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PUBLICATIONS OF RELEVANCE TO PAPUA NEW GUINEA AND MELANESIA

Bibliographic Citation List generated from MEDLARS

- 1 **Aithal V, Gupta AC, Vele D.**
Hearing loss in Papua New Guinea: a study of outpatients attending Port Moresby General Hospital.
PNG Med J 1995 Mar;38(1):36-44.
Hearing loss, with its cause, type and degree, was studied in patients who attended the Ear, Nose and Throat (ENT) Outpatient Clinic at the Port Moresby General Hospital for a period of 5 years from 1987 to 1992. It was found that 1150 (18%) of the patient population attending the ENT Clinic had hearing loss. Audiological evaluation was performed in 583 patients. More males presented to the clinic with hearing loss than females. Otitis media was the most common identified cause of hearing loss followed by ear trauma and meningitis/cerebral malaria. Assaults were the major cause of traumatic hearing loss. Lack of awareness on the part of both professionals and parents affected early identification of hearing loss, especially in children, whose development of speech and language was seriously impaired. The need for implementation of suitable rehabilitation measures by the health services is emphasized.
- 2 **Al-Yaman F, Genton B, Anders R, Taraika J, Ginny M, Mellor S, Alpers MP.**
Assessment of the role of the humoral response to *Plasmodium falciparum* MSP2 compared to RESA and SPf66 in protecting Papua New Guinean children from clinical malaria.
Parasite Immunol 1995 Sep;17(9):493-501.
The prevalence and concentration of naturally acquired humoral response (IgG) to merozoite surface protein 2 (MSP2), RESA, SPf66 and crude schizont extract were measured in a population living in a malaria highly endemic area of Papua New Guinea. A prospective longitudinal study in 0.5-15 year old children was conducted for one year in order to examine the relationship between the humoral response to these antigens and subsequent susceptibility to clinical malaria using a series of clinical definitions. The prevalence and concentration of antibodies to all antigens increased with age. Such correlation with age was most marked for MSP2 recombinant proteins. When age and previous exposure were controlled for, only antibody levels to MSP2 recombinant proteins (3D7 and d3D7) and to RESA predicted a reduction in incidence rate of episodes of clinical malaria. Our results support the inclusion of the recombinant proteins of the 3D7 allelic family of merozoite surface antigen 2 and RESA into a subunit vaccine against malaria.
- 3 **Al-Yaman F, Genton B, Kramer KJ, Taraika J, Chang SP, Hui GS, Alpers MP.**
Acquired antibody levels to *Plasmodium falciparum* merozoite surface antigen 1 in residents of a highly endemic area of Papua New Guinea.
Trans R Soc Trop Med Hyg 1995 Sep-Oct;89(5):555-559.
The prevalence and concentration of antibodies to a yeast-expressed N-terminal region (195A) and a baculo-virus-expressed C-terminal region (BVp42) of merozoite surface antigen 1 (MSA-1) were measured during a cross-sectional survey in the Wosera area of East Sepik Province, Papua New Guinea, in order to obtain baseline data on naturally acquired antibody response to this antigen in preparation for a vaccine trial. Overall, the seropositivity rate was 78% for 195A and 91% for BVp42. Although antibody prevalence to both molecules increased with age, higher antibody prevalence rates were observed for BVp42 in all age groups studied. In children, significant positive associations were found between parasite prevalence and antibody prevalence for both regions of MSA-1 and between spleen rates and anti-BVp42 antibody prevalence. Concentration of antibody against both regions increased significantly with age, but was always higher for BVp42. In children, antibody levels to both regions of MSA-1 were significantly higher in those infected (symptomatic and asymptomatic), while in adults no significant difference in antibody concentration was observed between those infected and those uninfected. However, enlarged spleens were associated with higher antibody concentration to both regions of MSA-1 in both children and adults. The C-terminal of MSA-1 appeared to be more recognized than the N-terminal, in terms of both antibody prevalence and concentration.
- 4 **Bereano PL.**
Genetic patents. Letter.
Science 1996 Jan 5;271(5245):14.
- 5 **Bryan JH, Dagoro H, Southgate BA.**
Filial vector studies in a diethylcarbamazine-treated and in untreated villages in Papua New Guinea.
J Trop Med Hyg 1995 Dec;98(6):445-451.
Entomological studies were undertaken in three villages in the East Sepik Province of Papua New Guinea. The inhabitants of one village, Nanaha, had been treated with diethylcarbamazine (DEC) to reduce the prevalence and density of microfilaraemia of *Wuchereria bancrofti*. No intervention was undertaken in the other two villages, Yauatong and Musenau, in which bancroftian filariasis was present but with markedly different human prevalence rates and mean parasite densities. In Yauatong, infection rates in anopheline vectors (*Anopheles punctulatus* and *An. koliensis*) varied from 20.5 to 46.6% with

- infectivity rates of 0-1.4% while these rates were 10.9-14.3% and 0-1.1% respectively in *Culex quinquefasciatus*. In Nanaha after DEC treatment, infection rates were as high as 16.3% in *An. koliensis* and infectivity rates reached 7.0% for *An. punctulatus* despite a 45% reduction in the number of people with detectable microfilariae (mf) and a 94% reduction in mf density in those who remained positive.
- 6 **Dent AW, Davies G, Barrett P, De Saint Ours PJ.**
The 1994 eruption of the Rabaul volcano, Papua New Guinea: injuries sustained and medical response.
Med J Aust 1995 Dec 4-18;163(11-12):635-639.
On 19 September 1994, with little warning, two volcanoes erupted at the Rabaul caldera, affecting the heavily populated Gazelle Peninsula, East New Britain Province, Papua New Guinea. Local health services were able to deal with the disaster without additional external resources. The preparedness of the population and their knowledge of safe areas gained from a disaster plan widely publicized a decade earlier contributed to the low number of casualties.
- 7 **Dewan PA, Brown N, Murthy DP, Danga Christian B, Haan E, Byard RW, Watters DA.**
Hydrometrocolpos and segmental colonic dilatation in a girl with megacystis-microcolon-intestinal hypoperistalsis syndrome.
J Paediatr Child Health 1995 Oct;31(5):479-482.
OBJECTIVE: To report a case of a newborn female infant noted to have features of the megacystis-microcolon-intestinal hypoperistalsis syndrome (MMIHS) with the additional features of hydrometrocolpos and segmental colonic dilatation and review the literature. **METHODOLOGY:** The details of the case were collated and compared with the previous published experience with this condition. **RESULTS:** Thus far there have been 58 previous cases of MMIHS described, only four of which have had colonic dilatation. A number of concurrent anomalies have been described, but not the hydrometrocolpos or dysmorphic features seen in this patient. **CONCLUSION:** This case appears to be MMIHS with additional features not previously recorded.
- 8 **Doherty RR.**
HTLV-I in Australia and Oceania: long-term resident or recent immigrant?
Med J Aust 1996 Jan 15;164(2):84-86.
Human T-cell lymphotropic virus type I (HTLV-I) has a worldwide distribution; infection rates of up to 14% have been found in Aboriginal communities, but there is little evidence of typical HTLV-I-associated disease. The strains among Australian Aboriginals and Melanesians are more closely related to each other at the molecular level than to strains from Africa, Japan and the Caribbean basin. The clinical significance of these Oceanic strains of HTLV-I in endemically infected communities is unclear.
- 9 **Duncan LE, Bukenya GB.**
Investigation of an outbreak of typhoid fever in two settlements near Port Moresby.
PNG Med J 1995 Mar;38(1):27-35.
From November 1985 to February 1986 two unplanned settlements near Port Moresby experienced a small person-to-person outbreak of typhoid fever, which included one death. Investigation showed that of the 20 individuals who were diagnosed as either ill, culture positive or a carrier, 15 were related by blood, marriage or through shared living quarters. The remaining 5 lived in the same house, but were not related to the larger group. Drinking water was contaminated with coliforms, but was not implicated. The outbreak resolved with no additional cases after February 1986. Outbreaks of this nature highlight the need for continuing public health education for local health officers in contact tracing, field testing and transportation of specimens, and epidemiological skills in investigating person-to-person outbreaks. They also make a strong case for public health laboratories equipped to perform rapid, comprehensive pathological examination of specimens collected during any outbreak of infectious illness.
- 10 **Dyke T.**
In the tail of the taipan. A personal view of snakebite and serum sickness.
Med J Aust 1995 Dec 4-18;163(11-12):614-615.
- 11 **Dyke T.**
Positively promoting health in Papua New Guinea.
PNG Med J 1995 Mar;38(1):1-5.
- 12 **Elfrink M, Elfrink RJ.**
Medical practice in Papua New Guinea.
Mo Med 1995 Dec;92(12):760-762.
Opportunities for medical service abound throughout the world. These experiences can allow development of clinical skills in the absence of advanced technology. We describe an eight-month experience in Papua New Guinea, including the most frequent illnesses treated and procedures performed.
- 13 **Erasmus RT, Sinha AK.**
Assessment of long-term glycaemic control in diabetic patients attending Port Moresby General Hospital.
PNG Med J 1995 Mar;38(1):16-19.
Good glycaemic control is important in preventing the acute and long-term complications of diabetes mellitus. We assessed long-term glycaemic control using glycosylated haemoglobins in 83 diabetic patients, of mean age 47 years and of mean known duration 4.5 years, attending Port Moresby General Hospital over a one-year period. Significant improvement in glycaemic control was observed in only 11 (13%) of the patients. Glycaemic control worsened in 13 (16%) and no change was observed in the remainder (71%). Mean glycosylated haemoglobin and fasting plasma glucose levels were similar at the beginning and end of the study period. Over a one-year period 53 patients (64%) exhibited poor

control with mean glycosylated haemoglobin levels exceeding 10%. Among the 19 newly diagnosed diabetic patients (23% of the total) glycaemic control improved in only 2 (11%). Glycaemic control was not influenced by sex, treatment, obesity or duration of diabetes. The demonstration of poor metabolic control in the majority of patients suggests that urgent measures are needed to reevaluate the management of diabetic patients, particularly with respect to education and diet. This may improve the poor survival rates reported in diabetic patients from Papua New Guinea.

- 14 **Felger I, Tavul L, Narara A, Genton B, Alpers M, Beck HP.**
The use of the polymerase chain reaction for more sensitive detection of *Plasmodium falciparum*. *PNG Med J* 1995 Mar;38(1):52-56.
The prevalence of *Plasmodium falciparum* in children and adults living in a malaria-endemic area in Papua New Guinea was determined by microscopy and by polymerase chain reaction (PCR). The sensitivity of detecting *P. falciparum* infections increased two-fold with PCR. Undetected infections by microscopy were more frequent in adults (including adolescents) than in children. Detecting this subpatent parasitaemia by PCR resulted in an equal *P. falciparum* prevalence in children and adults; in children the parasitaemia rate increased from 32% to 48% and in adults from 23% to 47%. In more than 50% of all blood samples positive for *P. vivax* and *P. malariae* an underlying *P. falciparum* infection remained undetected by microscopy. The introduction of PCR has opened up new possibilities in malaria diagnosis and research.
- 15 **Golledge C.**
Febrile child after visit to Solomon Islands. *Aust Fam Physician* 1995 Oct;24(10):1909-1910.
- 16 **Golpak V.**
Post-traumatic false aneurysm: a frequently missed condition in penetrating injuries. *PNG Med J* 1995 Mar;38(1):57-61.
- 17 **He G, Prakash CS, Jarret RL.**
Analysis of genetic diversity in a sweetpotato (*Ipomoea batatas*) germplasm collection using DNA amplification fingerprinting. *Genome* 1995 Oct;38(5):938-945.
A DNA amplification fingerprinting (DAF) approach was employed to develop individual-specific profiles and analyze genetic relationships among 73 plant introductions of sweetpotato (*Ipomoea batatas* (L.) Lam.) including unadapted lines from around the world and a few selected USA cultivars. Reliable and informative fingerprint profiles were obtained employing single octamer primers and Stoffel fragment Taq polymerase in the polymerase chain reaction, polyacrylamide-based vinyl polymer for electrophoresis, and silver staining to visualize the DNA. Using seven highly informative octamer primers, individual-specific DAF profiles were obtained for all accessions tested. The degree of polymorphism in the sweetpotato collection was
- 18 **Larsen FT.**
Typhoid review, Enga Province, from 1986 to 1991. *PNG Med J* 1995 Mar;38(1):20-26.
A typhoid epidemic in Enga Province between early 1986 and mid-1991 is reviewed. Initially 849 cases (46.9/10000 population) were diagnosed clinically in 1986, rising gradually to 2332 cases (122.2/10000 population) in 1990. The case fatality rate fell from 5.5% in 1986 to 2.7% in 1990, which can probably be explained by earlier diagnosis and over-diagnosing of cases as the epidemic progressed. The key factor in the transmission seems to have been a low level of personal hygiene with an increased transmission risk during public gatherings. Recommendations for the strengthening of the control program are made, based on improved diagnosis and patient management, health education about personal hygiene and the provision of public sanitary facilities.
- 19 **Murthy DP, SenGupta SK, Thurley JL, Cooke RA.**
Liver disease in Papua New Guinea 1981 to 1988, twenty years after the first surveys were done. *PNG Med J* 1995 Mar;38(1):6-15.
Twenty years after the first surveys of liver disease were done cirrhosis and hepatocellular carcinoma were still found to be the most important liver diseases in Papua New Guinea. Hepatitis B virus appears to be the main cause of both these conditions. Data from a number of different sources suggest a prevalence of hepatitis B positivity of about 17%. The most significant new finding was grade 3 iron deposition in 8 patients. This raises the question as to whether iron storage disease may now contribute to the spectrum of liver disease in Papua New Guinea. Many biopsies in the 1960s and 1980s were interpreted as nonspecific hepatitis; in the light of recent observations, at least some of these may have been due to hepatitis C infection.
- 20 **SenGupta A, Auto J, Pawape G.**
Unexplained pulmonary hypertension in children in the highlands of Papua New Guinea. *PNG Med J* 1995 Mar;38(1):45-51.
We report the clinical features, electrocardiographic and chest X-ray findings, and Doppler-measured pulmonary artery pressures in 22 children admitted to Goroka Base Hospital with

primary pulmonary hypertension and compare them with findings in 10 controls. Symptoms frequently reported by patients were recurrent cough (95%) and shortness of breath (77%). 82% of the patients had increased intensity of the pulmonary component of the second heart sound. 45% of the patients had clinical evidence of right heart failure. Chest X-rays were readable in 14 patients: the mean cardio-thoracic ratio was 65% and in the controls 58%; the mean diameter of the descending branch of the right pulmonary artery was 9 mm and in the controls 6.4 mm. 13 patients and 8 controls had electrocardiograms: 11 patients had right axis deviation, 2 a normal axis, and all showed evidence of right ventricular hypertrophy; 7 controls had a normal axis, 1 had right axis deviation, and 3 controls had right ventricular hypertrophy. Pulmonary artery pressures in the patients ranged from 41 to 137 mmHg with a mean of 79 mmHg. The control group had a mean pulmonary artery pressure of 28 mmHg, but 5 of the 10 controls had pulmonary artery pressures greater than the accepted norm (peak systolic pressure less than 30 mmHg). Altitude and chest infection may be playing a role in the pathogenesis of pulmonary hypertension in patients in the highlands but further studies need to be done to define the causes and the pathological changes in the pulmonary vasculature, as well as to determine local norms and the natural history of pulmonary hypertension in highland children.

21 **Shann F, Mackenzie A.**

Comparison of rectal, axillary, and forehead temperatures.

Arch Pediatr Adolesc Med 1996 Jan;150(1):74-78.

OBJECTIVE: To assess whether axillary and forehead temperatures accurately reflect the rectal temperature (the criterion standard). **DESIGN:** Prospective study with calculation of paired axillary-rectal and forehead-rectal temperature differences and their SDs. **SETTING:** Referral hospital. **PARTICIPANTS:** Convenience sample of 120 patients, with 20 patients in each of six age groups (ie, < 1 month, 1 to 5 months, 6 to 11 months, 12 to 23 months, 2 to 14 years, and adults). **RESULTS:** In newborns, the rectal temperature was equal to the axillary temperature plus 0.2 degrees C for each week of age up to 5 weeks; forehead strip thermometers gave inaccurate readings in this age group. In patients older than 1 month, the mean difference (SD) between the rectal and axillary temperatures was 1.04 degrees C (0.45 degrees C); thus the axillary temperature was adjusted by adding 1 degree C, and no adjusted axillary temperature differed from the rectal temperature by more than 1 degree C. The mean difference (SD) between the forehead temperature that was measured by the best forehead liquid crystal strip thermometer (FeverScan) and the rectal temperature was 0.14 degrees C (0.60 degrees C); 10 forehead temperatures differed from the rectal temperature by more than 1 degree C. **CONCLUSIONS:** Previous studies that have suggested that axillary and forehead temperatures do not provide a reliable guide to the rectal temperature have all used

inappropriate methods of analysis (correlation coefficients or sensitivity and specificity); previous studies that have based their conclusions on the correct method of analysis (paired differences and their SDs) have all found that the axillary temperature gives a good indication of the rectal temperature. The axillary temperature can be measured safely at any age, and the axillary temperature plus 1 degree C is a good guide to the rectal temperature in patients older than 1 month. Forehead strip thermometers are easy to use, but they do not estimate the rectal temperature as accurately as the axillary temperature does.

22 **Siegmund R, Tittel M, Schiefenhövel W.**

[Parent-child interaction during activity and rest behavior of inhabitants of Trobriand Islands (Papua New Guinea)]. [Ger]

Wien Med Wochenschr 1995;145(17-18):464-467.

Sleep/activity patterns were continuously registered using microelectronic actometers on inhabitants of Tauwema (Papua New Guinea) who represent a traditionally living society. Results of analysis of parent-infant interactions of 4 families with infants of 1, 2, 5, and 11 months of age are presented. Results of power spectral analysis suggest that time patterns of mother-infant interactions are changing with the infants' AE age. Consequences of this developmental process are discussed.

23 **Sykes B, Leiboff A, Low Beer J, Tetzner S, Richards M.**

The origins of the Polynesians: an interpretation from mitochondrial lineage analysis.

Am J Hum Genet 1995 Dec;57(6):1463-1475.

Using mitochondrial lineage analysis of 1178 individuals from Polynesia, the western Pacific, and Taiwan, we show that the major prehistoric settlement of Polynesia was from the west and involved two or possibly three genetically distinct populations. The predominant lineage group, accounting for 94% of Polynesian mtDNA, shares a 9-bp COII/rRNA(Lys) intergenic deletion and characteristic control region transition variants, compared to the Cambridge reference sequence. In Polynesia, the diversity of this group is extremely restricted, while related lineages in Indonesia, the Philippines, and Taiwan are increasingly diverse. This suggests a relatively recent major eastward expansion into Polynesia, perhaps originating from Taiwan, in agreement with archeological and linguistic evidence, but which experienced one or more severe population bottlenecks. The second mitochondrial lineage group, accounting for 3.5% of Polynesian mtDNA haplotypes, does not have the 9-bp deletion and is characterized by an A-C transversional variant at nt position 16265. Specific oligonucleotides for this variant were used to select individuals from the population sample who, with other sequences, show that the Polynesian lineages were part of a diverse group in Vanuatu and Papua New Guinea. The very low overall diversity of both lineage groups in Polynesia suggests there was severe population restriction during the colonization of remote Oceania. A third group, represented by only four individuals (0.6%) in

Polynesia but also present in the Philippines, shares variants at nt positions 16172 and 16304. Two Polynesians had unrelated haplotypes matching published sequences from native South Americans, which may be the first genetic evidence of prehistoric human contact between Polynesia and South America.

24 **Tuisuva J, Smyth JM, Davies GN.**

A sequential modular curriculum for oral health personnel.
Community Dent Health 1995 Dec;12(4):238-240.

25 **Yanagihara R, Saitou N, Nerurkar VR, Song KJ, Bastian I, Franchini G, Gajdusek DC.**

Molecular phylogeny and dissemination of human T-cell lymphotropic virus type I viewed within the context of primate evolution and human migration.
Cell Mol Biol 1995;41(Suppl 1):S145-S161.

A renewed interest in the emergence and evolution of the primate T-cell lymphotropic viruses has followed the discovery of genetically distinct variants of human T-cell lymphotropic virus type I (HTLV-I) in Melanesia and Australia. Phylogenetic trees based on selected regions of the gag, pol, env and pX genes of HTLV-I from widely separated geographic regions and of simian T-cell lymphotropic virus type I (STLV-I) from

African and Asian catarrhines, constructed using the neighbour-joining and maximum parsimony methods, indicated that the Australo-Melanesian and cosmopolitan strains of HTLV-I have evolved along separate geographically dependent lineages, with African STLV-I strains clustering with cosmopolitan HTLV-I strains and Asian STLV-I strains diverging from the common ancestral virus before the Australo-Melanesian HTLV-I strains. When viewed within the context of non-human primate evolution and human occupation of Australia and Melanesia, the rate of molecular change of HTLV-I and STLV-I is approximately $2.5-6.8 \times 10^{-7}$ substitutions per site per year. Overall, the sequence and phylogenetic analyses are in accord with interspecies virus transmission among non-human primates, as well as between non-human primates and humans, with independent evolution of HTLV-I in Southeast Asia and in Africa, and with dissemination of HTLV-I by forced or voluntary movements of human populations. The immunosuppressive and T-cell activation properties of HTLV-I places at added risk these Australian Aboriginal and Melanesian populations, some of which are in imminent threat of infection with human immunodeficiency virus type 1.

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- 3 **Garner PA, Hill G.** Brainwashing in tuberculosis management. *PNG Med J* 1985;28:291-293.

- 4 **Cochrane RG.** A critical appraisal of the present position of leprosy. In: Lincicome DP, ed. *International Review of Tropical Medicine*. New York: Academic Press, 1961:1-42.

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Tables and figures (an original with 2 copies of each) should be prepared on separate pages. Photographs should be glossy prints, either 7 cm or 14.5 cm in width. Graphs and charts must be prepared in India ink on stiff white paper, or presented as glossy photographs. Photomicrographs should have internal scale markers. Each table should have a heading and footnotes which make it understandable without reference to the text. Each figure should have a legend; figure legends should be typed together on a separate sheet. Indicate the top of figures lightly in pencil on the back.

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