, eight on pathogenesis and nine on treatment and prognosis are summarised. CONCLUSION: HUS is a thrombotic microangiopathy with several aetiologies currently thought to play a role. Vascular endothelial cell injury appears to be central to the pathogenesis of all forms of HUS, although the triggering factors may be different and not well understood in some cases. In HUS, supportive therapy is of paramount importance. Reported specific therapies do not have sufficient evidence to support them. Prevention of HUS is possible in Stx-associated form, but not in the others. In patients who go on to develop end-stage renal failure, transplantation is possible, but recurrence rates are high in forms other than those which are Stx-associated. Persisting sequelae in other organs in HUS are infrequent.

PMID: 10442115 [PubMed - indexed for MEDLINE]

Related Links

Shiga toxin-associated hemolytic uremic syndrome: absence of recurrence after renal transplantation. [Pediatr Nephrol. 2002]

Pathogenesis of Shiga toxin-induced hemolytic uremic syndrome. [Pediatr Nephrol. 2001]

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Haemolytic uraemic syndrome: an overview. [Nephrology (Carlton). 2006]

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12: East Afr Med J. 1998 Oct;75(10):616-8.Links

Erratum in:

East Afr Med J 1999 Jan;76(1):55.

Polycystic kidney disease in tuberous sclerosis complex: case report.

Kariuki N, **Karanja MN**, **McLigeyo SO**.

Department of Paediatrics and Child Health, University of Nairobi.

Tuberous sclerosis complex (TSC) is an inherited neurocutaneous disorder characterised by seizures, mental retardation, cutaneous lesions and visceral harmatoma. We describe a 4 1/2-year old boy in whom in addition to the commonly described features of TSC, adult-type polycystic kidneys, a scantily reported occurrence, was an associated feature.

PMID: 10065200 [PubMed - indexed for MEDLINE]

Related Links

Polycystic kidneys as the presenting feature of tuberous sclerosis. [Helv Paediatr Acta. 1987]

Tuberous sclerosis and polycystic kidney disease. [BMJ. 1993]

Tuberous sclerosis and polycystic kidney disease. A case report. [J Korean Med Sci. 1996]

Tuberous sclerosis complex and neonatal seizures. [J Child Neurol. 1998]

Tuberous sclerosis complex with end-stage renal failure. [Nephrol Dial Transplant. 1995]

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13: East Afr Med J. 1998 Oct;75(10):609-13.Links

Treatment options in lupus nephritis.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi.

Like systemic lupus erythematosus (SLE) itself, manifestations of lupus nephritis are highly varied in their clinical presentation, ranging from mild proteinuria to rapidly progressive glomerulonephritis causing renal insufficiency within weeks. The clinical variability is in keeping with the broad spectrum of histological abnormalities present in renal biopsy specimens from these patients. The therapeutic modalities currently being used in lupus nephritis include oral steroids, pulse methylprednisolone and cytotoxic drugs such as cyclophosphamide and azathioprine either singly or in combinations, depending on the World Health Organisation morphologic classification of the disease. The use of plasmapheresis for proliferative lupus nephritis (WHO class III and IV) and cyclosporin for membranous lupus nephritis (WHO class V) is based on open trials, but not

supported by randomised controlled trials. This review assesses the therapeutic modalities available for the treatment of lupus nephritis, giving the available evidence from the literature and acknowledging that none of them might be perfect.

PMID: 10065198 [PubMed - indexed for MEDLINE]

Related Links

Treatment of lupus nephritis in children. [Pediatr Nephrol. 2000]

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The course and treatment of lupus nephritis. [Annu Rev Med. 1994]

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Pathogenesis of lupus nephritis: a review.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi.

Systemic lupus erythematosus (SLE) is a non-organ specific autoimmune disease in which the primary autoantigen has been a subject of debate despite detection of antibodies to several nuclear antigens. Contrary to previously held belief that SLE and, by extension, lupus nephritis is an immune complex disease mediated by DNA-AntiDNA complexes, it is becoming increasingly clear that nucleosomes and possibly complement factor Clq are the major players in the pathogenesis of these entities. This review article looks at the structure, source and possible pathogenetic role of nucleosomes and anti-nucleosome specific antibodies in lupus nephritis. Additionally, the possible role of Clq and anti-Clq antibodies in the pathogenesis of lupus nephritis is considered.

PMID: 10065172 [PubMed - indexed for MEDLINE]

Related Links

Autoimmunity against nucleosomes and lupus nephritis. [Ann Med Interne (Paris). 1996]

Pathophysiology of lupus nephritis: the role of nucleosomes. [Neth J Med. 1994]

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Comment on:

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Herpes zoster in HIV/AIDS--a little recognised opportunistic infection with important clinical and cost implications.

McLigeyo SO.

PMID: 9803625 [PubMed - indexed for MEDLINE]

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Herpes zoster myelitis: report of two cases. [East Afr Med J. 2002]

Prolonged herpes zoster in a patient infected with the human immunodeficiency virus. [J Dermatol. 2001]

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Management issues in herpes zoster. [Aust Fam Physician. 1996]

Foscarnet-resistant multidermatomal zoster in a patient with AIDS. [Clin Infect Dis. 1995]

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T-cell subset counts and serum immunoglobulin concentrations in patients with chronic renal failure at the Kenyatta National Hospital.

Gogo KO, **McLigeyo SO**, **Bwayo JJ**, **Mumo JM**.

Egerton University, Medical Clinic, Njoro, Kenya.

This study was designed to determine whether there was any difference in the T-cell subset counts and serum immunoglobulin concentrations in patients with chronic renal failure as compared to normal controls. Ninety individuals participated in the study. These were divided into three groups as follows; (i) 30 subjects with normal renal function; (ii) 30 subjects with chronic renal failure (CRF)(creatinine clearance 10-50 mls/min), not requiring haemodialysis and; (iii) 30 subjects with end stage renal disease (creatinine clearance < 10 mls/min) on haemodialysis. The subjects in the three groups were matched for age and sex. In addition, it was ascertained that none of the subjects was on any medication or suffered from any ailment known to interfere with the immune system. The T-cell subset counts were carried out using flow cytometry while the serum concentration of immunoglobulins was measured using the radio-immunodiffusion method. Patients with CRF, whether on haemodialysis or not, had significantly lower lymphocyte counts as a proportion of total white cell count (19% and 19.2% respectively versus 39%) and low absolute CD4 cell counts per mm3 (337 +/- 94 and 449 +/- 116 respectively versus 891 +/- 360) and CD8 cell counts per mm3 (437 +/- 234 and 490 +/- 176 respectively versus 644 +/- 228) as compared to normals, with no statistically significant difference between the two groups with CRF. The CD4: CD8 ratios in the three groups studied were 1.487 +/- 0.233, 0.961 +/- 0.326 and 0.751 +/- 0.167 respectively, being significantly higher in normal controls than in any of the groups with CRF ($p < 0.05$) and in the group with CRF not requiring dialysis than in those requiring it ($p < 0.05$). The serum concentration of immunoglobulins in the two groups with CRF were similar to those in the group with normal renal function. It is concluded that CRF represents a state of immunodeficiency not significantly corrected by haemodialysis.

PMID: 9746996 [PubMed - indexed for MEDLINE]

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Association of reduced red blood cell deformability and diabetic nephropathy. [Kidney Int. 2005]

The immune status of uraemic children/adolescents with chronic renal failure and renal replacement therapy. [Pediatr Nephrol. 1989]

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17: East Afr Med J. 1998 Feb;75(2):61-2.Links

Recent infectious disease outbreaks in Kenya: have we been caught unaware?

McLigeyo SO.

PMID: 9640823 [PubMed - indexed for MEDLINE]

Related Links

[El niño and its consequences: outbreak of Rift Valley fever in Kenya] [Dtsch Med Wochenschr. 2007]

Climate and satellite indicators to forecast Rift Valley fever epidemics in Kenya. [Science. 1999]

Outbreak news. Rift Valley fever, Kenya. [Wkly Epidemiol Rec. 2007]

Outbreaks of Rift Valley fever in Kenya, Somalia and United Republic of Tanzania, December 2006-April 2007. [Wkly Epidemiol Rec. 2007]

Canadian physicians help fight RVF in Kenya. [CMAJ. 2007]

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18: East Afr Med J. 1998 Mar;75(3):171-4.Links

Smoking--an emerging risk factor for renal diseases.

McLigeyo SO.

College of Health Sciences, Department of Medicine, University of Nairobi, Kenya.

The health, economic and social costs of smoking are enormous and well known to physicians. Smoking results in a lot of morbidity and mortality mainly related to cardiovascular disease, cancer and pulmonary disease. The effect of smoking on the kidneys is little appreciated. It is the purpose of this review article to give evidence from available literature that smoking is indeed deleterious to the kidneys and may result in progression of chronic renal failure to end stage renal disease. It is concluded that nephrologists, and indeed all physicians, should make a concerted effort to save their patients from this vice.

PMID: 9640817 [PubMed - indexed for MEDLINE]

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The relationship of cigarette smoking to end-stage renal disease. [Semin Nephrol. 2003]

Smoking--a renal risk factor. [Nephron. 2000]

Adverse effects of smoking in the renal patient. [Tohoku J Exp Med. 2001]

Slowing the progression of diabetic nephropathy and its cardiovascular consequences. [Am Heart J. 2004]

[Risk factors in the development and progression of end-stage renal failure, the 21st century epidemic] [Nefrologia. 2001]

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19: East Afr Med J. 1997 Oct;74(10):647-51.Links

Cardiovascular disease in elderly in-patients at the Kenyatta National Hospital, Nairobi-Kenya.

Lodenyo HA, **McLigeyo SO**, **Ogola EN**.

Clinical Research Centre, Kenya Medical Research Institute, Nairobi, Kenya.

A prospective study to determine the prevalence and profile of cardiovascular disease in elderly patients admitted into the medical wards, Kenyatta National Hospital, was carried out between July 1991 and January 1992. Two hundred and two patients over 60 years of age were admitted into the medical wards over this period. This formed seven per cent of the total medical admissions. Two of these refused to take part in the study. Of the 200 elderly patients evaluated for cardiovascular disease, 146 (73%) were between 60 and 75 years of age with only 26 (13%) being over 85 years. Fifty seven per cent were males. Clinical evidence of cardiovascular disease was present in 79 (39.5%) of the patients evaluated. There was no sex difference in the prevalence of cardiovascular

disease as judged from clinical evaluation (37.7% males versus 41.9% females, $p > 0.05$). Cardiovascular diseases in our medical in-patients at Kenyatta National Hospital are common and especially so with hypertension which plays an important role in the aetiology of congestive heart failure and cerebravascular accidents. Cardiac arrhythmias are also common though not necessarily symptomatic. Rheumatic heart disease and cardiomyopathies were uncommon in our study population. A community-based survey is needed to determine the true prevalence of cardiovascular diseases in the elderly and their contribution to morbidity in this sector of the population.

PMID: 9529748 [PubMed - indexed for MEDLINE]

Related Links

Clinical and socio demographic aspects of congestive heart failure patients at Kenyatta National Hospital, Nairobi. [East Afr Med J. 1999]

Pattern of transitional cell carcinoma of the urinary bladder as seen at Kenyatta National Hospital, Nairobi. [East Afr Med J. 2004]

Some effects of the rising case load of adult HIV-related disease on a hospital in Nairobi. [J Acquir Immune Defic Syndr Hum Retrovirol. 1998]

The pattern of geriatric admissions in the medical wards at the Kenyatta National Hospital. [East Afr Med J. 1993]

Cardiovascular risk factors in patients with type 2 diabetes mellitus in Kenya: levels of control attained at the Outpatient Diabetic Clinic of Kenyatta National Hospital, Nairobi. [East Afr Med J. 2005]

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20: East Afr Med J. 1997 Oct;74(10):607-10.Links

Elderly patients should receive all forms of medical treatment: a philosophical argument.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

The use of old age as a criterion for rationing in medicine seems initially appealing. This is because many of the criteria currently being used for deciding the distribution of funds depend on subjective judgements. Age, however, is objective and therefore negates the need for value judgements. It has been suggested that justice and fairness require that limited resources be directed at young patients, who have not had a chance to live their lives, rather than at elderly patients who have already lived most of theirs. It is the purpose of this article to bring forth evidence that elderly patients should be accorded medical treatment on equal basis as younger patients and that policies which deny elderly

people treatment on the sole grounds of age, are both unfair and discriminatory and should therefore be resisted.

PMID: 9529737 [PubMed - indexed for MEDLINE]

Related Links

Protecting elderly people: flaws in ageist arguments. [BMJ. 1995]

Rationing scarce life-sustaining resources on the basis of age. [J Adv Nurs. 2001]

Dialysis decisions and the elderly. [Clin Geriatr Med. 1994]

Thinking about equity in health care. [J Nurs Manag. 2005]

Who is entitled to long-term health care? Emerging policy and moral debate. [J Nurs Manag. 1998]

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Items 1 - 20 of 70

21: East Afr Med J. 1997 Oct;74(10):605-6.Links

Successful ageing: an ideal developing countries should aim for.

McLigeyo SO.

PMID: 9529736 [PubMed - indexed for MEDLINE]

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Developing effective and affordable models for non-communicable disease prevention and control. [Int J Epidemiol. 2001]

[Health in the third age] [J Med Liban. 1995]

The Roll Back Malaria movement. [Trop Doct. 2002]

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22: East Afr Med J. 1997 Aug;74(8):503-9.Links

Treatment of hyperkalaemia by altering the transcellular gradient in patients with renal failure: effect of various therapeutic approaches.

Ngugi NN, **McLigeyo SO**, **Kayima JK**.

Department of Medicine College of Health Sciences, University of Nairobi, Nairobi.

Ten patients with acute and 60 with chronic renal failure (both groups having hyperkalaemia), were managed at Kenyatta National Hospital in the medical wards and Renal Unit between August, 1995 and January, 1996. They were divided into seven different treatment groups, each consisting of ten patients. Treatment A glucose 25g i.v. with insulin 10 units i.v., treatment B 50 mmol of 8.4% sodium bicarbonate infusion, treatment C 0.5mg of salbutamol i.v. in 50mls 5% dextrose, treatment D was a combination of treatments A and B, treatment E was a combination of treatment B and C, treatment F was a combination of treatments A and C while treatment G was a combination of treatments A and B and C. Serum potassium was measured, 30 minutes, 1 hour, 2 hours, 4 hours and 8 hours after treatment. Plasma glucose concentration was measured before treatment was given and 1 hour after in all patients. Electrocardiography was done before treatment on all patients and repeated 30 minutes and 1 hour after treatment for the patients with hyperkalaemic changes on the initial recording. All treatment modalities had satisfactory potassium lowering effects. Of the single therapeutic approaches, treatment A and C were equieffective, but better than treatment B ($P < 0.001$). Amongst the two regimen combinations, treatment D and F were more efficacious than treatment E and all the single therapeutic approaches ($P < 0.001$). Treatment G was the most efficacious in lowering serum potassium in this study. All treatment modalities had maximum serum potassium lowering effect at 1-2 hours. A fall in plasma glucose concentration was a notable feature of treatments A and D, but significant hypoglycaemia occurred in 20% of patients receiving treatment A and in none on treatment D. The ECG changes of hyperkalaemia did not correlate with serum potassium levels. The normalisation of hyperkalaemic ECG alteration occurred within the first 30 minutes after treatment. In conclusion, combination therapies for hyperkalaemia appear to be more efficacious than single therapeutic approaches. Inclusion of salbutamol seems to protect against insulin induced hypoglycaemia. The maximum potassium lowering effect is observed 1-2 hours of administration of either agents. The potassium reducing effect remains significant compared to baseline values even after 8 hours. If dialysis cannot be instituted early enough it seems reasonable to repeat treatment every 4-6 hours to sustain the effect. Repeated administration of glucose with insulin may not be safe because of the hypoglycaemic effect. Other single and combination therapies can theoretically be repeated regularly until dialysis is initiated although this requires further clinical evaluation.

PMID: 9487416 [PubMed - indexed for MEDLINE]

Related Links

Effect of bicarbonate administration on plasma potassium in dialysis patients: interactions with insulin and albuterol. [Am J Kidney Dis. 1996]

Acute therapy for hyperkalemia with the combined regimen of bicarbonate and beta(2)-adrenergic agonist (salbutamol) in chronic renal failure patients. [J Korean Med Sci. 1997]

Intravenous infusion or nebulization of salbutamol for treatment of hyperkalemia in patients with chronic renal failure. [Zhonghua Yi Xue Za Zhi (Taipei). 1994]

Effect of various therapeutic approaches on plasma potassium and major regulating factors in terminal renal failure. [Am J Med. 1988]

Treatment of hyperkalaemia in renal failure: salbutamol v. insulin. [Nephrol Dial Transplant. 1989]

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Potassium (Glu-K®, K+ 10®, K+ 8®, ...)Potassium is essential for the proper functioning of the heart, kidneys, muscles, nerves, and digestive system. Usually the food you eat supplies all of the potassium you need. However, certain diseases (e.g., kidney dis...

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23: East Afr Med J. 1997 Aug;74(8):467-73.Links

Comment in:

East Afr Med J. 1997 Aug;74(8):465-6.

Proteinuria, other selected urinary abnormalities and hypertension among teenage secondary school students in Nairobi, Kenya.

Muraguri PW, **McLigeyo SO**, **Kayima JK**.

Department of Medicine, College of Health Sciences, University of Nairobi, Nairobi.

Four hundred and three teenage secondary school students (50.6% males) from two girls' and two boys' Nairobi City Schools, selected by stratified sampling, were screened to determine the prevalence of proteinuria, haematuria, nitrituria and hypertension. Nine students (2.2%) had significant proteinuria while 14 (3.5%) had microscopic haematuria. Two students had combined proteinuria and haematuria. There was no statistically significant difference in the prevalence of proteinuria and/or haematuria between the sexes. Other urinary abnormalities detected were leucocyturia in 14(3.5%) and nitrites in four (1%). Leucocyturia was commonner in females ($p = 0.001$). Cloudy urinary appearance was significantly associated with the presence of leucocyturia ($p = 0.0028$) and proteinuria ($p = 0.0276$). Neither personal history of recurrent sore throat and skin infections nor family history of hypertension, diabetes mellitus or kidney disease was significantly associated with proteinuria or haematuria. Blood pressure tended to increase with age. Mean systolic and diastolic blood pressures were significantly higher in boys than girls in the age group 15-18 years ($P < 0.001$). Of the 397 students whose blood pressures were measured, four (1%) were found to be hypertensive. Weight and body mass index were strong positive correlates of blood pressure. The prevalence of proteinuria, haematuria, other urinary abnormalities and hypertension ranges between 1% and 3.5% among teenage secondary school children. The majority are asymptomatic and have no significant associations. It is recommended that routine urinalysis and blood pressure measurements should be part of the school health service so as to identify asymptomatic students who require close monitoring and/or intervention.

PMID: 9487409 [PubMed - indexed for MEDLINE]

Related Links

Mass urinary screening and follow-up for school children in Taiwan Province. [Acta Paediatr Taiwan. 2001]

Screening proteinuria and hematuria in Malaysian children. [Southeast Asian J Trop Med Public Health. 1995]

Urinary abnormalities in asymptomatic adolescent Nigerians. [West Afr J Med. 1994]

Prevalence of sustained hypertension and obesity in urban and rural school going children in Ludhiana. [Indian Heart J. 2004]

Prevalence and risk factors of smoking among secondary school students in Nairobi. [East Afr Med J. 2003]

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Comment on:

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Long distance truck driving: its role in the dynamics of HIV/AIDS epidemic.

McLigeyo SO.

PMID: 9487392 [PubMed - indexed for MEDLINE]

Related Links

[The HIV epidemic in Burkina Faso: current status and the knowledge level of the population about AIDS, 1994-1995] [Rev Epidemiol Sante Publique. 1998]

STD services for women at truck stop in Tanzania: evaluation of acceptable approaches. [East Afr Med J. 1997]

Prevalence of HIV among truck drivers visiting sex workers in KwaZulu-Natal, South Africa. [Sex Transm Dis. 2002]

[The HIV-pandemic in the third world--worse than anticipated?] [Tidsskr Nor Laegeforen. 2006]

HIV/AIDS in the Eastern Mediterranean: a false immunity? [East Mediterr Health J. 2002]

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25: Afr J Health Sci. 1997 Jan-Mar;4(1):20-2.Links

Continuous ambulatory peritoneal dialysis and the human immunodeficiency virus.

McLigeyo SO.

Department of Medicine, University of Nairobi, P.O Box 19676, Nairobi.

This review looks at the clinical performance of Immunodeficiency Virus (HIV) infected individuals with end stage renal disease (ESRD) treated using continuous ambulatory peritoneal dialysis (CAPD). It also considers the potential infectious nature of the peritoneal dialysis effluent (PDE) and offers suggestions on how to circumvent this risk.

PMID: 17583975 [PubMed - in process]

Related Links

Peritoneal dialysis in the Sudan. [Perit Dial Int. 2007]

First use of tamoxifen in an HIV patient with encapsulating peritoneal sclerosis. [Clin Drug Investig. 2007]

Chronic kidney disease in human immunodeficiency virus infection. [Panminerva Med. 2007]

Residual renal function plays an important role in regulating parathyroid hormone in patients on continuous ambulatory peritoneal dialysis. [Adv Perit Dial. 2007]

Idiopathic eosinophilic peritonitis in continuous ambulatory peritoneal dialysis: experience with percutaneous catheter placement. [Nephrology (Carlton). 2007]

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Prevention and control of tuberculosis.

Sindani SI, **McLigeyo SO**.

Department of Medicine, University of Nairobi, P. O. Box 19676, Nairobi, Kenya.

Tuberculosis is again becoming a major public health problem. In order to control this complex disease, case-management, chemoprophylaxis and vaccination are used. The aim of case-management is to virtually stop transmission of tuberculosis infection by multidrug chemotherapy. This is, however, hampered by poor drug compliance and the high cost of the most effective drugs. Bacilli-Calmette-Guerin (BCG) vaccination has been used for a long time but with contentious efficacy. Though recent studies put the efficacy at 50%, its cost-effectiveness has yet to be established. Isoniazid preventive therapy (1PT) for control of tuberculosis is also rapidly gaining acceptance. In patients who adhere to 80% of medication taken, the efficacy is usually high. As for the control of tuberculosis among health care workers, engineering, administrative and personal respiratory measures have been introduced. Following the introduction of these measures in USA, dramatic decline in the risk of tuberculosis among these workers has occurred.

PMID: 17583974 [PubMed - in process]

Related Links

Control and prevention of healthcare-associated tuberculosis: the role of respiratory isolation and personal respiratory protection. [J Hosp Infect. 2007]

Family tuberculosis contacts: resource-contingent management. [Fam Pract. 1985]

Impact of present control methods on the problem of tuberculosis. [Rev Infect Dis. 1989]

Occupational tuberculosis: a review of the literature and the local situation. [Hong Kong Med J. 2006]

[World Health Organization guidelines for prevention of tuberculosis in healthcare facilities in countries with limited resources (measures for prevention of tuberculosis)] [Med Pregl. 2004]

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Patient Drug Information

Isoniazid (Nydrazid®, Rifamate® as a combination product containing Isoniazid and Rifampin, Rifater® as a combination product containing Isoniazid, Pyrazinamide, and Rifampin)Isoniazid is used alone or with other drugs to treat tuberculosis (TB) and to prevent it in people who have had contact with tuberculosis bacteria. It eliminates only active (growing) bacteria. Since the bacteria may exi...

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27: Afr J Health Sci. 1997 Jan-Mar;4(1):2-8.Links

Prevention and treatment of acute renal failure using diuretics and/or low ("Renal") dose of dopamine: a critical review.

McLigeyo SO.

Department of Medicine, University of Nairobi, P. O. Box 19676, Nairobi, Kenya.

The currently available evidence suggest that diuretics and/or low dose dopamine increases renal blood flow (RBF), glomerular filtration rate (GFR) and natriuresis in experimental animals, and limits ATP utilisation and oxygen needs in nephron segments at high risk of ischaemic injury, actions that could potentially limit renal injury and accelerate recovery in acute renal failure (ARF). These effects have indeed been confirmed in most experimental animals while using mannitol or low dose dopanime. Frusemide, however, for unknown reasons, has been effective in some animal models, but not others. In humans, it can be said that diurectics have a limited value to prevent, reverse or speed recovery from acute renal failure. Most clinical studies have failed to demonstrate convincingly that low dose dopamine either prevents ARF in high risk patients or improves renal function or outcome in patients with established ARF. This confusing scenario is further complicated by the fact that both diuretics and low dose dopamine can result in severe metabolic and cardiovascular complications in critically ill patients.

PMID: 17583971 [PubMed - in process]

Related Links

Renal-dose (low-dose) dopamine for the treatment of sepsis-related and other forms of acute renal failure: ineffective and probably dangerous. [Clin Exp Pharmacol Physiol Suppl. 1999]

[Low dosage dopamine improves kidney function: current status of knowledge and evaluation of a controversial topic] [Anasthesiol Intensivmed Notfallmed Schmerzther. 1997]

Prevention of acute renal failure: role of vaso-active drugs, mannitol and diuretics. [Int J Artif Organs. 2004]

Perioperative renal dysfunction and cardiovascular anesthesia: concerns and controversies. [J Cardiothorac Vasc Anesth. 1998]

Renal-dose dopamine: from hypothesis to paradigm to dogma to myth and, finally, superstition? [J Intensive Care Med. 2005]

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28: East Afr Med J. 1996 Sep;73(9):614-8.Links

Kidney transplantation: recent medical experiences from the Kenyatta National Hospital, Nairobi.

Kayima JK, **McLigeyo SO**, **Were AJ**, **Luta M**.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

Renal transplantation is not readily available in the majority of countries in Africa. It is expensive and difficult to sustain on the meagre funds allocated to health. We report our short experience with fifteen living donor recipients followed in our unit for at least 24 months, range 26 - 48 (mean 35 months) post-transplantation. The donors and recipients were mostly young adults with mean ages of 36.7 years and 32.6 years respectively. The majority of the donors and recipients were males. The donors in most cases were siblings. Within this time, one graft has been lost at one year and the patient restarted on haemodialysis. Three patients died, two within the first year, the third at 23 months after transplantation, all with functioning grafts. The one year graft and patient survival rates were 93% and 86.6% respectively. The second year graft survival rates remained at 93% and the patients survival rate 80%. The nature and frequency of complications seen in these patients is comparable to those in other centres. Of all medical complications, bacterial infections contributed 69.4% of all infections. Cardiovascular complications comprised 31.25% of the complications. Hypertension seen in 85.5% of the patients accounted for 65% of the cardiovascular complications. Acute rejections were common and occurred in seven patients. Transplantation is a viable mode of renal replacement therapy (RRT) in our environment. The practice should be supported to make it more readily available to the many young end stage renal failure (ESRF) patients.

PMID: 8991246 [PubMed - indexed for MEDLINE]

Related Links

The UNOS Scientific Renal Transplant Registry. [Clin Transpl. 1999]

Living-related pediatric renal transplants: a single-center experience from a developing country. [Pediatr Transplant. 2002]

HLA-identical sibling renal transplantation--a 21-yr single-center experience. [Clin Transplant. 1999]

The UNOS renal transplant registry. [Clin Transpl. 2001]

A decade of experience with renal transplantation in African-Americans. [Ann Surg. 2002]

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29: East Afr Med J. 1996 Sep;73(9):607-10.Links

Emerging concepts about the renin angiotensin system: present and future clinical applications.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

This review article looks at the emerging concepts about the renin angiotensin system. The specific aspects it covers include angiotensin II receptors, angiotensin receptor antagonists and alternative enzymatic pathways for the conversion of angiotensin I to angiotensin II other than angiotensin converting enzyme. The review, additionally, looks at the current and future clinical applications of the above concepts.

PMID: 8991244 [PubMed - indexed for MEDLINE]

Related Links

The renin-angiotensin system and vascular function. The role of angiotensin II, angiotensin-converting enzyme, and alternative conversion of angiotensin I. [Heart Vessels. 1997]

[The renin-angiotensin-aldosterone system -- more complex as previously thought] [Med Klin (Munich). 2005]

Should we aim at tissue renin-angiotensin systems? [Pharm World Sci. 1998]

Targeting the renin-angiotensin system: what's new? [Curr Med Chem Cardiovasc Hematol Agents. 2005]

The physiological significance of the alternative pathways of angiotensin II production. [J Physiol Pharmacol. 2006]

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Prevalence of human immunodeficiency virus infection: its impact on the diagnostic yields in exudative pleural effusions at the Kenyatta National Hospital, Nairobi.

Owino EA, **McLigeyo SO**, **Gathua SN**, **Nyong'o A**.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

This was a descriptive cross-sectional study carried out at Kenyatta National Hospital (KNH), Nairobi, among consecutively admitted adult patients with exudative pleural effusions over a one year period. The aim of the study was to determine the prevalence of human immunodeficiency virus (HIV) infection in these patients and to compare the diagnostic yields from the pleural fluid and pleural biopsy between the HIV seropositive and HIV seronegative patients. Sixty six patients were studied, with a mean age of 33.8 (+/- SD = 15.6) years and a male to female ratio of 1.6:1. Overall, 27 patients(40.9%) were found to be HIV seropositive. The commonest cause of exudative pleural effusions, overall, was tuberculosis (78.8%) followed by neoplasms (7.6%). Comparing the aetiology of exudative pleural effusion in HIV seropositive and HIV seronegative patients, tuberculosis was still the commonest cause accounting for 42.3% and 57.7% of the cases in each of the groups respectively. Conversely, 42.3% of patients with tuberculous pleural effusions were HIV seropositive. There was no significant difference in yields from pleural fluid, pleural biopsy culture and histology in the diagnosis of tuberculosis in the two patient groups. The only two patients with empyema were HIV seropositive and the bacterial isolates were Salmonella typhimurium and Pseudomonas aeruginosa. Kaposi's sarcoma was the cause of exudative pleural effusion in the one HIV seropositive patient with a malignant effusion. The only patient with a parapneumonic effusion was HIV seronegative. No fungi were isolated.

PIP: 66 adult patients of mean age 33.8 years with exudative pleural effusions were studied to determine the prevalence of HIV infection and compare the diagnostic yields from the pleural fluid and pleural biopsy between the HIV-seropositive and HIV-seronegative patients. The patients were consecutively admitted to Kenyatta National Hospital (KNH) over a 1-year period and of male:female ratio 1.6:1. 27 patients were found to be HIV seropositive. Tuberculosis (TB) and neoplasms were the most common causes of exudative pleural effusions, responsible for 78.8% and 7.6% of cases, respectively. Comparing the etiology of exudative pleural effusion in HIV-seropositive and HIV-seronegative patients, TB remained the most common cause, accounting for 42.3% and 57.7% of cases in each of the groups, respectively. 42.3% of the patients with TB pleural effusions were HIV seropositive. No significant difference was identified in the yields from pleural fluid, pleural biopsy culture, and histology in the diagnosis of TB in the 2 patient groups. The only 2 patients with empyema were HIV seropositive and the bacterial isolates were Salmonella typhimurium and Pseudomonas aeruginosa. Kaposi's sarcoma was the cause of exudative pleural effusion in the 1 HIV-seropositive patient with a malignant effusion. The only patient with a parapneumonic effusion was HIV seronegative. No fungi were isolated.

PMID: 8991236 [PubMed - indexed for MEDLINE]

Related Links

Pleural effusion, tuberculosis and HIV-1 infection in Kigali, Rwanda. [AIDS. 1993]

Diagnosis of tuberculosis in patients with pleural effusion in an area of HIV infection and limited diagnostic facilities. [Trop Geogr Med. 1994]

The etiology of pleural effusions in an area with high incidence of tuberculosis. [Chest. 1996]

Prevalence of Helicobacter pylori and endoscopic findings in HIV seropositive patients with upper gastrointestinal tract symptoms at Kenyatta National Hospital, Nairobi. [East Afr Med J. 2002]

Causes of pleural exudates in a region with a high incidence of tuberculosis. [Respirology. 2000]

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Urinary tract infection in patients with short-term indwelling.

Mlieta KI, **McLigeyo SO**, **Waiyaki2 PG**, **Kayima1 JK**.

Department of Medicine, University of Nairobi, P. O. BOX 19676 Nairobi, Kenya.

Seventy patients (44(62.9%) females) requiring short-term urinary bladder catheterisation at the Kenyatta National Hospital, Nairobi formed the study population. Their mean ages +/- SD was 41+/-26 years (range 13-100 years). The common indications and objectives for catheterisation included keeping the environment dry (41.1%), relieving urinary retention (27.0%) and urinary incontinence (24.3%). Urinary Tract Infection (UTI) was documented in 48 (68.6%) of the patients. The commonest infection organisms were Klebsiella pneumoniae, Escherichia coli and Proteus mirabilis, the three accounting for 78.6% of the infections. Female gender and increasing age increased the risk of catheter-associated UTI. The risk of having catheter-associated UTI was higher in patients with medical and surgical conditions than in those with obstetric and gynaecology conditions. Patients who were on systemic antibiotics for other conditions acquired UTI less often (27%) than those who were not undergoing antibiotic therapy. The organisms isolated showed marked resistance to commonly available antibiotics. We conclude that UTI, due to resistant organisms, is common in patients undergoing acute urinary bladder catheterisation in our setting and recommend that urinary bladder catheterisation should be avoided whenever possible. In a situation where this is inevitable, closed drainage systems should be used for the shortest duration possible.

PMID: 17451307 [PubMed - as supplied by publisher]

Related Links

Catheter-related urinary tract infection. [Drugs Aging. 2005]

The association between indwelling urinary catheter use in the elderly and urinary tract infection in acute care. [BMC Geriatr. 2006]

There is a low incidence of recurrent bacteriuria in painful bladder syndrome/interstitial cystitis patients followed longitudinally. [Int Urogynecol J Pelvic Floor Dysfunct. 2007]

Antibiotic resistance patterns in children hospitalized for urinary tract infections. [Arch Pediatr Adolesc Med. 2005]

Types of indwelling urinary catheters for long-term bladder drainage in adults. [Cochrane Database Syst Rev. 2007]

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32: Afr J Health Sci. 1996 May;3(2):60-3.Links

Renal vein and intracaval invasion by an adrenal phaeochromocytoma with extension Into the right atrium: a case study.

McLigeyo SO, **Oiiech J**, **Rana FS**, **Amayo EO**, **Monda SM**.

Department of Medicine, University of Nairobi, P.O. Box 19676, Nairobi, Kenya.

A 30 year old female with an unexpected right adrenal phaechromacytoma invading the renal vein, the inferior vena cava and extending into the right atrium is presented. She also had BuddChiari syndrome due to invasion of the hepatic veins by the tumour. Additionally, the tumour had metastasised to the liver and the lungs. Despite elevated 24 hour urinary vanillylmandelic acid (VMA) the patient was normotensive pre-operatively. The patient underwent right adrenalectomy and extended nephrectomy with milking of the tumaur from the inferior vena cava. Unfortunately, the patient developed multiple hypotensive episodes and adult respiratory distress syndrome post-operatively and died three weeks after surgery.

PMID: 17451301 [PubMed - in process]

Related Links

Resection of phaeochromocytoma extending into the right atrium in a patient with multiple endocrine neoplasia type 2A. [Hong Kong Med J. 2005]

A case of non-functioning huge adrenocortical carcinoma extending into inferior vena cava and right atrium. [J Korean Med Sci. 2006]

Radical surgery for Budd-Chiari syndrome through exposure of the entire inferior vena cava of the hepatic segment. [Chin Med J (Engl). 2007]

[Adrenal cortex carcinoma with right atrium involvement. Surgery with cardiopulmonary bypass] [Actas Urol Esp. 2000]

Adrenocortical tumor with left renal vein, vena cava and intrahepatic venous extension. [J Cardiovasc Surg (Torino). 2008]

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Chronic ambulatory peritoneal dialysis in a patient with end-stage renal disease following radiotherapy and surgery for transitional cell carcinoma.

Mcligeyo SO, **Kayima JK**, **Oliech JS**, **Monda SM**.

PMID: 8893210 [PubMed - indexed for MEDLINE]

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Uretero-sigmoid diversion for carcinoma of the bladder. [J R Coll Surg Edinb. 1973]

Synchronous bilateral primary transitional cell carcinoma of the upper urinary tracts: ten patients with more than five years of follow-up. [Urology. 2004]

Laparoscopic radical cystoprostatectomy with bilateral nephroureterectomy: initial report. [BJU Int. 2006]

Radical radiotherapy and salvage cystectomy as the primary management of transitional cell carcinoma of the bladder. Results following the introduction of a CT planning technique. [Clin Oncol (R Coll Radiol). 2002]

Total cystectomy and ureterosygmoidostomy for carcinoma of the bladder. [Eur Urol. 1983]

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34: East Afr Med J. 1995 Jul;72(7):465-7.Links

Fibrosarcoma of the lung with extrapulmonary manifestations: case report.

McLigeyo SO, **Mbui J**, **Kungu A**, **Amayo E**, **Ogendo SW**.

College of Health Sciences, Department of Medicine, University of Nairobi, Kenya.

A 50-year-old female presented with a five months history of recurrent attacks of dizziness, sweatiness, tremors and fainting with loss of consciousness. These were found to be due to hypoglycaemic episodes with blood sugars less than 1 mmol/l and were treated as such. A diagnosis of insulinoma was initially considered, but the patient turned out to have fibrosarcoma of the lung, a

rare lung tumour. She also had finger and toe clubbing and features of hypertrophic pulmonary osteoarthropathy.

PMID: 7498032 [PubMed - indexed for MEDLINE]

Related Links

[Hypertrophic pulmonary osteoarthropathy. A paraneoplastic syndrome associated with lung cancer] [Ugeskr Laeger. 2000]

Secondary hypertrophic osteoarthropathy associated with solitary fibrous tumor of the lung. [J Am Acad Dermatol. 2007]

[Amelioration of secondary hypertrophic osteoarthropathy following tumor resection in a patient with primary lung cancer] [Ryumachi. 1991]

[Diagnostic image (144) A man with clubbing of fingers. Hypertrophic osteoarthropathy (Pierre-Marie-Bamberger syndrome)] [Ned Tijdschr Geneeskd. 2003]

Seropositive, symmetric polyarthritis in a patient with poorly differentiated lung carcinoma: carcinomatous polyarthritis, hypertrophic osteoarthropathy, or rheumatoid arthritis? [Arthritis Care Res. 1998]

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35: East Afr Med J. 1995 Jun;72(6):362-4.Links

The prevalence of hepatitis C virus antibodies in renal patients, blood donors and patients with chronic liver disease in Kenya.

Ilako FM, **McLigeyo SO**, **Riyat MS**, **Lule GN**, **Okoth FA**, **Kaptich D**.

Department of Medicine, College of Health Sciences, University of Nairobi.

We tested serum samples from four categories of patients with nephrological problems (nephrotic syndrome, stable chronic renal failure, haemodialysis patients and renal transplant recipients), patients with chronic liver disease and volunteer blood donors for the presence of antibody to hepatitis C virus (HCV). Screening was done by second-generation enzyme linked immunosorbent assay (ELISA) and confirmation with second-generation recombinant immunoblot assay (RIBA). Of all the renal patients, only 6.3% of the transplant patients tested positive for anti-HCV, while in patients with chronic liver disease anti-HCV was detected in 2.6% of the patients with chronic hepatitis and in none with liver cirrhosis or hepatocellular carcinoma. This finding of low prevalence in these patient groups was not in keeping with findings in studies done elsewhere. Our anti-HCV prevalence of 0.9% in blood donors was comparable to that found in Europe, USA and Taiwan. We recommend that the low prevalence of anti-HCV in some of our high risk groups should not lead to

complacence and hence further studies are necessary to evaluate the infectivity of anti-HCV positive patients and the potential for cross infection.

PMID: 7498004 [PubMed - indexed for MEDLINE]

Related Links

Hepatitis C virus infection in chronic liver disease in Natal. [S Afr Med J. 1996]

Hepatitis C virus infection in patients with nonalcoholic chronic liver disease. [Ann Intern Med. 1990]

Hepatitis C virus infection in Spanish volunteer blood donors: HCV RNA analysis and liver disease. [Eur J Gastroenterol Hepatol. 1996]

Prevalence of antibodies to hepatitis C virus in populations at low and high risk for sexually transmitted diseases in Rio de Janeiro. [Mem Inst Oswaldo Cruz. 1993]

Epidemiological and clinical aspects of hepatitis C virus infection in the Russian Republic of Daghestan. [Eur J Epidemiol. 1998]

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36: East Afr Med J. 1995 Jan;72(1):69-71.Links

Cost consideration in renal replacement therapy in Kenya.

Were AJ, **McLigeyo SO**.

Kenyatta National Hospital, Nairobi, Kenya.

End stage renal disease requiring renal replacement therapy is a common complication of several renal diseases that are seen in the tropics. World over, the costs of the various modalities of therapy that constitute renal replacement therapy, including hemodialysis, continuous ambulatory peritoneal dialysis and renal transplantation, is prohibitive. All the above modes of therapy are provided in Kenya, unlike most countries with similar level of socioeconomic development. This article analyses the factors behind the limited success that renal replacement therapy enjoys in Kenya, which is faced with more pressing basic problems of malnutrition and infection.

PMID: 7781562 [PubMed - indexed for MEDLINE]

Related Links

Economics of dialysis and renal transplantation in the developing world. [Transplant Proc. 1999]

Overview: end-stage renal disease in the developing world. [Artif Organs. 2002]

Is renal replacement therapy for all possible in developing countries? [Ethn Dis. 2006]

Cost analysis of renal replacement therapies in Finland. [Am J Kidney Dis. 2003]

End-stage renal care in developing countries: the India experience. [Ren Fail. 2004]

» See all Related Articles...

37: Afr J Health Sci. 1994 Nov;1(4):185-190.Links

Gromerular diseases in Kenya-another look at diseases characterised by nephrotic proteinura.

McLigeyo SO.

Department of Medicine, University of Nairobi, Kenya.

Renal biopsies were evaluated in 422 patients with nephrotic syndrome at the Kenyatta National Hospital between 1982 and 1993. Three hundred and fifty five (84.1%) of the patients were less than 30 years old (range: 7 months to 66 years; mean=SD: 28.4 - 9.2 years). The commonest histological lesions were mesangial proliferative glomerulonephritis (25.1%), minimal change nephropathy (17.5%) and focal segmental glomerulosclerosis (15.2%). Poststreptococcal aetiology was implicated in diffuse proliferative glomerulonephritis while use of skin lightening cosmetics appeared to play a role in the aetiology of minimal change nephrophathy in females. No aetiological role was apparent for hepatitis B virus, human immunodeficiency virus, malarial or schistosomal infection. All patients with minimal change nephropathy, focal segmental glomerulosclerosis and mesangial proliferative glomerulonephritis were treated with steroids and/or cytotoxics with a variable response.

PMID: 12153347 [PubMed - as supplied by publisher]

Related Links

Paulista Registry of glomerulonephritis: 5-year data report. [Nephrol Dial Transplant. 2006]

Increasing incidence of focal segmental glomerulosclerosis and an examination of demographic patterns. [Clin Nephrol. 2005]

[Instructions and implementations for percutaneous renal biopsy. Guidelines for the therapy of glomerular nephropaties] [G Ital Nefrol. 2003]

Patterns of glomerulonephritis in Zimbabwe: survey of disease characterised by nephrotic proteinuria. [Q J Med. 1984]

Histopathological diagnosis and outcome of paediatric nephrotic syndrome. [J Coll Physicians Surg Pak. 2004]

» See all Related Articles...

38: Afr J Health Sci. 1994 Nov;1(4):142-146.Links

Immunosuppression in renal transplantation: current status and application in developing countries.

McLigeyo SO.

Department of Medicine, University of Nairobi, P.O. Box 19676, Nairobi, Kenya.

Renal transplantation has become the most effective treatment for end stage renal failure. The numbers and survival rates of patients undergoing renal transplantation have increased immensely over the past decade. The use of immunosuppressive drugs has contributed greatly to the success of transplantation. Drugs such as azathioprine, corticosteroids, cyclosporin, FK 506, ATG/ALG and OKT3 are being used in several countries on a daily basis. New drugs and other modalities of immunosuppression are under investigation. This paper reviews these medications with respect to dosing, administration and adverse effects. Drugs being relatively expensive, the use of these drugs in developing counties is discussed.

PMID: 12153337 [PubMed - as supplied by publisher]

Related Links

Nursing implications of immunosuppression in transplantation. [Nurs Clin North Am. 1991]

[Development of antituberculous drugs: current status and future prospects] [Kekkaku. 2006]

Basiliximab: a review of its use as induction therapy in renal transplantation. [Drugs. 2003]

Calcineurin inhibitors in renal transplantation: what is the best option? [Drugs. 2003]

Clinical and cost-effectiveness of newer immunosuppressive regimens in renal transplantation: a systematic review and modelling study. [Health Technol Assess. 2005]

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Patient Drug Information

Azathioprine (Azasan®, Imuran®)Azathioprine is used with other medications to prevent rejection of kidney transplants. It is also used to treat severe rheumatoid arthritis (a condition in which the body attacks its own joints, causing pain and swellin...

» read more ...

39: East Afr Med J. 1994 Apr;71(4):253-5.Links

Autonomic nervous function in patients with chronic renal failure at the Kenyatta National Hospital.

Amayo EO, **Kayima J**, **McLigeyo SO**, **Kioy PG**.

Department of Medicine, College of Health Sciences, University of Nairobi.

Autonomic nervous function was assessed in twenty two patients (16 males and 6 females) with chronic renal failure on conservative management. The presenting symptoms were postural dizziness in 10(45%), impotence in 4(18%) patients and 1 patient each with diplopia, urinary urgency and nocturnal diarrhoea. The following autonomic function tests were performed; valsalva manoeuvre, heart rate response to deep breathing, heart rate response to posture and postural change in blood pressure. Fifteen (68%) patients had abnormal autonomic function tests. Out of these patients, 14(93%) had abnormalities of the parasympathetic system and only one had abnormalities in the sympathetic system. There was a negative correlation between the creatinine levels and the following; valsalva ratio ($r = -0.72$ $p < 0.001$), heart rate response to standing ($r = -0.56$ $p < 0.01$) and heart rate response to deep breathing ($r = -0.45$ $p < 0.05$).

PMID: 8062774 [PubMed - indexed for MEDLINE]

Related Links

Performing only one cardiovascular reflex test has a high positive predictive value for diagnosing autonomic neuropathy in patients with chronic renal failure on hemodialysis. [Ren Fail. 2006]

Twenty-four-hour pattern of blood pressure and spectral analysis of heart rate variability in diabetic patients with various degrees of autonomic neuropathy. Comparison to standard cardiovascular tests. [Clin Sci (Lond). 1996]

Effect of dialysis and renal transplantation on autonomic dysfunction in chronic renal failure. [Kidney Int. 1991]

Uremic autonomic neuropathy studied by spectral analysis of heart rate. [Kidney Int. 1999]

Autonomic dysfunction in multiple sclerosis is related to disease activity and progression of disability. [Mult Scler. 2001]

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40: East Afr Med J. 1994 Mar;71(3):141.Links

Comment on:

East Afr Med J. 1994 Mar;71(3):142-5.

East Afr Med J. 1994 Mar;71(3):146-8.

The elderly patient in sub-Saharan Africa: the past, the present and the future.

McLigeyo SO.

PMID: 7956857 [PubMed - indexed for MEDLINE]

Related Links

Disease burden in sub-Saharan Africa. [Lancet. 1998]

Health and the elderly in developing countries with special reference to sub-Saharan Africa. [East Afr Med J. 1997]

Sub-Saharan Africa. [Ir Med J. 2003]

Relation between burden of disease and randomised evidence in sub-Saharan Africa: survey of research. [BMJ. 2002]

Applying genomics-related technologies for Africa's health needs. [Afr J Med Med Sci. 2007]

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Comment on:

East Afr Med J. 1994 Feb;71(2):75-6.

Nitric oxide--sources, evolution and potential biological and clinical relevance.

McLigeyo SO.

PMID: 7925046 [PubMed - indexed for MEDLINE]

Related Links

Role of nitric oxide and free radicals in the contractile response to non-preactivated leukocytes. [Eur J Pharmacol. 1998]

Differential biological effects of products of nitric oxide (NO) synthase: it is not enough to say NO. [Life Sci. 2003]

Nitric oxide, free radicals and cell signalling in cardiovascular disease. [Biochem Soc Trans. 1997]

The dark side of nitric oxide: mediator of cell injury. [Pediatr Nephrol. 1995]

Free radical production by dysfunctional eNOS. [Heart. 2004]

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42: BMJ. 1993 Sep 25;307(6907):802-3./entrez/utils/fref.fcgi?PrId=3494&itool=AbstractPlus-nondef&uid=8219969&db=pubmed&url=http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=8219969/entrez/utils/fref.fcgi?PrId=3494&itool=AbstractPlus-nondef&uid=8219969&db=pubmed&url=http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=8219969 Links

Comment on:

BMJ. 1993 May 1;306(6886):1169.

Muscle cramps during prednisolone treatment.

Mcligeyo SO.

PMID: 8219969 [PubMed - indexed for MEDLINE]

PMCID: PMC1696455

Related Links

Muscle cramps related to corticosteroids. [BMJ. 1993]

Muscle cramps during treatment with nifedipine. [Br Med J (Clin Res Ed). 1982]

Muscle cramps during treatment with nifedipine. [Br Med J (Clin Res Ed). 1982]

Caffeine and muscle cramps: a stimulating connection. [Am J Med. 2007]

Debilitating muscle cramps after teriparatide therapy. [Ann Intern Med. 2005]

» See all Related Articles...

43: East Afr Med J. 1993 Jun;70(6):362-8.Links

Evolution of nephrology in east Africa in the last seventy years--studies and practice.

McLigeyo SO, **Kayima JK**.

Department of Medicine, College of Health Sciences, University of Nairobi.

Interest in renal disease and practice in East Africa started as far back as the first quarter of this century. Work in this colonial era concentrated on establishing the existence of renal diseases and identifying the nature and incidence of these diseases. This was achieved by case identification and

reporting as well as retrospective studies on post mortem and medical notes. The post independence period has not only identified the existence of even more renal diseases but also concentrated on getting a deeper understanding of the aetiology, nature, pattern, regional variations, complications and outcome of these diseases as seen in our environment. Apart from the better understanding of the prevalent renal diseases, emphasis has also been put on the expansion and delivery of renal services. Investigative and treatment facilities have been improved and a lot has been put into the training of the required local team of experts to man these services. This article reviews what has gone on in the last 70 years from the pure case-report and postmortem reports era to the era of locally available modern facilities including haemodialysis, peritoneal dialysis and kidney transplantation.

PMID: 8261958 [PubMed - indexed for MEDLINE]

Related Links

[Thirty years of nephrology and dialysis in Mantua: results and prospects] [G Ital Nefrol. 2003]

American Society of Nephrology Renal Research Report. [J Am Soc Nephrol. 2005]

[Historical Archives of Italian Nephrology. The history of instrumentation in nephrology. Part II: microscope and haemodialyzer] [G Ital Nefrol. 2003]

Nephrologist extraordinary--Michael Darmady (1906-1989). [Nephrol Dial Transplant. 2007]

The comprehension of nephrology in America a century ago. [Am J Kidney Dis. 1991]

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44: East Afr Med J. 1993 Feb;70(2):107-11.Links

The spectrum of echocardiographic findings in chronic renal failure.

Mathenge RN, **McLigeyo SO**, **Muita AK**, **Otieno LS**.

Department of Medicine, College of Health Sciences, University of Nairobi.

In a six month period at the Kenyatta National Hospital, 46 patients (30 males) with chronic renal failure (CRF) and 22 healthy subjects have had a clinical and echocardiographic study of their cardiovascular systems. The patients with CRF were further classified as stable or in end stage renal disease (ESRD), the latter group requiring dialysis. Hypertension and circulatory congestion were the commonest clinical cardiovascular findings in patients with CRF. The patients with ESRD had significantly higher blood urea nitrogen and serum creatinine than the ones with stable CRF. Echocardiographically right ventricular size, left atrial size, aortic root diameter, left ventricular internal diameters, left ventricular end diastolic and systolic volumes, stroke volume, cardiac output, left ventricular posterior wall and interventricular septal thickness, ejection time and mitral and aortic peak flow rates were significantly higher in patients with CRF than in controls. In contrast, the circumferential fibre shortening and the ejection fraction were reduced in patients with CRF. Global

left ventricular dysfunction was found in 47.8% of the patients. Using doppler flow studies, valvular incompetence was detected in a number of patients, mitral regurgitation being found in 84%.76% of the patients with CRF had varying degrees of pericardial effusion. The echocardiographic abnormalities and the pericardial effusions responded six weeks of haemodialysis in a variable manner.

PMID: 8513737 [PubMed - indexed for MEDLINE]

Related Links

Cardiac disease in dialysis patients in a Jamaican hospital: echocardiographic findings that predict mortality. [West Indian Med J. 2007]

The effects of maintenance recombinant human erythropoietin therapy on ambulatory blood pressure recordings: conventional, Doppler, and tissue Doppler echocardiographic parameters. [Artif Organs. 2005]

[Left ventricular systolic and diastolic dysfunction in patients with chronic renal failure treated with hemodialysis] [Pol Arch Med Wewn. 2003]

Left ventricular abnormalities in children, adolescents and young adults with renal disease. [Kidney Int. 1996]

Echocardiographic evaluation of the effect of hemodialysis on cardiac size and function in patients with end-stage renal disease. [Am J Med Sci. 1979]

» See all Related Articles...

45: East Afr Med J. 1993 Jan;70(1):6-9.Links

Menstrual disorders in patients with chronic renal failure.

Otieno MR, **McLigeyo SO**, **Kigondu CS**, **Rogo KO**.

Aga Khan Hospital, Nairobi.

Forty females, age 14 to 35 years (mean 28.6 years) with chronic renal failure (CRF) were included in the study. Their menstrual patterns were noted. The function of their hypothalamo-pituitary-ovarian axis was assessed by the serum levels of follicle stimulating hormone (FSH), Luteinising hormone (LH), prolactin (PrL), estradiol (E2) and progesterone (P) at different phases of the menstrual cycle in patients who continued to have normal menses (Group 1) and at weekly intervals for six weeks in patients with menstrual disturbances (Group II). The mean hormone levels during the initial contact Luteal phase in group I were FSH 12.0 IU/L (N, 1.0-3.0 IU/L), LH 1.8IU/L (N 1.5-101U/L), PrL 652mIU/L (N, 100-600 mIU/L) mE2 160 pmol/L (N 400-1400 pmol/L) and P5 nmol/L (N 14-60 nmol/L) for group I. Corresponding values for group II were 1.2, 10.3, 250, 600 and 3.0 in relevant units. All patients (fourteen) with end stage renal disease (ESRD) had amenorrhoae. On the other hand, most patients with stable CRF (22/26) had normal menses. Following initiation of

therapy (conservative or dialytic), there was no significant alteration in the hormonal profile or menstrual pattern. We conclude that other factors apart from the hormonal imbalances, may be responsible for the menstrual disturbances noted in patients with CRF.

PMID: 8513732 [PubMed - indexed for MEDLINE]

Related Links

Hormonal profile in pubertal females with chronic renal failure: before and under haemodialysis and after renal transplantation. [Acta Endocrinol (Copenh). 1987]

[Hyperprolactinemia and disorders of the menstrual cycle] [Med Pregl. 1999]

[Menstrual disturbances and alternations in hypophyseal gonadal axis in end-stage premenopausal women undergoing hemodialysis: a multi-center study] [Pol Arch Med Wewn. 2003]

Menstrual abnormalities in women with Cushing's disease are correlated with hypercortisolemia rather than raised circulating androgen levels. [J Clin Endocrinol Metab. 1998]

Hormonal and ultrasound characteristics of menstrual function during chronic hemodialysis and after successful renal transplantation. [Int J Gynaecol Obstet. 1992]

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Patient Drug Information

Progesterone (Prometrium®)Progesterone is used as a part of hormone replacement therapy in women who have passed menopause (the change of life) and have not had a hysterectomy (surgery to remove the uterus). Hormone replacement therapy usually in...

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46: East Afr Med J. 1993 Jan;70(1):37-9.Links

The pattern of geriatric admissions in the medical wards at the Kenyatta National Hospital.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi.

In a one year period (March 1990 to March 1991) the pattern of diseases in geriatric patients (over 60 years of age) admitted to the medical wards at Kenyatta National Hospital (KNH) was studied. In all, there were 1296 patients (M:F = 1.7:1) in this age group forming 11.5% of all admissions during the study period. 1008 (77.8%) of the geriatric patients were between 60 and 79 years of age. Most of the admissions (86.4%) were first admissions. The mean number of diseases per geriatric patient was 1.4. Hypertension and Cardiomyopathy were the commonest single diseases recorded, making up

43.9% of all diseases in this patient population. The commonest neurological diagnosis was stroke, which occurred in a setting of hypertension or cardiomyopathy in all the patients in whom it was diagnosed. The mean duration (+/- 2SD) of stay in the hospital in this patient population was 43 (+/- 19) days. Eighty eight (6.8%) of the patients died, the commonest cause of death being heart failure due to cardiomyopathy or hypertensive heart disease. It is concluded that geriatric patients form a sizeable proportion of our medical admissions and that a large proportion suffer from diseases of the cardiovascular system. It is thus recommended that further studies be carried out on the pattern of diseases in such patients and optimal management strategies for their ailments be outlined.

PMID: 8513726 [PubMed - indexed for MEDLINE]

Related Links

Morbidity and mortality of neonates admitted in general paediatric wards at Kenyatta National Hospital. [East Afr Med J. 2003]

[Old and new long stay patients in French psychiatric institutions: results from a national random survey with two-year follow-up] [Encephale. 2005]

[Hospital statistics as tool in epidemiologic studies: heart failure in Trieste] [Ital Heart J Suppl. 2002]

Pattern and outcome of medical admissions at the Ogun State University Teaching Hospital, Sagamu--a three year review. [West Afr J Med. 2000]

Surgical admissions to the Rift Valley Provincial General Hospital, Kenya. [East Afr Med J. 2002]

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47: East Afr Med J. 1993 Jan;70(1):3-5.Links

Calculation of creatinine clearance from plasma creatinine.

McLigeyo SO.

Department of Medicine, College of Health Sciences, University of Nairobi.

Glomerular filtration rate (GFR) is commonly assessed by measurement of endogenous creatinine clearance (Ccr). Several formulae have been described to calculate Ccr from plasma creatinine. I have evaluated the effectiveness of four formulae in 35 healthy subjects (21M and 14F, 18-34 years) and in 41 patients (24M, 17F, 20-69 years) attending a renal clinic with diminished renal function (serum creatinine 200-600 mumol/l). The GFR was measured using 51 Cr-EDTA clearance and endogenous Ccr. The Ccr was also estimated by four formulae. In healthy subjects Ccr calculated by the formulae of Cockcroft and Gault and Hull et al gave higher correlation coefficient (0.710 and 0.714 respectively) with endogenous Ccr than the formulae of Gates and that of Jellife (0.514 and 0.586 respectively). When all the subjects with a wide range of GFR (3.5-145 mls/min) were considered all the four formulae gave reasonable correlation, but the formula of Cockcroft and Gault

was the best. It is recommended that in developing counties with limited resources, the formula of Cockcroft and Gault can be used to estimate Ccr from plasma creatinines.

PMID: 8513724 [PubMed - indexed for MEDLINE]

Related Links

Prediction of creatinine clearance from plasma creatinine: comparison of five formulae. [Br J Clin Pharmacol. 1989]

Creatinine clearance estimation from serum creatinine values: evaluation and comparison of five prediction formulae in Nigerian patients. [Afr J Med Med Sci. 2000]

Lean body mass-adjusted Cockcroft and Gault formula improves the estimation of glomerular filtration rate in subjects with normal-range serum creatinine. [Nephrology (Carlton). 2006]

Difference of carboplatin clearance estimated by the Cockroft-Gault, Jelliffe, Modified-Jelliffe, Wright or Chatelut formula. [Gynecol Oncol. 2005]

[Differences between the glomerular filtration rate estimated by the MDRD equation and the measurement of creatinine and urea clearance in unselected patients with terminal renal insufficiency] [Nefrologia. 2002]

» See all Related Articles...

48: East Afr Med J. 1993 Jan;70(1):15-7.Links

Experience with the use of human albumin in renal patients at the Kenyatta National Hospital.

McLigeyo SO.

In a 20-month period (May 1990 to December 1991), 34 patients with diuretic resistant oedema due to nephrotic syndrome, 4 patients with severe hypotension during haemodialysis and 3 patients with refractory ascites on chronic haemodialysis were treated with infusion of highly purified human placental albumin (HPHPA). In the 34 patients with resistant oedema due to nephrotic syndrome, infusion with HPHPA resulted in prompt diuresis, weight loss and normalisation of the blood urea nitrogen. These effects were maintained for three weeks after stopping the daily infusions, but started reverting to the pretreatment levels thereafter. Twelve of the 34 patients in whom prior attempts or renal biopsy had failed because of gross oedema, had this done following the resolution of oedema. In the 4 patients with severe hypotension (blood pressure, Systolic/Diastolic mmHg; Mean SD +/- 792 +/- 50 +/- 9) during haemodialysis the blood pressure rose to 135 +/- 11/87 +/- 8 following a rapid infusion of 100mls of 25% HPHPA and remained at that level during the course of haemodialysis. Three patients on chronic haemodialysis with refractory ascites were treated with four sessions of large-volume paracentesis. At each session they were infused with 200mls of 25% HPHPA over one hour. No clinically overt haemodynamic disturbance was noted thereafter and the

patients were relieved of abdominal discomfort and respiratory difficulties for a period varying between 4 and 11 weeks before the ascites reaccumulated.

PMID: 8513720 [PubMed - indexed for MEDLINE]

Related Links

Chronic albumin infusions to achieve diuresis in patients with ascites who are not candidates for transjugular intrahepatic portosystemic shunt (TIPS). [Dig Dis Sci. 2005]

Efficacy of albumin and diuretic therapy in children with nephrotic syndrome. [Pediatrics. 1993]

A randomised prospective trial comparing daily paracentesis and intravenous albumin with recirculation in diuretic refractory ascites. [J Hepatol. 1990]

Cardiovascular, renal, and neurohumoral responses to single large-volume paracentesis in patients with cirrhosis and diuretic-resistant ascites. [Am J Gastroenterol. 1997]

An evaluation of ultrafiltration as treatment of diuretic-resistant oedema in nephrotic syndrome. [Acta Med Scand. 1985]

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49: East Afr Med J. 1993 Jan;70(1):1-2.Links

Symptomatic treatment of nephrotic syndrome.

McLigeyo SO.

PMID: 8513718 [PubMed - indexed for MEDLINE]

Related Links

The nephrotic syndrome. [N Engl J Med. 1998]

Congenital nephrotic syndrome responsive to captopril and indometacin. [Arch Dis Child. 1999]

Effect of dietary protein restriction and angiotensin converting enzyme inhibition on protein metabolism in the nephrotic syndrome. [Kidney Int Suppl. 1989]

Congenital nephrotic syndrome. [Neonatal Netw. 2007]

Renal effects of captopril, indomethacin and nifedipine in nephrotic patients after an oral protein load. [Nephrol Dial Transplant. 1996]

» See all Related Articles...

50: East Afr Med J. 1992 Nov;69(11):603-5.Links

Bacteriuria in patients with glomerular diseases.

McLigeyo SO, **Otieno LS**, **Kanja C**.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

In a comparative study of significant bacteriuria in an African population, 1.7% of 697 healthy subjects (10 females and 2 males) were found to have positive urine cultures. Of these, 5 subjects grew E. coli, 4 Klebsiella strains, 2 Staphylococcus aureus and 1 Serratia marcescens. Among 116 patients with glomerular disease, 15.5% (7 males and 11 females) yielded positive cultures. E. coli, Staph. aureus and Proteus species were commonly isolated organisms. There was a nine fold increase in prevalence of bacteriuria in patients with glomerular disease and in females, this correlated with the amount of protein lost per 24 hours. It is postulated that the presence of protein in urine per se favours bacterial growth and because of the high prevalence of bacteriuria in patients with glomerular disease, it is recommended that all such patients should be screened and treated appropriately.

PMID: 1298612 [PubMed - indexed for MEDLINE]

Related Links

Asymptomatic bacteriuria in health and glomerulonephropathies. [Nephron. 1986]

Bacteriuria in patients with cirrhosis. [J Hepatol. 1992]

Significant bacteriuria among the mentally retarded. Identification and antibiotic sensitivity of isolates. [Health Lab Sci. 1977]

[Prevalence and treatment of bacteriuria in the geriatric population] [Enferm Infecc Microbiol Clin. 1992]

Asymptomatic bacteriuria in school children in a rural area, Egypt. [J Egypt Public Health Assoc. 1991]

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51: Cent Afr J Med. 1992 Oct;38(10):421-4.Links

Intermittent peritoneal dialysis in the management of refractory heart failure.

Mcligeyo SO.

PMID: 1308718 [PubMed - indexed for MEDLINE]

Related Links

Evaluation of role of acute intermittent peritoneal dialysis in resistant congestive heart failure. [J Assoc Physicians India. 2002]

Long-term successful management of refractory congestive cardiac failure by intermittent ambulatory peritoneal ultrafiltration. [QJM. 1996]

Cardiorenal failure: treatment of refractory biventricular failure by peritoneal dialysis. [Uremia Invest. 1984]

Long-term therapy for heart failure with continuous ambulatory peritoneal dialysis. [Arch Intern Med. 1985]

[Peritoneal dialysis in treatment of refractory cardiac insufficiency] [Arq Bras Cardiol. 1965]

» See all Related Articles...

52: East Afr Med J. 1992 May;69(5):294-5.Links

Pregnancy in a patient on continuous ambulatory peritoneal dialysis (CAPD): a case report.

McLigeyo SO, **Swao JO**, **Wairagu SG**, **Luta M**, **Mwongera FK**, **Otieno LS**.

Renal Unit, Kenyatta National Hospital.

We present what we believe is the first case of pregnancy occurring in a patient on CAPD, and indeed end stage renal disease (ESRD), in Kenya. Pregnancy progressed very well until the thirtieth week when foetal movements and heart sounds were noted to be absent and this was confirmed by sonography. A macerated still birth was delivered per vagina following induction of labour. We review the literature on this rare occurrence and discuss the possible causes of the unpleasant outcome in our patient.

PMID: 1644051 [PubMed - indexed for MEDLINE]

Related Links

Pregnancy in patients on chronic ambulatory peritoneal dialysis. [Am J Kidney Dis. 1992]

Continuous ambulatory peritoneal dialysis as the primary approach in the management of severe renal insufficiency in pregnancy. [Obstet Gynecol. 1992]

Sclerosing peritonitis in continuous ambulatory peritoneal dialysis patients: one center's experience and review of the literature. [Adv Ren Replace Ther. 1998]

Supplementing renal function with CAPD in a patient with chronic renal failure and pregnancy. [Perit Dial Int. 1993]

[Pregnancy in patients with end-stage renal failure on maintenance dialysis: case reports] [Przegl Lek. 2000]

» See all Related Articles...

53: Cytopathology. 1992;3(2):119-28.Links

Renal transplant aspiration cytology. Role for simple morphological criteria.

Gouldesbrough DR, **McLigeyo SO**, **Anderton JL**.

Department of Pathology, University of Edinburgh Medical School, UK.

Fine-needle aspiration (FNA) is a well-recognized technique for sampling solid organs. It is used in renal transplantation to clarify the cause of a poorly functioning graft. Differential scoring techniques with respect to peripheral blood cell populations, and immunocytochemistry have been employed in this context. We describe the use of simple morphological criteria alone in renal transplant FNA. We compare these with needle biopsy and clinical parameters and show their value in the detection of active cellular rejection. Their limitations are discussed within the framework of other patterns of transplant pathology.

PMID: 1617161 [PubMed - indexed for MEDLINE]

Related Links

Fine needle aspiration biopsy in monitoring human renal transplant. [Indian J Pathol Microbiol. 1995]

Analysis of fine-needle aspiration biopsies by flow cytometry in kidney transplant patients. [Transplantation. 1997]

[Diagnosis of graft rejection] [Urologe A. 1994]

Fine needle aspiration biopsy and cytology in renal transplantation. [Curr Opin Nephrol Hypertens. 2000]

Transplant aspiration cytology: applications to kidney and liver transplantations. [Transplant Proc. 1991]

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54: Perit Dial Int. 1992;12(2):267-8./entrez/utils/fref.fcgi?PrId=3051&itool=AbstractPlus-def&uid=1586698&db=pubmed&url=http://www.pdiconnect.com/cgi/pmidlookup?view=long&pmid=1586698/entrez/utils/fref.fcgi?PrId=3051&itool=AbstractPlus-def&uid=1586698&db=pubmed&url=http://www.pdiconnect.com/cgi/pmidlookup?view=long&pmid=1586698 Links

Initial experience with CAPD in patients with HIV infection in a developing country.

Mcligeyo SO.

PMID: 1586698 [PubMed - indexed for MEDLINE]

Related Links

Incidence and spectrum of organisms causing peritonitis in HIV positive patients on CAPD. [Adv Perit Dial. 1990]

Outcome of polymicrobial peritonitis in continuous ambulatory peritoneal dialysis patients. [Am J Kidney Dis. 1995]

Continuous ambulatory peritoneal dialysis: an option in the developing world? [Perit Dial Int. 1994]

Continuous peritoneal dialysis in children: a single-centre experience in a developing country. [Pediatr Nephrol. 2006]

The spectrum of bacterial peritonitis in CAPD patients in a developing country: is it different? [Perit Dial Int. 2003]

» See all Related Articles...

55: East Afr Med J. 1991 Dec;68(12):993-8.Links

Acute renal failure following the use of herbal remedies.

Otieno LS, **McLigeyo SO**, **Luta M**.

Department of Medicine, College of Health Sciences, University of Nairobi.

Acute renal failure (ARF) complicated the use of traditional herbal remedies in six adult patients seen at Kenyatta National Hospital in a 2-year period (August 1984 to August 1986). This comprised 10.9% of all the cases of ARF and 24% of the cases of ARF due to medical causes. All the patients were oliguric and the period of oliguria in the four patients who survived ranged between 19-57 days (mean 26.3 days). Five of the patients had evidence of fluid overload. The blood urea nitrogen and serum creatinine were elevated in all the patients. The serum sodium was normal in all, while the serum potassium was elevated in 2 cases. Identity of the herbal medication was unknown in all the cases. The indication was abdominal pain in 4 cases, infertility and abdominal pain in one and prophylaxis against witchcraft in the other. All the patients were started on haemodialysis, two of them having had periods of peritoneal dialysis for 12 and 16 days. Two patients died. Of the four surviving patients, follow up has been carried out for 8, 6, 5 and 4 months. At four months follow up the creatinine clearance in the 4 surviving patients have been 54, 63, 51 and 43 ml/min.

PMID: 1800100 [PubMed - indexed for MEDLINE]

Related Links

Multicenter clinical trial of recombinant human insulin-like growth factor I in patients with acute renal failure. [Kidney Int. 1999]

Rhabdomyolysis and acute renal failure. [Aust N Z J Med. 1985]

Acute renal failure complicating rifampicin therapy. [J Assoc Physicians India. 2001]

The pattern of acute toxic nephropathy in Ife, Nigeria. [West Afr J Med. 1999]

Herbal remedy-associated acute renal failure secondary to Cape aloes. [Am J Kidney Dis. 2002]

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Patient Drug Information

Potassium (Glu-K®, K+ 10®, K+ 8®, ...)Potassium is essential for the proper functioning of the heart, kidneys, muscles, nerves, and digestive system. Usually the food you eat supplies all of the potassium you need. However, certain diseases (e.g., kidney dis...

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56: East Afr Med J. 1991 Nov;68(11):841-3.Links

Treatment of urinary infections.

McLigeyo SO.

PMID: 1800076 [PubMed - indexed for MEDLINE]

Related Links

[Sensitivity to antibiotics of 2081 bacterial strains isolated from urinary tract infections. Critical study and treatment suggestions] [Schweiz Med Wochenschr. 1968]

Single-dose therapy of uncomplicated urinary tract infections in females--treatment of choice? [Infection. 1989]

[Drug treatment of urinary tract infections] [Gynakologe. 1988]

Single dose treatment of acute urinary infections in women. [J Antimicrob Chemother. 1980]

Antibiotics for urinary tract infections in women. [Ann Intern Med. 1990]

» See all Related Articles...

57: East Afr Med J. 1991 Oct;68(10):789-94.Links

Ascites in patients undergoing intermittent haemodialysis at Kenyatta National Hospital.

McLigeyo SO, **Otieno LS**, **Kinuthia DM**, **Mwongera FK**, **Ongeri SK**.

Department of Medicine, Kenyatta National Hospital, Nairobi.

In a two-year-period (August 1984 to August 1986), 77 patients were admitted into the maintenance haemodialysis programme at Kenyatta National Hospital. 24 (31.5%) of these had ascites during haemodialysis. Nine (37.5%) of the patients who had ascites had prior peritoneal dialysis, while 15 (62.5%) had congestive cardiac failure at the time of development of the ascites. In 21 (87.5%), the ascites responded to therapy with diuretics, salt and fluid restriction, antibiotics when indicated and to ultrafiltration during dialysis. In 3 (12.5%) of the patients, the ascites developed in the absence of any predisposing cause. The ascites progressively increased in amount and was associated with marked wasting. These patients were considered to have refractory ascites of haemodialysis.

PMID: 1813302 [PubMed - indexed for MEDLINE]

Related Links

Complications seen in patients undergoing intermittent haemodialysis at the Kenyatta National Hospital in the period 1984-1986. [East Afr Med J. 1988]

Seroprevalence of hepatitis B and C in maintenance dialysis in a public hospital in a developing country. [S Afr Med J. 2003]

Nutritional requirements in chronic renal failure and end stage renal disease at the Kenyatta National Hospital. [East Afr Med J. 1991]

The clinical spectrum of ascites associated with maintenance dialysis. [Am J Med. 1976]

[Problems about the management of active pulmonary tuberculosis patients undergoing haemodialysis--our experiences and nation-wide questionnaire survey] [Kekkaku. 2003]

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58: East Afr Med J. 1991 Sep;68(9):720-6.Links

Conversion from cyclosporin to azathioprine in renal allograft recipients.

Otieno LS, **Kinuthia DM**, **McLigeyo SO**, **Orinda DA**, **Mwongera FK**.

Department of Medicine, D.M.W., Kinuthia.

Renal function in five patients who were on a combination of Cyclosporin A (CyA) and Prednisone for 2-6 years following renal transplantation, were evaluated, in order to consider change from CyA-prednisone combination to conventional therapy. (Azathioprine-prednisone combination). This was necessitated by CyA nephrotoxicity, its high cost and unreliable monitoring. The maintenance dose of CyA ranged between 200 and 400 mg per day. The BUN levels during CyA treatment ranged from 6 to 15 mmol/l (normal 3.7-6.7 mmol/l), and plasma creatinine from 200 to 300 Umol/l (normal 67-107 Umol/l). The serum electrolytes were normal. The urine outputs were normal. Rejections were treated by pulses of one gram of methyl-prednisolone daily for 3 days. Maintenance prednisolone ranged from 10-15 mg per day. After tapering off the CyA and eventually stopping it, Azathioprine 100-150 mg daily with prednisolone 10-15 mg per day were instituted. There were significant drops in creatinine and BUN levels after the change over, with general well being and good urinary outputs. The patients refused consent for renal biopsy to prove CyA histologic toxicity.

PMID: 1797535 [PubMed - indexed for MEDLINE]

Related Links

Long-term renal allograft function under maintenance immunosuppression with cyclosporin A or azathioprine. A single center, five-year follow-up study. [Transpl Int. 1991]

Safe conversion from cyclosporine to azathioprine with improved renal function in pediatric renal transplantation. [Pediatr Nephrol. 1989]

Conversion from cyclosporin to azathioprine 3 months after renal transplantation--is it safe? [S Afr Med J. 1986]

Importance of allograft biopsy in renal transplant recipients: correlation between clinical and histological diagnosis. [Am J Kidney Dis. 1998]

Cyclosporin A used alone or in combination with low-dose steroids in cadaveric renal transplantation. [Klin Wochenschr. 1983]

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Patient Drug Information

Prednisone (Prednisone Intensol®, Sterapred®, Sterapred® DS)Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednis...

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Mercaptopurine (Purinethol®)Your doctor has ordered the drug mercaptopurine to help treat your illness. The drug is taken by mouth in tablet form.

» read more ...

Azathioprine (Azasan®, Imuran®)Azathioprine is used with other medications to prevent rejection of kidney transplants. It is also used to treat severe rheumatoid arthritis (a condition in which the body attacks its own joints, causing pain and swellin...

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» See all 4 Drug Reports ...

59: East Afr Med J. 1991 Jul;68(7):567-75.Links

Nutritional requirements in chronic renal failure and end stage renal disease at the Kenyatta National Hospital.

Wachira AW, **McLigeyo SO**, **Otieno LS**.

Renal Unit, Kenyatta National Hospital, Nairobi.

Since August, 1984 renal replacement therapy with haemodialysis, peritoneal dialysis and renal transplant has been carried out regularly at the renal unit of the Kenyatta National Hospital (KNH). Various nutritional disturbances have been met. Nausea, vomiting and anorexia have been noticed frequently particularly in those on intermittent peritoneal dialysis (IPD). The same problems were experienced in those few patients who were on continuous ambulatory peritoneal dialysis (CAPD). The patients were usually malnourished, the malnutrition being of protein-calorie type. At the start of the programme of renal replacement therapy in 1984, the problems of poor nutrition were worse but are currently improving. At the moment our patients with chronic renal failure (CRF) and end stage renal disease (ESRD) on dialysis are scattered all over the medical and paediatric wards at KNH. This has impeded the smooth surveillance of patients' diets by the few available nutritionists. The review of our performance from 1984-1988 on the nutritional status of patients with CRF and ESRD is an attempt to create a normal dietary cover for patients with the above problems.

PMID: 1756709 [PubMed - indexed for MEDLINE]

Related Links

Dietary protein and energy requirements in ESRD patients. [Am J Kidney Dis. 1998]

[Residual renal function and nutritional status in patients on continuous ambulatory peritoneal dialysis] [Med Pregl. 2005]

Renal dietitians' perspective: identification, prevalence, and intervention for malnutrition in dialysis patients in Texas. [J Ren Nutr. 1998]

Nutritional problems associated with end-stage renal disease in the developing world. [Artif Organs. 2002]

[Peritoneal dialysis in the aged] [Med Pregl. 1999]

» See all Related Articles...

60: East Afr Med J. 1991 Jun;68(6):477-83.Links

Outcome of pregnancy in nephrotic syndrome: a report on five cases.

McLigeyo SO, **Otieno LS**, **Kinuthia DM**, **Mwongera FK**, **Wairagu SG**.

Renal Unit, Kenyatta National Hospital, Nairobi, Kenya.

In a 6 year period (1984-1989) we have had the opportunity to take care of five patients who had nephrotic syndrome and became pregnant. Four of them had mesangial proliferative glomerulonephritis while one had focal segmental glomerulosclerosis. Four of the pregnancies went to term while one was terminated at 34 weeks gestation because of deteriorating renal function in the mother. All the pregnancies ended in delivery of normal babies. However, two patients have since died of end stage renal disease, while the remaining three continue to be nephrotic with reduced levels of renal function following the deliveries.

PMID: 1752228 [PubMed - indexed for MEDLINE]

Related Links

Focal and segmental glomerulosclerosis in nephrotic syndrome: a new profile of adult nephrotic syndrome in Zaire. [Mod Pathol. 1993]

Nephrotic syndrome in Namibian children. [S Afr Med J. 1999]

Renal biopsy in pregnancies complicated by undetermined renal disease. [Acta Obstet Gynecol Scand. 2001]

Idiopathic nephrotic syndrome of the adult with asymptomatic thrombosis of the renal vein. [Am J Nephrol. 1988]

Dense intramembranous deposit disease: a clinical comparison of histological subtypes. [Clin Nephrol. 1990]

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61: East Afr Med J. 1991 Jun;68(6):442-7.Links

Vascular access for haemodialysis.

Ngugi PN, **McLigeyo SO**, **Kayima JK**, **Otieno LS**, **Mogere R**.

Department of Medicine, College of Health Sciences, University of Nairobi.

In a fifteen month period (August 1987 to November 1988) forty patients requiring haemodialysis had 83 angioaccess procedures performed. Arteriovenous (AV) shunts and arteriovenous fistulae were the commonest procedures, comprising 56 (67%) and 20 (24%) of the patients respectively. Subclavian catheters and artificial grafts were used less frequently. Nephrologists and senior house officers attached to the Renal Unit were responsible for fashioning A-V shunts and inserting subclavian catheters while the A-V fistulae were fashioned by the urologists and vascular surgeons. The commonest complication of A-V shunts were clotting, occurring in 31 (55.4%) followed by bleeding in 14 (25%). Eight (32%) of the A-V fistulae never functioned from the beginning. It is noted that we are still very dependent on A-V shunts for vascular access in end stage renal disease (ESRF) patients and this is associated with an unacceptable level of complications. This dependency on A-V shunts in ESRD patients should be stopped or phased out. A-V fistulae should be used more frequently. Their constructions should be well thought out, executed and supervised by the few surgeons who are versed in them together with their follow-ups.

PMID: 1752223 [PubMed - indexed for MEDLINE]

Related Links

Medical adjuvant treatment to increase patency of arteriovenous fistulae and grafts. [Cochrane Database Syst Rev. 2003]

Relation between gender and vascular access complications in hemodialysis patients. [Am J Kidney Dis. 2000]

Vascular access in hemodialysis patients with central venous obstruction or stenosis: one center's experience. [Ann Vasc Surg. 2005]

[Are permanent catheters a safe vascular access in chronically hemodialysed children?] [Przegl Lek. 2006]

Arteriovenous grafts for vascular access in haemodialysis. [Br J Surg. 1979]

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62: East Afr Med J. 1991 May;68(5):352-8.Links

Adult polycystic liver disease.

Ogutu EO, **McLigeyo SO**.

Department of Medicine, College of Health Sciences, University of Nairobi.

Characteristics of 14 patients above 12 years of age with congenital polycystic liver disease attending liver clinic at KNH were analysed. The diagnosis was mainly based on ultrasonographic findings. The disease was found predominantly among the Kikuyu ethnic group with a female/male ratio of 6:1 and the peak age at presentation was in the 5th decade. The liver function tests were essentially normal in all cases with no complication directly relating to liver disease. Hypertension was found in 78.6% of cases and chronic renal failure in 35.7% of cases. There was an associated polycystic disease in at least one other abdominal organ in all cases.

PMID: 1935729 [PubMed - indexed for MEDLINE]

Related Links

[Hereditary polycystic liver disease] [Duodecim. 1998]

Ecographic epidemiology of non-parasitic hepatic cysts. [J Clin Ultrasound. 1993]

Liver changes and complications in adult polycystic kidney disease. [Adv Nephrol Necker Hosp. 1985]

[Solitary liver cysts and polycystic liver disease: aspects of surgical management of congenital cystic liver disease] [Swiss Surg. 1999]

Clinical profile of autosomal dominant polycystic liver disease. [Hepatology. 2003]

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63: East Afr Med J. 1991 Mar;68(3):216-24.Links

Renal failure diagnosis and management.

Otieno LS, **McLigeyo SO**.

Department of Medicine, College of Health Sciences, Nairobi.

Acute and chronic renal failure (ARF and CRF) are primary health problems in health centres, district and provincial hospitals. Their managements should be initiated in these areas of the health services. Some of the managements of CRF & ARF should be initiated in private clinics by private practitioners. ARF is a medical emergency while CRF is insidious with non-specific features. Discussions on CRF and ARF and their timely managements are mandatory if the mortality and morbidity associated with them are to be prevented.

PMID: 2070758 [PubMed - indexed for MEDLINE]

Related Links

Renal failure in childhood. [Compr Ther. 1983]

Role of the laboratory in management of acute and chronic renal failure. [Ann Clin Lab Sci. 1981]

Parathyroid hormone as a marker for the differential diagnosis of acute and chronic renal failure. [Ren Fail. 2007]

1,5-anhydroglucitol as a marker for the differential diagnosis of acute and chronic renal failure. [Nephron. 1996]

[Kidney in shock and shock kidney. Pathogenesis, diagnosis and therapy] [Anasthesiol Intensivmed Prax. 1974]

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64: East Afr Med J. 1990 Sep;67(9):667-73.Links

Acute renal allograft rejection: the role of monoclonal antibodies in treatment: experience with orthoclonal anti-T3 cell antibody.

McLigeyo SO, **Notghi A**, **Anderton JL**, **Dick J**.

Transplant Unit, Western General Hospital, Edinburgh.

We have reviewed the literature relating to the use of monoclonal antibodies in acute renal allograft rejection. More emphasis has been placed on Orthoclone OKT3 which has been more commonly used and summarise our experience with its use as rescue therapy in renal allograft rejection.

PMID: 2123786 [PubMed - indexed for MEDLINE]

Related Links

OKT 3: nursing considerations for use in acute renal transplant rejection. [ANNA J. 1990]

Effectiveness of a second course of OKT3 monoclonal anti-T cell antibody for treatment of renal allograft rejection. [Transplantation. 1988]

Orthoclone OKT3 treatment of acute renal allograft rejection in patients receiving maintenance cyclosporine therapy. [Transplant Proc. 1987]

Use of Orthoclone OKT3 monoclonal antibody to reverse acute renal allograft rejection unresponsive to treatment with conventional immunosuppressive regimens. [Transplant Proc. 1987]

Orthoclone OKT3 treatment of acute renal allograft rejection. [Transplant Proc. 1987]

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65: East Afr Med J. 1990 Jun;67(6):387-95.Links

Management of lupus nephritis at the Kenyatta National Hospital.

Otieno LS, **McLigeyo SO**, **Kayima JK**, **Sitati S**.

Department of Medicine and Pathology, College of Health Sciences, University of Nairobi, Kenyatta National Hospital.

In 7 years (1981-1988) at the Kenyatta National Hospital (KNH), Nairobi the diagnosis of systemic lupus erythematosus (SLE) was made in 67 patients. In 23 of these patients lupus nephritis complicated the SLE. Lupus nephritis was diagnosed through renal biopsy, haematuria and proteinuria in urine with positive lupus erythematosus (LE) cell phenomenon. The histology found in these patients included 5 patients with minimal lesion, 7 patients with membranous, 3 with focal, 4 with diffuse, 3 with crescenteric and one with membranoproliferative glomerulonephritis. While patients with minimal, membranous and focal nephritis had general good outlook on low dose maintenance or intermittent high dose steroid therapy the others with diffuse, crescenteric and membranoproliferative nephritis had poor prognosis. Patients with diffuse proliferative, membranoproliferative and crescenteric nephritis tended to have septicaemia, pulmonary oedema, fluid overload and chronic renal failure with poor prognosis. These patients responded poorly to oral and parenteral steroid therapy whether high or low dose.

PMID: 2279466 [PubMed - indexed for MEDLINE]

Related Links

The prognosis of lupus nephritis in African-Americans: a retrospective analysis. [Am J Kidney Dis. 1994]

Clinical significance of necrosis in lupus nephritis. [Intern Med. 1994]

Nonlupus nephritides in patients with systemic lupus erythematosus: a comprehensive clinicopathologic study and review of the literature. [Hum Pathol. 2001]

Long-term outcome of diffuse proliferative lupus glomerulonephritis treated with cyclophosphamide. [Am J Med. 2006]

[Development of lupus nephritis in childhood] [Pediatr Med Chir. 1986]

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Patient Drug Information

Hydrocortisone Oral (Cortef®, Hydrocortone®)Hydrocortisone, a corticosteroid, is similar to a natural hormone produced by your adrenal glands. It is often used to replace this

chemical when your body does not make enough of it. It relieves inflammation (swelling, ...

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66: East Afr Med J. 1990 Jun;67(6):377-80.Links

Nephrotic syndrome in the tropics.

McLigeyo SO.

PMID: 2279464 [PubMed - indexed for MEDLINE]

Related Links

Nephrotic syndrome in the tropics. [Lancet. 1980]

Glomerular disease in the tropics. [J Assoc Physicians India. 1992]

[Epidemiology of nephrotic syndrome] [Nippon Rinsho. 2004]

The nephrotic syndrome in Bantu children. [S Afr Med J. 1972]

[Effect of various environmental factors on the incidence of nephrotic syndrome in children] [Pol Tyg Lek. 1984]

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67: East Afr Med J. 1990 Feb;67(2):109-12.Links

Platelet function in nephrotic syndrome patients at the Kenyatta National Hospital.

Kayima JK, **Otieno LS**, **McLigeyo SO**, **Kyobe J**.

Department of Medicine, College of Health Sciences, University of Nairobi, Kenya.

Platelet function was assessed in 40 patients with nephrotic syndrome but without renal failure in order to establish whether or not there is any haemostatic disorder lending to hypercoagulable state. The findings were compared with those from 40 normal controls. There was no clinical evidence of thromboembolic phenomena in the patients. Values for the mean platelet counts and clot retraction were similar (P less than 0.05), whereas significant decrease of platelet adhesiveness (P less than 0.001) as well as prolonged platelet aggregation time (P less than 0.001) were noted. This is different from some reports in literature which have frequently reported enhanced platelet function. There may be a difference in the way platelets metabolise arachidonic acid to potent aggregating agents, in the African patients as compared to patients studied elsewhere. The hypercoagulable state in our

nephrotic syndrome may be explained by alterations in other haemostatic parameters rather than in platelet function.

PMID: 2361443 [PubMed - indexed for MEDLINE]

Related Links

Platelet activation markers in patients with nephrotic syndrome. A comparative study of different platelet function tests. [Nephron. 2002]

Comprehensive study on platelet function, hemostasis, fibrinolysis, peripheral serotonergic system and serum lipids in nephrotic syndrome. [Pol J Pharmacol. 1996]

Thrombus formation and platelet-vessel wall interaction in the nephrotic syndrome under flow conditions. [J Clin Invest. 1994]

Haemostatic measurements in childhood nephrotic syndrome. [Eur J Pediatr. 1991]

Platelet functions in patients with meningococcal meningitis at the Kenyatta National Hospital, Nairobi. [East Afr Med J. 2002]

» See all Related Articles...

68: Postgrad Med J. 1988 Oct;64(756):783-6.Links

Problems with a renal replacement programme in a developing country.

McLigeyo SO, **Otieno LS**, **Kinuthia DM**, **Ongeri SK**, **Mwongera FK**, **Wairagu SG**.

Renal Unit, Kenyatta National Hospital, Nairobi.

Since August 1984 patients with end-stage renal disease in Kenya have been started on haemodialysis with a view to renal transplantation. In a two year period (August 1984-August 1986) 77 patients mean age 29.6 years (49 males), have been dialysed. The mean duration on dialysis prior to death or transplantation was 2.9 months (range 1 day to 11 months). Fifty patients (65%) died while on dialysis, including 2 who had had unsuccessful transplantation. Fourteen patients were still on dialysis, 11 had discharged themselves to peripheral hospitals for conservative management, and 2 had had successful renal transplantation. The possible causes of this abysmal experience include admission of critically ill patients, shortage of trained staff, over-dependence on arteriovenous shunts for vascular access, lack of centralization of patient management, recurrent shortage of essential equipment and reagents and a slow pace of transplantation.

PMID: 3076664 [PubMed - indexed for MEDLINE]

Related Links

Comparison of mortality in all patients on dialysis, patients on dialysis awaiting transplantation, and recipients of a first cadaveric transplant. [N Engl J Med. 1999]

Staff-assisted nursing home haemodialysis: patient characteristics and outcomes. [Nephrol Dial Transplant. 2007]

End stage renal failure: 14 years' experience of dialysis and renal transplantation. [Arch Dis Child. 1988]

Continuous peritoneal dialysis in children: a single-centre experience in a developing country. [Pediatr Nephrol. 2006]

[Analysis of the survival of permanent vascular access ports] [Nefrologia. 2001]

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69: East Afr Med J. 1987 Nov;64(11):726-9.Links

Pulmonary oedema between dialyses during intermittent haemodialysis at the Kenyatta National Hospital (KNH).

Otieno LS, **McLigeyo SO**.

PMID: 3505848 [PubMed - indexed for MEDLINE]

Related Links

Complications seen in patients undergoing intermittent haemodialysis at the Kenyatta National Hospital in the period 1984-1986. [East Afr Med J. 1988]

Ascites in patients undergoing intermittent haemodialysis at Kenyatta National Hospital. [East Afr Med J. 1991]

The pattern of acute pancreatitis at Kenyatta National Hospital (KNH): retrospective study. [East Afr Med J. 1988]

Hypertension over a 4-year-period at Kenyatta National Hospital (KNH). [East Afr Med J. 1985]

Upper gastrointestinal tract in chronic renal failure as seen at Kenyatta National Hospital, Kenya. [East Afr Med J. 1988]

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70: East Afr Med J. 1984 Sep;61(9):724-6.Links

Acquired immunodeficiency syndrome in an African.

Obel AO, **Sharif SK**, **McLigeyo SO**, **Gitonga E**, **Shah MV**, **Gitau W**.

PMID: 6535728 [PubMed - indexed for MEDLINE]

Related Links

Widespread papules and nodules in a Ugandan man with acquired immunodeficiency syndrome. African blastomycosis. [Arch Dermatol. 1996]

Eosinophilic neuritis and eosinophilic panniculitis in a patient with advanced acquired immunodeficiency syndrome. [Arch Pathol Lab Med. 2006]

Leprosy, Kaposi's sarcoma and the acquired immunodeficiency syndrome in two African patients. [Trans R Soc Trop Med Hyg. 1993]

The dietary attitudes and practices of low-income African-Americans with acquired immunodeficiency syndrome. [J Am Diet Assoc. 2001]

Progressive multifocal leukoencephalopathy and JC virus genotypes in West African patients with acquired immunodeficiency syndrome: a pathologic and DNA sequence analysis of 4 cases. [Arch Pathol Lab Med. 1999]

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[Kidney in shock and shock kidney. Pathogenesis, diagnosis and therapy]

Anasthesiol Intensivmed Prax. 1974; 9(1):85-92.