

HOWZIT



Manipal Alumni Association Newsletter

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A very big
welcome
to **Dr. Arun Kumar,**
our new President



The humanistic side of
Manilpailtes-flood
relief voluntarism

MAAM
to be active in
CPD activities



Obstetrics, Gynaecology & Reproductive Medicine CPD 2015

To share knowledge and provide needed information to healthcare professionals who are interested to update their skills and knowledge.

Date : 18 January 2015 (Sunday)

Time : 9.00am - 1.30pm

Venue : TMC Fertility Centre, 2nd Floor



Like us on our Facebook Page [Manipal Alumni Association Malaysia](https://www.facebook.com/ManipalAlumniAssociationMalaysia)



Follow us on Twitter @ManipalMAAM



1st Edition of **HOWZIT** for **2015.**

MAAM-Mobile App

Dear Manipalites,

The MAAM has launched its own Mobile App on both the App Store and Google Play.

The idea of this App is allow members to have first-hand information on the happenings of the Alumni.



The information on the Mobile App will be updated from time to time and it is linked to our Facebook page and Website.

I hope you enjoy yourself browsing through our new App.

Please download the App on your iPhone or Android device. Just type MAAM in search or click to download the App



to the
welcome

The year 2014 had been an eventful year for us, especially with the hosting the our first ever International Health, Science and Technology Convention. which saw a coming together of Manipalites from various parts of the world.

Being an election year of our association, it saw the changing of Presidency from Dr Nirmal Singh to Dr Arun Kumar. With this change of helm as well as the new line up of office bearers, everything is all gung ho at our alumni.

We have recognised the need to develop our members professionally in line with the aspirations of our country to have a healthcare sector second to none in this part of the world. Therefore apart from the Convention last year, we are foraging into the provision of CPD activities for our members to get CPD points which will soon be a prerequisite before an Annual Practising Certificate (APC) is issued by the Malaysian Medical Council. These points are a must for any medical doctor, irrespective of specialty before they get their APCs.

The Association is also looking into ways to assist our members who are looking at specialising in the various fields of medicine. To maximise the benefits of being a member of this Association, you will need to be kept abreast of current happenings. That can only happen if you take the effort to update your details with our secretariat.

It is much appreciated if you could provide us with your current specialty, place of work and latest contact details and send it back to us via email at manipalmaam@gmail.com or any other electronic means.

Dr. KC Koh
Editor

President's message



I am delighted to address you in my first term as President of the Manipal Alumni Association Malaysia in the first volume of HOWZIT for 2015.

At the back of a very successful and memorable 1st Global Manipal Alumni Health, Science and Technology Convention in August, 2014, it is a daunting task to lead the committee and our members through a meaningful two years. Congratulations to Dr. Nirmal and his team.

Since starting our term, we have already completed two CPD events and also the Consensus Summary of last year's convention. Our AGM is scheduled for May, 2015 and we hope to have a CPD session prior to the meeting as well as dinner and dance for our members' benefit. We welcome suggestions and resolutions but they need to be sent in at least two weeks before the AGM. The exact date for the AGM will be communicated to members soon.

The big concern for our committee is our database. We need members to please update their contact details including email, postal address and telephone contact. It will be a shame if you are unable to receive important information of our events because we don't have your contact details.

This year we are also planning an Alumni trip to the Rain Forest Festival in Kuching, Sarawak from 7 to 9, August, 2015. Our HOWZIT has more details. Please book early to avoid disappointment.

Our association's facebook is thriving with 813 Likes. I encourage members to get on to our facebook to be updated.

Looking forward to my committee and me serving you meaningfully for this term.

Dr. Arun Kumar
President MAAM

Manipalites in flood relief work



It is unprecedented, the massive widespread occurrence of floods in Malaysia, at least not if I can recall. The news media itself was flooded (pun intended) with news related to this phenomenon from the final month of 2014 right into 2015.

Things were perceivably chaotic in the first week or two due to the unexpected onslaught of H₂O, both from the rivers and the heavens. It was made worse by a lack of communication from the ground. What was anticipated as a yearly occurrence of flooding soon turned out to be a nightmare for all concerned as even areas that were not previously exposed to this annual phenomenon succumbed to it.

As government aid was ham strangled during the initial few days due to logistical issues, many individuals as well as Non Governmental Organisations (NGOs) scamped to provide assistance to those affected by the floods.

Being charitable at heart, as evidenced by our fund raising effort during the previous typhoon haiyan in 2014, we at MAAM swung into action. What was evident at that point of time showed the need for humanitarian efforts in the form of daily necessities as well as manpower.

As MAAM is not a humanitarian organisation, it was not feasible for us to organise a team of our members to offer aid. Our MAAM members then sought out other humanitarian organisations where we could join up with, in their efforts to offer assistance to those affected by the floods.

Dr Eugene Tan, our charming young Captain in the Malaysian Armed Forces, was deployed to Kelantan for flood relief duties.

Dr Jeyanthi, teamed up with Mercy Malaysia and spent some time offering aid to those in need. Do read her account of what transpired during her tour of duty.

Dr Koh Kar Chai went along with the Tzu Chi International Medical Association to Kuala Krau in Pahang which was inundated with the torrent of muddy waters. Apart from offering medical aid, a massive clean up or rather throw out of damaged household items was done. There were also donation drives at popular shopping centres in the Klang Valley to tap onto the generosity of our Malaysian shopping crowd.

Our Manipal alumni from overseas showed their generosity and camaraderie by donating generously in the form of financial pledges. A big appreciation to our fellow Manipalites from overseas.



Flood Relief Response

As the year 2014 was coming to a close, my thoughts were as to how I would be spending the coming of the New Year. Somehow I wanted it to be meaningful and as if the Universe heard me right, on Tuesday 30th of December at 11 am, Dr Philip George calls me asking for volunteers to assist Mercy Mission at the Flood Relief Centers in Perak. His plea of help invoked an almost immediate response that I would be there, I didn't have to think or even ask my family for permission as I knew this is something I had to do. Amidst the two disasters that had already crippled the nation, I was feeling sad and helpless, hence I just had to do what I can for my country and my people.

I was asked to report to Mercy Mission's headquarters by 1pm that very day, and I scuttled home, barely knowing what to pack. Throwing in whatever I thought I needed, I got myself to Mercy Headquarters just before 1 pm. I was happy to see my fellow volunteers trickling in one by one and we were then ready to go! We were told what our mission was and what to expect. Our role defined to us was that we would need to provide health education to the victims of the flood, who were all living together in crowded areas. The phase one of immediate response was already taken care of and we were phase two of disaster management.

It took us approximately 4 hours to get to the base camp, which was at Seri Iskandar and I had to sigh in relief to find that the base camp was not as bad as I had pictured it! After settling in, we were



briefed by our Head, En Tajol on our duties and the plan for the next day, as it was already too late to go to the sites. We met the Public Health expert En. Fadli who informed us as to how we were going to do the health education and requested us to work on the module of education that would then be used by the team now and even in the future, if found to be successful.

The following day, after getting our module ready to be used and discussing our modus operandi, we moved out to the flood relief sites. It was indeed an eye opener for some of us as we saw the crowds huddled together in schools and camps. Each family found their own little areas within the camp, some entertaining themselves to a game of chess, the children distracted with games already planned for them. Mass cooking were taking place, whilst some were just wandering aimlessly about. We made a visit to every mobile clinic to gauge the situation of medical ailments that these flood victims were already encountering. We noticed that though the medical team seemed to be coping, they did not have any direction. They were treating each case as they came without looking at the big picture. There was no surveillance going on. Nobody even thought of giving them directions as to what to look out for, what they can expect to encounter, what their outbreak plan was. At one centre we were surprised to find out, they had 3 scabies infections detected, but no action taken to prevent this from spreading. It was disappointing to know that the medication to treat Scabies was not even available, nor was any request sent out. We noted that it was purely a CURATIVE type of medical treatment going on, and nothing preventive.

This was where we came in! Now, we realised how crucial it was to disseminate information and education to the flood victims. There were 13 flood relief centers, hence we identified the centers with the highest volume of victims and set about to reach out to them. Travelling to these centers took approximately an hour each. On 31st of December at about 9 pm, after getting all the logistics settled, we commenced our education to our first relief center at MRSM, Pasir Salak reaching out to approximately 900 people. The awareness was well received, it was indeed a pleasant experience to see that women and children were most attentive with a high level of participation. It gave us the zest to continue on to the next center which was about 10 minutes away from this center and hosting more than 1000 victims.

It was already 10 pm, but the people were still awake, hence we got them all excited to listen to us, got them to participate in an activity and of course the kids got rewarded with sweets! We finished this session at 11.45 pm on the 31st of Dec 2014 and we were so pleased with ourselves. As we drove back to our base camp, we wished each other a Happy New Year at the stroke of midnight! Phew! what a way to usher in the new year!

The next day, we were on the roll, to reach out to as many camps as possible, but however was only able to cover 3 more centers. With the ongoing rain, flooded roads impeding our journey to the centers, we were able to reach only 3 more centers. We knew that, our effort needed to be continued as the people had to be reminded how to take care of themselves and their families. The children were out there playing in the flood waters, families were returning to their flood filled homes, continuing to eat and wash their clothes there, not worried about the dangers that lurk in

the flood waters. They needed to know that it was not okay to go back to their homes, they needed to know that they needed to wash their hands and to take care of their personal hygiene as well as the environment. Prevention was key during these times, as families huddle together in these centers, a rise in cholera, dysentery, scabies, skin infections and worm infestation occurs!

There is so much to be done and reaching out and helping as much as we can, is what each and everyone of us must endeavour to do. My heart goes out to the families as they wait to go back to their homes and start afresh. Many of them were holding their own, some say it's God's destiny and some take it in their stride. There were some worried about what will happen to their earnings, how to rebuild and start from scratch... it's a sorry state and its sometimes not fair.

By Dr. Jeyanthi Vengadasalam



They need help, they need our support... so please spare some of your precious time to help them!

FIGHT the fear

Educating the community and dispelling myths play a key role in dealing with pandemics like Ebola.



By Dr. Unni Karunakara

Let us start with facts about Ebola. Ebola Virus Disease first appeared in 1976, in what are today the countries of South Sudan and the Democratic Republic of Congo. The virus was discovered by Peter Piot and his colleagues, at the Institute for Tropical Medicine in Antwerp, from blood samples of a nun working in the village of Yambuku, south of the Ebola River. Humans are infected through contact with bodily fluids, organs, or secretions of infected animals such as apes, monkeys, antelopes, or fruit bats. The virus then spreads from human-to-human through direct contact with bodily fluids, including breast milk and semen, and surfaces or objects such as infected bedding or clothing.

Since 1976 it is estimated that there have been over 1,800 cases of Ebola, with nearly 1,300 deaths, before this latest outbreak. West Africa — largely Guinea, Liberia, and Sierra Leone — is now experiencing the largest outbreak of the Zaïre strain of the Ebola Virus in history. The current outbreak was officially declared on March 23, 2014, and has killed close to 5,000 people of the approximately 14,000 who are thought to have been affected.

Now for the myths about Ebola: Ebola spreads through water, through air and... through chocolate, apparently. While responding to Ebola outbreaks in the Republic of Congo (2002-2003), I experienced first-hand how myths and misunderstanding about its spread can affect effective response.

For organisations like Médecins Sans Frontières (MSF) and others, this misinformation and misreporting of facts affects not just containing the epidemic but also the response to it, by impacting the willingness of health workers to volunteer in such tough medical emergencies and fight the disease where it should be fought — on the ground.

And then there is the hysteria. The fear that Ebola may strike at home has forced media and governments across the world to have a blinkered view about the problem. In the last few weeks, the focus has shifted from the problem at hand — the continuing epidemic in West Africa — to a handful of cases in developed nations. The best guarantee against the spread at home is to mount a concerted and effective response to the epidemic in West Africa.

The discussion and debate about the disease, however, has come to a crucial point: Do we allow the myths around the disease to consume us or do we practice a rational, scientific and experience-based discourse around it? For us, the strict protocols we lay down for health workers dealing with Ebola comes from our long experience in dealing with the disease and from valid information provided by science and ongoing research. The pertinent point is that the protocols that we and others, such as the Centre for Diseases Control and Prevention (CDC), have developed are effective. A person is contagious only when he/she exhibits known symptoms of the disease. This is the reason why we do not enforce self-quarantine but educate all

health workers about associated risks. What we drill into our field workers is vigilant monitoring of one's own health, frequent communication with our offices, and immediate reporting of symptoms that suggest Ebola.

Our expertise in dealing with contagious disease outbreaks has taught it that, during public health crises, educating the community and dispelling myths play a key role in breaking the chain of contact. Only when one understands the disease and how it spreads can stringent measures be taken to prevent it. This critical aspect will play a life-saving role in breaking the current chain of infection transmission.

Part of the challenge in tackling the current contagion of Ebola is in dismantling the layers of myths by relying on scientific discourse. It is here that the media can do a great deal of good by consistently highlighting the facts, over and over again. Humanitarian organisations are battling Ebola on the ground but the media can strengthen our work by taking on the equally formidable enemy: Fear.

The writer is former International President (2010-2013) and MSF India trustee.

NOTE: This article was first published in the Hindu, on 23 November 2014



MAAM FUTSAL



On the 1st of November 2014 the Manipal Alumni Association Malaysia (MAAM) had organized a friendly futsal match in Melaka. The friendly match was against current students from Batch 27 & 28 of Melaka Manipal Medical College (MMMC). The MAAM team comprised of former students of MMMC from Batch 9. Around 20 players were involved and the match took place in Kompleks Sukan Batu Berendam, Melaka from 11.30am to 1.30pm. Few rounds of matches each lasting 15 minutes were played and the MAAM team was the overall winner. The cost of the event was borne by MAAM. This event is mainly to get our alumni members together on a regular basis and also promote a healthy living life style through sports. Plus it enabled us to interact with currents students of Manipal and keep our Manipal spirit alive!! Inspired by Life!!

by Dr. L.Sivasuthan



The need to **Specialise, Specialise** and Specialise in this **Modern Era** for **Medical Graduates**



Prof. Sachchithanantham Kanagasabai,
FRANZCOG,FRCOG,FACS,FICS DIMH MBBS & Dr. Devinaga Rasiah

A Senior Gynaecologist ,academician teacher, editor & author of multiple text books and clinical articles having spent 32 years training post graduate students locally and abroad tells his story of his fervent rhetoric as to why medical doctors of today need to specialize and is most qualified to do so.

INTRODUCTION

The yesteryears

I suspect that when I go down memory lane back to the seventies when I joined the medical career, most current medical graduates are not aware that the medical practice in this country was managed by the medical officers and a few specialists. The Local specialists were few in number and the rest were mostly expatriates from India and Burma, perhaps one to a unit and none in fields like pediatrics and ENT , and their scarcity led to on many occasions for the less qualified to do the decisions on their behalf .However it cannot be denied that the medical officers of the era were well trained that they would duplicate the activities of their superiors and rise to the occasion to provide exemplary treatment

It was during the eighties when both critical medical education and health care reforms were developing throughout the country and abroad. The early post-graduation was done by doctors from this country obtaining their FRCS (general surgery /ophthalmology,orthopaedics was part of General Surgery), MRCOG and MRCP from the United Kingdom. These physicians who were formally trained were mostly educated in the schools of England and Scotland, and to a lesser extent in Europe. Many were graduates of the University of Edinburgh's School of Medicine, which, during the 18th century, was considered to be one of the leading medical schools in Europe, if not the world. Hence, this school had great influence on medical practice throughout the world, and even into the early 19th century.

It was in the early eighties that the first postgraduate programme in orthopedics was drawn up the National University of Malaysia as its inception and hence examined the rise of specialization and the establishment of other specialties in the two premier Universities in Kuala Lumpur. Although initially the programmes were limited to a few candidates in view of the limited number of specialties ,it paved the way for the development of residency programs throughout the Country during the period 1990 to the present. Today there are five Universities offering postgraduate studies.

Current scenario

This article published: August 19, 2013 reiterates the country's needs

Malaysia needs more medical specialist, says Health minister

Despite an increasing number of medical graduates, the country is facing a shortage of specialist doctors. Today's statistics from Health Malaysia 2012 mentions that there are a total of 38,718 doctors practising, 27,478 in the public sector and 16,240 doctors in the private sector.

It cannot be denied that approximately 6% are specialists in the public sector and the numbers are dwindling as migration in large numbers to the private sector due to better remunerations by the private sector .The private hospitals are currently numbering 220 when compared to public hospitals which number 138. Ironically the private sector sees approximately 4 million patients compared to 49 million in the public sector.

To address this shortage of specialists currently, about 500 to 600 doctors are sent for training each year to become specialists every year. This has been an ongoing feature for the past twenty years .It is not the numbers that go for training which are of concern, but the dropouts from this programme is of concern, so the final numbers produced is not sufficient to address the pending crisis now and in the near future.

Apparently doctors who can specialise in cardiothoracic, hepatobiliary surgeries and other new infectious, lifestyle and chronic diseases are in dire need the most.

The country currently has 36, 607 doctors including specialists with a doctor population ratio of 1:791 based on the estimated population of 34 million.

The Ministry is hoping to have 85,000 doctors by 2020 to reach the standard ratio of 1:400 by 2020. It may be obvious why medical officers are reluctant to embark on a post graduation,likewise

the reasons for doing post graduation too are pretty obvious. What is pertinent at this junction is to address the reasons for reluctance so that we can hope for a large cohort of specialists in the various discipline to man the needs of the country.

REASONS FOR RELUCTANCE TO SPECIALIZE

1. The long trying hours at housemanship resulting in loss of passion for medicine. Eventually work becomes a chore and not relinquished, resulting in disappointment of having chosen the medical profession.
2. The perception that Specialisation requires long devoted time, unable to make time in this modern era when other priorities take precedence, like getting married and having children.
3. The current salaries being paid for housemanship and Medical officers are handsome and having achieved a sense of positioning in society with this economic satisfaction reached deprives one to further continue with further studies.
4. Lack of motivation by peers, seniors and Mentors. Apparently the mentors of today need motivation in view of the large numbers of litigation faced by them
5. Not a priority at this juncture inevitably resulting in postponement to make a decision
6. No guidance from established institution espacilly Universities to show ways and means of securing information to pursue postgraduate studies.
7. The Medical officer applicant need to be confirmed when applying and after submitting the application , he may not be selected.
- 8 Recurrent applications for post-graduation to universities which can be turned down further aggravating the situation.
9. A genuine reason being encouraged to take over the family practise

REASONS WHY ONE SHOULD SPECIALISE

1. Sense of being doyens of their respective discipline
2. The pride, grandeur and leadership of being a specialist should be a strong motivating factor

3. No senior medical officers in the respective unit should be left to idle, ownness is on the senior consultant to motivate, provide study leave, monetary benefits for attending courses and admire their success.
4. From the perspective of return of investment, Specialist in public sector have easy access to promotions and a Superscale C 's take home with allowances can easily be in the region of 23K. The prospect in the private sector could range from 50k to 100k.
5. If one does not qualify for the local postgraduate programme, it would be easy to start studying for the British Post graduate in MRCS, MRCP, MRCOG, MRCP (Paeds), Radiology in selected hospitals etc.
6. Those who want to migrate or work overseas would fear better if one has a foreign post graduate degree.
7. Ultimately the country needs a large number of specialists in view of the large number of patients who attend the public hospitals

CONCLUSION

The above recommendations are perhaps long term measures to get more specialists .However in order to fill the void , get the medical specialists trained overseas to return home .This may require the Government to have salary revisions to attract them. The second option would be to increase the number of post graduates admitted for training. This certainly would require the cooperation of the Universities .The third option would be for Government to approach the Private medical colleges to initiate their own post graduate programmes. Lastly collaboration with the Royal Colleges abroad to have local training programmes which can be accredited.

If one fails to embark on a postgraduate programme sooner or later there is a high probability of ending up as a glorified medical officer at the hospital. Subsequently anger ,disappointment and frustration will get the better of one , forcing these officers to the private sector as a general practioner where the challenges can be insurmountable.

Registration fee

Registered with WATTzapDoc	RM100
MMA / MPS / Manipal Alumni Member	RM100
Non Member	RM150
Nurses' Symposium (for nurses only)	RM80

Note:

- Seats are Limited
- After 17 April 2015, will attract late fees of RM50
- No on-site registration
- For healthcare professionals only
- CPD points awarded

Download the Registration Form & Programme at www.cleve.com.my

For further information, please contact the Event Secretariat:
 Ms Jessie: 012 631 3436 /
 Ms May: 012 638 8128
 Email: clev.info@yahoo.com /
may@cleve.com.my

Traumatic Brain Injury

– An Overview



Part 1 of a TWO Part Review

**Dr. R. C. Krishna, Consultant Neurologist,
New York, USA**

DEFINITION

Traumatic brain injury occurs when an external mechanical force causes brain dysfunction temporarily or permanently that may or may not be detectable with current diagnostic technologies.

Traumatic brain injury usually occurs as a result of a sudden and violent blow or jolt to the head or body. An object penetrating the skull, such as a bullet or shattered piece of skull, also can cause traumatic brain injury.

Mild traumatic brain injury (MTBI) may result in temporary dysfunction of brain cells (neurons). More serious traumatic brain injury could result in bruising, torn tissues, bleeding and other physical damage to the brain that can result in worse outcomes, long-term complications or death.

Severity of traumatic brain injury (TBI) is typically defined by the initial Glasgow Coma Scale (GCS) score. The GCS score is a widely used assessment of neurological function that has been validated in many studies since it was first introduced in 1976¹.

Severity of TBI as determined by initial GCS score is as follows:

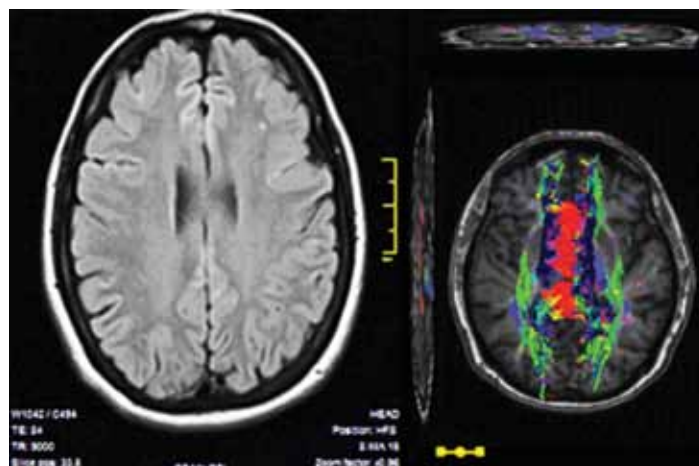
- Mild (GCS score 13 to 15)
- Moderate (GCS score 9 to 12)
- Severe (GCS score <9)

TBI is usually classified based on severity, anatomical features of the injury, and the mechanism (the causative forces)². Mechanism-related classification divides TBI into closed and penetrating head injury. A closed (also called non-penetrating, or blunt)³ injury occurs when the brain is not exposed.[4] A penetrating, or open, head injury occurs when an object pierces the skull and breaches the dura mater, the outermost membrane surrounding the brain⁴.

SEVERITY

Severity of Traumatic Brain Injury

	GCS	PTA	LOC
Mild	13-15	<1day	0-30min
Moderate	9-12	1>1 to <7 days	>30min to <24hrs
Severe	<9	>7days	>days



Brain injuries can be classified into mild, moderate, and severe categories on the basis of Glasgow coma scale. The Glasgow Coma Scale (GCS), the most commonly used system for classifying TBI severity, grades a person's level of consciousness on a scale of 3–15 based on eye-opening reactions to stimuli, verbal and motor. It is generally agreed that a TBI with a GCS of 13 or above is mild, 9–12 is moderate, and 8 or below is severe^{5,6,7}. Similar systems exist for young children⁶. However, the GCS grading system has limited ability to predict outcomes. Because of this, other classification systems such as the one shown in the table are also used to help determine severity. A current model developed by the Department of Defense and Department of Veterans Affairs uses all three criteria of GCS after resuscitation, duration of post-traumatic amnesia (PTA), and loss of consciousness (LOC)⁸. It also has been proposed to use changes that are visible on neuroimaging, such as swelling, focal lesions, or diffuse injury as method of classification. Grading scales also exist to classify the severity of mild TBI, commonly called concussion; these use duration of LOC, PTA, and other concussion symptoms⁹.

Mild traumatic brain injury (TBI) occurs with head injury due to contact and/or acceleration/deceleration forces. It is typically defined as mild by a Glasgow Coma Scale (GCS) score of 13 to 15, measured at approximately 30 minutes after the injury (table 1). Some recommend classifying patients with a GCS score of 13 as moderate head injury (GCS score of 9 to 12) because they seem more similar with regard to prognosis and incidence of intracranial abnormalities.

The term concussion is often used in the medical literature as a synonym for mild TBI, but it probably describes a subset of milder brain injury. The Quality Standards Subcommittee of the American Academy of Neurology defines concussion as a trauma-induced alteration in mental status that may or may not involve loss of consciousness.

- Concussion may be caused by a direct blow to the head, face, neck, or elsewhere on the body with an 'impulsive' force transmitted to the head.

- Concussion typically results in the rapid onset of short-lived impairment of neurologic function that resolves spontaneously. However, in some cases, symptoms and signs may evolve over a number of minutes to hours.
- Concussion may result in neuropathological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than structural injury, and as such, no abnormality is seen on standard structural neuroimaging studies.
- Concussion results in a graded set of clinical syndromes that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course. However, it is important to note that in some cases, symptoms may be prolonged.

Acute symptoms and signs — The hallmark symptoms of concussion are confusion and amnesia, sometimes with, but often without, preceding loss of consciousness. These symptoms may be apparent immediately after the head injury or may appear several minutes later. It is important to emphasize that the alteration in mental status characteristic of concussion can occur without loss of consciousness. In fact, the majority of concussions in sports occur without loss of consciousness and are often unrecognized.

The amnesia almost always involves loss of memory for the traumatic event but frequently includes loss of recall for events immediately before (retrograde amnesia) and after (anterograde amnesia) the head trauma. An athlete with amnesia may be unable to recall details about recent plays in the game or details of well known current events in the news. Amnesia also may be evidenced by the patient repeatedly asking a question that has already been answered. Details regarding the presence and the duration of loss of consciousness, confusion, and amnesia are considered potentially important to understanding the severity of the injury and the risk of subsequent complications.

Other signs and symptoms of a concussion may immediately follow the head trauma or evolve gradually over several minutes to hours. Early symptoms of concussion (within minutes to hours) include headache, dizziness (vertigo or imbalance), lack of awareness of surroundings, and nausea and vomiting. Over the next hours and days, patients may also complain of mood and cognitive disturbances, sensitivity to light and noise, and sleep disturbances. Many concussions occur without observed findings. Signs observed in someone with a concussion may include the following:

- Vacant stare (befuddled facial expression)
- Delayed verbal expression (slower to answer questions or follow instructions)
- Inability to focus attention (easily distracted and unable to follow through with normal activities)
- Disorientation (walking in the wrong direction, unaware of time, date, place)
- Slurred or incoherent speech (making disjointed or incomprehensible statements)
- Gross observable incoordination (stumbling, inability to walk tandem/straight line)
- Emotionality out of proportion to circumstances (appearing distraught, crying for no apparent reason)
- Memory deficits (exhibited by patient repeatedly asking the same question that has already been answered or inability to memorize and return three of three words and three of three objects for five minutes)

- Any period of loss of consciousness (coma, unresponsiveness to stimuli)

Seizures — Early post-traumatic seizures are those that occur within the first week after head injury. These seizures are considered to be acute symptomatic events and not epilepsy. Post-traumatic seizures occur in fewer than 5 percent of mild or moderate traumatic brain injury (TBI), and they are more common with more severe TBI, especially if complicated by intracranial hematoma.

About half occur within the first 24 hours of the injury; one quarter occurs within the first hour. The earlier a seizure begins, the more likely it will be generalized in onset; after the first hour more than half are either simple partial (pure motor) seizures or focal with secondary generalization. Complex partial seizures are rare in this setting.

Early seizures increase the risk of post-traumatic epilepsy by fourfold, to more than 25 percent. While anticonvulsants may be used in the treatment of early seizures, they are not helpful in the prevention of post-traumatic epilepsy.

Complicated concussion — With uncomplicated, mild TBI, limited structural axonal injury may be present but not evident on diagnostic computed tomographic (CT) scanning or magnetic resonance imaging (MRI). However, mild TBI can be complicated by coexistent cortical contusions and the development of intracranial hemorrhage.

Neurologic deterioration after mild TBI is highly suggestive of an evolving intracranial hematoma, which may be intracerebral, or sub- or epidural and usually occurs secondary to a tear in an intracranial artery or vein.

Traumatic brain injury can have wide-ranging physical and psychological effects. Some signs or symptoms may appear immediately after the traumatic event, while others may appear days or weeks later.

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KONJE MRCOG Course Part I & II

Part II course
17th to 21st May 2015
&
Part I course
22nd to 24th May 2015

For House Officer, MO, Registrars, Specialists

Organised by
Centre of Excellence for PostGraduate Studies
Melaka Manipal Medical Collage
(MANIPAL UNIVERSITY)

In conjunction with
Obstetrical & Gynaecological Society Malaysia
MAAM & Kementerian Kesihatan Malaysia

Registration detail:

Prof. Sachchithanatham: 014-230 9567
sachchi@manipal.edu.my

Mrs Angesh: 06-289 6662 extn 1043

**Melaka Manipal
Medical Collage**



MRCP Part I Course

31st May to 5th June 2015

For House Officer, MO, Registrars, Specialists

Organised by
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Melaka Manipal Medical Collage
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In conjunction with
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In case of online payment kindly furnish the proof of payment
to sochchi@manipal.edu.my



MAAM Seminar on Work Related Trauma and Chronic Injuries

Supported by PERKESO

This happened on 21st December at Ara Damansara Medical Centre. Holding this Continuous Professional Development (CPD) event at such a late date in the year, especially in the weekend prior to Christmas was a real challenge as everyone was busy winding down for the year and will be away for the holidays.

Participation was good from our doctors, complemented by a group of medical students from Melaka Manipal Medical College who had left early from Melaka to ensure that they arrived on time.

It was a fruitful day as the topics presented were not the run of the mill medical topics but ones which were related to trauma and injuries at the work place. The various speakers provided pearls of wisdom for the participants to take home.

Our appreciation to Ara Damansara Medical Centre, a tertiary medical centre of excellence, for allowing us the use of their premise and also to Miss Sue Lee, their CEO for being with us on that day.





Obstetrics, Gynaecology and Reproductive Medicine **CPD 2015**

The opening Continuous Professional Development (CPD) programme for 2015 involved the subject of Obstetrics, Gynaecology and Reproductive Medicine which was held on 18, January, 2015 at the TMC Fertility Centre situated in Tropicana Medical Centre.

Reproductive medicine has been making inroads of late in Malaysia with the setting up of quite a few Reproductive Medicine and Fertility Centres.

As families become smaller with marriages happening at a later stage of life, notably among the urban dwellers, pregnancies become more precious. Thus the need for more specialised care in reproductive medical services.

Granted that it carries with it a whole host of ethical issues, but I do foresee the expansion of this sub specialty of Obstetrics and Gynaecology.

Dr Surinder Singh of TMC Fertility Centre, himself a Manipalite, did a good introduction of reproductive medicine to the participants who were present on that day



3 Days 2 Night Rainforest World Music Festival Package



4 Days 3 Night Rainforest World Music Festival Package



DAY1 Friday, 7th August (KUL-KUCHING)

- Assemble at KLIA/ KLIA2 for flight to Kuching
- On arrival, you will be met and greeted then proceed to hotel for check in.
- Free at own leisure
- Overnight at the hotel

DAY2 Saturday, 8th August (KUCHING)

- Breakfast at hotel
- Free at own leisure
- In the evening, proceed for the Rainforest World Musical Festival
- Overnight at the hotel

DAY3 Sunday, 9th August (KUCHING - KUL)

- Breakfast at hotel
- Check out and transfer to airport for flight back to KUL

ONE HOTEL SANTUBONG (3*) **From RM950.00**
DAMAI PURI SANTUBONG (5*) **From RM1750.00**

Package included:

- Domestic airfares + taxes
- 2 Night accommodation on Twin sharing basis
- Daily breakfast at the hotel
- Return airport transfer
- English speaking driver cum guide
- 3 days - Entrance ticket for Rain Forest World Music Festival
- Travel insurance

Package excludes:

- Lunch & dinner
- Tipping for guide/driver
- Other expenses not mentioned above

**Rates quoted are subject to change*

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DAY3 Sunday, 9th August (KUCHING)

- Breakfast at hotel
- Free at own leisure
- Overnight at the hotel

DAY4 Monday, 10th August (KUCHING - KUL)

- Breakfast at hotel
- Check out and transfer to airport for flight back to KUL

DAMAI PURI SANTUBONG (5*) **From RM2175.00**

Package included:

- Domestic airfares + taxes
- 3 Night accommodation on Twin sharing basis
- Daily breakfast at the hotel
- Return airport transfer
- English speaking driver cum guide
- 3 days - Entrance ticket for Rain Forest World Music Festival
- Travel insurance

Package excludes:

- Lunch & dinner
- Tipping for guide/driver
- Other expenses not mentioned above

**Rates quoted are subject to change*

A non refundable deposit of Rm500 per pax is needed for confirmation.

Please contact Ms Josephine, at MAAM Secretariat Office, 7A, Jalan Telawi Lima, Bangsar Baru, 59100 Kuala Lumpur

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