Vol XX For members only

HOWZIT

Manipal Alumni Association Newsletter

UNDERPRIVILEGED Education Fund
A new beginning...

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To all Manipalites in and around Malaysia,

Hi guys,

How are things since the beginning of 2013? I hope you love the new look and design of the HOWZIT Newsletter. Sincerely, to tell you the truth, I have received quite a good amount of recommendations and comments for future improvement. Anyway, the Editorial team will progressively improve HOWZIT so that it will be more readable, enjoyable and on top of it, a great tool for your career development. As before, we like to welcome your generous comments and will be delighted if you could contribute articles to share with the rest of us. Thank you in advance.

Since the last newsletter, and subsequently after further Executive Committee Meetings, our task was to increase the number of Alumni members, so also to get our existing members to be active in the Alumni. We have plenty of Manipalities who are spread out all over Malaysia, but many have not joined the band-wagon as yet or have not been participating in our activities. With this, we have decided to put in the Membership Application Form into this issue so that the present members can get their Manipal peers in their area to join the Alumni. Photocopies of the form are acceptable and can be post-mail, fax or e-mail to the given address.

To those existing Alumni members, the database that we have are outdated and time forgotten. Therefore, we are requesting that you spend about 5 minutes to send to us your new contact numbers, mailing addresses and e-mails so that we could send to you the latest activities of the Alumni regularly.

Anyway, let us see what the Committee has done so far. Just before the end of the year of 2012, we had the last CPD Lecture Series on the 8th December at Eastin Hotel, Petaling Jaya on Medical Concepts of Opioid Dependence and How Not To Miss Mood Disorders, by none other than our prominent speakers, Dr. Philip George and Dr. Prem Kumar.

Then, after the New Year Celebration, we were fortunately invited by the people from BMW Auto Bavaria in Sungai Besi to try out some of the Beemers and put our foot down on the pedal of their test-drive cars. Following that on 16th February, we had our first CPD Lecture Series of 2013 in Melaka Manipal Medical College. Our top Breast Surgeon, Dr. Patricia Gomez and Dr. Josephine Subramaniam, Interventional Radiologist was there to entertain the crowd with their topics Breast Lumps – When to Worry and Spectrum of Imaging in Diabetes. The number of attendees was good which also included MMMC faculty members and medical students. We also had Community Health Camps as part of our charitable work, which you could read it in this issue. The Organizing Committee for the 1st Global Manipal Alumni Health Sciences Convention are also steaming up into full mode in preparing to host this auspicious event for all the Manipalites from around the planet.

Alright, to sum up all in this issue, do join us this coming May 4th for the 27th Convention, 28th AGM and 'Masquerade' Dance & Dinner. Well, if you think you miss the 'Luau' Hawaiian Party in Penang, please be appropriately dressed for this night event then. And last but not least, after this 'crazy' night, hope you guys can still think rationally and cast your vote for a better Malaysia in GE13.

Kudos and bye for now.

Dr. Eugene Tan

Dr. Sothiratnam Kandiah was the lucky person to take home the new iPad during the 26th Convention and not Dr. Nesa Mani. ***The error is regretted.***

A year has passed since I took over with this young committee. I must commend my committee for the excellent job that they are doing despite their hectic schedules of family demands and work overload.

It has been a challenging year especially when we have had predecessors who have done sterling work to lift MAAM to the heights that we are at today. I am glad to say that we have more than survived.

Let me give you a quick run through what is in the pipeline and what has transpired.

2014 is going to be a landmark year for MAAM as we play host to the prestigious 1st Global Health Sciences Convention from 7th to 9th August at the Royal Chulan, Kuala Lumpur. A two day multi disciplinary event followed by a day of games and social activities to rekindle our traditional camaraderie Manipal style. Mark your calender for this not to be missed event.

In 2012, we rocked the Pearl of the Orient again - Bayview Beach Hotel, Penang was the epicenter of the event. Our Vice President cum Organizing Chairman, Dr Sivaroshan, led the way with his constant companion – the iPhone, delivering on his word as Organizing Chairman to host an unforgettable event. We were honoured to have the Chief Minister, Mr. Lim Guan Eng, as our chief guest, who left a daunting impression on many on that wonderful evening. I will not be doing justice if I overlooked the informal night. We had a moonlit night on the beach minus the rain – our first after 7 years. A Hawaiian theme complete with flower girls, fire dancers and a great rock band that got the squirrels rocking too, made the night truly one that is still talked about.

In an effort to persevere in the field of Continuing Medical Education (CME) our 1st CPD lecture series was a 2 day event during our Convention in Penang. The first afternoon was in Orthopaedics, Diabetes and Hypertension. The high point of the day was the tussle for the iPad and other prizes which were given to the few fortunate people. The next morning, we had a session on Renal Anaemia after which Dr Kewaljit took the role of auctioneer with two golf sets.

The next CME session was in Petaling Jaya which was centered on Psychiatry and to keep things exciting, we had an offshore investment consultant who gave us tips on how to make our money work harder for us

A Scientific Committee 2014 meeting was held in Melaka-Manipal Medical College after which we adjourned to a CPD session on Breast Lumps and Interventional Radiography. There was a good mix of students and faculty members from the MMMC who attended which saw lively Q & A sessions. Watch out for our next CME session will be on the 4th of May 2013 at Saujana Hotel; Subang Airport road.

In an attempt to give back to the underprivileged, I would say that we can do so much more if we had more support from our members. MAAM has to transcend the norm and do great things as collectively we are a force to be reckoned with.

- Our Community Project at Sungei Buloh needs to be revived with your support.
- In Penang, Dr Sham Kumar was up against the wall but off late he seems to have sighted some light at the end of the tunnel. I wish him luck and let us hope something positive comes out of his efforts.
- A survey was done in Sungei Siput in an attempt to identify how we could contribute to the poor in that region. Five MAAM members have come forward and donated money to sponsor a teacher for a year to help in home schooling children of single mothers.

In this area we are hoping to get a mandate from the floor to help upkeep two teachers for a year, which is a mere Twelve Thousand Ringgit. Do I hear an aye?

For all the tech-savvy folks, we have something exciting for you. MIMS mobile is an iPhone 'App' which is being discounted for MAAM members at a great prize of only RM50 per year. This application is an interactive MIMS-on-the-go. It is downloaded on to your iPhone to be used anywhere without wifi connection. For those who are interested please get in touch with the secretariat and Josephine will be happy to assist you.

We are always looking for great offers and deals to improve member benefits. Information about all this is posted on the web. Make the MAAM web page your morning fix by visiting us frequently. There are some great offers from companies dealing in property, cars, and beverages to name a few. We are in the midst of negotiating with insurance companies and banks to offer some good deals for our members. All this information can only be found on our website. The web page has been upgraded so please log on for information of events and promotions and give us your feedback. Do not forget - log on to: www.manipal.org.my

We have a lot more to do and I urge you to get involved and play a part in shaping the future of MAAM. I firmly believe we have the opportunity to make MAAM truly great, a comradeship with a purpose. Step up and be a part of something great.

Till we meet on the 4th of May… keep well.

Dr Nirmal Singh
President 2012 – 2014

1ST GLOBAL MANIPAL ALUMNI HEALTH SCIENCES CONVENTION 2014

In conjunction with
28th Manipal Reunion

DATE: 7th to 10th of August, 2014

SUPPORTED BY
Melaka-Manipal Medical College

Sunny Malaysia plays host to the 1st ever Manipal Alumni Scientific Convention from the 7th to the 8th of August, 2014. It aims to bring together Manipal Medical Alumni from around the world to share ideas and experiences in their medical practice as well as to develop collaborations among Alumni in various disciplines and fields. Invited speakers are authorities and key opinion leaders in their field and many are from the Alumni of Manipal in countries such as the United States of America, Canada and Australia as well as from Melaka Manipal Medical College and Manipal University, India. They will cover areas in Medicine, Dentistry and Pharmacy.

There will be Free Paper and Poster Presentations and delegates are encouraged to submit abstracts for these as there are many prizes awaiting the best papers. There will be a Convention Dinner on the first evening open to all delegates and cultural performances will be staged then. The 2 day Scientific Convention ends on Friday, 8th of August, 2014 and then starts the informal Manipal Alumni Reunion. There will be a night for batch get-togethers, a day full of games and activities for Alumni as well as their spouses and family members and finally a Formal Reunion Dinner on the 9th of August, 2014. Please log-on to www.manipal.org.my for more information.

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 and dining opportunities exist. The Royale Chulan Hotel offers guests 5-star Malaysian hospitality just adjacent and walking distance to the KL Twin Towers. Please visit http://royalechulankualalumpur.com/ for more information on the venue. Please be advised that negotiations are still underway to source a competitive rate at the venue for delegates and this will be informed through our webpage www.manipal.org.my

Assoc Prof Dr. Philip George
Organising Chairman
1st Global Manipal Alumni Health Sciences Convention 2014

So make a date and be prepared to be educated, enjoy and relive your memories. Bring your family so they meet the buddies and chommies you studied with, shared great and bad times with and will always remember. Rekindle old memories and make new ones in this not be missed event.

Overall Event at a glance

DAY	EVENT	VENUE	INVOLVES
Thursday 7th Aug, 2014	Scientific Convention Convention Dinner	Hotel ballroom Ballroom	All registered delegates All registered delegates
Friday 8th Aug, 2014 Am to pm Night	Scientific Convention continues Evening night out in respective batches from Manipal	Same Various venues	All registered delegates All Manipal Alumni delegates
Saturday 9th Aug, 2014 Am to pm Night	Alumni and family games eg: cricket, futsal, tennis, squash, netball etc… MAAM 29th AGM Formal Gala Dinner	TBA TBA Hotel	All Manipal Alumni & families All Manipal Alumni & families
Sunday 10th Aug, 2014	Breakfast and goodbyes	Hotel	Manipal Alumni & families

Underprivileged Education Fund

Dear Members,

The MAAM has always tried to give back to society whenever and wherever we can. We embarked on adopting a village in Kuala Selangor, the goal being to help uplift the village from all sectors, Health, Education, Social wellbeing and Quality of life. What we realised was that the project required great responsibility and lots of support. We were able to handle the Health aspects to a certain level, but there was absolutely no support from the MAAM members.

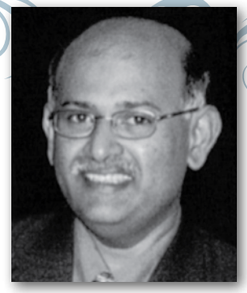
That's when we realised that there were already well established organisations doing what we had set out to do. All they needed was funding. The first location was in Sungai Siput, Perak. This is an Orang Asli Village, as the education level is so poor, they have hired a teacher, who goes in and teaches these children. It cost money to do this, RM600/month, A few members of the MAAM have started the ball rolling and we have sent RM6000 for this year 2013. And the project is underway. We want this to continue and for that we need funding.

If you have seen the showcase video of the history of Manipal, Manipal is not only about medicine. It's about education, it's a vision of education that Dr TMA Pai had and made it a reality. Today Manipal is known all over the world. So let's learn from our Alma matter and try and carry on this tradition.

My suggestion is to start an Underprivileged Education Fund, we can start with a collection box during our AGM and if the response is good we can even open an account and members can directly contribute into this fund. We can then give a breakdown of the accounts in our AGM report.

This will only be possible for the MAAM to undertake if we have the cooperation and approval from all our Members.

Roshan.



"It matters not how a man dies, but how he lives." – *Samuel Johnson*

Dr. Rasikalan T. Selvaratnam
7th July 1959 – 25th Feb 2013

I have known Rasi since 1981.We first bumped into each other at the famous Malligas in Udupi. We have been good friends ever since.I remember him riding around Manipal . He used to have a tuft of hair back then. Not surprisingly half of it fell whilst I was his roommate.

We were meant to be near each other I think. When I first got posted to Taiping as a houseman he ended up there .Then some years later I moved to KL only to find that his practice was less than 2 km from mine in Puchong. Many a afternoon was spent having a cup of tea at the mamak shop nearby whilst we waited for our respective practices to pick up. His trademark sarcasm never failed to amuse me.

You have been a wonderful husband, a loving father, a dutiful son, a caring bother and uncle and most of all a great friend. Someone once said, "A friend is a gift you give yourself". I must say I certainly got myself a gem. Weakness, if you had any, seemed overshadowed by your gentle and loyal heart. Not intrusive but always there in times of need.

So many memories running in my mind as if it were only yesterday, all the things we spoke and argued about... I can't go on. Rasi my dearest friend, my heart aches and I fear I will start to cry. I can almost see you with your cynical smile from above saying ; "Getting all soft and mushy eh…'? I am giving you this chance to write about me, so cut the crap and don't screw it up Naysa. "

I and all of us who hold you near and dear will miss you so much buddy.Your family meant the world to you.Please be comforted that I will always be there as Uncle Dr. Naysa for little Subhan.
As I put down my pen with a heavy heart the words of Thomas Campbell reverberates in my mind "To live in the hearts we leave behind is not to die." ~ … And so you will always be alive in our hearts Rasi.

Your friend of 32 years,

Naysa
Dr. Naysadurai

"O Captain! my captain!
our fearful trip is done,
O the bleeding drops of red,
where on the deck my captain lies,
Fallen cold and dead"

Eulogy for Dr. S. Thillainathan
(fondly known as S. T.)

Passed away 21st February, 2013

On the morning of 21st February 2013, we received sad news of the tragic and untimely demise of Dr. S. Thillainathan (better known as S.T.), formerly of Kasturba Medical College, Manipal - Year of 1984.

During his time in Manipal, S.T. was a popular figure, who was well known and respected by his teachers, seniors and juniors alike. He always gave his best, an attribute which was most evident on the sports field, where he excelled especially in football and hockey, in which he represented at both class and college levels.

S.T. had just been promoted as Chief of Obstetrics and Gynaecology at Slim River Hospital, Perak. He left behind a grieving wife and four young children. S.T.'s untimely passing will be deeply felt by all Manipal Alumni. To me personally I have lost a dear friend who was with me both in the classroom and on the field. His sad demise was indeed very shocking and saddening. Our prayers and condolences go out to his family and loved ones. He will always be remembered as an outstanding KMC Alumni.

by
Dr. Martin George
(Medical Officer, Accident & Emergency, Hospital Fatimah, Ipoh)

Hardly a century ago, Helen Keller aptly described - The most beautiful things in this world are not what can be seen, heard or held by hand; but what is deeply felt inside the heart.

S.T. touched everyone's heart like no other. S.T was the great sportsman, the Champion among champions; the towering greater-than-life character who made his presence felt wherever he was. He was the born leader of the pack!

A true sportsman till the end, he was the rare gem of a character with a fighting spirit till the end.

Your memories will always be with us, long after your light has gone.

RIP my dear friend
by
Dr. Rajeentheran Suntheralingam
(Consultant Urologist, Damansara Specialist Hospital, KL)

Meeting the new Director General of Health

I had the chance to meet up with Datuk Dr Noor Hisham bin Abdullah twice in dialogue sessions since he assumed his office as the Director General of Health.

by Dr Koh Kar Chai

He spoke on a lot of issues, but top on his mind is the improvement of our present healthcare system. For that to be able to take place smoothly, he stressed on the importance of unity. Our DG mentioned about the fragmentation among the doctors of Malaysia which is not good for the medical fraternity as it will dilute the voice of us doctors. We need a single umbrella body which will lend strength to the whole medical fraternity.

His view on leadership really got me thinking about what is really happening with some of the medical associations out there. He said that a leadership which thinks about what is best for the association or the medical fraternity as a whole will empower us doctors unlike the present moment where we see the leadership of certain medical associations with an agenda of their own, which will tend to lead us nowhere. A leader is not there to rule but to govern. The key then, is good governance. There is a need for common goals, without which it would not be possible to move forward in healthcare. It is not about the leader as such, but about what the leader can do to improve the present situation. Our DG is of the opinion that being an effective leader is not about giving excellent speeches, but about having a good outcome and performance. *True indeed, but there really is much to learn about being a leader.*

He further stated, “ We all have our differences which should be respected, but our commonalities must come together as one ”.

He enumerated the three things that is being looked at in the healthcare of this country. First is quality which is of utmost importance. Second is accessibility of healthcare to all and third is equity of care.

Our DG mentioned that there is a need to improve our healthcare system based on our own experience and history. We need not adopt the healthcare system of another country as it may not be relevant to us. But we do need to have a system which have a maximum impact at a minimum cost.

What is the one care system? He insisted that it is not about healthcare financing which many people are harping on. Right now in this country we have the two care system, private and public, and it doesn’t bode well for our country. There is a need for us to bridge these two systems. *Rightly said, but how many of us doctors out there agree on this?*

Datuk Dr Noor Hisham stated that presently, the rich in Malaysia are making use of both the private and public systems. They utilise the public system for the more complex cases which need highly specialised management which may not be available in the private sector. The poor have got no choice but to rely only on public healthcare facilities. As the public system continue to improve, there will be increased utilisation of it’s resources leading to more congestion at public healthcare facilities. This will also lead to a dilution of the resources available to the public system. *I can personally vouch that it is true that there are some who are economically stable and yet prefer to avail of public healthcare services. However, it is not only due to the improved services being offered but also because treatment is available almost free.*

There are five stages in the transformation of healthcare in this country. Our DG is of the opinion that we may need only ten years to reach stage five as we are able to learn from the mistakes of other countries. With this, we may be able to accelerate the rate of transformation of healthcare in Malaysia. There is a need for all to understand the five stages that are involved here. *It is not so complex if we were to look at the chart with an open mind.*

He further added that right now, there is a move to improve the public system by strengthening it’s services and working on quality issues. Decongestion of public hospitals remain a priority and processes are being developed to decongest the public health facilities by literally keeping patients out of the hospitals. Patients are not kept longer than is necessary. Certain facilities and services are being taken out of the hospitals. Clinical services should be offered outside the hospital and not within. Day care services are deemed crucial to reduce the load on in-hospital services. Home care is also something that is being worked on. Early discharge back to primary care level will reduce the load on the specialists.

Our DG further opined that specialists should not be wasting their expertise on primary care cases. They should be earning based on their expertise and not on primary care level consultation. Giving in to market forces will mean the demise of all GPs as patients will only demand for specialist care for the most trivial of cases. The healthcare system will then collapse due to the increasing cost of medical care, something which we should steer clear of. *I will reserve my comments here, as being a GP myself, I would greatly welcome a system which benefits primary care doctors.*

More were discussed with the DG that will fill many more pages here. But suffice it to say that our new DG is a person who understands what it will take to transform the healthcare of this nation of ours. In his own words, he is going to break down the walls of resistance to change, brick by brick, starting first within the Ministry of Health itself.

Understandably, there will be some of our members who will beg to differ from the opinion of our new DG. According to Datuk Dr Noor Hisham, you may visit his face book where you can engage him in a discussion on issues that matter.

Dr Koh Kar Chai

PRESS RELEASE!!

Functional cure for HIV infection seen in a two year old child! This is what the world has been waiting for!

But hold your horses here. What is so special about a functional cure seen in this two year old child? We should instead be upset that a child has been born with HIV infection present when every other country in the world worth it’s salt is having programmes to prevent mother to child transmission of this dreaded virus.

If this can happen in an advanced nation, then think about Malaysia. Are we missing many cases of HIV infection in pregnant mothers? Are we creating a population of HIV babies in this country?

We do have In Malaysia, a programme for the Prevention of Mother To Child Transmission which is carried out in public health institutions, including at primary care level. Awareness is also created among the private healthcare providers to ensure their participation in this programme.

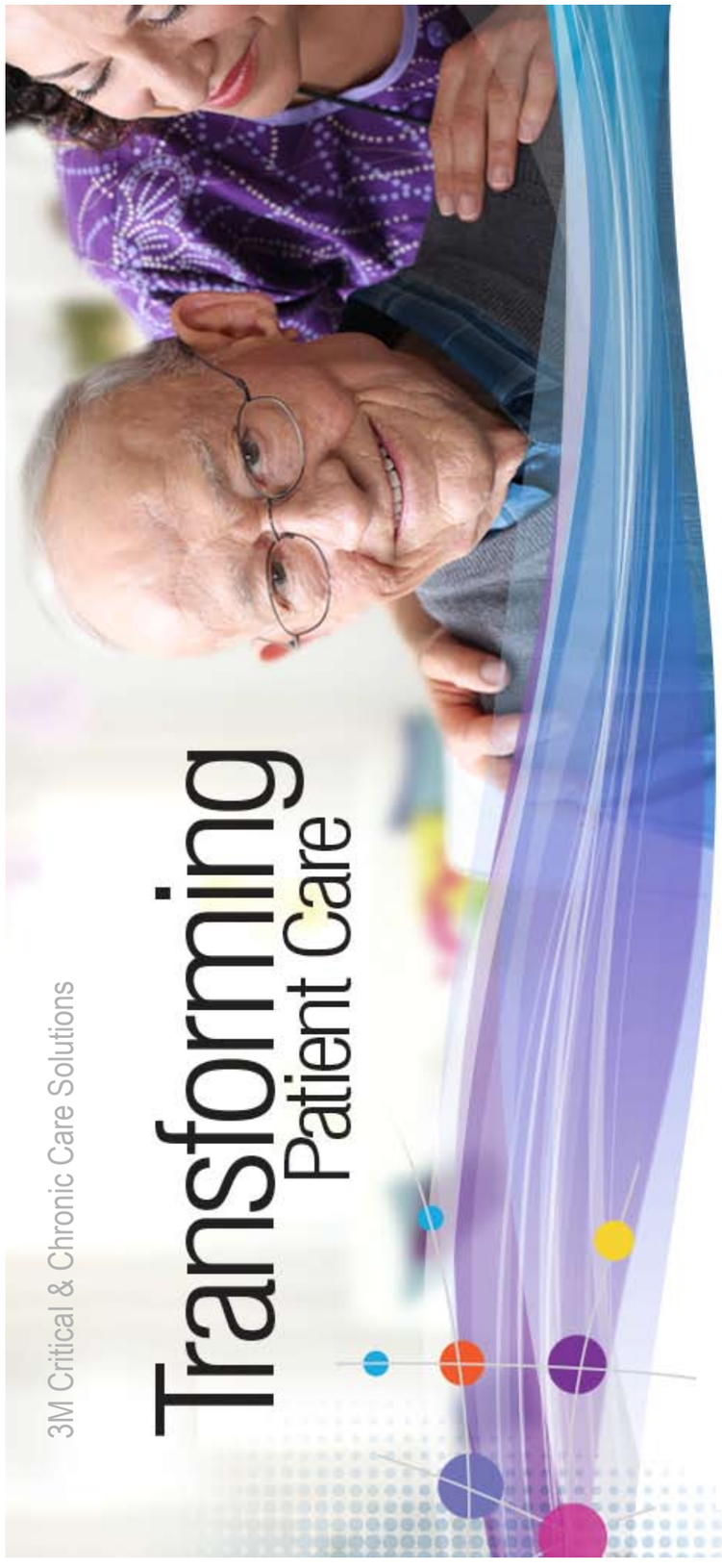
This requires a three fold strategy which are

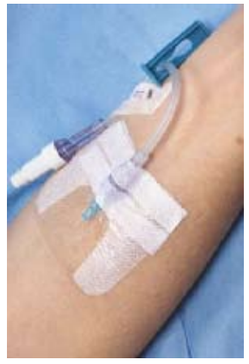
1) Prevention of HIV infection among prospective parents.
2) Avoidance of unwanted pregnancies among HIV positive women.
3) Prevention of HIV transmission from HIV positive mothers to their infants during pregnancy, labour, delivery and breast feeding.

The crux to note here would be an effective screening for HIV infection during the antenatal period. This will ensure that mothers who are screened positive for HIV infection will be started on anti retroviral therapy during pregnancy, safer delivery practices will be carried out as well as counselling and support given on infant feeding methods.

All these will lead to a drastic reduction in the transmission of HIV from mothers to their children. This is the message that needs to be carried across to everyone instead of the euphoria created by the first ‘functional cure’ of HIV infection in a two year old child.

TOWARDS ZERO TRANSMISSION OF HIV FROM MOTHER TO CHILD.





Diagnosis, Treatment and Management of Seizures

Part I of Four Parts - Definition, Classification & Etiology

R.C. Krishna MD Neurologist

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

Seizures are sudden episodes of transient neurologic symptoms such as involuntary muscle movements, sensory disturbances with or without altered consciousness. Seizures are characterized as episodes of disturbed brain activity that cause changes in attention or behavior.

Epilepsy:

- Epilepsy is characterized by recurrent epileptic seizures due to a genetically determined or acquired brain disorder [1]. Approximately 0.5 to 1 percent of the population has epilepsy.
- Non-epileptic seizures (NES) are sudden changes in behavior that resemble epileptic seizures but are not associated with the typical neurophysiological changes that characterize epileptic seizures [2-4].

Status Epilepticus:

Status epilepticus generally refers to the occurrence of a single unremitting seizure with duration longer than 5 to 10 minutes or frequent clinical seizures without an inter-ictal return to the baseline clinical state.

Types of Seizures:

The term “seizure” is often used interchangeably with “convulsion.” Convulsions are when a person’s body shakes rapidly and uncontrollably. During convulsions, the person’s muscles contract and relax repeatedly. There are many different types of seizures. Some have mild symptoms and no body shaking.

CLASSIFICATION — Seizures are categorized as clinical (full expression/manifestation), subtle (minimal expression/manifestation), or subclinical (no clinical or outward manifestation of the electrical seizure activity). Clinical seizures are classified on the basis of the individual’s ictal behavior with consideration of the electroencephalography (EEG) findings.

The International Classification of Epileptic Seizures is used by most neurologists to classify seizure types [3]. This classification divides seizures into two basic groups based upon clinical and EEG data: partial and generalized. The classification scheme developed in 1981 is still the one that is in broadest use. A need to revise the classification is generally acknowledged but attempts to do so have not been widely accepted. Most recently the ILAE published some limited recommendations for revisions in 2010 [4].

Partial seizures — Partial seizures are “those in which, in general, the first clinical and electrographic changes indicate initial activation of a system of neurons limited to part of one hemisphere.” A partial seizure is classified primarily on the basis of whether or not consciousness is impaired during the attack. When consciousness is fully maintained, the seizure is classified as a **simple partial** seizure. When consciousness is impaired, the seizure is classified as a **complex partia**l seizure” [3]. “Impaired consciousness is defined as the inability to respond normally to exogenous stimuli by virtue of altered awareness and /or responsiveness” [3].

Partial seizures are further subdivided primarily on the basis of the clinical signs and symptoms and the EEG localization. Examples include:

- Motor seizures may manifest as focal motor activity, sometimes with an anatomic spread or march of activity (Jacksonian), versive movement (turning of the eyes, head and/or trunk), vocalization, or arrest of speech.
- Sensory seizures can be manifest by paresthesias, feelings of distortion of an extremity, vertigo, gustatory sensation, olfactory symptoms, auditory symptoms, and visual phenomena such as flashing lights.
- Autonomic seizures may include an epigastric “rising” sensation (a common aura with medial temporal lobe epilepsy), sweating, piloerection, and pupillary changes.

- Simple partial seizures may also manifest higher cortical, psychic symptoms including dysphasia, feelings of familiarity (“deja-vu”), distortions of time, affective changes (particularly fear), illusions, and formed hallucinations. Simple partial seizures are often referred to as auras.
- During complex partial seizures, the patient may have a variety of repetitive semi - purposeful movements that are referred to as motor automatisms. These can include oral-buccal movements (chewing, swallowing, sucking), complex motor phenomena including bicycling and kicking movements, flailing of the arms, and even running, jumping, and spinning. Complex partial seizures involve regions of both hemispheres, thus explaining the impaired consciousness and the more complex and often bilateral motor symptomatology.

Partial seizures may start in a “silent” area of the brain such as the frontal lobe and become clinically apparent only when they spread to neighboring cortex such as the precentral gyrus of the frontal lobe or the hippocampus of the temporal lobe. In these cases, the EEG monitoring can be critical to the detection of a focal seizure onset.

Generalized seizures — Generalized seizures are those in which the first clinical changes indicate initial involvement of both hemispheres. Consciousness may be impaired and this impairment may be the initial manifestation. Motor manifestations are bilateral. The ictal electroencephalographic patterns are bilateral from onset, and presumably reflect neuronal discharge which is widespread in both hemispheres” [3]. Generalized seizures can be convulsive and non-convulsive, depending upon the presence or absence of significant motor concomitants. Patients with non-convulsive seizures, such as absences, may have low amplitude myoclonic movements as well as mild tonic involvement of the limbs and trunk and simple motor automatisms, similar to those seen in complex partial seizures.

Clinical behavior during seizures and non-epileptic events — Some general rules apply to the majority of seizures and provide the information necessary to distinguish true epileptic events from psychogenic non-epileptic events, other paroxysmal behavior or physiological events that may mimic seizures such as those based on cardiovascular dysfunction, and non-epileptic events with a central nervous system origin (e.g., paroxysmal dystonia, infantile shuddering attacks, tics).

As examples:

- Episode of sudden loss of tone with or without loss of consciousness in otherwise healthy children often are cardiogenic in origin. Occasionally, a child with atonic seizures will make a protective move during the fall. However, these seizures usually occur in a neurologically abnormal child (eg, Lennox-Gastaut syndrome, other developmental encephalopathies) and are rarely the sole seizure type.
- If there is color change during a seizure, usually a generalized motor seizure, it will be cyanosis. Consider syncope as a cause for the event if the child is described as pale.
- Consistent crying before a “seizure” is suggestive of a cyanotic breath-holding spell.
- Pallid infantile syncope is a common benign pediatric syndrome characterized by sudden transient bradycardia with collapse and pallor, sometimes followed by an anoxic seizure. Recovery is spontaneous. These are often precipitated by a mild unexpected blow to the head and upper torso and are caused by excessive vagal tone of unknown etiology.
- True absence seizures (“petit mal”) cannot be predictably interrupted by calling the child’s name or by tactile stimulation, as can the staring spells or behavioral inattentiveness (“spacing out”) commonly seen in children with attention deficit hyperactivity disorder (ADHD). Absence seizures often interrupt conversation or ongoing physical activity such as eating and play, whereas a pseudoabsence of inattention or “daydreaming” tend to occur during more sedentary activity (eg, sitting at a school desk). Absence seizures usually occur multiple times during the day and last only a few (rarely more than 10 to 30) seconds.

ETIOLOGY

Epilepsy — Epilepsy may be due to a medical condition or injury that affects the brain or the cause may be unknown (idiopathic). Less than one-half of epilepsy cases have an identifiable cause. It is presumed that epilepsy in most of these other patients is genetically determined. In the remainder of patients in whom an etiology can be determined, the causes of epileptic seizures include [6]:

- Head trauma
- Brain tumors
- Stroke
- Intracranial infection
- Cerebral degeneration
- Congenital brain malformations
- Inborn errors of metabolism

In the elderly, vascular, degenerative, and neoplastic etiologies are more common than in younger adults and children [7]. A higher proportion of epilepsy in children is due to congenital brain malformations than in other age groups.

Acute symptomatic seizures — Patients often experience seizures in the setting of acute medical or neurologic illness or injury (e.g., stroke, traumatic brain injury, meningitis, anoxic encephalopathy) [11]. Such patients are not necessarily considered to have epilepsy. While this occurrence places them at risk for future epilepsy, a seizure in the acute setting does not carry the same risk for seizure recurrence as does an unprovoked seizure that occurs after recovery from the acute illness - so-called remote symptomatic seizure [15].

A subset of acute symptomatic seizures is those that occur in the setting of an acute medical illness or metabolic disturbance. In contrast to the setting of an acute stroke or traumatic brain injury, patients with seizures provoked by metabolic derangements are not felt to be at risk for future epilepsy or recurrent seizures in the absence of recurrence of the medical condition. Another feature of these provoked seizures is that the risk of seizures is felt to occur in proportion to the rapidity of the onset, rather than to the severity of the underlying metabolic disturbance [11,12].

These conditions include:

- Hypoglycemic seizures are most common in diabetic patients who take excessive amounts of insulin or oral hypoglycemics; islet cell tumors are much less common, but seizures may be the initial presentation. Prodromal symptoms of hypoglycemic seizures include diaphoresis, tachycardia, anxiety, and confusion.
- Nonketotic hyperglycemia most commonly occurs in elderly diabetics and can cause focal motor seizures.
- Precipitous falls in serum sodium concentrations can trigger generalized tonic-clonic seizures, usually in association with a prodrome of confusion and depressed level of consciousness. These convulsions are associated with a high risk of mortality and must be treated urgently.
- Hypocalcemia is a rare cause of seizures and most often occurs in neonates. In adults, hypocalcemia may occur after thyroid or parathyroid surgery or in association with renal failure, hypoparathyroidism, or pancreatitis. Typical prodromic symptoms and signs are mental status changes and tetany.
- Magnesium levels below 0.8 mEq/L may result in irritability, agitation, confusion, myoclonus, tetany, and convulsions, and may be accompanied by hypocalcemia.
- Renal failure and uremia are often associated with seizures, particularly myoclonic seizures. Generalized tonic-clonic seizures occur in approximately 10 percent of patients with chronic renal failure, usually late in the course. Seizures may also occur in patients undergoing dialysis as part of the dialysis disequilibrium syndrome; associated symptoms are headache, nausea, muscle cramps, irritability, confusion, and depressed level of consciousness.
- Hyperthyroidism can cause seizures and can exacerbate seizures in patients with epilepsy.
- Disorders of porphyrin metabolism may cause seizures. Acute intermittent porphyria (AIP) is due to a partial deficiency of porphobilinogen deaminase, which results in excess delta-aminolevulinic acid and porphobilinogen in the urine.
- Cerebral anoxia as a complication of cardiac or respiratory arrest, carbon monoxide poisoning, drowning, or anesthetic complication can cause myoclonic and generalized tonic-clonic seizures. Cerebral anoxia due to syncope can result in very brief tonic and/or clonic movements without a prolonged postictal state, which is why syncope frequently results in an evaluation for seizures.
- Withdrawal states (particularly alcohol and benzodiazepine withdrawal) are associated with seizures. Alcohol withdrawal seizures typically occur within 7 to 48 hours of the last drink.
- Drug toxicity/intoxication is also reported to cause seizures.

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MAAM 27th CONVENTION, CPD & 28th AGM

Date : **4th May 2013**

Venue : **The Saujana Hotel,**
off the old Subang Airport Road.

Dear Members,

The MAAM will be organizing the 1st Global Manipal Alumni Health Sciences Convention in August 2014, thus this year we unfold a one day 27th Convention, CPD and 28th AGM. It may not be our usual forte but we guarantee an exciting night.

Time :

10.00 am
Registration

10.30 am to 10.40 am
Welcome Address

10.40 am to 11.15 am
We will start the morning with the Launch of Renal Anemia Practice Points presented by our sponsor, Roche. This will be done in collaboration with MMA.

11.15 am to 11.50 am
Roche will continue to update us on the latest information regarding Renal Anemia, this will include a discussion with questions & answers from the doctors.

11.50 am to 12.00 noon
Launch of Renal Anaemia Practice Points for GP's by the MMA President, Dr S.R Manalan

12.00 noon to 1.30 pm
Lunch

1.30 pm to 5.30 pm
The MAAM with the help of its members have organized a Hands on Orthopedic Infiltration methods, this will include joints of the upper limb and lower limb. There will be an initial theoretical introduction followed by a breakout session for further hands on training. The session will be headed by

- Dato' Dr K.Selva Kumar A/L A. Kanagarah.
- Dr Surendra A/L Masilamoney.
- Dr Anbanandan
- Dr Vivekananda

We hope that our members take this opportunity to learn and add to their knowledge a new skill that will help them in their practice.

The session is open to all doctors. Please pass the word around to all your friends.

CME POINTS WILL BE AWARDED

5.30 pm to 6.00 pm
We will have a short Tea break, Registration for the AGM will commence concurrently.

6.00 pm to 7.30 pm
The 28th Manipal Alumni Association Malaysia Annual General Meeting will commence.

This is a non-election year, but never the less there are many things that need to be discussed.

We hope that all our members attend and that we will have a productive discussion with the current committee to help take MAAM to greater heights.

If any member would like to discuss any issue, please email anyone of the committee members or the secretariat so we can accommodate this in our agenda.

7.30 pm onwards...
Finally, what we have been waiting for, the Convention Dinner. The theme this year is a "Masquerade Dance ", all you need is a "Mask" (it can be a fancy one or as simple as one of those birthday masks). This means you can be wearing you formal or semi-formal outfits for the CPD and the AGM, but with a swish you will be transformed for the night.

We are doing away with our normal sit down dinner and having a buffet style instead. There will be table seating available for everyone.

Dr. Thevi (Manipalite) & Company will entertain us with some instrumental music over dinner for about an hour.

And then we have a young DJ that specializes in Retro music to take over and keep us entertained till we decide to call it a night.

So make a date with the **MAAM on the 4th of May 2013**.

Price :

- RM100 for members (this is for the whole event, the price will remain the same even if you opt for just the dinner).
- RM50 for spouses and children 12yrs and above attending the dinner.
- Children below 12yrs , Free
- If you would like to spend the night at the Hotel, The MAAM has been given a special rate, rooms are subject to availability.

The Saujana Hotel - Kuala Lumpur

- Superior: RM265.00++ per room per night (Single/Twin)
- Deluxe: RM335.00++ per room per night (Single/Twin)
- Executive Deluxe: RM385.00++ per room per night (Single/Twin)

* *The above room rates include daily complimentary buffet breakfast at Suria*

Please note that the above rates are quoted on a per room, per night basis, subject to 10% service charge and 6% government tax, non-commissionable.

Please be advised that the hotel rooms are available for guest check-in after 2:00 pm, and checkout before 12:00 noon.

Please RSVP Josephine at the secretariat by
15th of April 2013

Email: manipalmaam@gmail.com

Tel: +603-2282 7355 or +6016 223 8079

Sg. Siput walkabout
with YB Dr Michael Jeyakumar

by Dr Mohanadas

It was dawn on Sunday 16th. morning when Dr. Jeyaretnam (Ipoh member) and me sat down for breakfast at a restaurant near Dr. Manalan's clinic at Tasek, Ipoh. We were joined shortly by YB Dr. Michael Jeyakumar (Member of Parliment, Sg. Siput) and his son, Rovin. We then waited for Dr.Nirmal (President of MAAM), to join us. We then left for Sg.Siput and gathered at YB's service centre with the other volunteers. Dr. Bala Kumaran of Klinik Tweedie, Sg. Siput had graciously sent 2 nurses as volunteers to help us out.

The agenda was to determine the socioeconomic status, health status, average household income, the basic needs of everyday living, any umbrella protection offered by SOCSO,EPF, disabilities etc.

During the briefing, we were allocated to 5 teams comprising of 3-5 volunteers each.

Subject of survey : Taman Lintang ,Sg.Siput, a low cost housing area with around 200-300 houses.

We started the survey at 9am and finished at 12.30 pm. We managed to do a survey of 100 houses.

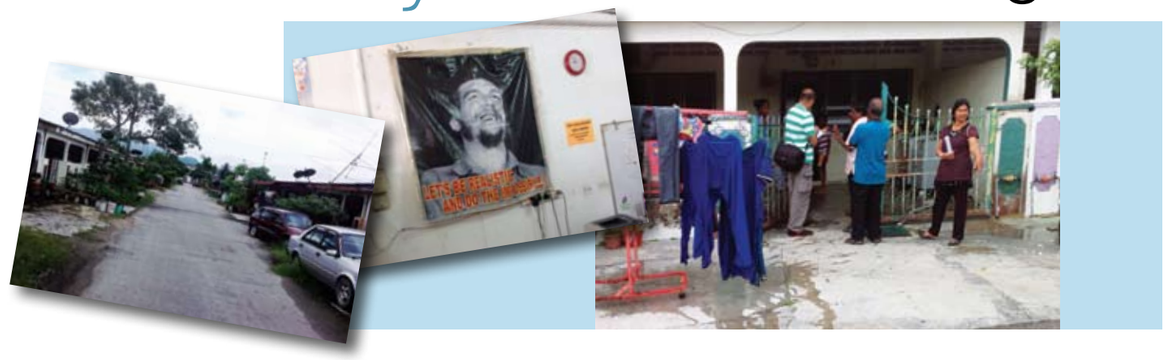
We then met back at YB's office, compiled all the data, and took copies for cross references. Breakfast and light refreshments were provided by YB.

Besides that we were also informed that YB's group of volunteers have started shelters for single mothers , with and without children. At present they are running 5 homes with support from the church, Sai Baba's group and other volunteer organisations. It costs around RM5,000 a month to maintain all the above homes.(inclusive of rental, food, tuition for children of single mums, utilities etc).

After saying our goodbyes, we adjourned to Chemor town, where we were treated to a sumptuous lunch at the famous Samy's restaurant by Dr.Bala Kumaran.

From there on, we dropped Dr.Jeyaretnam at Ipoh before driving back to KL (both Nirmal and me in separate cars)

Sg. Siput walkabout
Survey at Taman Lintang



Several members of PSM Sg Siput and the Manipal Alumni carried out a house-to house survey on 16/12/2012 using the survey questionnaire reproduced as Appendix One. The purpose of the survey was to identify the problems faced by the residents of Taman Lintang with a view to assessing how the PSM and the Manipal Alumni might be able to work together to solve some of these problems.

There was no attempt to randomly select respondents – we visited as many houses as we could and interviewed whoever was in and who didn't mind answering our questions. Altogether 73 houses were interviewed (Table One)

Table One: Taman Lintang Families Surveyed

	Male Head of Hsehold	Female Head of Hsehold	Total
Chinese	8	3	11
Indian	39	18	57
Malay	5	0	5
Total	52	21	73

There was a predominance of Indian families in Taman Lintang which is a Taman of low cost houses. Indians make up some 21% of Sg Siput's population, but about 78% of the families we managed to interview in Taman Lintang were Indian. It is of significance that 29% of the families in this taman were headed by women.

There was no report of any child without a BC. However there were 2 people without blue ICs – a 59 year old Indian woman and 42 year old Indian man.

In terms of the age distribution of the people surveyed there was a preponderance of younger people as depicted in Table Two.

Table Two: Age and Ethnic Distribution of the Taman Lintang Survey Population.

	Chinese	Indian	Malay	Total
< 10	2	40	4	46
11 – 20	7	76	6	89
21 – 30	4	39	1	44
31 – 40	6	30	3	39
41 – 50	3	37	6	46
51 – 60	6	28	1	35
61 – 70	0	15	3	18
>70	3	1	1	5
Total	31	266	25	322

continued on pg 25

In the early and ongoing management of patients with OA knee pain…

VISCOENGINEERING

Unique formulation of SYNVISC/Synvisc-One mimics the high molecular weight and elastoviscous properties of healthy, young synovial fluid[1,2]

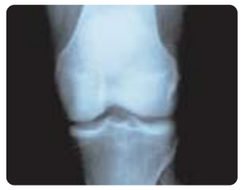
- Provides superior pain relief and long-lasting efficacy[3-10]
- Potential cartilage preservation[11,12]
- Delay in time to total knee replacement[13]

Choose SYNVISC/Synvisc-One to help your patients with OA of the knee move beyond pain

SYNVISC® HYLAN G-F 20 | SYNVISC ONE® HYLAN G-F 20

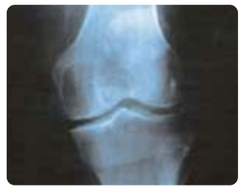
MOVING BEYOND PAIN

SYNVISC ONE Start Synvisc-One Early for Better Results[14]



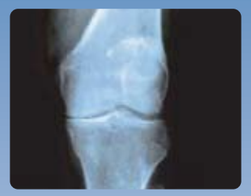
Grade 1

91%[14] Response Rate



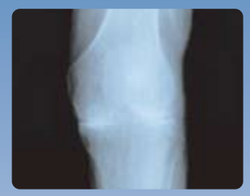
Grade 2

80%[14] Response Rate



Grade 3

76%[14] Response Rate



Grade 4

58%[14] Response Rate

8-9 out of 10 persons
with Grade 1 & 2 OA
respond well to treatment

Synvisc & Synvisc-One Abbreviated Product Information

Description: Synvisc-One (Hylan G-F20) 6ml. Hylan G-F 20 is a sterile, nonpyrogenic, elastoviscous fluid containing hylans. Hylans are derivatives of hyaluronan (sodium salt of hyaluronic acid) and consist of repeating disaccharide units of N-acetylglucosamine and sodium glucoronate. Indication: Synvisc-One is a treatment to decrease pain and discomfort, allowing more extensive movement of the joint. It is a temporary replacement and supplement for synovial fluid. Synvisc-One is only intended for intra-articular use by a physician to treat pain associated with osteoarthritis of the knee. **Contraindications**: If venous or lymphatic stasis is present in the relevant limb, hylan G-F 20 should not be injected into the joint. Hylan G-F 20 should not be used in infected or severely inflamed joints or in patients having skin diseases or infections in the area of the injection site. **Warnings and Precautions for use**: Do not inject intravascularly. Do not inject extra-articularly or into the synovial tissues and capsule. Adverse events, generally in the area of the injection, have occurred following extra-articular injection of Synvisc. Do not concomitantly use disinfectants containing quaternary ammonium salts for skin preparation because hyaluronan can precipitate in their presence. Hylan G-F 20 should not be use if there is a large intra-articular effusion prior to the injection. As with any invasive joint procedure, it is recommended that the patient avoid any strenuous activities following the intra-articular injection, and resume full activities within a few days. Hylan G-F20 has not been tested in pregnant women or children under 18 years of age. Hylan G-F 20 contains small amounts of avian protein and should not be used in patients with related hypersensitivities. **Adverse events**: Adverse events involving the injected joint: transient pain and/or swelling and/or effusion in the injected joint may occur after intra-articular injections of hylan G-F20. Intra-articular infections did not occur in any of the clinical trials of Synvisc/Synvisc-One and have been reported only rarely during clinical use of Synvisc. The post marketing experience has identified the following systemic events to occur rarely with Synvisc administration: rash, hives, itching, fever, nausea, headache, dizziness, chills, muscle cramps, parethesia, peripheral oedema, malaise, respiratory difficulties, flushing and facial swelling. In the controlled clinical trials with Synvisc, there were no statistically significant differences in the number of types of systemic adverse events between the group of patients that received Synvisc and the group that received control treatments. In the controlled clinical trial with Synvisc-One, the frequency and types of adverse events were similar between the group of patients that received Synvisc-One and the group that received placebo. **Dosage and administration**: Administer using strict aseptic procedures. Use 18-20 gauge needle. Synvisc-One recommended treatment regimen is one injection in the knee. The injection may be repeated 6 months after the first injection, if justified by the patients symptoms. **For further prescribing information, please contact**: sanofi-aventis (Malaysia) Sdn Bhd

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Damansara Heights, 50490 Kuala Lumpur.
Tel: 03-2089 3333 Fax: 03-2089 3338/9

continued from pg 21

The employment characteristics of the surveyed population was as follows:

Table Three: Employment of Residents aged 21 – 60 years

	Malay Men	Malay Women	Indian Men	Indian Women	Chinese Men	Chinese Women	Total Men	Total Women
Not specified	0	0	0	4	2	0	2	4
Government	1	0	2	1	0	0	3	1
Checkroll	1	0	14	10	0	0	15	10
Contract	2	1	26	15	10	1	38	17
Working (unspecified)	0	0	4	3	0	1	4	4
Unemployed	0	0	15	41	0	8	15	49
Total	4	1	61	74	12	10	77	85

The following features should be pointed out

- About 25% of the Indian males between the ages of 21 and 60 were not working. This indicates a fairly high level of dysfunction given the fact that this is a poor residential area – most families could do with some extra income, yet 25% of men in the working age group were not going to work. Although the percentage of women aged 21 – 60 not working is higher at 55%, this is more probably due to the role played by women as the home-maker.
- Out of the 79 Indians working, only 3 were working in government – a percentage of 3.8% of all the Indians working in this survey. Given that government jobs make up about 12% of all jobs, one would expect 12% of our survey population or 9 individuals to be working as government staff. This reflects the ethnic bias in recruitment for government jobs.
- A large number of the Indians working - 52% - were working in contract jobs which are much more insecure and uncertain as compared with persons on checkroll of companies or in the government.

Some disturbing features regarding the Indian Youth in the Taman were also picked up by the survey -

Table Four: Status of Indian Youth Aged 16 – 22 years

	Male 16 - 19	Female 16 - 19	Male 20 - 22	Female 20 - 22
Activity not specified	1	1	1	2
Studying	13	7	2	2
Working	5	0	4	6
Total	19	8	7	10

Of the 17 Indian youth aged 20 - 22, 10 (59%) were already working. That would mean that they did not follow up their secondary schooling with vocational or technical training. This would also mean that they are facing competition from the lowly paid but hard-working foreign workers! And that their pay and career prospects are not very bright! However this survey did not ask for the number of family members who are staying out – either working or studying out-station.

Of the 19 Indian boys between the ages of 16 and 19, 5 (25%) are already working. In other words it is likely that they did not even complete their secondary school education.

We asked about pay received in the course of our interviews. From the answers received we can construct the table below. However pay is one issue that people are not particularly truthful about!

Table 5: Monthly Hsehold Income of the Families Surveyed.

	Chinese	Indian	Malay	Total
< RM 500		1		1
501 – 1000		8	1	9
1001 – 1500	1	13	1	15
1501 – 2000	3	10	2	15
2001 – 3000	2	4		6
>RM 3000	1	2		3
Total	7	38	4	49

Table Six: House by Status of Ownership

	Chinese	Indian	Malay	Total
Fully paid up	8	10	3	21
Still paying bank loan	2	26	2	32
In Arrears	0	6	0	4
Renting	1	12	0	13
Not specified	0	3	0	3
Total	11	57	5	73

The data on housing gives the impression that the Indian families are worse off economically compared with the other ethnic groups in the same taman as:

- the percentage of families with fully paid up houses is only 18% compared to 73 for the Chinese and 60% for the Malay families.
- 6 out of the 32 Indian families still paying their housing loans are in trouble.

The data that was obtained from the question on disabilities is given in the Table below –

Table Seven: Disabilities Reported

House Number	Race	Age	Sex	Problem
73	I	53	M	Paralysed
117	I	2	M	OKU
123	M	11	M	OKU
163	I	53	M	Quadriplegic
165	I	8	M	Dumb
167	I	57	M	Gout
175	I	34	M	Blind
181	I	16	M	Leg deformity
196	I	62	M	Stroke
201	I	33	M	OKU
236	I	59	M	SOCSO llat
303	I	16	M	OKU
317	I	52	M	Bedridden
351	M	85	F	Bedridden
351	M	4	F	Mentally retarded

This table provides strong support for the argument that the males are the weaker sex!

Table 8: Problems Identified by the Residents

	Problem	Number of people mentioning		Problem	Number of people mentioning
1.	**Vehicles**		**3.**	**Children**	
	- driving at high speeds	2		- Drop out of school	1
	- young children riding m/bikes	1	**4.**	**Facilities**	
2.	**Youth**			- Drainage	13
	- Misbehaving	1		- Lack of games facilities for children	1
	- Drinking alcohol at early age	2		- Field not maintained	1
	- Noisy after midnight	1		- Rubbish collection not regular	4
	- Gang fights	4		- Telephone pole rotten	1
	- Fights with parangs	1			
	- No one giving them motivation	1			
	- No sports club	1			

	Problem	Number of people mentioning		Problem	Number of people mentioning
5.	**Health**		**7.**	**Crime**	
	- Mosquito	2		- Theft	4
	- Dengue	1		- Robbery	1
	- Alcohol	2	**8.**	**Pay is low**	1
	- Rats	1		**Can't get good job**	2
	- Snakes	1			
6.	**Houses**				
	- Atap terbang	4			

Drainage and youth delinquency (alcoholism and gangsterism) seem to be the 2 major issues that the residents complained about.

Conclusions

Several problems have been identified through this survey. How can these be addressed? One has to bear in mind that neither the PSM nor the Alumni Association has the capacity to address one of the root problems – low wages. Low wages not only causes poverty but also mandates that the parents spend more time at work – doing overtime or taking a second job, or having to go off to KL or Singapore to get a job with better pay. It also breeds a culture of hopelessness and apathy that makes substance abuse more likely.

However having said that, there are still many things that can be done, for example

- starting tuition classes for the primary and secondary school children;
- visiting all the people with disabilities to see if they are getting the assistance that they should be getting;
- helping the 2 red IC holders;
- starting a youth club to promote games and other healthier activities;
- packing off some of the youth to vocational training before they end up in the gangs – places like Montfort etc;
- forming a committee of the residents to address the drainage and other problems.

Community Health activities


With the community


Our doctors at work


Doctors in deep discussion


Chief with his hardworking girls


Sorting out the medication

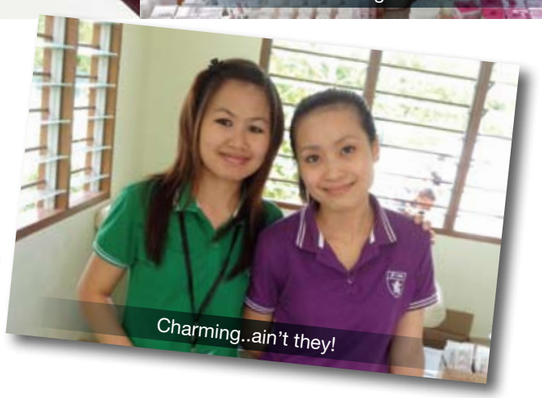

Diabetes screening


Our nursing assistants


Nursing assistants with a patient


Patients waiting for their turn


Closing up view. what next


Charming..ain't they!


Unpacking the medical supplies


Local residents

It's Borobudur & Prambanan come August 2013

Get ready everyone, we have another exciting trip planned for Manipalites who love history and ancient architecture. This one is closer to our shores.

Borobudur & Prambanan - UNESCO World Heritage Sites.

It will be a mix of activities – Historic, Scenic, Volcanic and not forgetting Funtastic. This will be heaven for the shutterbugs.

Interested???

It will be a four days, three nights trip somewhere in August 2013. All other details including pricing will be advised at a later date. So watch out for it.

This is a trip that should not be missed and it will be etched in your memory. Look out for the website announcements or register your interest with our secretariat and we shall revert soonest possible.

If you are wondering Where??

..What??

..Why??

...Borobudur & Prambanan,

read on for a little insight to this wonder on earth.

Borobudur

…This famous Buddhist temple, dating from the 8th and 9th centuries, is located in central Java. It was built in three tiers: a pyramidal base with five concentric square terraces, the trunk of a cone with three circular platforms and, at the top, a monumental stupa. The walls and balustrades are decorated with fine low reliefs, covering a total surface area of 2,500 m2. Around the circular platforms are 72 openwork stupas, each containing a statue of the Buddha. The monument was restored with UNESCO's help in the 1970s.

(Extract from UNESCO Site)

Event Timelines

Hindu religion in Indonesia as early as 0-100 AD

Buddhism introduced 700AD

760
Numerous Hindu temples built in the Dieng Plateau of Central Java

750 - 850
Saliendra Dynasty in Central Java "The Golden Age"

790
Ratu Boko Palace construction

790 - 860
Borobudur Temple constructed in the Kedu Basin, in a straight line with Pawon and Mendut Temples

850
Prambanan's main complex of temples, Loro Jonggrang, constructed

920
Power shifts from Central Java to East Java

Religious structures left untended exposed to volcanic eruptions, earthquakes and the ravages of the local vegetation

1200s
Islam begins to sweep Indonesia, and is the dominant religion by 1600

1733
Dutchman C.A. Lons re-discovers Prambanan site and reports of ruins and a great part buried underground

1814
Sir Thomas Ramford Raffles re-discovers Borobudur and commissions first clean up

1885
1st efforts commence to restore the Pramban temple complex

1907 - 1911
Significant restorations of Borobudur take place under Theodor Van Erp

1938
Restorations to Ratu Boko commence

1968
UNESCO votes to raise funds and safegueard Borobudur

1971 - present
Second major restoration of Borobudur

1991
Borobudur and Prambanan inscribed on the UNESCO World Heritage List

2006
Large earthquake in Central Java damages many temples in the region, including Prambanan

Imaging in DIABETES

Dr. Josephine Subramaniam

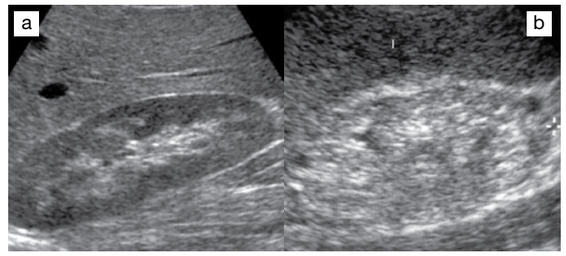
Statistics from the Ministry of Health Malaysia in 2011 show that in people over 18 years of age, there is a 20.8% prevalence of diabetes, with an upward projection in the years to come. It is a systemic disease and the major complications are retinopathy, peripheral vascular disease, heart disease, neurovascular disease, infection and renal impairment/failure. The underlying cause of all this is damage to small blood vessels from a high glucose level.

Imaging is useful in screening diabetics, and particularly important in the assessment and treatment of its complications.

Renal impairment

A baseline ultrasound of the kidneys would tell us if there is cortical thinning from chronic renal disease, and allows us to exclude renal calculi and obstruction. In patients who have acute renal failure, image guided dialysis catheter insertion is performed so the patient can dialyze for the 6 weeks required while a forearm fistula matures.

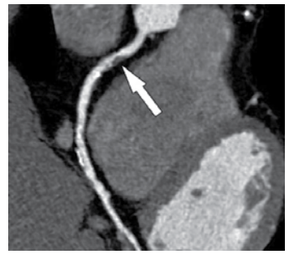
Doppler ultrasound can be used to look for vein stenosis in long term fistulas and angiographic balloon dilatation of the fistula if there is a stenosis.



(a) Ultrasound of Normal Kidney
(b) Ultrasound of Chronic Renal Parenchymal Disease

Ischaemic Heart Disease

CT coronary calcium scores inform us of the risk of coronary stenosis by measuring the amount of calcified plaque in the vessels.
CT angiograms are performed to look for vessel narrowing and ejection fraction in patients who are at high risk or have atypical chest pain.
MRI can be used to look at cardiac function, with structural assessment and myocardial perfusion. Segments of at risk ischaemic muscle or infarcted myocardium are visualized.

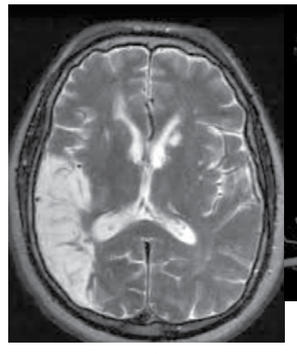


CT Angiogram: Coronary Calcification and non-calcified plaque causing a 60% stenosis

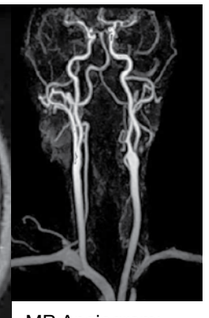
Neurovascular disease

Plaque in the extracranial carotid arteries can be directly visualized with a Doppler ultrasound. It informs us if the plaque is new or old and can assess if there is ulceration of the plaque, the usual cause of embolism or acute stroke.

CT and MRI are exquisite at looking for strokes and intracranial arterial stenosis. Intracranial stenosis is a more common cause of strokes in Asians; therefore ultrasound assessment of the extracranial arteries alone is insufficient.



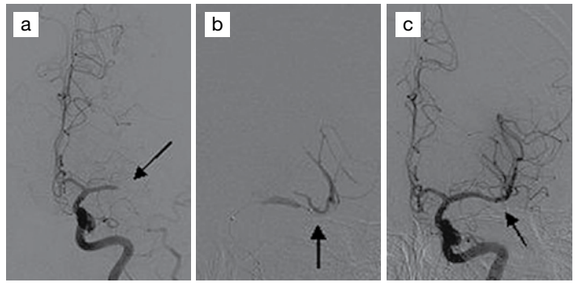
MRI brain: Infarction



MR Angiogram: Stenosis of Left Vertebral artery and Left Internal Carotid artery

In patients with acute stroke, treatment with thrombolytics can be done if the patient comes to the hospital early.

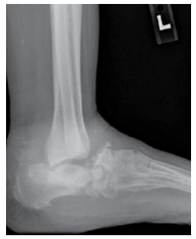
Intravenous thrombolysis is performed within the first 4.5 hours, intraarterial thrombolysis within the first 6 hours in the anterior circulation, and first 8 hours in the posterior circulation. Much of the decision making on treatment hinges on imaging, as haemorrhage needs to be excluded, and assessment of the size of the stroke and viable brain with perfusion CT or MR. New clot retrievers are now available to angiographically extract the clot from the arteries if there is a large clot burden or if there is a contraindication to thrombolysing agents.



Catheter Thrombolysis of Acute Stroke:
(a) Occlusion of the middle cerebral artery
(b) Catheter thrombolysis
(c) Re-establishment of flow

Peripheral vascular disease

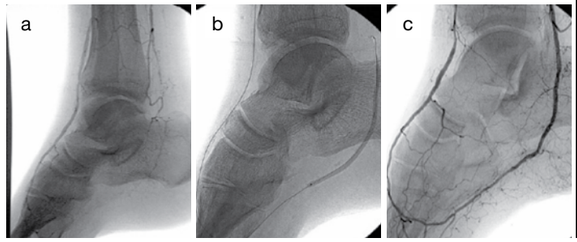
Diabetics suffer from a combination of peripheral neuropathy and arteriopathy.
The neuropathy is a result of damage to the vasa vasorum of the nerves and can result in a Charcot joint. This, together with the arteriopathy can also pre-dispose to infection. Imaging is excellent at directly assessing the blood supply to the lower limbs, the degree of damage in the joint and the extent of infection involved.



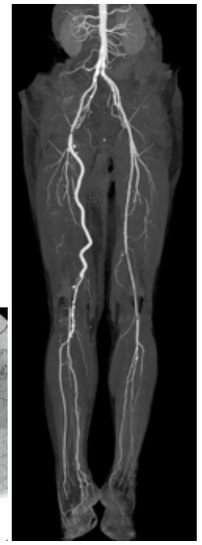
Xray Ankle:
Neuropathic joint

The arteriopathy can also be treated with balloon angioplasty and stents.

The aim of treatment is to prevent amputation and allow non-healing ulcers to heal. The angiosome concept is now propogated, in which revascularization must be performed within the target arterial territory, often into the plantar arch.



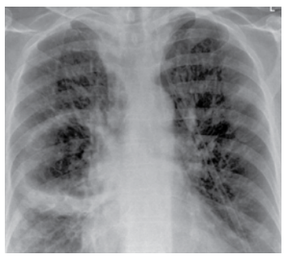
(a) Diabetic foot ulcer: Pre angioplasty
(b) Diabetic Ulcer: Balloon angioplasty
(c) Diabetic Ulcer: Post angioplasty



CT Angiogram:
Non-healing ulcer
left foot

Infection

Diabetics are at greater risk for certain kinds of infection and have greater complications with the usual infections.
Soft tissue infections like necrotizing fasciitis, emphysematous pyelonephritis, emphysematous cholecystitis, empyemas and pulmonary mucormycosis are but a few. MRI demonstrates soft tissue well, and infections that produce air are well seen on CT. The humble chest x-ray is still extremely useful in chest infections.



Chest Xray :
Right lung abscess

In summary, diabetes is a systemic disease which affects most of our organs due to damage to small vessels. Imaging is utilized in the pro-active management by performing screening for high risk patients. It is also useful to assess the degree of complications and guides us to treat the patient in the best manner possible.

Lastly, interventional radiological management of the diabetic foot, stroke and dialysis fistulas promotes quality of life for patients with chronic disease.

A Glimpse of Nightlife in Bangkok

by Dr KC Koh

What is it about Bangkok that continues to draw crowds of visitors to this megacity? The word, ‘nightlife and sex’ almost invariably comes to the lips of many. But I would beg to differ. There is much that this megacity has to offer it’s visitors and it is this diversity of offerings which include shopping and food that continue to draw crowds of visitors.


Nana Plaza


Condom lights

Condoms in the hotel minibar

On the subject of food, there is an establishment which is known as the Cabbages and Condoms Restaurant. It is a well known restaurant which is frequented by locals and foreigners alike. My first visit to the establishment was in the 90s when it was a modestly sized set up. It has now grown significantly and though the food is nothing to shout about, it is worth a visit to experience what it has to offer.

Which restaurant have you been to that gives you condoms together with your bill? This restaurant was conceptualized in part to promote better understanding and acceptance of family planning and to generate income to support various development activities of the Population and Community Development Association.

The attraction here are the works of art which are made using condoms. You get to see various manikins made of condoms and lamps made of, you guessed it, condoms. There are wall decorations of condoms and messages on prevention of HIV infection. Well worth a visit.

But for me, I prefer to frequent the smaller joints as well as some of the more hygienic road side food vendors in order to enjoy good Thai food.

Many of us who have been to Bangkok would have heard of Patpong, the infamous red light area. It has seen it’s heyday and is now nothing more than a night shopping street not unlike many others you see in South East Asian Cities. It is interspersed with a few establishments catering for the curious male visitors.

Nightlife in Bangkok has since moved on to other areas, with one notable spot known as Nana Plaza which is within walking distance from the afore mentioned Cabbages and Condoms Restaurant. It is a three storeys high establishment which caters for adult activities. It is relatively safe for tourists who wish to have an exotic visual experience and who want to take a photo or two.

For the curious, do maintain an open mind and explore the various types of adult activities they have in store for you. However, bear in mind that should you wish to partake of the action available there, there is no such thing as safe sex.

If you do forget to pack some condoms for your trip, you may be able to find a box of condoms along with the minibar snacks in your hotel room.

Shopping is another experience to sought after in Bangkok. With so many shopping malls scattered over the city, do ensure that you have enough credit in your credit cards. But I will leave this to the shopaholics to decide if Bangkok is indeed a shopping paradise.

Condom man


Condom that came with the bill


Fresh Thai Prawns

Breast Lumps
- When to Worry!

Let's face facts, every single one of us knows someone who has breast cancer!

Dr. Patricia A. Gomez
Consultant Breast Surgeon
Breast Care Centre
Ground Floor, Block C,
Pantai Hospital Kuala Lumpur

Breast cancer is after all the commonest female cancer in Malaysia and the second commonest cancer throughout the world; lung cancer being the first. However, unlike lung cancer, breast cancer is NOT a 'death sentence' if it is diagnosed early and treated adequately.

In actual fact, in most developed countries, the incidences as well as deaths from breast cancers have been declining due to the excellent and varied methods of treatment available in the present time. Early breast cancer is beginning to be treated like a 'chronic disease' i.e. diabetes or hypertension, where there is also no "cure" available, but prolonged control of the disease is possible, and with good quality of life.

As much as we would like to believe that breast cancer is a disease of the elderly woman, we are in fact seeing younger women being diagnosed with breast cancer; women in their 30's and 40's and even those as young as 20 are getting breast cancer. This is especially so for Asian women. It is also a well known fact that 1% of breast cancer patients are men.

The commonest symptom of breast cancer is a painless lump in the breast or axilla. Unfortunately because there is usually no pain, women are often lulled into complacency and do nothing about this lump until it is sometimes too late. In the Western countries where the incidence is very high (1 in 8 or 9 women get breast cancer), there are government run screening programs, but in Malaysia this is not available, and the onus is upon women aged 40 years and above to come forward for screening mammograms.

However, not all breast lumps are cancers! The commonest cause of a lump in the breast is usually a benign water cyst or a fibroadenoma; but ALL breast lumps must be investigated and usually by 'Triple Assessment'; clinical examination, imaging (either a mammogram and or ultrasound) and a needle biopsy.

A mammogram involves an x-ray of the breasts. The radiation dose is very minimal, and is the 'gold standard' for detecting early breast cancers; sometimes even before a lump can be felt, or even a pre-cancer (ductal carcinoma in situ) which shows up as microcalcifications and is curable. Digital mammography is fast overtaking analogue mammography as the images are better, clearer and the need for repeat views is minimised. The radiation dose is also less with digital mammograms.

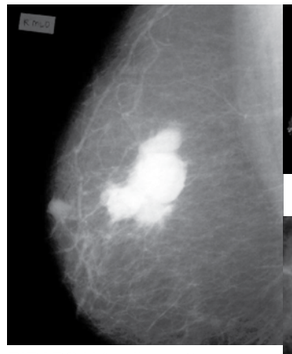
The ultrasound is an adjunct tool to supplement mammography findings and especially in dense breasts, and in women under the age of 40 years. The ultrasound can very quickly define lumps, ascertain if they are water filled, solid or complex, and define the vascularity or elasticity of a lump as well as assist in accurate guided biopsies.

MRI (Magnetic Resonance Imaging) is not usually used as a screening tool, but has its advantages in detecting new malignancies after surgery and radiation, and in screening very high risk families. Enhancement curves should be done to diagnose cancers.

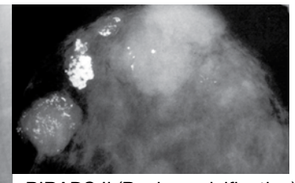
The BIRADS (Breast Imaging-Reporting and Data System) is an excellent tool to standardise reporting on Breast Imaging, started for mammography and now used for ultrasound and MRI reporting as well.

BIRADS CLASSIFICATION

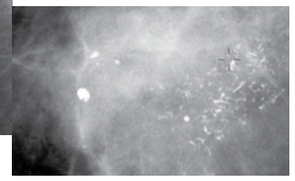
0	Incomplete assessment, other imaging or repeat
I	Normal, normal follow up
II	Benign, normal follow up
III	Probably benign. Needs close follow up (MMG at 6 months, then every 6 to 12 months for 1 to 2 years)
IV	Suspicious, Biopsy recommended
V	Highly Suspicious of malignancy. Biopsy Indicated
VI	Biopsy proven abnormality. Urgent action.



BIRADS V (malignant)



BIRADS II (Benign calcification)



BIRADS IV
(Suspicious microcalcification) warrants a biopsy

So remember mastalgia is usually not a symptom of breast cancer, but when presented with inflammation in the breast, always remember to biopsy the wall of the abscess, as rarely, cancers can present as inflammation (Inflammatory breast cancers).

Important to mention here is Chronic Granulomatous Mastitis (CGM) which presents as recurring abscesses, and has often been mistaken for tuberculosis or breast cancers. This particular mastitis is believed to be auto-immune in aetiology, and therefore often requires steroids as treatment, in addition to antibiotics and drainage.

Also do not disregard breast lumps in pregnancy or while breastfeeding. Investigate as with all other breast lumps.

Recommended screening is now

Age	Recommended screening	Frequency
20 to 35 years	Clinical Breast Examination CBE	Annually
35 to 40 years	CBE, Ultrasound Breasts	Annually
40 to 75 years	CBE, Mammogram, +/- Ultrasound breasts	Biannually
Above 75 years	CBE	Annually

Note: Those with 'High Risk' (eg. Family history, on HRT etc) will require more frequent screening (Annually)

Treatments for breast cancer include surgery (breast conserving for early cancers), chemotherapy, radiation, hormonal treatments and newer targeted therapies. Most women believe that surgery always involves removal of the breast (mastectomy) but the truth is that with early cancers, the breast can be saved, or if necessary 'oncoplastic' surgery can be done creating a new reconstructed breast after a mastectomy.

Breast Cancer is the Number One Cancer Killer of Malaysian women, it is our responsibility to increase awareness and encourage women to come forward for screening to decrease the morbidity and mortality from this dreaded disease.

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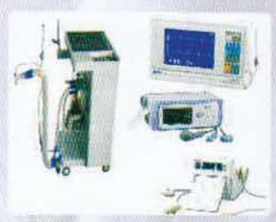

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