

adoption of the IADPSG diagnostic criteria and to discuss the implications of this change²².

When applying the IADPSG criteria on the HAPO cohort, the majority of women diagnosed with GDM were identified by the FPG and the 1-hour measurement of the 75 g OGTT (8.3% and 5.7% of the entire study population, respectively)³. Adding the 2-hour measurement identified another 2.1%. Thus, alternative diagnostic strategies such as measuring FPG alone or omitting the 2-hour blood draw can indeed be appealing. It would thus be interesting to verify their cost-effectiveness in comparison with the unmodified IADPSG diagnostic recommendations in a large prospective multicentre trial.

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Childhood obesity in Greece: the emerging role of primary health care

Dear Editor,

The prevalence of overweight and obesity among children and adolescents seems to be rising at particularly alarming rates in many regions of the world. This fact is particularly important in terms of cardiovascular health since childhood obesity tracks into adulthood and is associated with the presence of cardiovascular risk factors and target organ damage. Greece has a predominant place with regard to this issue, since it has been reported to have one of the highest prevalences in childhood obesity with significant rising trends¹⁻⁴.

Childhood obesity has a multifactorial pathogenesis with genetic background, reduced physical activity along with a sedentary status, and poor dietary habits as contributory factors, although the role of each of them in the emergence of obesity remains elusive. However, the available evidence, although not strong enough, suggests that practices such as appropriate dietary behaviour and regular physical activity appear to be protective against weight and fatness gain during childhood and adolescence. These observations are important in the context of developing primary prevention programs against childhood obesity.

In the last years, several cross-sectional studies have assessed obesity status in Greek children with measured data and according to the International Obesity Task Force standards. These studies report childhood obesity rates from 4% to 11%¹⁻⁴. Factors which may account for the observed discrepancies include time period of the study, characteristics and representativeness of the sample examined. It should be noted that the purpose of this letter was not to conduct a systematic review and of-course there are studies not mentioned. However, in most of these studies, overweight and obesity affect about one third of the examined young population. Moreover, overweight/obesity rates seem to be higher among boys compared to girls^{1,2,4} although there are studies not confirming this observation³.

Another interesting observation is that obesity rates are consistently high in peripheral, mainly rural districts⁴. This observation is very important since it implicates primary care physicians in the early recognition and management of this public health issue. In particular, primary health care providers should be: (i) well aware of the epidemiologic dimensions and the implications of this public health issue, (ii) able to recognize children at risk for overweight/obesity, (iii) willing to implement screening and follow-up programs and develop preventive strategies in cooperation with other structures such as family and/or school, (iv) familiar with the provision of basic nutrition and physical activity education, and (v) able to consider sub-specialist referrals timely when co-morbidities persist. It should be realized that the active role of the primary care physicians is of paramount importance in order to curtail the childhood obesity epidemic.

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A Case of Askin's Tumor Presenting with Pleural Effusion and High Level of Adenosine Deaminase

Dear Editor,

Askin's tumor (AT) is a rare malignant small-cell neoplasm arising from the thoracopulmonary region with high tendency for local recurrence. It is usually seen between 10-30 years of age and more commonly in women¹. Pleural effusion is seen in approximately 70% of cases. Biochemical characteristics of pleural fluid are rarely known, though it is presented commonly as exudative². Complete surgical resection has an important role on prognosis and intensive combined modality treatment of chemo-radiotherapy in addition to surgical resection might also help for better prognosis¹.

A 21 year-old male patient with complaints of left-sided chest pain, fever, and dyspnea was admitted. Respiratory system examination revealed decreased respiratory sounds over whole left hemithorax. Left-sided homogeneous density was seen on chest X-ray. Thoracentesis from left hemithorax was performed and hemorrhagic pleural effusion with high LDH and ADA levels (2513 IU/l and 85 IU/l, respectively) was found. Cytologic examination of the pleural fluid revealed no malignant cells. Histopathologic examination of closed-pleural biopsy revealed desmoplastic small-round-cell neoplasia. Thorax CT sections showed two masses at the left paracardiac region with 10x10cm in diameter and on posterior costal pleura with 5x2cm in diameter. In order to make definitive diagnosis and surgical treatment, left thoracotomy, extrapulmonary intrathoracic mass excision, total decortication and 6th rib resection were performed. Post-operative pathological examination revealed AT with positive immunohistochemistry findings of CD99, NSE, PGP9.5 and chromogranin. The patient was treated with cycles of EVAIA protocol (Etoposide, Vincristine, Actinomycin-D, Ifosfamide and Adriamycine) and radiotherapy. Three months after following the treatment, increased 18F-FDG uptake was encountered in left upper lobe, left lower lobe, lateral precordial region, and in the area between left lower ribs and spleen in whole body positron emission tomography. Respiratory condition of the patient gradually worsened, and he died two months later.

It is commonly accepted that tuberculosis pleural effusion (TPE) is the most common form of extrapulmonary tuberculosis in populations younger than 35. Although histopathological diagnosis with pleuroscopic biopsy is gold standard, non-invasive tests, principally ADA level in pleural effusion, can help to distinguish between tuberculosis pleurisy and other diseases including malignancies³.

In this paper, we want to emphasize that the ADA test cannot be the only tool for TPE diagnosis, even in countries in which tuberculosis is more prevalent. Furthermore, differential diagnosis of pleural effusions with high ADA level should include not only tuberculosis pleurisy but also other inflammatory diseases and chest wall malignancies, such as AT in young patients. In conclusion, appropriate histopathological examinations should be performed in order to avoid misdiagnosis in pleurisy cases in young populations.

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