Vol 21 For members only

HOWZIT

Manipal Alumni Association Newsletter

1st Global Manipal Alumni Health, Science & Technology Convention and 28th MAAM Convention

Debut of **MAAM CPD Series** & Alliance between Manipal Hospitals Klang **(Arunamari Specialist Medical Centre)** and **MAAM**

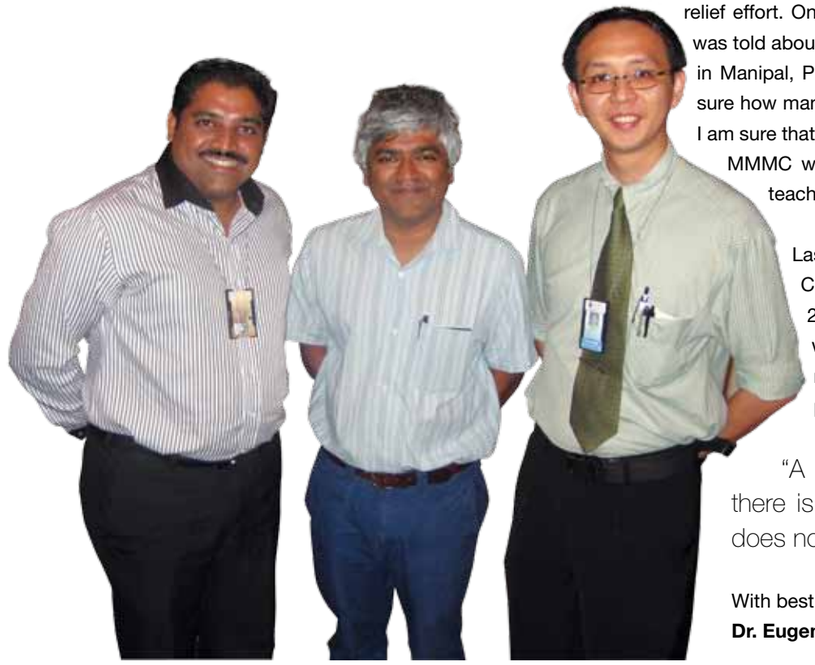
Like us on our Facebook Page Manipal Alumni Association Malaysia Follow us on **Twitter** @ManipalMAAM

Hello People,

Well, it has been quite a while ago since our last HOWZIT newsletter early this year. Many things have happened along the way. Most of it was on the gearing-up for the 1st Manipal Alumni Global Health, Science and Technology Convention & the 28th MAAM AGM in August 2014. Personally, I must say that the vibe towards this inaugural event is tremendous, not only from inside Malaysia but also from overseas. Everyone involved in this project had put in their own limitless contributions, sweat and time to make this event a successful one. Just look through this newsletter and I am sure you will get to understand what I mean. In this latest issue, we will be looking at some very interesting articles written by our own Manipalites. Just when we thought that we had forgotten our Anatomy days, Dr. Koh Kar Chai brought us back to those glorious days of First Year in Manipal. There is also a Dental Case report in this issue, which I hope it will be useful to all of us. Our Vice President, Dr. Sivaroshan gave us an insight on Estrogen dominance in males. Eventually, I hope that you guys will take some of your precious time and read through this newsletter. I would definitely appreciate any comments or suggestions to make our HOWZIT newsletter a worthwhile reading material. You can e-mail to me at ujintan@gmail.com if you have anything to say.

Looking back on the months that have passed, I was very fortunate to be able to meet with our Manipal University Chancellor, Padma Bhushan Datuk Dr. Ramdas Pai and his son, Dr. Ranjan Pai in June this year during the Melaka Manipal Medical College 11th Graduation Ceremony in Melaka. Later in August, Assoc. Prof. Dr Rishya and myself were lucky to listen to a lecture by Dr. Unni Krishnan, President of Medicins Sans Frontiers in University Malaya Medical Center. MAAM then gave our support for his quest to collect funds for MSF project in India by cycling around India in October 2013. Lately too, we are also happy to see our Manipalites featured in our local media on medical topics of interest, namely, Dr. Patricia Gomez and Assoc. Prof. Dr. Philip George. Besides that, kudos to Dr. C.S. Kumar who selflessly helped a toddler out from a burning car following a road traffic accident along the highway on August 2013.

Coming to this year end, many things have happened in and around the world. The recent Haiyan Typhoon had caused mayhem in our neighboring country, the Philippines, in which MAAM had successfully contributed some funds towards their relief effort. On November 21st, I was saddened when I was told about the passing away of my Forensic lecturer in Manipal, Prof. Dr. Koodly Yoganarasimha. I am not sure how many of us that were his students before, but I am sure that most of my seniors and batch mates from MMMC would definitely remember him as a great teacher.



Lastly, I would like to wish all of you, Merry Christmas and a very Happy New Year 2014. Make your resolutions quick and work on it as soon as you can. Let me end my editor's note with a quote that I had personally made:

"A hero is the one who knows that there is or may not be a tomorrow if he does not do his part for humanity."

With best regards,
Dr. Eugene Tan

August 2014 is just nine months away.

I urge all Manipalites to come together and make this the event of the century.

With 7000 Manipalites in Malaysia, 100,000 around the globe and 60 years of the Academy under its belt I can visualize the Royale Chulan bursting at its seams come 7th August 2014.

"Networking Globally for the Future of Healthcare & Technology"

is the tag line for the event… So let's make it happen. A very apt tagline with the number of Manipalites globally, it is time we network well for that much needed impact.

Manipal International University's participation has made this complete with the Dental and Engineering faculties having separate break out sessions.

Tan Sri Dato Dr Mohamed Salleh Mohamed Yasin, the Vice Chancellor and Prof Zanuldin of MIU are working closely with the scientific committee.

Not forgetting our immediate past president, the charismatic Dr Jeyalan heading the Dental section assisted by Dr Thomas Abraham, Dr Prabha and Dr Ratnasothy.

The plans for a pre congress Emergency Medicine and Ultra sound workshops are falling into place and we are expecting a full house.Both the organizing and scientific committees are fully occupied in this organization.

Dr Philip George our Organizing Chairman is working in overdrive to realize the expectations of many for 2014.

I urge you all to register early. There are prizes awaiting the early registrants.

Our last CPD and AGM were concluded successfully on the 4th of May, a day before the infamous GE 13. The numbers had dwindled due to the GE 13 but nevertheless it went well. The full report of which is in our General Secretary's report.

On a different level, my heart goes out to all the victims in Tacloban, Phillipines. The destruction, the immense human sufferings the many dead lying unattended even on a TV screen can move a hard man to tears.

This is an arena where Manipalites' around the Globe can and should be doing loads in the form of selfless service. With 7000 in Malaysia and 100,000 globally, I believe we can work closely with bodies as MERCY Malaysia or Medisans Sans Frontier (MSF).

A Manipalite who was the chief of MSF till recently - Dr Unni Krishnan, is now on a bicycle ride from Kashmir to Kerala on a charity drive for underprivileged children. You can follow his route on our facebook.

Just as I am writing this an e mail blast is going out calling for donations & volunteers to assist in Tacloban.
Ladies and gentlemen I urge you to donate with an open heart. Help the the innocent children who could do with your generosity.

Be a part of this giving exercise.

We have the numbers and our strength is in the numbers and the camaraderie that we have amongst us. But alas where art thou? These huge numbers are missing from our register and it becomes very difficult to move forwards. We have many likes on our face book page but these likes are out there in cyberspace floating and floating. Gravitate people, gravitate for a cause. Can I call it a networking cause?

Manipal hospitals have made an entry into Malaysia with the acquisition of Arunamari hospital in Klang and they plan to open up 5 more within the span of 2 years. The ongoing dialogue between MAAM and Manipal Hospitals is promising to be beneficial bilaterally. Quaternary care is in the pipeline.

Mark your calendar for the **7th, 8th & 9th of August 2014**

Dr. Nirmal Singh
President MAAM

Organising Chairman's message

Coming back from Manipal and starting work as a House-officer was both exciting and anxiety provoking. The thought of finally putting to practise what I spent 5 years learning and getting paid for it too, was attractive. Coupled with uncertainty of what to expect from colleagues, seniors, consultants and patients, I started work in February of 1989.

Some of what I hoped and looked forward to did come true, as I reflect back on those important formative months and years but in the first few weeks of every new posting there was an overwhelming anxiety and worry. This worry was, I believe, largely related to the fact that I was an Indian Medical Graduate and not someone from University Malaya or from a British Medical School. There was, sadly, at that time a general view that Indian Medical Graduates were inferior and less capable compared to others. The first question as I reported to a new Consultant or Senior Medical Officer during posting rotations was, "where did you qualify from". And predictably there was a certain negative facial expression when I replied that I was from Manipal. It was prevalent in most Hospitals where other Alumni reported for work and I heard some resorted to lying and saying that they graduated from Manchester instead of Manipal as in their credentials (Man) could be confused for either.

Years later and working as a Specialist and now as a Consultant and Associate Professor and Associate Dean, I sincerely feel I perservered and showed my fellow colleagues from other so-called Ivy League Universities that I and all other Manipal graduates were no different. In fact, I sense we even have better communication and patient skills as that was a must in the environment we studied in just to survive.

The 1st Global Manipal Alumni Health, Science and Technology Convention, 2014 is hoping to showcase this fact and highlight that we as an Alumni are high achievers and contribute significantly to the nation's healthcare and biotechnology domains. It is already boasting of 30 plus speakers from around the world who are authorities in their field of speciality. In this day and time of constant development and innovation, keeping abreast, especially as a healthcare profesional is essential to providing quality and appropriate service. The Convention will be a venue to update and enhance professional development and CME points will be awarded to all delegates by Malaysian, USA and Canadian CME provider authorities.

Friends and fellow Alumni, the "1st Global Manipal Alumni Health, Science & Technology Convention" will be held from the 7th to the 8th of August, 2014. It aims to bring together Manipal Medical, Dental, Pharmacy and Engineering Alumni as well as other Healthcare and Engineering Professionals from around the world to share ideas and experiences in their medical, dental, pharmacy, biotechnology and engineering practice as well as to develop collaborations among Alumni in various disciplines and fields. It also aims to bring back people who shared important years together and built bonds and relationships that perhaps distance prevents reunioun.

Invited speakers are authorities and key opinion leaders in their field and many are from the Alumni of Manipal in countries such as India, the United States of America, Canada, South Africa, Malaysia and Australia as well as from Melaka Manipal Medical College, Manipal International University, Nilai and Manipal University, India.

Supported by Manipal University, India, Melaka Manipal Medical College, Manipal International University, Nilai and MNE Solutions, this event promises to be a truly unique and educative experience. There will be Free Paper and Poster Presentations and delegates are encouraged to submit abstracts for these as there are many prizes awaiting the bestpapers. There will also be a Convention Dinner on the first evening with local entertainment open to all delegates giving the opportunity to unwind and catch up with old and new acquaintances.

Book early and tell all your previous batchmates and colleagues. Log-on to www.manipal.org.my for more information and registration details. This Inaugural event is to be held at the prestigious and famous, Royale Chulan Hotel, Kuala Lumpur. It is located in downtown Kuala Lumpur within the Golden Triangle precinct of Bukit Bintang where great shopping anddining opportunities exist. The Royale Chulan Hotel offers guests 5-star Malaysian hospitality just adjacent and walking distance to the Kuala LumpurTwin Towers. Please visit http://royalechulankualalumpur.com/ for more information on the venue.

Remember – This is an event about YOU and who YOU are. Manipal Alumni forever!

Look forward to welcoming all of you to this 'not to be missed' event.

Regards,
Assoc Prof Dr. Philip George
Organising Chairman
1st Global Manipal Alumni Health, Science & Technology Convention, 2014.

ORGANISING COMMITTEE

Organising Chairman
- Assoc Prof Dr Philip George

Co-chairman
- Dr Nirmal Singh

Deputy Chairman
- Dr P Sivaroshan

Hon Secretary
- Dr Thomas John

Treasurer
- Dr Kewaljit Singh

Committee Members
- Dr Ann Kailath (USA Representative)
- Dr Arun Kumar
- Dr Bhamini A/P S Raja Chandran
- Dr Eugene Tan Choon Li
- Dr Jayanti Visvanathan
- Dr Jeyanthi Vengadasalam
- Dr Koh Kar Chai
- Dr Kumar Rajah
- Dr Malkit Singh
- Dr Mohandas Nair
- Dr Nyana Kalaiwani D/O Krishnan
- Dr Rishya Manikam
- Dr Shanty Siva
- Dr Sumithra Ranganathan

SCIENTIFIC COMMITTEE

Scientific Committee Chairman
- **Prof Dr Jaspal Sahota**
  - Consultant ENT Surgeon and Dean, Melaka Manipal Medical College

Committee Members
- **Assoc Prof Dr Philip George**
  - Psychiatrist and Assoc Dean, International Medical University
- **Tan Sri Dato'Dr Mohamed Salleh**
  - Vice Chancellor
- **Prof Zainudin Ahmad**
  - Acting Vice Chancellor
- **Datin Dr Sivasakthi Velayuthapillai**
  - Consultant Anaesthesiologist
- **Prof Sachchithanantham Kanagasabai**
  - Consultant Obstetrician and Gynaecologist
- **Dr K K Iswaran**
  - Consultant Obstetrician and Gynaecologist
- **Dr Poopalarachagan Sinnathurai**
  - Consultant Obstetrician and Gynaecologist
- **Dato Dr Siva Mohan Namasivayam**
  - Consultant Obstetrician and Gynaecologist
- **Dr Surinder Singh Ranbir Singh**
  - Consultant Obstetrician and Gynaecologist
- **Dr Patricia Gomez**
  - Consultant Breast Surgeon
- **Dr Josephine Subramaniam**
  - Consultant Radiologist
- **Dr Kewaljit Singh**
  - Consultant Ophthalmologist
- **Dr Sunder Ramasamy**
  - Consultant Ophthalmologist
- **Datuk Dr Teoh Siang Chin**
  - Director of Health, Melaka State
- **Dr Koh Kar Chai**
  - General Practitioner
- **Dr Jeevanan Jahendran**
  - Consultant Otorhinolaryngologist
- **Mr Arasu Sinnaya T**
  - Consultant Pharmacist
- **Dr Jayendran Dharmaratnam**
  - Consultant Oncologist
- **Dato' Selva Kumar**
  - Consultant Orthopaedic Surgeon
- **Dr Prem Kumar**
  - Consultant Psychiatrist
- **Dr Anoop Kumar**
  - Consultant Obstetrician
- **Dr Selvakumar Selvarajah**
  - Consultant ENT Surgeon
- **Dr Balachandran Appoo**
  - Consultant ENT Surgeon
- **Dr S R Manalan**
  - General Practitioner & Occupational Medicine Specialist
- **Dato' Dr Devan Pillay**
  - Consultant Cardiologist
- **Dr Jeyalan Samanther**
  - Consultant Dentist
- **Dr Thomas Abraham**
  - Consultant Dentist
- **Datuk Dr Arumugam**
  - Consultant Cardiologist
- **Dr Rishya Manikam**
  - Consultant Emergency Medicine Specialist
- **Datuk Dr Kuljit Singh**
  - Consultant ENT Surgeon
- **Dr Lakshumanan Sanker**
  - Consultant Physician
- **Dr Sanjay Woodhull**
  - Consultant Paediatrician

tentative PROGRAM

(Subject to change)

Thursday - 7th August, 2014

8.00am - 8.40am	**P1: Plenary 1 -** Conference Hall				
8.40am - 9.10am	**P2: Plenary 2 -** Conference Hall				
9.10am - 10.15am	**Keynote Address & Opening Ceremony -** Conference Hall				
10.15am - 10.30am	**Morning Coffee Break** / Exhibition & Poster Viewing - Banquet Hall				
10.30am - 11.00am	**SL 1: Special Lecture 1 - Dental** Conference Hall			**W1: Workshop 1** TBA	**W2: Workshop 2** TBA	**W3: Workshop 3** Engineering and Biotechnology
11.00am - 11.30am	**SL 2: Special Lecture 2 - Pharmacy** Conference Hall					
11.30am - 12.00noon	**SL 3: Special Lecture 3** Conference Hall					
12.00pm - 12.30pm	Q & A					
12.30pm - 2.00pm	**LUNCH SYMPOSIUM -** Banquet Hall					
2.00pm - 5.00pm	**S1. Symposium 1** Conference Hall 1 Cardiovascular System	**S2. Symposium 2** Conference Hall 2 Dental	**S3. Symposium 3** Metabolic Syndrome	**W1: Workshop 1** TBA	**W2: Workshop 2** TBA	**W3: Workshop 3** Engineering and Biotechnology
5.00pm - 5.15pm	**Evening Coffee Break -** Exhibition & Posters Viewing					
7.00pm - 10.30pm	**Welcome Dinner -** Banquet Hall					

Friday - 8th August, 2014

8.00am - 8.40am	**P3: Plenary 3 -** Conference Hall				
8.40am - 9.10am	**P4: Plenary 4 -** Conference Hall				
9.10am - 9.50am	**P5: Plenary 5 -** Conference Hall				
9.50am - 10.30am	**P6: Plenary 6 -** Conference Hall				
10.30am - 10.45am	**Morning Coffee Break** / Exhibition & Poster Viewing - Banquet Hall				
10.45am - 11.15am	**SL 4: Special Lecture 4** Conference Hall			**W1: Workshop 1** TBA	**W2: Workshop 2** Ultrasound Full Day Workshop	**W3: Workshop 3** Engineering and Biotechnology
11.15am - 11.45am	**SL 5: Special Lecture 5** Conference Hall					
11.45am - 12.15pm	**SL 6: Special Lecture 6** Conference Hall					
12.15pm - 12.30pm	Q & A					
12.30pm - 2.00pm	**LUNCH SYMPOSIUM** Banquet Hall					
2.00pm - 5.00pm	**S1. Symposium 1** Conference Hall 1 Orthopaedics Hands-On	**S2. Symposium 2** Conference Hall 2 Pharmacy	**S3: Symposium 3** Cancer in Women	**W1: Workshop 1** TBA	**W4: Workshop 4** Dental Half Day Workshop	**W3: Workshop 3** Engineering and Biotechnology
5.00pm - 5.15pm	**Evening Coffee Break -** Closing Ceremony					

tentative list of SPEAKERS

(Subject to change)

Dr Unni Krishnan Karunakara
President Médecins Sans Frontières International, Geneva, Switzerland
"Medical Humanitarian Action - A Médecins Sans Frontières Perspective"

Dr Sreedhar Potarazu
CEO Vital Springs, USA
"The Future of Healthcare Service Delivery - Models to Ponder

Dr Sanjay Woodhull
Consultant Paediatrician, Sime Darby Medical Centre Subang Jaya
"Current Approach To Wheezing in Preschool Children"
"Examining Kids. Tricks of The Trade"

Assoc Prof Dr Philip George
Associate Dean & Consultant Psychiatrist, International Medical University, Malaysia
"Challenges to Assessing and Treating Major Depression in Primary Care in Malaysia"

Dr Rajiv Nanda
Consultant Dental Surgeon, Boston, USA
"The Oral-Systemic Link - Cardiovascular Disease, Diabetes with Periodontal Disease"

Dato' Dr Sheikh Muszaphar Shukor
Al-Masrie – Malaysia's First Astronaut
"How My Medical Education Helped in Making Me Malaysia's First Astronaut"

KEYNOTE SPEAKER
T V Mohandas Pai
Chairperson of the Board of Manipal Global Education Services Private Limited and Advisor to the Manipal Education and Medical Group

Dr R C Krishna
Consultant Neurologist, New York
"Fits and Faints- Diagnosis and Treatment"

Dr Nagesh Pai
Professor of Psychiatry
"There's More to Antipsychotic Induced Obesity"

Dr Mandyam Dhati Ravi
Professor of Pediatrics and Vice principal (Clinical), JSS Medical College, Mysore
"Update on Pneumococcal Vaccines"

Assoc Prof Dr Rajasingam
Whats "New" in Treatment Resistant Essential Hypertension? - An Overview of Renal Denervation by Catheter-based Radiofrequency

Dr Suresh Ratnam
Emergency Physician, Cambridge University Hospital, Cambridge, UK
"Updates on Emergency Medicine"

Professor Ramdas Pai
Medical Director, Heart & Imaging Center, Loma Linda University Medical Center, USA
"Recent advances in Cardiac Imaging"

Dr K Ramnarayan
Vice Chancellor, Manipal University, India
"Becoming World Class: Thinking Beyond Conventional Boundaries"

Prof Dr Charles M Wiener
Dean/CEO, Perdana University, Graduate School of Medicine, (in collaboration with Johns Hopkins University School of Medicine), Malaysia
"Genes & Society"

Dr Ravindran A/L Thuraisingham
"Hand Surgery: Minimal Invasive & Reconstructive Procedures"

Dr Harjit Kaur
Consultant Breast Surgeon, Prince Court Medical Centre, Kuala Lumpur, Malaysia.
"Women's Cancers"

Professor Dr Jayakrishnan
Chief Cardiothoracic Surgeon and Director Omega Hospital, Mangalore, India
"Coronary Artery Bypass Surgery - State of The Art"

Dr Subash Mathews
Derbyshire Community Health Services NHS, United Kingdom
"Managing Depression in Primary Care – A UK NHMS perspective"

Mr Askar Kukkady
Clinical Director, Department of Paediatric Surgery, Consultant Paediatric Surgeon and Urologist, Waikato Hospital, Hamilton, New Zealand

Professor Dr Lucy Gilbert
Director of Gynecological Oncology, McGill University, Canada
"Ovarian Cancer - Unmasking The Great Pretender"

Vasudeva Kamath
Columbia University, New York NY USA
"Fetal Origins of Adult Diseases" Old Wine in A New Bottle?

Shashidhar Kori
MD VP, Allergan Corporation, California, USA
"Pharmaceuticals and Medicine"

Dr Riza Ibrahim
BMI Highfield Hospital, BMI Priory Hospital- Edgbaston, United Kingdom
"The Modern Management of Aortic Aneurysms"

Professor Dr Princy N Kumar
Professor of Medicine and Microbiology, Georgetown University School of Medicine, Washington, DC, USA
"Antibiotics and Resistance-an Update for The Clinicians"

Dato' Dr Devan Pillay
Consultant Cardiologist, Prince Court Hospital, Malaysia
"What's New in Interventional Cardiology"

Prof J P Gosalakkal
School of Medicine, Wright State University, Dayton Ohio
"Refractory Seizures and Therapy". Is Ketogenic Diet The Solution?

Dr Shailesh Patel
MD, FACC., Cardiac Electrophysiology, Columbus Cardiovascular Associates, Inc., Columbus, Ohio, USA
"Atrial Fibrillation: Past, Present and Future"

Prof C S Pandav
All India Institute of Medical Sciences, New Delhi
"Global Perspectives on Goiter"

Professor Dr R Warrier
New Orleans, LA, USA
"Childhood Malignancies"

Dr Kalpesh Amin
Assistant Professor of Cardiology, NS/LIJ Hofstra School of Medicine, USA
"Perspectives on Coronary Artery Disease and Heart Failure"

Dr Wazeer Ahmad
Emergency Physician, Cambridge University Hospital, Cambridge, UK
"Updates on Emergency Medicine"

Assoc Professor Dr A Paramesh
New Orleans, Louisiana University, USA
"Renal Transplantation"

Clinical Associate Professor Anthony Joseph
Royal North Shore Hospital, New South Wales, Australia

registration FORM

A. Personal Details

Title _____ Full Name _____

Name on badge _____

Profession _____ Dietary Requirement ☐ Vegetarian ☐ Non-Vegetarian

Place of work _____

_____

_____

Postcode _____ Country _____

Mobile Phone _____ Email _____

B. Registration Fees

	Before 01/05/2014	After 01/05/2014	AMOUNT
MAAM Members	RM 700	RM 800	
Non MAAM Members	RM 800	RM 900	
Foreign Delegates	USD 550	USD 650	
Students (Undergrads)	RM 450	RM 550	
Spouse/ Accompanying Person *includes Opening Ceremony and Convention Dinner*		RM 200	
(This package does not include Accommodation)		**TOTAL**	

C. Payment

1. For Online payment, please log on to ***http://event.manipal.org.my/***
2. For Malaysians only, cheques are to be issued in favour of **MAAM 2014 Convention**
   Cheque No. _____ Bank _____
   Amount RM _____
3. Payments can be made via telegraphic transfer to :
   Bank Name : **Alliance Bank Malaysia Berhad** Account No : **141670010021537**
   Bank Address : **No 1 Jalan Telawi 5, Bangsar Baru, 59100, Kuala Lumpur.**
   Swift Code : **MFBBMYKL** Beneficiary Name: **MAAM 2014 Convention**
   Beneficiary Address : **No 7A, Jalan Telawi Lima, Bangsar Baru 59100, Kuala Lumpur**
   Beneficiary Contact No: **+6016 223 8079 / +6012 631 3436 / +6012 638 8128**
4. All Bank charges for the telegraphic transfer and Online payment will have to be borne by the delegate.

Signature _____ Date _____

Sending Option:
By post : 7A, Jalan Telawi Lima, Bangsar Baru, 59100 Kuala Lumpur.
Tel: +603-2282 7355 /+6016 223 8079 / +6012 631 3436 Fax : +603-2282 8355

Our 27th MAAM Convention and 28th AGM was held on May 4th 2013, at the Saujana Resort Subang Jaya.

It was decided to hold both the convention and the AGM on one day, instead of having the usual 2 night, 3 day affair – this was to trim our expenses, given that our next convention, to be held in August 2014, will make heavy demands on our budget!

Registration started at 8.30 a.m. This was followed by CME sessions, which began at 9.30 a.m. The CMEs were very well attended, with some non-MAAM delegates who were sponsored by Roche. Among the highlights of these sessions was an intensive Ortho session where the speakers took turns to teach delegates about local infiltrating techniques for the various joints, namely shoulders, elbows, wrists, knees and ankles. There was also a very interesting session by some chiropractic doctors, who demonstrated some of the latest treatments for sports injuries.

The CMEs ended by 4 p.m., and then it was time for some fun. A few of us took the opportunity to test drive the latest BMW X1, as well as the BMW 3 and 5 series – we were able to take them for a spin up to the old Subang airport.

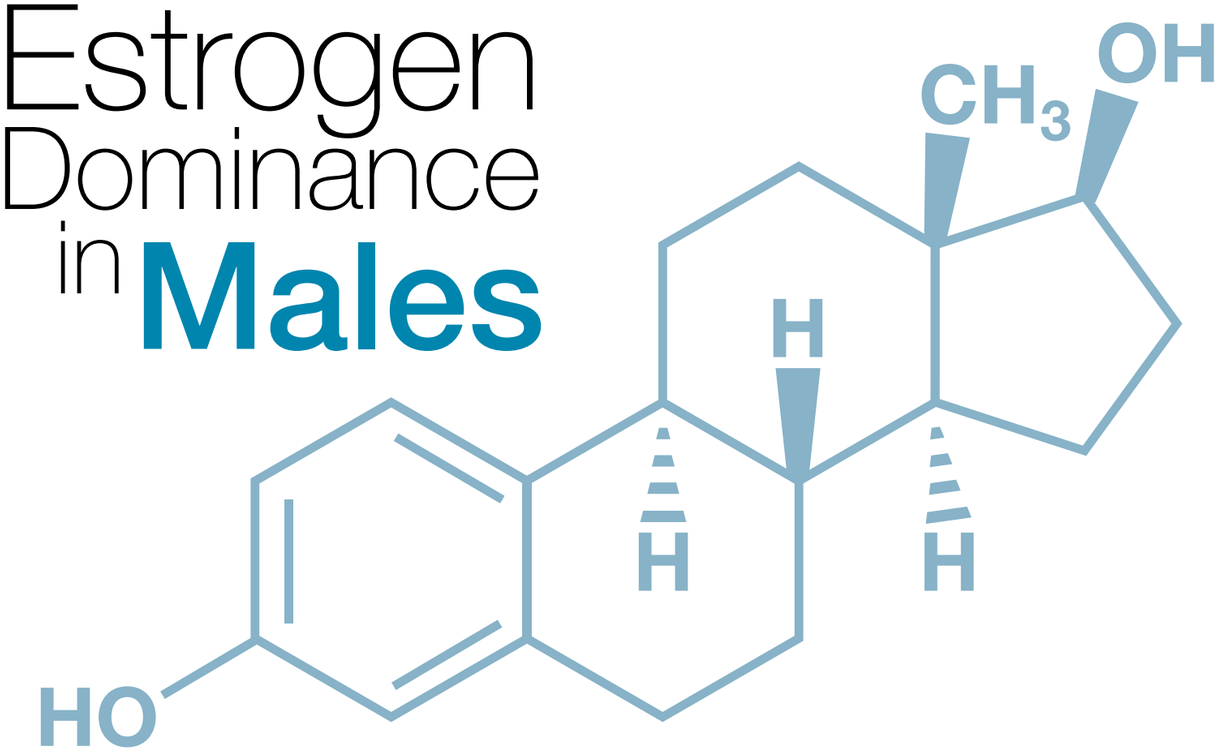
After that, it was back to business again with the AGM, which started at about 6.10 p.m. It was not well attended, with only 36 members. But the low turnout was for a very good reason – it was the day before the eagerly anticipated 13th General Elections, and many of our members from Ipoh, Penang, Johor and Seremban had taken the opportunity to head back home, determined to cast their votes and make sure their voices were heard. The AGM was over in an hour; one of the main items on the agenda was to make the decision to postpone the next AGM from May 2014 to August 2014, so that it will coincide with the Global Convention to be held next August.

After the AGM, at about 7.30, we started on cocktails and light snacks, before moving on to the convention dinner at 8.15. Dr. Thevi provided sophisticated entertainment, showing her prowess as a classical piano player.

Our sponsors BMW generously provided gifts for lucky draws, and many people went home with interesting gift bags. Once this was over, the DJs took to the music machine, and the doctors took to the dance floor! They certainly impressed with their funky moves to the latest dance beats. At midnight, the dancing came to an end and everyone went home. Some of us stayed overnight at the hotel. But we all got up bright and early the next day, excited to cast our ballots and make sure our votes counted.

Dr Thomas John
Honorary General Secretary

Estrogen Dominance in Males



I am sure you are a little puzzled at this topic. Well guys, it is a real problem. Estrogen dominance has always been something for the ladies, but guess what with modernization it now has become a problem of men too. We have heard that the testosterone levels throughout the world are dropping. We agree that the loss of morning erection increases your risk for heart disease. We are seeing a lot of young men dropping dead to heart attacks. We almost always blame it on their lifestyle. Was there another cause that we may have missed?

Estrogen dominance is a growing health concern for people around the world. Although it is more common in women than men, it can also affect men, causing problems such as infertility, erectile dysfunction, enlarged prostate, gynaecomastia, heart problems, prostate cancer and breast cancer in men.

Although estrogen is best known as a female hormone, it is naturally produced by the male body in small amounts. Estrogen dominance is a hormone imbalance that occurs when levels of the hormone estrogen are too high in relation to other hormones in the body. It can be caused either by excessive production of estrogen or insufficient production of other hormones, such as testosterone and progesterone.

Although estrogen dominance in men is most commonly caused by factors such as obesity, alcoholism and exposure to any form of environmental estrogen called xenoestrogens, it can be caused by a number of serious medical problems, including pituitary diseases and testicular tumours.

These xenoestrogens are EVERYWHERE and contribute to estrogen dominance. They mimic estrogen, binding to hormone receptors when they enter the body. It is nearly impossible to avoid them, and they are a principal cause of estrogen dominance in men, women, and children.

The most common xenoestrogens include, pesticides, fungicide, solvents, food colouring, commercial chicken and beef, spermicides, detergents, BPA (bisphenol), phthalates, and parabens. Phthalates are found in chemical fragrances such as perfume, hair sprays, and candles, whereas parabens are in personal care products like lotions. BPA is found in everything from plastic bottles to new furniture. All of these chemicals act like estrogen in the body and have caused cancer in animals. In humans, the ill health effects of high chemical estrogen levels include heart problems, behavioural issues, and obesity.

Endogenous estrogen is the kind produced within the body. Hormonal balance is a complicated process, you may have too much of internally produced estrogen for a number of reasons:

- You are overweight. Regardless of gender, fat tissue increases levels of an enzyme called aromatase that turns testosterone to estrogen.
- You are deficient in certain nutrients (magnesium, vitamin D, selenium, zinc). Nutrient deficiencies elevate aromatase significantly. For example, men with vitamin D deficiency have low testosterone and elevated estrogen due to increased aromatization.
- You drink alcohol regularly. Alcohol, especially beer, increases aromatase and it's been repeatedly linked to low testosterone and high estrogen in men.
- Your body isn't metabolizing estrogen effectively due to poor gastrointestinal health, lack of certain nutrients, or low dietary fiber intake. Inability to eliminate estrogen quickly will dramatically increase breast and prostate cancer.

Symptoms of Excessive Estrogen in Men:

- Low sex drive
- Impotency/erectile dysfunction
- Infertility
- Gynecomastia, or "man boobs"
- Weight gain
- Enlarged prostate
- Prostate cancer
- Testicular cancer
- Increase risk of Heart disease

For middle-aged and older men, especially those over age 50, prostate problems are an unpleasant fact of life. It is estimated that half of men in the 50-plus age group suffer from benign prostatic hyperplasia (BPH), an abnormal enlargement of the prostate gland.

This swelling of the prostate usually manifests as urinary problems: urinary frequency, urinary hesitation, reduced urinary flow, etc. The prostate gland is also the most common site for cancer to develop, with over 300,000 new cases in the U.S. in 1996. The medical establishment places the blame for these prostate problems on the male hormones testosterone (T) and dihydrotestosterone (DHT), yet this belief generates an obvious paradox. The highest levels of T/DHT occur in young men, and T/DHT levels drop with aging. Yet prostate problems are almost non-existent in young men, while they increase with age, affecting 90 % of all men by age 85, when T/DHT levels are extremely low.

Most people think of progesterone as a "female hormone." Yet men normally produce progesterone as well, in both their adrenal cortex and testicular tissue. Unfortunately, male progesterone levels drop with aging, just as do male testosterone levels. Severe and prolonged stress also depletes progesterone, since the "state-of-siege" stress hormone cortisol is made from progesterone, as are testosterone, estrogen, aldosterone and other steroid hormones.

One of the most important roles for progesterone is to oppose the many toxic effects of excess estrogen. Progesterone expert Dr. John Lee noted multiple roles for progesterone in antagonizing estrogen and promoting prostate health.

Progesterone inhibits the conversion of testosterone to Dihydrotestosterone (DHT). DHT is a weaker androgen than testosterone, and thus lowers the androgen/estrogen ratio in favour of estrogen. In addition, DHT is a far more potent stimulant of prostate cell growth than testosterone. Both testosterone and progesterone stimulate the activity of a protective gene called "p53." The products of this gene activation are anti-cancer, and promote healthy apoptosis. Apoptosis is a "programmed cell suicide" that plays a key role in preventing cellular overgrowth (e.g., BPH) and cancer. Estrogen, on the other hand, activates a gene called "BCL2" which inhibits healthy apoptosis.

The prostate is embryologically the same as the uterus in the female. Research Studies have shown that when prostate cells are exposed to estrogen, the cells proliferate and become cancerous. When progesterone or testosterone was added, cancer cells die. During the aging process, progesterone levels fall in men, especially after age 60.

The role of progesterone has been severely underestimated in men. Depending on the stage of a woman's menstrual cycle, men can have just as much progesterone in their bodies as women. Most scientific studies have focused on the effects of progesterone on women, and its role in men has been neglected. It's only recently that scientists have started to realize how important this hormone is in men.

The latest studies suggest progesterone is just as important as estrogen and testosterone. In fact, progesterone is a precursor to both of these hormones (meaning both estrogen and testosterone are produced from progesterone), so it plays a big role in deciding the levels of these hormones. Guys with man boobs generally have high estrogen and/or low testosterone. Progesterone works, by lowering estrogen, and raising levels of testosterone.

Progesterone has many of its own effects on the body. In men, the studies suggest that progesterone works a lot like testosterone, so much that it can even be considered a **second male sex hormone**. In a study, published in the book, **The Hidden Structure of Interaction**, researchers found that progesterone and testosterone levels rise and fall together in weekly and monthly cycles. Both testosterone and progesterone levels rise together in response to increased sexual activity in men.

Progesterone is also the most potent known inhibitor of the enzyme 5-alpha-reductase, which converts testosterone into dihydrotestosterone (DHT). DHT is a known cause of male pattern balding, prostatic hyperplasia, and prostate cancer. By blocking 5-alpha-reductase, progesterone promotes higher levels of testosterone in your body.

Not only does progesterone raise levels of and have similar actions to the male hormone testosterone, it also acts against estrogen, much like testosterone does. Progesterone antagonizes the estrogenic effect on your body via multiple different mechanisms. One such mechanism is via regulation of cell metabolism to promote the oxidative pathway. This prevents conversion of the much weaker form of estrogen, estrone, to a more potent form, known as estradiol.

We know for example, that like testosterone, progesterone reduces estrogen-driven cancers like prostate cancer in men, and breast and endometrial cancer in women. As men age, both their levels of testosterone and progesterone decrease, while estrogen levels increase. When high estrogen levels are unopposed by testosterone and progesterone, it leads to a condition called estrogen dominance. Amid the myriad of different problems, symptoms and conditions caused by estrogen dominance, it is also the single most important cause of gynecomastia (man boobs).

Using a progesterone supplement can help reduce prostate size and lessen symptoms of benign prostatic hypertrophy (**BPH**).

The side effects associated with the use of progesterone cream are minimal. Studies reveal a decrease in sperm production when progesterone cream is applied to males. Additionally, progesterone doses not produce feminizing characteristics in males.

Apply 8 – 12 mg daily, Monday through Saturday. It is good to skip one day a week. It is applied to thin skin areas, such as to the inner forearms and sides of trunk. You can get bio identical progesterone creams from a compounding pharmacy.

Since progesterone is a natural substance it can't be patented for sale at high profit margins. That makes pharmaceutical companies uninterested in marketing and promoting progesterone. If pharmaceutical representatives don't market a product to doctors, most doctors tend to be unaware of its benefits.

Here are some natural ways of raising your progesterone levels:- Progesterone is essentially an animal hormone. The only food source of progesterone is placenta. Certain animals eat their placenta after birth which gives them the required progesterone surge.

Eggs
Eggs contain progesterone in abundant amounts. Egg yolk especially is very rich source of progesterone. Women with progesterone deficiency should definitely eat eggs.

Dairy Products
Dairy products such as milk, cheese made from cow's milk contain high amounts of progesterone. Cow's milk is especially rich in progesterone.

Chicken
White meats such as chicken also contain progesterone hormone in small quantity. However, these days, poultry are artificially impregnated with hormones. Consuming such meat may not be the best idea to increase your progesterone levels. Unless you look for free range, grass fed chicken.

Zinc Rich Foods
Red meat, shellfish, turkey can contribute to increasing the levels of progesterone in the body. However, beware of hormone impregnated beef or pork.

Foods With Phyto Progesterone
Phyto progesterone can overcome progesterone deficiency in the body and maintain progesterone-estrogen balance. It is found in some of the following plant sources.

Yams
Yam or wild yam contains certain phytochemicals which act like progesterone when inside the body. However, these yams are not to be confused with sweet potatoes, which are also called yams in some areas. FDA requires you to mention both names yam and sweet potato on the packaging. Hence, make sure you read the label carefully while buying yams.

Vitamin B6 Rich Foods
Foods rich in vitamin B6 such as walnuts, whole grains, fortified cereals and soy milk are good sources of phyto progesterone.

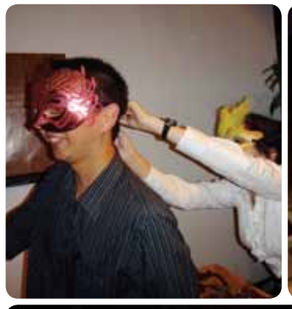
The above foods with progesterone in them must be consumed in moderate amounts only. Excess levels of progesterone may disrupt hormonal balance in the body.

Dr. P.Sivaroshan
Vice President

MAAM 27th Convention, CPD & 28th AGM

Dr Koh Kar Chai CPD Chairman

Through out the years, our Manipal conventions are well known for the fun filled activities which also invariably include our favourite “happy hour” sessions which is a misnomer as the sessions start early morning till late night, though “happy” is an apt word to use.



However, in line with the need to garner CPD points in order to renew our Annual Practicing Certificates, it was time that we Manipalites got serious and CPD activities are now the norm with our activities. During the recent convention, we managed to pack in a full day of CPD lectures before moving on to our AGM.

The morning session was on Renal Anemia which included both a lecture as well as the launch of the Renal Anemia Practice Points for GPs. Came the afternoon, we had a workshop on Infiltration Techniques in Orthopaedics. This included a hands on session involving artificial models of joints.

Our AGM was a serious session, going through the minutes and all other mundane issues affecting our association. Members present were introduced to our forthcoming 2014 Convention which will be on a global level. It is envisaged that there will be a coming together of Manipalites from the medical, dental and engineering fields from all over the world.

Party time commenced soon afterwards with the convention dinner which had the theme, “Masquerade Dance” necessitating our dinner guests to don masks with the premise that they can be naughty without anyone recognising them. But alas, yours truly did not manage to fool anyone under the disguise of the mask.

It was a night full of music, song, dance and food made delicious by the accompaniment of the all too familiar beverage of an intoxicating nature. It was a time of revelry when fellow Manipalites came together to exchange stories of a time when they were much younger, not that they are any older now, at least not in spirit.

This Convention cum AGM cum CPD shows that we Manipalites can mix business with pleasure to the benefit of all concerned, thus dispelling the myth that Manipalites only know how to mix drinks with pleasure.

Medication may seem the most reliable and scientific way to manage health problems, and in some cases it is. But many ailments can be managed more effectively-simply by making some lifestyle changes.

Lifestyle changes can prevent problems and their resultant effects can be much more wide ranging and longer lasting. Exercise, for example, burns energy (which helps control body weight), but it can also improve cardiac efficiency and blood circulation, brain function and mood, and increase insulin sensitivity and bone strength. Likewise FOOD provides plenty of health promoting substances and is one of the most important lifestyle factors that can influence your health. So I will attempt to give you some tips on how to manage common health problems usings simple foods and specifically herbs.

FOOD CURES

COMMON FLU AND COLDS

There's an old joke that says if you treat a cold aggressively, it will be gone in 7days, but if you do absolutely nothing, it will drag on for a full seven days.

YOUR FOOD PRESCRIPTION

1. Water, juices and tea (decaffeinated)

Drinking plenty of water and fluids help keep your mucous membranes moist so they are better able to trap viruses as flu bugs thrive in dried-out throats and nasal passages.

If you have a sore throat, sip your water hot with a bit of honey (to coat your throat) and lemon juice (to shrink swollen throat tissue and help kill off virus cells). You can also add honey and lemon to tea. Gargling warm salt water helps by clearing away dead white cells and increasing blood flow to the throat. Or squirt saltwater into your nostrils one at a time to help clear nasal mucus. Drink fresh orange juice as it contains much more Vitamin C than the ready-to-drink kind as most of the vitamin C gets oxidized in cartons/bottles.

2. Chicken/Vegetable soup

Hot soups raise the temperature in your nose and throat which produces an inhospitable environment for the viruses that prefer a cool and drier area. Hot soups also thins out mucus, making it easier to blow out.

3. Garlic

The pungent cloves of garlic contain allicin, a potent anti-microbial that fends off bacteria,viruses and fungi. Allicin is formed when garlic is chopped or crushed and is easily destroyed by heat.

Not many of us can stand chewing raw garlic so you can chop it and add them to your soups along with onions. Chop garlic first and let it stand for 10mins as it allows the allicin to form and only add garlic to the soup just before serving to reduce the destructive effect of heat on the allicin. You can even take garlic supplements if you don't like it in it's natural form.

4. Spices and spicy condiments

According to Ayuverda, cinnamon, coriander, ginger promotes sweating which help break a fever. You can help unclog stuffy nose by spicing up some dishes with chilli, cayenne pepper or horseradish or even wasabi (Japanese horseradish Paste). Each of these condiments shrink the blood vessels in your nose and throat to relieve congestion. Try this Ayuverdic fever reducer; mix ½ teaspoon each of powdered cinnamon and coriander along with ¼ teaspoon of powdered ginger in a cup of hot water. Allow it to steep for 10mins, then drink.

NUTRIONAL SUPPLEMENTS

1. Vitamin C

Vitamin C doesn't seem to help prevent a cold, but there is plenty of evidence to suggest that taking moderate amounts of vitamin C help shorten the illness period. Vitamin C acts as an antihistamine and an anti-inflammatory to help dry up a runny nose. Look for a vitamin C supplement that contains bioflavinoids- anti-oxidants found in citrus fruits, tea and other foods.

Some practitioners recommend high doses of vitamin C, such as 1000mg or even more but studies show that 250mg of vitamin C is enough to obtain the above effects.

2. Zinc

Taking zinc gluconate or oxalate lozenges every few hours within the first 2 days of a cold can decrease its duration. When in close contact with your mucous membrane its promotes overall immune function.

Sadly taking zinc supplements preventively doesn't seem to do much to keep you from catching a cold.

3. Vitamin E

This anti-oxidant vitamin, another immune system booster has shown in clinical studies to prevent the onset of colds. 200mg daily is recommended.

Foods to avoid

It's always better to skip caffeinated drinks such as coffee, caffeinated tea and cola as these tend to cause dehydration. Lastly, please abstain from alcohol (hate to say this) as we all are aware of the dehydration it causes.

G MAN

Natal Teeth
A CASE REPORT

Dr M.Shanthi [1], Dr Ravi Chandra PV [2], Dr Swetha Reddy [3], Dr Ratna Sothy [4]

[1]*Senior Lecturer*
Department of Paediatric Dentistry

[2]*Professor & HOD*
Department of Conservative & Endodontics

[3]*Senior lecturer*
Department of Paediatric and Preventive Dentistry

[4]*Associate Professor & HOD*
Department of Family Dentistry

Corresponding Author
Dr M.Shanthi
Mahsa University College
Level 6, Block E, PBD
Kuala Lumpur
Malaysia
Phone No - 0166542489
Email Id - **shanthineha2012@gmail.com**

Abstract

Teeth that are present in newborn infant are called “natal teeth”. In some cases, the infant is born without teeth, but eruption may occur in the first four weeks following delivery. These types of teeth are called “neonatal teeth”. They are most commonly the mandibular central incisors, which are the teeth that usually erupt first. The incidence of natal and neonatal teeth is difficult to determine, and reports vary widely, most certainly under reported because in some cultures great fear and negativity was associated with natal teeth. One re-view of 359 recorded cases suggests an incidence of 1 in at least 3,000 births. Natal teeth are more common than neonatal teeth with a ratio of 3:1. Natal teeth might cause discomfort to a nursing mother and present a risk of aspiration and swallowing by the infant if they are loose. Also, they may cause irritation and trauma to the infant’s soft tissues. Under these circumstances, natal teeth need to be extracted. In this article, a case report of infant with two natal teeth is presented. The teeth were present in the mandibular incisor region and excessively mobile. Because the teeth caused problems in the nursing process and ran a risk of aspiration, they were removed and histopathologically examined.

Key words: Natal tooth, Neonatal tooth, Hypoplasia.

Introduction

In 1950, Massler and Savara[1] introduced the now commonly used terms “natal teeth” for teeth present at birth and “neonatal teeth” for teeth that erupt within the first 30 days of life. These terms only define the time of eruption and give no consideration to anatomy, histology or whether the tooth is a component of primary dentition or supernumerary teeth[2,3]. Various terms such as congenital teeth, fetal teeth, pre-deciduous teeth, precociously erupted teeth (Mayhall and Bodenhoff), premature teeth, dentitia praecox and dens connatalis have been used to describe these teeth in the past. The normal eruption of the primary teeth typically begins at six months of age[4]. Natal teeth are present at birth and are usually a benign problem[5].However, natal teeth might interfere with breastfeeding and, if loose and mobile, might be swallowed or aspirated during nursing[6] .The presence of natal and neonatal teeth is definitely a disturbance of biological chronology whose aetiology is still unknown[7]. It has been related to several factors, such as superficial position of the germ[8,9],osteoblastic activity inside the germ area related to the remodelling phenomenon[10], transmission of a dominant autosomal gene[11,12](hereditary), eruption accelerated by febrile states[13] or hormonal stimulation, malnutrition and hypovitaminosis. Natal teeth may also be associated with cleft lip, cleft palate[14]and cyclopia. Most of the time, natal teeth are not related to a medical condition. However, sometimes they may be associated with Ellis-van Creveld Syndrome[15], Hallermann-Streiff syndrome[16], Jadassohn-Lewandowski Syndrome, Soto syndrome[7]. Studies showed that the incidence of occurrence of natal and neonatal teeth is 85% in mandibular incisors and usually in pairs, 11% in maxillary incisors, 3% in mandibular canines and molars and only 1% in maxillary posterior regions. Natal and neonatal cuspids are extremely rare. More than 90% of natal and neonatal teeth are prematurely erupted whereas less than 10% are supernumerary. With respect to gender, there was no difference in prevalence between males and females. However, a predilection for females was cited by Kates et al[17] (1984) reporting a 66% proportion for females against a 31% proportion for males. A case report is presented in this article where an infant was born with two natal teeth.

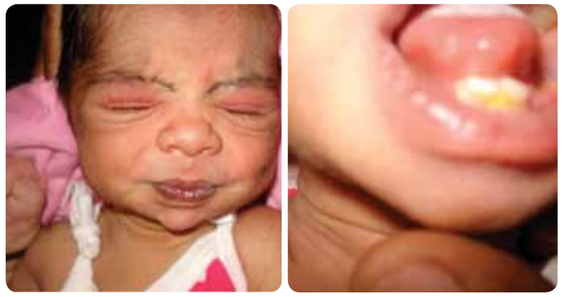


Figure 1& 2: Infant with natal teeth

Case Report

A 12 days old female infant was brought to department of paediatric dentistry by her parents with the chief complaint of teeth in her lower jaw. Mother also complained that child exhibits pain during suckling and could not nurse properly (Figure 1&2). There was no familial history of any similar oral manifestation. Medical history revealed that the infant was delivered naturally following a 40-week pregnancy. There was no evidence of systemic disease, congenital anomalies or syndromes. Intra-oral examination revealed calcified teeth-like structures, whitish yellow in colour and exhibit grade II mobility are present corresponded to those of teeth 71 and 81. The structures were smaller in overall dimensions as compared to the corresponding primary teeth. The baby seemed to be uncomfortable and mouth was kept open during feeding and hence was spoon fed. Examination of the rest of intra oral mucosa revealed no other lesions. Due to lack of co-operation from the baby, intraoral radiographs could not be taken. The teeth were diagnosed as “natal teeth” since it was present in the infant’s mouth at the time of the delivery. It was decided to extract the mobile natal teeth for two reasons: a) to prevent aspiration and b) to ensure proper feed for the baby. Extraction was done with minimal blood loss and haemostasis was readily achieved and teeth were send for histological examination. The removed natal teeth had dimensions of 5 mm to 4 mm and the root development had been incomplete. It also had a hypoplasic appearance (Figure 3). Histological report suggests normal enamel with enamel lamellae and dentin with dentinal tubules with prominent terminal branching with large vascular pulp (Figure 4). There was no evidence of root formation. The features were suggestive of natal teeth. After 2 days of extraction infant was re-evaluated, recovery was satisfactory and feeding was normal.

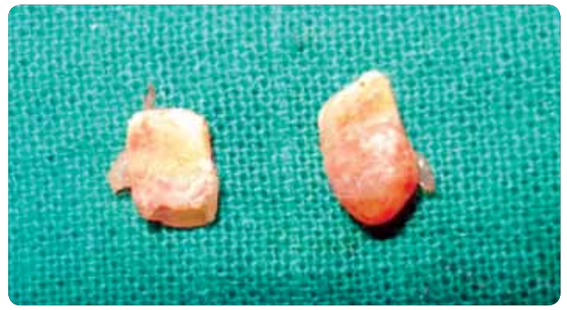


Figure 2: Extracted natal teeth

Figure 3: Histological appearance of natal teeth

DISCUSSION

Normally primary teeth begin to erupt at age of six months[18] which is a milestone both in terms of functional and psychological changes in the child’s life and in emotional terms for the parents. The expectations about the eruption of the first teeth are greater and even more when the teeth appear early in the oral cavity. In rare cases, the chronology to tooth eruption is significantly altered and the first teeth are present at birth or will emerge shortly after birth.

On the basis of clinical characteristics, these teeth were then classified into: Mature—when they are fully developed in shape and comparable in morphology to the primary teeth; immature—when their structure and development are incomplete. Hebling (1997)[19] recently classified natal teeth into 4 clinical categories: 1. Shell-shaped crown poorly fixed to the alveolus by gingival tissue and absence of a root; 2. solid crown poorly fixed to the alveolus by gingival tissue and little or no root; 3. eruption of the incisal margin of the crown through gingival tissue; 4. oedema of gingival tissue with an un erupted but palpable.

Clinically, the natal teeth are small or of normal size, conical or of normal shape. They may reveal an immature appearance with enamel hypoplasia and small root formation. Natal teeth may exhibit a brown yellowish or whitish opaque color. They are

attached to a pad of soft tissue above the alveolar ridge. The dimensions of the crown of these teeth are smaller than those of the primary teeth under normal conditions. There is some fear that a natal tooth could come loose, and the baby could aspirate (inhale) it. However, this appears to be rare

Most frequent difficulty is during feeding including Riga-Fede disease[20] where the presence of natal or neonatal teeth in association with nursing or suckling leads to ulceration on the ventral surface of tongue. Prolonged gingival irritation from natal or neonatal teeth may cause localized inflammation of the gingiva or fibrous hyperplasia.

Histologically, the majority of natal teeth have dysplastic or hypomineralized enamel, irregular dentin and osteo dentin in the cervical portions, and interglobular dentin in the coronal regions[21]. The incisal edge might lack enamel. Both Hertwig's sheath and cementum might be absent. There is often an increase in the number of dilated blood vessels in the pulpal tissue. Root formation is often incomplete.

Differential diagnosis may include bohn's nodules and epulis might be confused with natal teeth. Bohn's nodules are usually multiple and found along the buccal and lingual aspects of the mandibular and maxillary ridges[22]. These remnants of mucus-gland tissue are firm with whitish rice-like appearance, asymptomatic, do not interfere with feeding and are spontaneously shed within several weeks. Epulis are tumour-like growths of the gum that might be either sessile or pedunculated, and are reactive rather than neoplastic lesions. Other differential diagnoses include lymphangioma and hamartoma of the alveolar ridge. A dental roentgenogram is always indicated to differentiate the premature eruption of a primary deciduous teeth from a supernumerary tooth[5,6] Difficulty in obtaining a radiographic appraisal of the region, due to the child's age, prevented immediate confirmation of whether the tooth in question belonged to the normal series or was supernumerary. However, with subsequent patient follow-up and eruption of the remaining teeth, made possible to confirm that the teeth belong to normal complement of primary dentition.

Regarding management of natal teeth, no intervention is necessary if teeth is asymptomatic and does not interfere with breastfeeding. Teeth extraction if indicated should be planned carefully due to its several complications like post extraction haemorrhage and premature loss of primary teeth may cause consequent malocclusion in permanent dentition. Consultation with a paediatric dentist is strongly recommended. Extraction of the teeth should be followed by curettage of the socket if necessary to prevent continued development of the cells of the dental papilla[23]. Failure to curette the socket might result in the eruption of odontogenic remnants and necessitate future treatment[24].

Paediatricians are usually, the first who find natal teeth and early consultation with paediatric dentist can prevent complications. Although their occurrence is rare, it is still possible to encounter natal teeth in daily practice. In these cases, it is important to make the appropriate decision, taking into consideration the adverse effects these teeth may have for both the infant and the mother.

References

1. Massler M, Savara BS. Natal and neonatal teeth. A review of 24 cases reported in the literature. J Paediatr 1990; 36:349–59.
2. Anderson RA. Natal and neonatal teeth: Histological investigation of two black females. J Dent Child 1982;49:300-3.
3. Alvarez MP,Crespi PV, Shanske AL. Natal molars in Pfeiffer syndrome type 3:A case report. J Clin Pediatr Dent 1993;18(1):21-4.
4. Uzamis M, Olmez S, Ozturk H, et al. Clinical and ultra structural study of natal and neonatal teeth. J Clin Pediatr Dent 1999;23:173-177.
5. Leung AKC. Natal teeth. Am J Dis Child 1986;140:249-251.
6. Cunha RF, Boer FAC, Torriani DD, et al. Natal and neonatal teeth: review of the literature. American Academy of Pediatric Dentistry 2001;23:158-162.
7. Bigeard L, Hemmerle J, Sommermater JI. Clinical and ultra structural study of the natal tooth: enamel and dentin assessments. J Dent Child1996; 63:23-31.
8. Boyd, JD, Miles, AE. Erupted teeth in Cyclops foetus. Br Dent J 1951;91:173.
9. Shafer WG, Hine MK, Levy BM. Distúrbios do desenvolvimento das estruturas bucais e parabucais. In: Tratado de Patologia Bucal. 4a Ed. Rio de Janeiro: Guanabara;1985:2-79.
10. Jasmin JR, Clergeau-Guerithalt. A scanning electron microscopic study of the enamel of neonatal teeth. J Biol Buccale 1991; 19:309-314.
11. Hals H. Natal and neonatal teeth. Oral Surg Oral Med Oral Pathol 1957; 10:509-521.
12. Bodenhoff J. Natal and neonatal teeth. Dental Abstr 1960; 5:485-488.
13. Leung AKC. Management of natal teeth(letter). JADA1987; 114:762
14. Cristiane Machado De Almeida, Marcia Ribeiro Gomida. Prevalence of natal/neonatal teeth in cleft lip and palate infants. Cleft palate-cranio facial journal 1996;33(4):297-299.
15. Chow MN. Natal and neonatal teeth. JADA 1980; 10:215-216.
16. Fonseca MA, Mueller WA. Hallermann-Streiff syndrome:case report and recommendations for dental care. J Dent Child 61:334-337, 1995.
18. Kates GA, Needleman HL., Holmes LB. Natal and neonatal teeth: A clinical study. J Amer Dent Assoc 1984; 109: 441-443.
19. Gorlin RJ, Goldman HM, Thoma K. In: Patologia Oral. 4th Ed. Barcelona: Salvatore; 1973:pp.163-166.
20. Hebling J, Zuanon ACC, Vianna DR.Dente Natal—A case of natal teeth. Odontol Clín1997; 7:37-40.
21. Hedge R. Sublingual traumatic ulceration due to neo natal teeth(Riga-Fede Disease). J Indian Soc Pedo Prev Dent March 2005;51-52.
22. Zhu J, King D. Natal and neonatal teeth. J Dent Child. 1995;62: 123-128.
23. Ziai MN, Bock DJ, Do Silveira A et al. Natal teeth: A potential impediment to nasoalveolar molding in infants with cleft lip and palate. The Journal of Craniofacial Surgery. 2005;16:262-266.
24. Seminario AL, Ivancakova R. Natal and neonatal teeth. Acta Medica 2004;47:229-233.
25. To EW. A study of natal teeth in Hong Kong Chinese. Int J Paediatr Dent 1991;1:73-76.

Diagnosis, Treatment and Management **of Seizures**

Part II of Four Parts
– Differntial Diagnosis and Investigations

R.C. Krishna MD, Consultant Neurologist, New York
(Manipal Alumni, Year of 1982)

DIFFERENTIAL DIAGNOSIS:

Syncope

Syncope may not be benign in this population. Causes include

- hypovolemia (e.g., blood loss, diuretics)
- decreased arterial or venous tone (e.g., vasodilators, autonomic dysfunction)
- limited cardiac output (e.g., aortic stenosis, arrhythmias)
- inappropriate baroreceptor reflexes (e.g., emotional situations, Valsalva maneuver)

Upright posture at onset and a typical warning of lightheadedness, nausea, warmth, and fading vision and hearing are common but not universal, and stroke patients may have difficulty reporting these sensations. Cardiac arrhythmias, some potentially fatal, may lead to sudden loss of consciousness, even in the supine position. In these patients, palpitations may be noted if onset is not sudden or at other times.

A few myoclonic jerks commonly accompany syncope, and tonic stiffening (as well as more complex movements) may also occur, especially if the head is kept upright. The pathophysiology of such convulsive syncope is release of brain stem activity from cortical influence rather than an electrocortical seizure.
In addition, syncope can rarely occur as a vertebrobasilar TIA, especially when flow through one or both carotids is severely compromised[55].

Migraine

The episodic headache and other symptoms of migraine sometimes are preceded by an aura, 5 to 60 minutes of cortical or brain stem dysfunction. Migraine auras are distinguished from seizures by their more gradual, often visual, warning and longer duration. Associated symptoms include nausea or vomiting, photophobia, and phonophobia. Headache usually, but not always, follows. "Migraine equivalents" without headache are more common in the elderly and are occasional causes of TIA-like symptoms or of actual TIAs. Loss of consciousness is rare but may occur with so-called basilar migraine.

It must be recognized that migraine and epilepsy can coexist, that headaches often follow epileptic seizures, and that a migraine attack can, rarely, precipitate a seizure.
Migraine is discussed more fully in Migraine and epilepsy[55].

Transient ischemic attacks (TIAs)

TIAs themselves can be confused with seizures, although they have characteristic symptoms and (if prolonged enough to persist to the time of evaluation) signs consistent with known vascular territories. They typically evolve over minutes and last minutes to hours.

Jackson was first to point out that seizures generally manifest "positive" symptoms, such as stiffening or shaking in the motor system or hallucinations in the special sensory modalities, whereas ischemic symptoms are usually "negative" (e.g., weakness, sensory loss). Exceptions to this rule include ischemic paresthesias, rare motor inhibitory seizures, and "limb-shaking" TIAs.

"Limb-shaking TIAs" are rare manifestations of severe carotid stenosis. They can be distinguished from motor seizures mainly by

- their consistently postural character, usually occurring promptly on standing
- their involvement of arm, leg, or both, sparing facial muscles and cognition

On the other hand, rare seizure types, such as ictal amaurosis (total or hemianopic, not monocular) or aphasic status epilepticus, require EEG to be distinguished from TIAs.

Patients with cerebral amyloid angiopathy have been noted to have transient events for which the underlying pathophysiology has not been established; no evidence of microscopic bleeding, transient ischemia, or epilepsy has been discovered. The duration is more similar to that of TIAs than of the other potential etiologies[55].

Movement disorders

Movement disorders can usually be readily distinguished from seizures because they are typically long-lasting and associated with preserved consciousness. Although usually bilateral, they may be unilateral after infarction, particularly infarction of the basal ganglia, thalamus, or subthalamus.
In patients with depressed mental status, toxic or metabolic processes may at times produce movement disorders, such as extrapyramidal reactions to neuroleptics or multifocal myoclonus in uremia. Although the multifocality is not typical of seizures, and the movements are not time-locked to epileptiform discharges on EEG, such discharges are often present and imply "cortical irritability" that may later be manifest as clear-cut seizures.

Asterixis, an abrupt, repetitive loss of muscle tone during maintenance of certain postures, often occurs in patients with depressed mental status due to hepatic or other encephalopathies. After cerebral or brain stem stroke, it can occur unilaterally, contralateral to the lesion. Its positional nature usually distinguishes it from motor seizures, although rare cases of epileptic asterixis have been reported.

Antiepileptic drugs, especially at toxic levels, also can produce involuntary movements, such as dystonia with phenytoin or tremor with valproate[55].

Sleep disorders

Sleep disorders may result in microsleeps or more prolonged sleep attacks due to any cause of hypersomnolence. The most common cause is disrupted sleep from obstructive sleep apnea, a condition which (like stroke) is common among patients with hypertension, atherosclerosis, and obesity. Furthermore, many thrombotic strokes, in particular, occur during sleep and are characterized by patients' awakening with a new deficit.

The second most common medical reason for sleep deprivation leading to sleep attacks is the movement disorder termed periodic limb movements in sleep. These movements usually involve one or both lower limbs, with dorsiflexion of the ankle and flexion of the knee and hip, and are sustained for 1 to 2 seconds and repeated approximately every one-half minute. This condition is associated with restless legs syndrome, a need to walk around or otherwise move the legs, often in response to a crawling sensation felt when lying in bed or otherwise at rest.
Narcolepsy is a more dramatic but much less common cause of hypersomnolence, usually associated with symptoms of hypnagogic or hypnopompic hallucinations, sleep paralysis, and especially cataplexy. Onset is rare after early adulthood, although symptomatic cases related to brain stem trauma, demyelination, and, rarely, infarction have been reported. Although microsleeps may occur without warning, more prolonged sleep attacks are usually preceded by a subjective feeling of sleepiness. Unlike in complex partial seizures, the eyes are usually closed, and the patient may be awakened with stimulation.

Parasomnias can be difficult to distinguish from nocturnal seizures. The classic parasomnias of slow-wave sleep, sleepwalking, and night terrors are conditions of childhood, although the former sometimes persists into adulthood. They are not associated with stroke. In the population at risk for stroke, nocturnal wandering is more likely to occur after a complex partial seizure, and patients usually return to normal awareness rapidly, if stimulated.

A parasomnia of rapid eye movement (REM) sleep, REM behavior disorder, by contrast, typically begins late in life and may be associated with extrapyramidal syndromes such as Parkinson's disease. Cases in patients with stroke may be coincidental, given the typical ages for both disorders. These attacks consist of partial arousals from REM with a loss of the usual muscle atonia, resulting in "acting out" of dreams, often in a violent manner that may reflect defensive behavior prompted by a frightening dream. The timing of the spells later in the night, when REM periods are longer, can be a useful clue. Polysomnography with additional EEG electrodes may be necessary to distinguish this disorder from nocturnal partial seizures.

Sleep disorders are discussed more fully in Sleep disorders and epilepsy.

Toxic-metabolic disturbances

Altered behavior due to toxic-metabolic disturbances usually lasts much longer than changes due to seizures. The possibility of certain causes of encephalopathy (e.g., hyperglycemia, hypoglycemia, hyponatremia, hypocalcemia, hypomagnesemia) precipitating acute symptomatic seizures can further confuse the picture.

The EEG, although typically showing diffuse slowing, can, at times, display multifocal sharp waves or the triphasic wave pattern, which may be difficult to distinguish from the generalized sharp-slow complexes of non-convulsive generalized SE.

These disturbances are discussed more fully in Metabolic disorders and seizures.

Psychogenic nonepileptic seizures

Distinguishing psychogenic nonepileptic seizures (NESs), also known as pseudoseizures or psychogenic seizures, from epileptic seizures is a major undertaking of epilepsy monitoring units. Evidence suggests that this phenomenon is most common in young adults, especially women, but there are few data on the frequency and manifestations in elderly patients, and it may be underdiagnosed.

Patients with a previous psychiatric history are likely to be at higher risk, as may be those with depression or other psychiatric complications of stroke, but data are unavailable.

In general, compared to epileptic seizures, psychogenic NESs display less stereotypy, longer duration, a more waxing and waning nature, and nonphysiologic progression. Eyes tend much more often to be closed during unresponsive periods. Environmental precipitants are more likely and injuries less likely, although there are many exceptions. Unlike epileptic seizures, NES do not arise from sleep, although they may arise from "pseudosleep," and video-EEG monitoring may be required.

Increased intracranial pressure

Transient increases in intracranial pressure can result in temporary alteration in awareness or, less often, focal neurologic dysfunction. The classic situations are a posterior fossa mass or intermittent obstruction of ventricular flow by a third ventricular tumor, but acute hydrocephalus can occur in patients after subarachnoid hemorrhage or after ischemic or hemorrhagic stroke in the cerebellum.

Patients with cerebral edema as a result of hemispheric infarction are likely to show catastrophic focal deficits followed by progressive obtundation.

Headache is common in all of these scenarios, if the patient is alert and articulate enough to report it.

DIAGNOSTIC STUDIES

Laboratory screening

Causative metabolic abnormalities — A patient with a first epileptic seizure typically has screening laboratory studies to exclude a metabolic or toxic cause for an acute symptomatic seizure.

Laboratory evaluations that are appropriate for the evaluation of a first seizure include electrolytes, glucose, calcium, magnesium,

hematology studies, renal function tests, liver function tests, and toxicology screens, although the likelihood of finding a relevant abnormality in unselected patients is low[13].

Prolactin — Serum prolactin assessment has limited utility as a diagnostic test for epileptic seizures[14]. The serum prolactin concentration may rise shortly after generalized tonic-clonic seizures and some partial seizures. Typically, a level is drawn 10 to 20 minutes after the event and compared with a baseline level drawn six hours later. Criteria for abnormality are not well established; many investigators use twice the baseline level.

Other seizure biomarkers — Other serum markers have been used to help distinguish epileptic seizures from syncope, psychogenic nonepileptic seizures, and other physiologic events. These include: creatine phosphokinase (CPK), cortisol, white blood cell count, lactate dehydrogenase, pCO2, ammonia, and neuron specific enolase[15-18]. CPK levels in particular are often elevated after generalized tonic-clonic seizures, but not after partial seizures. The later rise and prolonged elevation, up to 24 hours postictally, makes this test somewhat more useful in the outpatient setting. However, a defined threshold level for abnormality, sensitivity, and specificity remain to be determined for CPK, as for other serum markers[19,20].

Lumbar puncture — A lumbar puncture is essential if the clinical presentation is suggestive of an acute infectious process that involves the central nervous system or the patient has a history of a cancer-type that is known to metastasize to the meninges[21]. In other circumstances the test is not likely to be helpful and may be misleading since a prolonged seizure itself can cause cerebrospinal fluid pleocytosis.

Lumbar puncture should only be performed after a space occupying brain lesion has been excluded by appropriate neuroimaging studies.

Electroencephalography — The electroencephalogram (EEG) is an essential study in the diagnostic evaluation of epileptic seizures[13, 22]. If abnormal, the routine, interictal EEG may aid in supporting the diagnosis of epileptic seizures and may also suggest whether a patient has generalized or partial seizures.

Use of sleep deprivation and provocative measures during the test, such as hyperventilation and intermittent photic stimulation, increase the yield[23, 24].

However, a normal EEG does not rule out epilepsy, and many EEG abnormalities are nonspecific. As an example, diffuse slowing may also occur with a wide variety of encephalopathies or in association with some medications, especially at high dosages. Epileptiform abnormalities are usually more informative than less specific changes.

Specialized Techniques — Specific methods can be employed to improve the detection of IEDs and the sensitivity of the test.

Routine activating techniques — A standard routine EEG usually includes hyperventilation and photic stimulation.

- Hyperventilation increases the rate of generalized discharges in childhood absence epilepsy and other generalized epilepsies[27]. One study in 80 patients undergoing long-term EEG monitoring found that hyperventilation had an activating effect on EEG recording, but only in those patients whose AEDs were being tapered[28].
- Photic stimulation induces IEDs in some individuals with idiopathic generalized epilepsy, and infrequently in patients with focal seizures arising from the occipital lobe[29,30].

Sleep and sleep deprivation — Sleep is a neurophysiologic activator of epilepsy; 20 to 40 percent of epilepsy patients with an initial normal recording will have IEDs on a subsequent recording that includes sleep[31-33]. Sleep is sometimes captured on a routine EEG, but sleep deprivation increases this likelihood. Sleep is also usually captured on prolonged EEG monitoring and alternatively, can be induced by administration of a sedative, usually chloral hydrate.

When sleep-deprived EEG was compared to 24-hour ambulatory EEG monitoring in 46 patients with "presumed epilepsy", IED detection was similar (24 versus 33 percent)[34]. However, clinical seizures were also captured in 15 percent of the ambulatory EEGs and in none of the sleep-deprived EEG.

It is generally agreed that a follow-up EEG in a patient with possible epilepsy and a normal routine EEG should include sleep. Clinicians can order full or partial sleep deprivation, but it is not clear how much this affects the yield[35]. The choice of test (sleep-deprived, sleep with oral sedation, or prolonged EEG monitoring) should be individualized to the patient's circumstances. Because sleep deprivation can be quite disruptive and carries some risk of seizure exacerbation, we generally prefer 24-hour-ambulatory EEG studies over sleep-deprived studies.

Video-EEG monitoring — Video electroencephalography (EEG) monitoring is the synchronous recording and display of EEG patterns and video-recorded clinical behavior. Short recordings of several hours can be performed as an outpatient in an EEG laboratory, while longer recordings of 24 hours or more are generally done in a hospital inpatient setting.

Advantages of video-EEG — While considerably more expensive than aEEG, there are several advantages to this test, including the continuous video-monitoring that allows for analysis of both the clinical and electrographic features of a recorded event[36]:

- Staff trained in EEG monitoring may detect seizure activity on remote viewing of the video or EEG at the nursing or monitoring station. They can interact with and test the patient during a spell or seizure aura, and push the event button. This can be very important for characterizing impairment of awareness and subtle lateralizing features, including postictal aphasia or hemiparesis.
- Both video and EEG quality are usually superior with inpatient, monitored recordings. Video cameras in inpatient units usually allow infrared viewing of patients in the dark, as well as remote control of the camera, including zooming in as needed, from the nursing or monitoring station. As a result, when a seizure occurs, subtle clinical features with lateralizing importance can be better appreciated, such as dystonic posturing, eye deviation, facial clonus, postictal nose-wiping, brief Todd's paresis, etc. Video can also help identify artifacts produced by nonseizure-related rhythmic movements (blinking, chewing, toothbrushing, scratching) that can mimic seizures on EEG
- Electrode application can be more frequently monitored and maintained, limiting artifact. Additional electrodes, such as inferior temporal electrodes, are impractical in the outpatient setting, and can be more easily monitored and maintained in the inpatient setting. These electrodes can provide information that would be unavailable from the standard electrode array.

Neuroimaging — A neuroimaging study should be done to exclude a structural brain abnormality if the patient's first seizure was clearly not a provoked seizure[13,22]. Brain magnetic resonance imaging (MRI) is preferred over computed tomography (CT) to identify specific lesions such as cortical dysplasias, infarcts, or tumors.

Nevertheless, a brain CT scan is suitable to exclude a mass lesion, hemorrhage, or large stroke under emergency situations or if an MRI is unavailable or contraindicated (eg, in patients with pacemakers, non-compatible aneurysm clips, or severe claustrophobia). Relevant findings included intracranial hemorrhage, brain abscess, and tumor.

In young to middle-aged adults, common MRI findings are mesial temporal sclerosis, sequelae of head injury, congenital anomalies, brain tumors, cysticercosis, and vascular lesions. In the elderly, MRIs often reveal strokes, cerebral degeneration, or neoplasms. However, up to 50 percent of patients, regardless of age, have normal neuroimaging studies. Also, while structural abnormalities on brain MRI or CT usually suggest a symptomatic, focal-onset epilepsy syndrome, these findings should not be interpreted in isolation. Many MRI findings are nonspecific and may be incidental[25,26].

References

1. Chang BS, Lowenstein DH. Epilepsy. N Engl J Med 2003; 349:1257.
2. Vossler, DG. Nonepileptic seizures of physiologic origin. J Epilepsy 1995; 8:1.
3. Alper K, Devinsky O, Perrine K, et al. Psychiatric classification of nonconversion nonepileptic seizures. Arch Neurol 1995; 52:199.
4. Bortz, JJ. Nonepileptic seizures: issues in differential diagnosis and treatment. CNS Spectrums 1997; 2:20.
5. uptodate.com/contents/overview-of-the-classification-etiology-and-clinical-features-of-pediatric-seizures-and-epilepsy
6. Schachter SC. Iatrogenic seizures. Neurol Clin 1998; 16:157.
7. Schold C, Yarnell PR, Earnest MP. Origin of seizures in elderly patients. JAMA 1977; 238:1177.
8. Cleary P, Shorvon S, Tallis R. Late-onset seizures as a predictor of subsequent stroke. Lancet 2004; 363:1184.
9. Annegers JF, Hauser WA, Coan SP, Rocca WA. A population-based study of seizures after traumatic brain injuries. N Engl J Med 1998; 338:20.
10. Temkin NR. Antiepileptogenesis and seizure prevention trials with antiepileptic drugs: meta-analysis of controlled trials. Epilepsia 2001; 42:515.
11. Beghi E, Carpio A, Forsgren L, et al. Recommendation for a definition of acute symptomatic seizure. Epilepsia 2010; 51:671.
12. Riggs JE. Neurologic manifestations of electrolyte disturbances. Neurol Clin 2002; 20:227.
13. Krumholz A, Wiebe S, Gronseth G, et al. Practice Parameter: evaluating an apparent unprovoked first seizure in adults (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society. Neurology 2007; 69:1996.
14. Shukla G, Bhatia M, Vivekanandhan S, et al. Serum prolactin levels for differentiation of nonepileptic versus true seizures: limited utility. Epilepsy Behav 2004; 5:517.
15. Willert C, Spitzer C, Kusserow S, Runge U. Serum neuron-specific enolase, prolactin, and creatine kinase after epileptic and psychogenic non-epileptic seizures. Acta Neurol Scand 2004; 109:318.
16. Pritchard PB 3rd, Wannamaker BB, Sagel J, Daniel CM. Serum prolactin and cortisol levels in evaluation of pseudoepileptic seizures. Ann Neurol 1985; 18:87.
17. Shah AK, Shein N, Fuerst D, et al. Peripheral WBC count and serum prolactin level in various seizure types and nonepileptic events. Epilepsia 2001; 42:1472.
18. Hung TY, Chen CC, Wang TL, et al. Transient hyperammonemia in seizures: a prospective study. Epilepsia 2011; 52:2043.
19. Wyllie E, Lueders H, Pippenger C, VanLente F. Postictal serum creatine kinase in the diagnosis of seizure disorders. Arch Neurol 1985; 42:123.
20. Petramfar P, Yaghoobi E, Nemati R, Asadi-Pooya AA. Serum creatine phosphokinase is helpful in distinguishing generalized tonic-clonic seizures from psychogenic nonepileptic seizures and vasovagal syncope. Epilepsy Behav 2009; 15:330.
21. Krumholz A, Wiebe S, Gronseth G, et al. Practice Parameter: evaluating an apparent unprovoked first seizure in adults (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society. Neurology 2007; 69:1996.
22. Fountain NB, Van Ness PC, Swain-Eng R, et al. Quality improvement in neurology: AAN epilepsy quality measures: Report of the Quality Measurement and Reporting Subcommittee of the American Academy of Neurology. Neurology 2011; 76:94.
23. Shinnar S, Kang H, Berg AT, et al. EEG abnormalities in children with a first unprovoked seizure. Epilepsia 1994; 35:471.
24. Leach JP, Stephen LJ, Salveta C, Brodie MJ. Which electroencephalography (EEG) for epilepsy? The relative usefulness of different EEG protocols in patients with possible epilepsy. J Neurol Neurosurg Psychiatry 2006; 77:1040.
25. Ramirez-Lassepas M, Cipolle RJ, Morillo LR, Gumnit RJ. Value of computed tomographic scan in the evaluation of adult patients after their first seizure. Ann Neurol 1984; 15:536.
26. Betting LE, Mory SB, Lopes-Cendes I, et al. MRI reveals structural abnormalities in patients with idiopathic generalized epilepsy. Neurology 2006; 67:848.
27. Seneviratne U, Cook M, D'Souza W. The electroencephalogram of idiopathic generalized epilepsy. Epilepsia 2012; 53:234.
28. Jonas J, Vignal JP, Baumann C, et al. Effect of hyperventilation on seizure activation: potentiation by antiepileptic drug tapering. J Neurol Neurosurg Psychiatry 2011; 82:928.
29. Pillai J, Sperling MR. Interictal EEG and the diagnosis of epilepsy. Epilepsia 2006; 47 Suppl 1:14.
30. Seneviratne U, Cook M, D'Souza W. The electroencephalogram of idiopathic generalized epilepsy. Epilepsia 2012; 53:234.
31. Tartara A, Moglia A, Manni R, Corbellini C. EEG findings and sleep deprivation. Eur Neurol 1980; 19:330.
32. Roupakiotis SC, Gatzonis SD, Triantafyllou N, et al. The usefulness of sleep and sleep deprivation as activating methods in electroencephalographic recording: contribution to a long-standing discussion. Seizure 2000; 9:580.
33. Mattson RH, Pratt KL, Calverley JR. Electroencephalograms of epileptics following sleep deprivation. Arch Neurol 1965; 13:310.
34. Liporace J, Tatum W 4th, Morris GL 3rd, French J. Clinical utility of sleep-deprived versus computer-assisted ambulatory 16-channel EEG in epilepsy patients: a multi-center study. Epilepsy Res 1998; 32:357.
35. Glick TH. The sleep-deprived electroencephalogram: evidence and practice. Arch Neurol 2002; 59:1235.
36. Worrell GA, Lagerlund TD, Buchhalter JR. Role and limitations of routine and ambulatory scalp electroencephalography in diagnosing and managing seizures. Mayo Clin Proc 2002; 77:991.
37. Schachter SC. Advances in the assessment of refractory epilepsy. Epilepsia 1993; 34 Suppl 5:S24.

Dr. R.C. Krishna is a Consultant Neurologist in New York and was in the 1982 batch of KMC, Manipal. He is an invited speaker for the 1st Global Manipal Alumni Health Sciences Convention, in Kuala Lumpur from the 7th to the 8th of August, 2014

theSun
Typhoon Haiyan Relief Fund

"It did not take us too long to decide to set up a fund-raising campaign as it was out of compassion for the needy that moved us to contribute to the victims of Typhoon Haiyan. This should be a similar reason for everyone out there to contribute to this fund,"

said the alumni's president, Dr Nirmal Singh.

(From left) theSun's financial controller Ricky Ng, theSun's managing editor Freddie Ng, Dr Nirmal and alumni assistant secretary Dr Philip George at the mock cheque presentation at theSun's office. SUNPIX

PETALING JAYA (Nov 18, 2013):

It took Manipal Alumni Association Malaysia just one day to raise RM30,000 for theSun Typhoon Haiyan Relief Fund.

Nirmal said the funds were mainly contributed by colleagues and friends of the alumni members.

"The fund-raising will continue. We won't stop at this amount. However, we hope to speed things up as the victims in the affected area are in need of medical support," he said.

The alumni, which currently has 1,000 members, is calling out to potential members to register as alumni members.

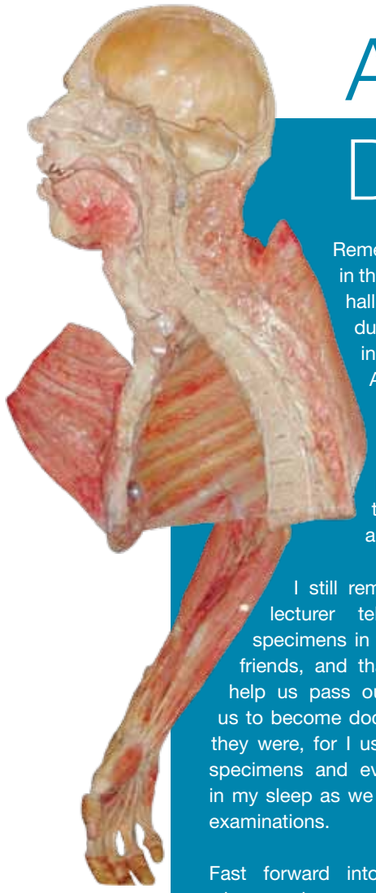
"We have potentially 7,000 members nationwide, but only 1,000 are officially registered. We can raise more funds if our alumni numbers grow. We welcome them to come forward in joining us in this worthy cause," he said.

Nirmal also urged all Malaysians to come forward and give aid to the Philippines.

"They are our neighbour, and there should not be any show of apathy towards such a crisis happening to a neighbouring country," he said.

To date, theSun Typhoon Haiyan Relief Fund has successfully raised RM80,000.

These contributions will be channelled to Mercy Malaysia for emergency medical support purposes. These include purchasing of medical supplies, fuel, water and food supplies for volunteers.



Anatomy DAYS

Remember the days spent in the anatomy dissecting hall day in and day out during our early years in the medical course? As if that was not enough, we used to spend hours and hours in the anatomy museum studying the well preserved anatomy specimens.

I still remember my anatomy lecturer telling us that the specimens in the museum are our friends, and that they are there to help us pass our exams and allow us to become doctors. Friends indeed they were, for I used to memorise the specimens and even dreamt of them in my sleep as we near the date of the examinations.

Fast forward into the present time where we have a sudden mushrooming of medical institutions with the sudden deluge of medical students. Cadavers are an expensive commodity and not many lucky students get to spend enough time with a human cadaver to learn the secrets of human anatomy. Many institutions resort to importing cadavers for their students if they are not able to arrange for cadavers from the Ministry of Health, which are mainly unclaimed corpses.

Some institutions also resort to artificial anatomical models. With the modern technique of preserving human body parts through plastination, present day students have access to well preserved anatomy specimens for their study.

Dr Koh Kar Chai

Ever heard of the Silent Mentor Programme? I was informed that it is a voluntary donation of the human body to be used by medical students on the demise of the donor. Presumably, it would obviate the need to import cadavers from overseas.

I was then asked what we did with the remains after the medical students had carved up the cadaver. Some of us may remember the sand pit outside our anatomy museum where the remains were buried. As to the claim that the remnants were fed to a crocodile that was kept in the museum, I don't think that crocodiles would favour meat that has been preserved in formalin.

This brought up the subject of respect towards a human body that has been dedicated by the living person for the use of the medical fraternity on his/her demise. It is not an easy decision to make after envisioning one's own body being disembowelled and dismembered in the process of study by the students.

However, I need to clarify that the Silent Mentor Programme is not about donating a human cadaver for the use of medical students to study anatomy. It is about having unpreserved cadavers which will allow our trainee doctors to learn procedures which would otherwise be only possible with a living patient. In the Silent Mentor Programme by UMMC's Minimally Invasive Laparo-Endoscopic Surgery Training Centre, donated bodies of the recently deceased are used in simulation programmes. Due respect is given to the silent mentors after each session with prayers offered. The bodies are covered up decently during the simulation. At the completion of each programme, the bodies will be prepared to as near natural appearance as possible before being given back to the family of the deceased. Of utmost importance here is the respect and gratitude that is given to the Silent Mentors for their selfless donation of their bodies for the sake of modern medicine.

In the words of a silent mentor, 'It is better that mistakes are made on my lifeless body than a single mistake made on a living patient"

Manipalites in the **Media**

Regn, No: 377/86 WP

MANIPAL ALUMNI ASSOCIATION MALAYSIA

7A, Jalan Telawi Lima,
Bangsar Baru, 59100 Kuala Lumpur
Tel: 03-2282 7355 Fax: 03-2282 8355

Membership No: _____ Name: _____ NRIC No: _____

Home No: _____ Office No: _____ Office No: _____

Home Address: _____

_____

Office Address: _____

_____

Email: _____

_____
Member Signature

Update Form

Please fill in your latest information and send it either via post-mail, fax or e-mail back to us. Thank you in advance.

MAAM CPD series

14, December, 2013 saw the debut of our MAAM CPD Series which is aimed at allowing our MAAM members as well as our fellow brothers and sisters in the medical fraternity access to CPD programmes as well as creating a sense of fellowship amongst all.

MAAM aspires to conduct such CPD programmes regularly with the aim of garnering more alumni members to participate in our activities. This MAAM CPD Series is also open to non MAAM members as it will help to dispel the notion that MAAM is an association of "thirsty" members.

We are no doubt still "thirsty", but the craving now is for professional development. At the rate that the field of medicine is progressing, as well as in the arena of science and technology, it is no easy task for all of us professionals to remain at the forefront of our areas of practice. Hence the need for our MAAM CPD Series.

MAAM has not forgotten our non medical MAAM members. More activities will be introduced that allows for the participation of alumni members that are not within the medical profession.

14, December, 2013 also saw the alliance between Manipal Hospitals Klang (Arunamari Specialist Medical Centre) and MAAM in the last CPD event for this year. Manipal Hospitals aims to make it's presence known in Malaysia and is set to expand it's services with the setting up of more hospitals in this country.

A total of four speakers were fielded, namely Dr Anbazhagan Kuppusamy, Consultant Physician and Infectious Disease Specialist; Dr Muthu Kumar Murugesan, Consultant ENT, Head and Neck Surgeon; Dr Baskaran Arunasalam Pillay, Consultant Obstetrician and Gynaecologist; and Dr Krishnakumar a/l Marimutho, Senior Medical officer.

Mr Ramkumar Akella, CEO and Managing Director, Manipal Hospitals, Malaysia did a presentation on what the Manipal Education and Medical Group(MEMG) has done, both within and without Malaysia. He hopes for a continuous alliance with MAAM with a view to increase our alumni members exponentially to the mutual benefit of both MAAM and MEMG.

PPi
Professional Portfolio International

Avoiding the TAX MAN

The Mention Of Tax Havens

Usually conjures up images of pop stars or wealthy businessmen hoarding their fortunes in remote places where the tax department can't get access. However. Tax avoidance, as opposed to tax evasion, is perfectly Legitimate - and there are some two hundred so-called tax havens worldwide to help the tax payer achieve this. With rising personal incomes in the region, both among expatriates and local residents, many more people are seeking to invest their assets off-shore, thereby minimizing their tax burdens. However, with so many different destinations offering a wide variety of tax concessions, it is a complex matter deciding who should consider using a tax haven, under which circumstances and where. A tax haven is defined as a country, a republic or an island that offers special tax concessions to investors or companies as a means of attracting overseas money. They are usually places such as the Channel Islands, Luxembourg, or Monte Carlo that has limited indigenous industries. However, what they all have in common is that they provide an opportunity to reduce, eliminate or defer income-tax liabilities to varying degrees. The Bahamas, Bermuda, Virgin Islands, Cayman Islands, Cook Islands and Panama are truly tax free, while Hong Kong and Labuan in Malaysia are low-tax jurisdictions. Often wealthy investors set up companies in tax-haven countries to minimize income tax and estate duties on their assets. But there are other ways to enjoy the tax breaks, including off-shore trusts, insurance products or portfolio management services when considering whether to use a tax haven, investors must first carefully evaluate their short and long-term goals.

Ron S.N FAIQ CII. (Lon.)
Executive Adviser
Professional Portfolio International
Email : ron.nanthan@ppi-advisory.com
Tel : +6 03-220 15825 or +6 012 221 2524

Registered Office: Level 15 (A2), Main Office Tower, Financial Park Labuan, Jalan Merdeka, 87000 Labuan F.T., Malaysia
Company No.: LL08455 / LFSA Licence No.: BS201289
www.ppi-advisory.com

INDONESIA I MALAYSIA I THAILAND

FIRST ANNOUNCEMENT

1st Global Manipal Alumni Health, Science & Technology Convention and 28th MAAM Convention

Networking Globally for the Future of Healthcare & Technology

7th to 8th August 2014

Kuala Lumpur

MALAYSIA 7th to 8th August 2014

DATE: 7th to 8th of August, 2014

Royale Chulan Hotel, Kuala Lumpur, Malaysia

ORGANISER

Manipal Alumni Association of Malaysia

SUPPORTED BY

Manipal Education and Medical Group (MEMG)