

Nepalese Doctors' Association (UK)

Established 1985



NDA Journal/Souvenir

27th

Annual Conference

27th – 29th July 2012

**Metro Centre Marriott,
Newcastle-upon-Tyne, UK**

Many Nepalese doctors have been coming to the United Kingdom for their postgraduate studies for many years. Some of them have settled in various parts of Britain and made this their home from home. In 1984 they held a series of meeting at various venues with the aim of bringing these doctors and families together, and Nepalese Doctors' Association NDA (UK) was established in 1985. The first Annual General Meeting was held in 1986 at Durham University under the chairmanship of Dr. Prem B Hamal. The association has since then grown and the tradition of an annual meeting every summer has continued. This annual event is not only a chance to share medical knowledge in the scientific session and discuss the progress of the organisation, but is also a great social event to catch up with old friends and meet new ones. The association is a non-political, non-racial and non-profit making voluntary organisation open to all Nepalese doctors presently residing in UK.

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Mr. Bharat Shrestha	Chairman
Dr Arun Jna	Vice Chairman
Mr. Badri Man Shrestha	General Secretary
Dr. Siri Gautam	Treasurer
Dr. Dhiraj Tripathi	Joint Secretary
Dr. Ramesh Khoju	Member
Dr. Beena Subba	Member
Dr. Robin Serchan	Member
Dr. Phauda Thebe	Member (immediate past chairman)

Local Organising Committee for this AGM 2012

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Dr V Karn	Member
Dr KL & Mrs Shrestha	Members
Mrs Seema Gautam	Member
Dr & Mrs Lekhak	Members
Dr BD Lekhak & Vijay Lekhak	Members
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Dr Vidyia Parajulie	Member
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Dr Mithilesh Lal	Member
Dr R & Mrs B Pandey	Members
Dr Sarju & Mrs T Shrestha	Member
Dr TL & Mrs G Shrestha	Members

Editorial Policy

NDA Journal is published annually from the material provided by doctors, their family members and friends in the UK and abroad. Both medical and non medical articles are welcome. Medical articles should be original, properly referenced e.g. Vancouver style. Interesting case histories

and abstracts of articles published in other journals are also accepted. Non-medical articles should be interesting, informative, impartial, non-political and if possible linked to Nepal and Nepalese cultural heritage.

Material for publication should be typed clearly in double space and submitted preferably electronically as a word attachment well in time for publication. The editorial board reserves the right to reject any article they deem inappropriate, or submitted after the deadline.

Articles, both medical and non-medical should be brief and concise, and should preferably not exceed 1500 words (although exceptions will be made at the editorial board's discretion).

Abstracts should be submitted as a word document not exceeding 400 words (although exceptions will be made at the editorial board's discretion). A format of Introduction, Methods, Results and Conclusions should be followed.

Short stories, poems, travel experiences, recipes, anecdotes, etc are included in the journal. Views, particularly in relation to medical, dental and social aspects of life are most welcome. Relevant health news, news and achievements in academic and social life of NDA (UK) members and their families are given ample space. There is also space for readers' feedback in the form of letters to the editor.

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Opinions and views expressed in the published articles in the journal are not necessarily the views of the Nepalese Doctors' Association (UK).

Editorial



It is a privilege for me to introduce the NDA (UK) Journal 2012. I am confident that there will be something to interest all delegates. There is a healthy mixture of science and light reading.

NDA (UK) remains very much involved in charity. This year I was delighted to organise the charity dinner in Birmingham to raise money for the Mental Health First Aid programme, and in particular geriatric care. I would like to thank all those who attended and in particular my wife Rajani, parents and brother for their help, and Dr Jha for his support. **Dr Jha's** highly informative article gives us some insight into some of the challenges facing those involved in mental health care in Nepal.

Staying with the theme of mental health, I would like to give a special thanks to a Nepalese doctor in training for his article on bipolar disorder. The very personal account counters the common belief that people with mental illness are somewhat weak and less successful in their life. We wish the doctor a bright and healthy future in the UK

Mr Badri Man Shrestha's article on research in medicine is very well written and a must read for those of you who may have second thoughts about undertaking research. **Dr Anne Shrestha's** article takes us through the historical and present day challenges of women in surgery, a branch of medicine that still remains heavily male dominated.

I do hope you find my article on **Budd Chiari Syndrome** interesting. BCS is at least 10 times more common in Nepal than in the UK and other western countries. The review is a summary of the present knowledge, and hopes to highlight the need for a stepwise approach to management.

Dr Sudhir Lohani, Hind Vaidya and **Dr Badri Man Shrestha** articles will appeal to all readers. You will now be an expert on making fish and be more aware of the pros and cons of the giant social networking site Facebook.

There are 3 excellent **abstracts** which demonstrate the hard work of Nepalese doctors in the UK with regard to research and audit.

NDA (UK) Constitution is published in full on page 23. The agenda for the AGM this year includes a proposal for a change to the constitution as detailed in **General Secretary's Annual Report** on page 5.

Many thanks to **Mr Badri Man Shrestha** for editorial assistance, and to **Dr Siri Gautam and the organising committee** for all their efforts in hosting the NDA (UK) AGM 2012 in Newcastle-upon-Tyne.

With kind regards

Dr Dhiraj Tripathi MD FRCP
NDA (UK) Joint Secretary

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Welcome Message from Dr Siri Gautam, Chairperson, Local Organising Committee

On behalf of the local organizing committee, welcome to the 27th Annual General Meeting of the Nepalese Doctors Association (UK), at the Newcastle Metro Centre Marriott Hotel. Many thanks for making the effort to travel to this part of the country. Welcome to those for whom it is the first NDA AGM.

The Nepalese Doctors' Association AGM has traditionally been the last weekend in July (give or take a week or two), and it's a weekend I have always looked forward to and anticipated. It gives us the opportunity to "down tools" for the whole weekend, enjoy great company, learn what charitable/educational activities our friends and families have been up to, as well as enabling children of the next generation to get to know each other and sustain long lasting friendships.

This to me is the essence of the NDA. I am sure many of those attending feel the same way.

Thank you to all the local organising committee members for their hard work and tireless effort over the last year. I am sure you will get to know all members of the local organizing committee this weekend ie everyone from the North East of England.

We hope that during your time here you are able to enjoy the beauty and the cultural highlights of the North East of England-from viewing the Angel of the North, to seeing the Baltic Art Gallery, walking along the Millenium Bridge and also having a taste of this part of the country by immersing yourselves in the streets of Newcastle Upon Tyne

We hope you enjoy the programme and have a relaxing, enjoyable weekend.

Siri

Dr Siri Gautam
Consultant in Paediatric Emergency Medicine
BSc,MBBS,MRCPCH,DTM&H,DipMedEd

NDA Executive Committee 2011 -2013



Mr Bharat Shrestha
Chairman



Dr Arun Jha
Vice Chairman



Mr Badri M Shrestha
General Secretary



Dr Siri Gautam
Treasurer



Dr Dhiraj Tripathi
Joint Secretary



Dr Ramesh
Khoju
Member



Dr Beena Subba
Member



Dr Robin Serchan
Member



Dr Phauda Thebe
Member (Immediate
Past Chairman)

Chairman's Message



Dear Colleagues

It gives me immense pleasure to welcome you all in Newcastle for the 27th Annual General Meeting (AGM) of Nepalese Doctors Association (NDA), UK. I am confident that this year's venue at Marriot Hotel will provide all the enjoyment and everlasting happy memories to the participants.

I also believe those who attended last year's event at Plymouth had a wonderful and memorable time. My wife, Rekha and I would like to thank all the participants for their efforts to make the last AGM successful.

Earlier this year on my visit to Nepal, Rekha and I had the privilege and pleasure to meet the President of Nepal, Dr. Ram Baran Yadav. I took the opportunity to apprise the President with our activities and extended my invitation to participate in this year's AGM. The president appreciated our activities and expressed his immense desire to meet us here but considering current political situation and logistics involved in the planning of Presidential visit did not give me much hope with the available time.

Since 1985 NDA has evolved progressively and has been supporting many charities and health related projects in Nepal as well as in the UK. This year we organized a very successful charity event in Birmingham for Mental Health First Aid (MHFA). I would like to thank Dr. Arun Jha for successfully running MHFA in Nepal and to Dr. Dhiraj Tripathi and his team to organize the event in Birmingham. To this end, I would like to encourage NDA members to engage in these activities to serve the broader society and raise our profile. I would personally like to ensure full support on behalf of NDA, UK.

It is also being realised that we need to increase our membership. Dr Robin Sherchan is working hard on this task and with every ones support, we hope to be able to further flourish as a dynamic association.

This year we are witnessing many important events in the UK. In June, we celebrated 60 years of Her Majesty's reign (i.e. Diamond Jubilee) and we are also going to participate in the summer Olympic to be organized from 27 July-12 August. I am sure NDA members and their families would be able to enjoy this event too.

Last but not the least, I would like to thank the NDA executive committee and the members, without their help and hard work it would not be possible to run the association and organize the events. I highly appreciate Dr Siri Gautam and her organising team for their hard work. On behalf of the organisation, a big 'thank you' to Siri and her team!

Yours sincerely

Dr Bharat R. Shrestha
Chairman, NDA (UK)

Annual Report by General Secretary: General Secretary's remarks



It is a great pleasure to all of us to assemble in the beautiful venue of Marriott Hotel in Newcastle to attend the 27th Annual General Meeting (AGM) of the Nepalese Doctors Association (NDA) this weekend, which is a great occasion to all members of the association and their families for catching up with each other after an years gap since the last AGM in Plymouth. I am very impressed with the enthusiasm shown by all members and their families and would like to thank all of you for undertaking a long journey to attend the meeting and make it a success.

Plymouth AGM was a great success, which was attended by 180 persons. Dr Bharat Shrestha, Dr Rekha Shrestha, Dr Lalit Hamal et al. have the credit of making the AGM memorable. Everybody enjoyed the boat trip. Inclusion of non-medical personnel in the executive committee of the NDA was discussed in the AGM, which, although was not approved by the majority of the members, will be discussed again in the AGM this year. I hope, this will be successful on this occasion.

I would like to extend my special thanks to Dr Dhiraj Tripathi and his parents (Dr Bharat Tripathi and Mrs Nirmala Tripathi) for organising the Charity Dinner in support of Mental Health First Aid Programme in Nepal, which had raised a substantial sum of £763 for the cause. The NDA journal is in its best possible format and standards, which has been possible due to relentless effort made by Dr Dhiraj Tripathi and contribution of articles from the NDA members and their families.

Dr Ramesh Khoju has made great contribution towards maintaining a high quality and up to date NDA website and the accounts of the association. We all extend our heartfelt thanks and congratulate him for his achievements. Thanks to Dr Robin Sherchan for actively exploring and expanding the membership of the association.

Dr Siri Gautam, Dr Tej Lal Shrestha, Dr Keshar Lal Shrestha and members of the local organising committee deserve special thanks, who have worked very hard in organising the AGM this year in Newcastle, which, unquestionably, is going to be a memorable event. I wish you and family members a very enjoyable weekend.

Mr Badri Man Shrestha MS, MPhil, MD, FRCS(Eng, Edin and Gen), FICS, General Secretary NDA(UK)

NDA (UK) Announcements

Dr Dhiraj Tripathi

The announcements below have been volunteered by the individuals concerned or their families/friends. Well done to all!!

Dr Alice Shrestha: Entry into GP registrar training from August 2012.

Dr Anne Shrestha: Passed MRCS (Eng).

Mr Badri Shrestha: Doctor of Medicine (M.D.) after research in experimental renal transplantation.

Kavi Gautam-Aitken born 13th December 2011 (parents Eva and Ross, grandmother Seema Gautam, aunt Dr Siri Gautam).

Marriage of **Prativa Pokharel** and **Ayush Dhital**.

Marriage of **Shruti Dhungana** and **Binay Acharya**.

Dr Sheril Gulgulia: Passed MRCPCH exams. We wish her all the best as she embarks on a new career in Clinical Genetics as a Specialist Registrar in Leicester. Proud husband Dr Amit Bajracharya.

A cheque for £355 from the Ramji Gautam Memorial Fund was donated by **Dr Keshar Lal Shrestha** to the NDA charity to fund the Mental Health Project in Nepal

Dr Akhilesh Jha has got a place as registrar in respiratory medicine from coming August 2012. Proud parents Arun and Meena Jha.

New born grandson Levi



Your daddy informed us
 That you were born
 My soul travelled faster
 Than the speed of light
 And even faster than
 The neutrinos to hold you
 In my heart and bless you!
 And I know that
 You are lying
 In safe and cosy
 Arms of your proud mum
 Love you and bless you!

E-mail came with your photograph
 You were so cute and sweet!
 You are a precious gift for us
 We will cherish you in our life
 You will be the shining star
 With other stars
 In our heart
 Love you and bless you!

Hind Vaidya
 18/11/2011

Introduction

I feel privileged to write this report on the charity dinner organised by the Nepalese Doctors' Association UK on 28 April 2012 at the Clarendon Suites, in Birmingham (Figure 1). In last 25 years, NDAUK has organised several fund raising events, but it is the first time it has done something very meaningful for older people with dementia and their carers in Nepal. The Chief Guest was Professor C. Mohan, an eminent Sri Lankan Psychiatrist in Birmingham, who came along with 8 other Sri Lankan psychiatrists to support us that evening. Dr. Dhiraj Tripathi deserves full credit for organising such a wonderful event almost single handedly. You can watch the event as You Tube Video on <http://www.youtube.com/watch?v=HPlvaiPETIU>.

Epidemic of Dementia in Nepal

Dementia is not part of normal ageing, but it is more common in older people. It has been estimated that by 2050, the population of people aged 65 and above will increase to 2 billion from 680 million in 2009. Ageing puts older people at a higher risk of developing psychiatric morbidity including depression and dementia.

In Nepal, during the period of 1991-2001, the annual elderly population growth rate was 3.39%, compared to 2.3% of the general population. The proportion of the population 65 years and older will rise from 4.2% in 2000, to 5.8% in 2025 (Figure 2).

Geriatric services in Nepal

Modern health services started in Nepal in 1933 with the establishment of Department of Health Services, but the strategic planning began with the first long term health plan (1975-90). Following the People's movement of 1990, a radical National Health Policy was brought in 1991 that has set up one health facility in every village development committee ensuring access to PHC locally. In all these planning exercises, the government has shown commitment to provide basic health care to all citizens of Nepal through primary health care. As a result, the high death and high birth rate scenario has changed into low birth and low death rate. As mentioned above, the age structure is changing and the elderly population is on the increase. Non-communicable diseases require special attention besides child health, family health and communicable diseases.

MoHP has launched special programmes for senior citizens (aged 60 and above) in order to provide free health care services for them. Geriatric care units are being established in tertiary care hospitals and the first geriatric care unit was set up in Patan Hospital in 2011.

Following the second World Assembly on Ageing in 2002, the Government of Nepal identified older people as one of its main target groups and formulated the Senior Citizens Policy and Working Policy (2002, 2058BS), the Senior Citizen Act, 2006 (BS 2063) and the Senior Citizens Regulation in 2009 (2065 BS). Among other things, the Regulation provides guidelines for healthy ageing and how to establish and run old age homes and day care centres. Nepal's Interim Constitution of 2007 ensures that every

Figure 1: Glimpses of Charity dinner in Birmingham in April



Dr. Bharat Shrestha, President



Prof. Mohan, Chief Guest

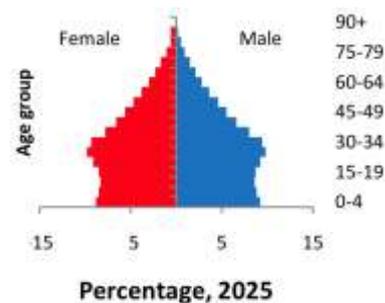
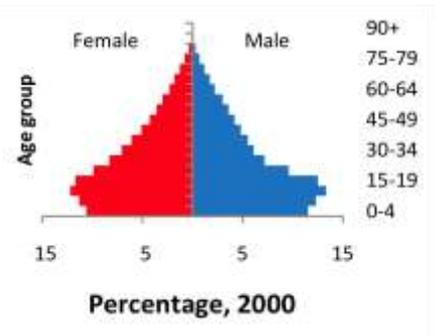


NDA Dinner Guests



Dr Arun Jha, presenting Mental Health First Aid and Dementia care in Nepal

Figure 2: Age structure in Nepal, 2000 and 2025
(Source: NCDs Policy Brief- Nepal (2011). World Bank, South Asia)



citizen has the right of availing free basic health care services provided by the state. The three-year Interim Plan 2007-2009 accepted the universal principle of health as a fundamental human right for every one including senior citizens. Unfortunately, the health issues of older people remain unaddressed because the Health Sector Strategy of 2003 focused mainly on attaining the Millennium Development Goals of reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases by 2015. However, in 2004, the Ministry of Women, Children and Social Welfare introduced the Senior Citizens Treatment Guidelines (Jyestha Nagrik Swasthya Upchar Nirdeshika 2061) to provide free medicine and up to Rs. 2000 (\$27) towards treatment cost to all older people affected by poverty. However, these schemes have minimal coverage and the government does not have the necessary resource to implement these guidelines. In 2010, the Geriatric Centre Nepal reviewed the situation of elderly in Nepal focusing on socio-economic, health and nutrition aspects, and came up with various recommendations including some specific health-related recommendations such as:

1. Promote health research activities in collaboration with universities, colleges and old age homes both in private and public sectors
2. Develop research programs on various geriatric health problems and strengthen national health research centre for the purpose.

Minimum actions required for dementia care

In 2006, the WHO produced a report on the public health challenges of managing the most important neurological conditions including dementia, epilepsy, headache disorders, multiple sclerosis, neuroinfections, Parkinson's disease, stroke and traumatic brain injuries, and other related conditions. For dementia care, it recommends ten minimum actions for low-resource countries (Table 1).

Past Contributions of NDAUK to Nepalese mental health and geriatric care

The NDA(UK) Psychiatry Chapter has been involved in fund raising events for mental health and geriatric care in Nepal since 2008. It organised the first charity dinner in conjunction with the Hertfordshire Transcultural Psychiatry Forum on 16 February 2008 in Watford and raised £1000 for Janakpur Mental Health Project. The event was graced by the then Nepalese Ambassador, Murari Raj Sharma. The historical evening ended with a scholarly post-dinner speech by Professor John Cox, the Secretary General of the World Psychiatric Association followed by the vote of thanks from the NDA (UK) Chairman, Dr. Prasanna Gautam.

On the occasion of the World Alzheimer's Day on 21 September 2008, I met the Nepalese president (Figure 3) and represented NDA(UK) at the memory walk organised by the Alzheimer's Association of Nepal as well as the Alzheimer's workshop organised by the National Senior Citizen Organisation Network. (Details are on www.ndauk.org.uk/mentalhealthweek20 Sept 2008.pdf).

In January 2009, Dr. Prasanna Gautam, Dr. Shambhu Adhikaree, and I, were invited by the Connect for Change to organise Health Ageing Conferences in Nepal, which we did in Kathmandu, Biratnagar and Nepalgunj one by one. In June 2009, the NDA(UK) Psychiatry Chapter organised another charity dinner and raised funds for Nepalese mental

health services. In September 2009, a team of consultant old age psychiatrists and dementia specialist nurses went to Nepal for dementia training in Kathmandu and Biratnagar. We organised a Gurkha Health Screening camp in 2010.

Future Contributions

We raised £763 at the charity dinner. The event was organised to support mental health First Aid Programme in Nepal. MHFA is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The First Aid is given until appropriate professional help is received or until the crisis is over. The MHFA programme was originally created in 2001 by two Australian experts - Betty Kitchener and Professor Tony Jorm. It became international in 2003 and by 2010 it has been adopted and adapted by fifteen countries including Nepal. The MHFA was launched in Nepal in December 2010 and evaluated in 2011.

In 2012, the NDA(UK) Psychiatry Chapter decided to support Dementia care in Nepal. We invited Dr. Nidesh Sapkota to attend the Alzheimer's International Conference in London in March (Figure 4). He is Assistant Professor of Psychiatry with special interest in dementia care at BPKIHS, Dharan.

The Psychiatry Chapter has helped establish the Alzheimer's and related Dementias Society (ARDS) in Nepal in May 2012 and we have contributed £300 towards its official launch on 13 July 2012 (<http://www.ardsnepal.org>). Dr. Sapkota and I have written "Dementia First Aid" book in Nepali, which will be published by the ARDS Nepal on its launch day in July. The fund we raised at the charity dinner (£763) has been transferred to ARDS account towards the cost of publication of the book.

Through ARDS Nepal, we can raise public awareness of dementia in Nepal, conduct epidemiological survey and other research projects, provide dementia training to doctors and other health and social care professionals and carers. I will keep you posted. I would like to thank all NDA (UK) members and their family and friends for their continued support.

Figure 3: Meeting with the President, 2008



Figure 4: Dr. Sapkota (right) at Dr. Chuda Karki's Residence



Table 1: Minimum actions required for dementia care in low-resource countries

	Recommendations	Actions
1	Provide treatment in primary care	Recognize dementia care as a component of primary health care. Include the recognition and treatment of dementia in training curricula of all health personnel. Provide refresher training to primary care physicians (at least 50% coverage in five years).
2	Make appropriate treatment available	Increase availability of essential drugs for the treatment of dementia and associated psychological and behavioural symptoms. Develop and evaluate basic educational and training interventions for caregivers.
3	Give care in the community	Establish the principle that people with dementia are best assessed and treated in their own homes. Develop and promote standard needs assessments for use in primary and secondary care. Initiate pilot projects on development of multidisciplinary community care teams, day care and short-term respite care. Move people with dementia out of inappropriate institutional settings.
4	Educate the public	Promote public campaigns against stigma and discrimination. Support nongovernmental organizations in public education.
5	Involve communities, families and consumers	Support the formation of self- help groups. Fund schemes for nongovernmental organizations.
6	Establish national policies, programmes and legislation	Revise legislation based on current knowledge and human rights considerations. Formulate dementia care programmes and policies: – Legal framework to support and protect those with impaired mental capacity – Inclusion of people with dementia in disability benefit schemes – Inclusion of caregivers in compensatory benefit schemes Establish health and social care budgets for older persons
7	Develop human resources	Train primary health-care workers. Initiate higher professional training programmes for doctors and nurses in geriatric psychiatry and medicine. Develop training and resource centres.
8	Link with other sectors	Initiate community, school and workplace dementia awareness programmes. Encourage the activities of nongovernmental organizations.
9	Monitor community health	Include dementia in basic health information systems Survey high-risk population groups.
10	Support more research	Conduct studies in primary health-care settings on the prevalence, course, outcome and impact of dementia in the community.

Bipolar Disorder and My Experience

Bipolar disorder known in the past as manic depression is a condition that affects your moods, which can swing from one extreme to another. Bipolar disorder and other mental illnesses are often stigmatised. Many people fail to seek help because they fear being labelled as crazy. While there are some promising breakthroughs on the horizon, there is currently no definitive medical test for this disorder. Furthermore, there are a number of physical conditions and quite a few psychiatric disorders which present symptoms that can be confused with those of bipolar disorder. And just to complicate things a bit more, a great many psychiatric disorders can occur in tandem. However, bipolar disorder can be managed with medication along with other remedies which may be suitable for patients. Examples of famous people with bipolar disorder are, Abraham Lincoln, Isaac Newton, Jean-Claude Van Damme, Jim Carey, Jimi Hendrix, Ludwig Van Beethoven, Marilyn Monroe, Mel Gibson, Napoleon Bonaparte and many more.

Human race has advanced to such an extent that one can find out about almost anything, including bipolar disorder, just by searching the internet. While I don't have the credibility of a psychiatry masters degree to allow me to lecture on this condition, as a victim I would like to share my everyday battle with this condition.

I was diagnosed with bipolar disorder II 10 years ago. I felt as if 2 people were inside me, like Jekyll and Hyde. Now I realise that it was a manic stage (euphoria, over energetic phase, flight of ideas, belief in myself that I could do anything) followed or alternating with depression (loss of energy, feeling tired, as if the whole world was against me). I felt like there was no hope and treatment for my condition. I cried a lot and couldn't even control my emotions. God exists in different forms and I am lucky that my mom was there when I needed her the most. I was diagnosed with bipolar disorder and was prescribed sodium valproate for 6 months followed by lithium 1200mg. My dose of lithium has now been reduced to 200mg per day. I check my lithium level every 3 months to see whether it is in the therapeutic range.

In my experience, I have dealt with bipolar disorder by inventing my own formula to combat it. No doubt medication can be a miracle in this condition, but I believe that if you ask any affected person, they have devised their own strategies to fight the condition. First of all, to be treated you have to accept your condition, take your medication at regular times as prescribed by your psychiatrist and check your own condition regularly. Besides that, make it a habit to learning what your trigger factors are i.e. a regular sleeping time is essential and avoiding alcohol and coffee. I have developed a keen interest in body building and it helps me to relax when I am in a manic state. On the other hand, when I am in depressive mode, I watch movies. Books encouraging positive attitudes, along with a supportive family are essential elements for my treatment.

In a nutshell, I would like to state that normal life is possible with bipolar disorder. I believe awareness and proper understanding is critical with regards to bipolar disorder, as it is treatable like other medical conditions.

Anonymous

Perspectives on the Research in Medicine

Mr Badri Man Shrestha MS MPhil MD FRCS(Eng, Edin and Gen) FICS
Consultant Transplant Surgeon, Sheffield Teaching Hospitals NHS Trust, United Kingdom.

Abstract

Medical science has made a dramatic progress over last seven decades in the diagnosis and treatment of diseases involving human body, which has been possible through the continuous scientific research. In this short review, the historical, current, future and personal perspectives of research in medicine are highlighted.

Key words: Research, ethics, perspectives, trials, outcomes.

Introduction

Research has played a vital role in the development of medicine leading to the current state of success in the understanding of pathophysiology and management of a wide range of medical conditions. Research in medicine is undertaken systematically to increase the stock of knowledge and to devise new application for the benefit of the patients. It is used to establish or confirm facts, reaffirm the results of previous works, solve new or existing problems, support hypothesis or develop new theories.¹ This short review highlights the historical, current, future and personal perspectives of research in medicine.

Historical perspectives

The word research is derived from the French word “recherché”, which means “to go about seeking” and the word “recherché” itself is derived from the French word “recherchier”, a compound word from “re” + “cerchier”, or “searcher”, meaning “search”. Research is broadly defined as the process of steps used to collect and analyse information and facts to answer a specific question for the advancement of knowledge. Broadly speaking, research can be primary or secondary; qualitative or quantitative; and basic or clinical.

The development of medicine dates back to the era of Aristotle (384 BC – 322 BC), who is considered as one of the early figures in the development of the scientific methods. Since then, research methodology has evolved and the proposed steps in conducting research involved; (a) identification of specific question or hypothesis, (b) literature review, (c) data collection by adopting a defined protocol, (d) analysis and interpretation of data, and (5) report and evaluation of research. Finally, dissemination of completed research data to the medical fraternity was expected by presentations in scientific meetings and publications in peer-reviewed journals. The ethical aspect of research was not regulated until 1947, when the “Nuremberg Code” was established, which defined the legitimacy of medical research in relation to the consenting of the human volunteers on taking part in experiments. Subsequently, the “Declaration of Helsinki” in 1964, more precisely, defined the regulations of clinical research employing human volunteers, which is strictly followed in the current era.² The concept of statistics, which started nearly 1500 years ago, has evolved with leaps and bounds and has been instrumental in the interpretation of data and their relationship with clinical events. Austin Bradford Hill for the first time published a randomised controlled trial (RCT) in 1948, entitled “Streptomycin treatment for pulmonary tuberculosis”, and is credited to have conceived the modern RCT.³

Although there are innumerable achievements accrued from the research over last centuries, Maurice Hilleman (1919-2005), an American microbiologist from Walter Reed Army Medical Centre, USA, is credited with saving more lives than any other scientists of the 20th century, as he pioneered in developing 8 of the currently used 14 vaccines

(measles, mumps, hepatitis A, hepatitis B, chickenpox, meningitis, pneumonia and Haemophilus influenza), which has been made possible through his explorative research in the field of vaccinology.⁴

Current perspectives

The modern research in medicine is focussed on understanding of diseases at their cellular and molecular levels so that interventions are carried out at this level to modify the course of the diseases that would be applicable in their prevention and treatment. Targeting genes and receptors present in the cells and to modify their functions, particularly the protein synthesis, has been the basis of immune modulation in the prevention, spread and recurrence of cancers in oncology and rejection in organ transplantation medicine in experimental animal and human clinical settings. Similarly, evaluation of the efficacy and safety of drugs in targeting various cells to alter their functions, are being done through clinical trials in both experimental animal and human clinical trial settings, which are tightly regulated. Current emphasis is laid on the translational research, where the findings in basic research can be translated into medical practice leading to meaningful outcomes.⁵

The clinical trials can be either observation study or an interventional study. They can also be prevention, screening, diagnostic, treatment, quality of life or compassionate use trials. The introduction of any new modality of treatments involves establishing its safety and pharmacokinetic profiles (Phase 1), study of the therapeutic effects (Phase 2), comparison of the new treatment with the existing standard treatment (Phase 3) and post-marketing study to study the long-term effects (Phase 4). RCTs is considered as the most reliable form of scientific evidence (Level 1 evidence), which is used to influence health policy and practice, because RCTs reduce spurious casualties and bias. Results of multiple RCTs are combined in systematic reviews or meta-analysis and the synthesised information is used in evidence-based medicine.⁶

Assessment of the best evidence, although done through meta-analysis, can be associated with discrepancies resulting from the variations in the studies with respect to the inclusion criteria, data interpretations and statistical analysis. To obviate this problem, an international voluntary organisation called Cochrane Collaboration, named after Archibald Cochrane, an eminent statistician from Cardiff, Wales, was established some 25 years ago, which prepares, maintains and disseminates systematic reviews of RCTs of health care interventions. These have been instrumental in developing treatment guidelines for maintaining uniformity of standard in between the hospitals.⁷

There has been a change in the provision of involvement in research during the training period of doctors at the core training or specialty training grades, which has proven rather disadvantageous in getting training posts. However, the opportunities for research can be exploited at the training grades if one can plan this in an organised manner.

Future perspectives

Genomics, Proteomics, and Metabolomics are the three most recent advancements in the medical research. Genomics studies the entire DNA sequence of organisms and fine scale genetic mapping, thereby identified specific genes responsible for the causation of specific medical diseases in human. Proteomics is a large-scale study of structures and functions of proteins in human body, which can be identified at every single stage of synthesis from the time of gene transcription to the final stage of protein synthesis. All proteins in the body can be characterised through the study of their amino acid sequences using a mass spectrometry technique. Proteomics is expected to prove extremely valuable in the diagnosis and treatment of a multitude of medical conditions. Likewise, metabolomics studies the chemical processes involving metabolites in all chemical reactions taking place within the human body, which is influenced by genomes and proteomes. Genomic, proteomic and metabolomic-based research is gradually being introduced in a few centres in the UK, including in the University of Sheffield and is expected to move forward rapidly.⁸

Personal perspectives

I have been involved in clinical research since 1987 starting with “assessment of antibiotics sensitivity in surgical wound infections in Bir Hospital, Nepal” followed by appointment as a research fellow in Cardiff University, which involved looking at the infectious complications following renal transplantation, evaluation of the causes transplant losses in long-term, effect of platelet activating factor antagonist in acute pancreatitis and 20 more major projects later on over the years. Currently, I have the privilege of being a Principal Investigator of three major National Multicentre Clinical Studies. Laboratory-based animal experiment work (kidney transplantation in rats) has contributed significantly towards understanding of the mechanisms of kidney transplant failure and is in progress.

The major advantages of involvement in the basic and clinical research, I have personally perceived, has been acquisition of up to date knowledge on ones specialty through constant touch with the published literature and interaction with learned people from one’s specialty. Presentations to the learned society and publication in journals have helped gain insight into the subject and make more friends at the national and international levels. Critical vision is necessary in medicine, which develops more rapidly through involvement in research. The major problem with my involvement in research had been the constraints imposed by lack of time because of heavy clinical commitments in transplantation, but this was not insurmountable. I have also learnt that research can inflict significant damage to one’s physical and social health, if one fails to balance various domains of life appropriately.

Conclusions

In conclusion, research is important for the progress of medicine and patient care and should be in the pursuit of doctors involved in patient care. Research does involve adherence to the rigid principles and discipline, which is very rewarding in long-term both to the patients and the researcher.

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Life

Life is like a season

Everything happens for a reason

I have crossed my comfort zone

My third eye is always open

Joys and blessings I have found

Kissing and hugging with my grand children

With them, I have so much fun!

Endless love! They have given

Neither can I stand still

On this constantly moving planet

Nor could I avoid up hills

On the journey of my life

Ahead is my destination

Balancing the soul in every situation

I do have some imagination

Bliss of Life is my inspiration

Life is like a season

Everything happens for a reason

I have crossed my comfort zone

My third eye is always open

Hind Vaidya

March 2012

Abstract

Historically women were barred from becoming surgeons as surgery was considered as a specialty only suitable for men. In the current era, women have shown genuine interest in surgery and training and working environment attractive to women have been created, which has increased the number of women in surgical specialties. In this short review, the historical and current perspective of women in surgery is presented.

Key words: Surgery, women, training, specialisation.

Introduction

Increasing number of women are taking surgery as their career despite previous reluctance on their part due to the demanding nature of the specialty. Flexible training schemes and job descriptions have made surgery attractive to women. This review discusses the historical and current perspectives of the women in surgery.

Historical perspectives

Throughout history, women have been discouraged or prevented from practising surgery. However, the role of women in surgery is as old as the profession itself. Ancient wall paintings from Egyptian temples and tombs going as far back as 3500 BC depict women performing surgical procedures. Similarly, flint and bronze surgical instruments were uncovered from the grave of Queen Shubad of Ur and there are records of female medical students in Heliopolis circa 1500BC¹.

The dark ages is often cited as beginning after the fall of Rome in 476AD. What followed was a time of tremendous social, political, religious, and economic transition brought about by the merging of the classical Roman culture and its new Christian religion with that of the barbarian Germanic tribes. This resulted in a decline in the knowledge of the Greeks that cut Christian Western Europe off from an important source of ancient learning. This was a disappointing time for women in general arising from the predominance of the male dominated church. In particular this was a disaster for the practice of medicine and surgery for all women. The Arabs however did keep the knowledge of the ancient Greeks alive through copious translations into Arabic that slowly filtered back in to Western Europe throughout the Middle Ages and beyond.

Despite such a dire situation, women surprisingly continued to make important contributions to the understanding of medicine, surgery and anatomy. This was due primarily to special enclaves of enlightened attitudes where women could flourish. During the 11th century the education of women continued in the city of Salerno in present day Italy, where Tortula wrote a volume on the practice of gynaecology and midwifery that would be referenced for several centuries to come².

During the 14th Century, progress in medical sciences was minimal. Regulations in surgery were made and this included barring women from surgery. In Paris, women were only allowed to practise surgery if they were a widow. King Henry VIII was quoted as saying "No carpenter, smith, weaver or women shall practise surgery."² Regardless, women continued to practise without formal training or recognition in England and eventually North America for the next several centuries.

Female surgical pioneers

Dr. James Barry, born 1789, possibly christened as Margaret Ann Bulkley, is an example of the lengths to which she had to take in order to pursue her career; she had to pretend to be a man. She was a surgeon in the British army and among her accomplishments was the first

caesarean section in Africa by a British surgeon in which both the mother and child survived the operation. She was only discovered to be a woman after her death, but was officially buried as a man³.

Elizabeth Blackwell, was possibly the first official female doctor in America. She trained at Geneva College of Medicine in New York, gaining her MD in 1849. Although she graduated with the gold medal, she was not able to obtain a residency position anywhere and ended up serving as an obstetrical nurse in France⁴. Emily Blackwell, the younger sister of Elizabeth became the second female doctor in America.

Elizabeth Garrett Anderson was the first woman to qualify as a physician and a surgeon in Britain. She started her working life as a nurse. She applied to many medical schools, including Oxford, Cambridge, Glasgow, Edinburgh and the Royal College of Surgeons, she was refused admission by all. In 1862, she was finally admitted for private study by the Society of Apothecaries. She continued her fight to qualify by studying privately with various professors, including some at the University of St Andrews, the Edinburgh Royal Maternity and the London Hospital Medical School. In 1865, she obtained a licence from the Society of Apothecaries and qualified as a doctor. In 1873, she gained membership of the British Medical Association and remained the only woman member for 19 years after. The London School of Medicine for Women, later renamed the Royal Free Hospital School of Medicine, was formed by an association of pioneering women physicians Sophia Jex-Blake, Elizabeth Garrett Anderson, Emily Blackwell and Elizabeth Blackwell with Thomas Henry Huxley in 1874. Dr. Anderson continued to work there for the rest of her career and was dean of the school from 1883 to 1902. She was also the first female mayor of England, being elected as the mayor of Aldeburgh on 9 November 1908⁵.

Eleanor Davies-Colley studied medicine at the London School of Medicine for Women and was awarded the MD degree by the University of London in 1910. In 1911, she became the first female Fellow of the Royal College of Surgeons (FRCS)⁶.

Current state of female surgeons

In 1919, there were only 4 women with an FRCS. By 1990, there were 320 women, this increased to 1184 in 2009. According to Universities and Colleges Admissions Service (UCAS), in 2009, 55.5% of the people accepted on to medical degree courses in the UK were women. In 2009, women only made up 7% of the consultants in England. The increased number of female medical students, however, this has not translated into the proportional increase of women surgeons. In 2010, 24% of surgical trainees were women; 22% of paediatric surgical trainees were women, 16% in plastic surgery, 13% in maxilla-facial surgery, 37% in general surgery and 15% in orthopaedic surgery⁷.

Research suggests that women who have chosen surgery as a career is as a result of positive role models, and believe surgery is both intellectually and technically challenging and also feel they have, or have been told they have, "the

surgical personality.⁸ Conversely, women who have not chosen surgery as a career either perceive it to be too difficult, are not encouraged, have no role models, perceive it to be too time-consuming, feel it is not a family-orientated career or believe the lifestyle is not suited to them.

Women in Surgical Training (WIST) carried out a survey in 2005 to look into the percentage of surgeons with successful FRCS who had either progressed to a consultant or not, or if they had abandoned surgery as a career, and the reasons they felt had contributed to their perceived problems or failure. The response rate was 49% and two-thirds were female. More women than men had left surgery as a career. Main factors identified were family commitments, surgery a wrong career choice, lack of career progression, long working hours and length of the training period.⁹

Various organisations have been set up to encourage women in surgical training. These include WIST which was set up in 1991. This was later changed to Women in Surgery (WinS) in 2007 and continues to develop The Royal College of Surgeons of England's work supporting women surgeons.¹⁰ Its aims are as follows:

- To raise the profile of women in surgery
- To work towards an understanding of the issues facing women in surgery
- To encourage attitudinal change ensuring women are seen as an integral part of the profession
- To provide advice, guidance and pastoral support for those women already in surgery or considering entering it

Flexible training or less than full time (LTFT) training has played a vital role in the women surgical training. This has enabled women to have a family while pursuing their surgical career, hence have a more controlled work-life balance. This does lengthen the number of years spent in training in proportion to the reduced hours.

Conclusions

With the increasing number of female medical students, there will hopefully be more surgical trainees. More understanding of women in surgery by the medical professional bodies will enable women to continue progression in this field. A lot of work still has to be done in changing attitudes and requires supporting women in a very male dominated arena.

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यात्री

सुधीर लोहनी

जन्मेको छैन म
न मेरो मृत्यु हुन्छ
म एउटा आत्मा
अमर छु म ।

संसारको रहस्यमा
जन्म, मृत्यु शरीरको
मेरो त केवल यात्रा हो
म एउटा यात्री ।

म हुं रामको अंश
मेरो चरित्र राम
म पवित्र गंगामय
स्वच्छ समुद्रको जल ।

म व्याप्त छु जता तै
म नै हुं श्रृष्टी
म हुं जीवनको रहस्य
सर्वशक्तिमान इश्वर ।

म हुं यो आत्मा
आत्मा राम हो
राम परमेश्वर
राम जीवनको सार ।

ममा समाएको छ
सारा जगको सार
जीव तिमी जो छौं
म आत्मा त्यही हुं ।

तिमी म सब एक
तिमी राम सबै एक
श्रृष्टीमा राम मात्र एक
सबको सार राम एक ।

रामको नाम चिनाँ
साक्षात्कार गरौं
रामलाई नमस्कार
आत्मालाई नमस्कार ।

Buying fresh fish

To have truly fresh fish, either you have to go fishing yourself or you have to have a fisherman friend. Alternatively you can visit a fish farm and choose which fish you want yourself when you are not living nearby the sea, you can buy fish either from the fish market or from the fish section of the supermarket that could be fresh fish lying on top of ice or frozen ones. You can check the label to see whether the fish is farmed or wild.

Frozen packets may have labels saying whether fish are local or imported. So you have got the choice. I prefer local fish although imported ones are cheaper.

Fresh wild fish is expensive, but, they are tastier than farmed fish. However farmed fish are available throughout the year and it is an alternative way to produce fish from over fishing in the sea.



Rainbow trout

Both types of fish (farmed and wild) are good to consume in right amount. I prefer fish cuisine once a week.



Red porgy

Trout, cod, haddock, salmon, red mullet, red porgy, sea bass and sea bream are my favourite fish.

Trout is good for making curry, Battered cod, haddock and red mullet are tastier deep-fried. Sea bream and sea bass are good for grilling, baking and steaming. Slices of Salmon for pan frying and baking.

I am diabetic and my cooking style and diet have changed. I have stopped deep frying fish at home. If I visit the seaside or bakewell, I can't avoid fish and chips. Fish fillets can be pan fried in less oil.

It is very easy and quick. I prefer fish soup as well. I like the Greek style of cooking fish, but, I use less oil. Greek recipes measure olive oil in cups.



Sea bream

Preparation of fish

I really like to buy whole fish and scale it myself. I like to see the gills if it is red or not. If it is red, that is a sign of freshness. Gills should be taken out and should never be eaten. Some fish have sharp spines and hard scales and fillets require pin-boning.

After scaling, lay the fish flat and make a slit underneath from head to tail with a sharp knife. Take the insides out. You need to clean blood, and fillet it following the back bone from head to tail. But, when you buy fish, you can ask the fishmonger to gut and fillet it for you.

Greek Style Pan-fried fish fillets

(Easy, quick and delicious)

Ingredients

- (I)
 4 fillets of your choice (trout, sea bass, sea bream)
 4 tbsp of plain flour
 4tbsp olive oil
 Salt and freshly ground black pepper
 1 tsp of dried oregano



(II)

- 1 Lemon juice
 2 tbsp olive oil
 2 cloves garlic, crushed



Preparation

Brush the fillets with olive oil and sprinkle salt, oregano and freshly ground black pepper. Then toast with plain flour.

Mix olive oil, lemon juice and garlic (II) in a bowl and leave aside.



Frying

Heat a pan, put in about two table spoons of oil. When the oil is nearly smoking, lay in two fillets skin side down and cook for 1 minute on a medium heat or until the skin goes brown. Then turn the



Sea bream

fillets and cook for another 1 minute or until light brown. Don't overcook. Remove the fillets from the pan and arrange in a serving dish. Pour in a little oil and repeat the process with another two fillets.

Spoon lemon, oil and garlic mixture all over the fillets.

Serve with salad or vegetable of your choice.

Serves 4



Trout

Romanian Style Parcel of Salmon fillet or steak

I had a chance to observe the preparation and baking of this by a Romanian lady who was working in Greece. This is a traditional Romanian dish. It is delicious. I have substituted the vegetable oil with olive oil and avoided carrot in the ingredients.

Ingredients

- 4 Salmon fillets or steaks
 2 onions cut into rings
 2 tomatoes cut into rings



1 Red pepper, cut into slices
 1 lemon juice
 2 cloves garlic, crushed
 6 tbsp of olive oil
 Salt and freshly ground black pepper
 Some chopped fresh herbs of your choice (dill, coriander, parsley)

Step 1

Cut kitchen foil into 8 pieces about the size of dinner napkins. Place two pieces of foil together and lay flat to make four sets. Brush each set of foil with oil. If you are using salmon steak, lay it in the centre of the kitchen foil and bring two ends together making a cavity in the centre. Decorate with onions, tomatoes and pepper inside and outside of the salmon steak. If you are using salmon fillet, lay it in the centre of the foil and decorate with onion, tomato and pepper around it.



Step 2

Make a mixture of garlic, lemon juice and olive oil and spread all over the ingredients. Sprinkle with salt and pepper.

Fold the foil and then gather up the sides to make loose parcel. Repeat the process with each salmon steak. By wrapping the fish in foil, moisture is sealed within the steak or fillet.



Step 3

Preheat the oven at 200°C (400°F) gas mark 6. Brush a baking tray with oil, arrange the parcels and bake in the centre of preheated oven for 25 minutes.



Step 4

Open the parcels, transfer to a serving dish and garnish with herbs of your choice and serve with salad or vegetables of your choice.

Serves 4

Greek Style Fish Soup (Psarosoupa)

Greeks prepare this traditional fish soup on special occasions. I have found some variations in making this soup from one Greek family to another. Some like thicker soups by adding flour or rice, some like thin soup without adding flour or rice. I prefer to thicken my soup by mashing some potatoes without adding flour. Cooking and serving is an art. So there are going to be some variations from me too, using less oil and adding some extra ingredients.



Ingredients

(I)

2 whole Fish of your choice (, trout, cod, haddock, sea bream)
 2 carrots, peeled and cut into chunks
 2 onions cut into chunks
 2 courgette (zucchini), cut into chunks
 1 leek stalk, cut into chunks
 2 potatoes, peeled and cut into chunks



Addition of extra ingredients:

4 garlic cloves, peeled and diced, 4 Bay leaves, 1 tsp of whole cumin seeds, 4 fresh tomatoes, chopped

(II)

8 tbsp of olive oil
 1 Lemon juice
 Salt and freshly ground black pepper
 Some fresh dill, chopped

Step 1

It is better to use two cooking pans. Put all the ingredients (I) in one pan with two and half pints of water. Bring to the boil, reduce the heat and simmer for 45 minutes.

While the vegetables are simmering, the fish needs to be scaled, gutted and the gills removed. Separate the head and tail with a sharp knife and leave aside. Then cut the fish into two pieces, so you have four chunks of fish.

In a bowl, mix 4 table spoons of olive oil and lemon juice and leave aside.



Step 2

Put the fish heads and tails in an another pan and add a pint of water just to cover the contents. Bring to the boil and simmer for 15 minutes. Strain the stock through a sieve and add to the first pan and simmer for a few more minutes. Then drop the fish pieces into the pan, bring to a boil and simmer on a low heat for 15 minutes. The fish should not be over cooked. Then remove the fish carefully in a serving dish, pour the mixture of lemon juice and olive oil over the fish pieces. Sprinkle salt and pepper and garnish with dill.

Step 3

Now is the time you can mash half of the potatoes and vegetables with the back of a soup ladle so that the ingredients blend together. Add salt and pepper and the remaining olive oil. Stir and serve the soup alongside the fish and bread.

Serves 4



Note: Vegetables are cut into big chunks in Greek recipes for this soup. Then cooked vegetables are removed from the pan. About half of the vegetables are cut into small pieces and put back in the pan. The rest are kept with fish pieces in the plate.

An overview of Budd Chiari Syndrome

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Abstract

Budd-Chiari syndrome (BCS) is a rare disorder caused by hepatic venous outflow obstruction and resulting hepatic dysfunction. It is 10 times more common in Nepal than in the western hemisphere. Despite a lack of prospective randomised trials much progress has been made in its management over the last twenty years. The main goals of treatment are to ameliorate hepatic congestion and prevent further thrombosis. The selective use of anticoagulation, vascular stents, TIPSS and liver transplant has resulted in a significant increase in survival. The diagnosis, initial management and long-term follow up of patients with BCS is reviewed. The concept of individualisation of treatment and a step-wise approach to invasive procedures is also discussed.

Key words: Budd Chiari Syndrome, hepatic venous obstruction, hepatic vein, inferior vena cava, thrombus, transjugular intrahepatic portosystemic shunt, TIPSS, transplantation.

Introduction

Budd-Chiari syndrome (BCS) is defined as hepatic venous outflow obstruction at any level from the small hepatic veins (HV) to the junction of the inferior vena cava (IVC) and the right atrium, regardless of the cause of obstruction. Outflow obstruction caused by the sinusoidal obstruction syndrome (formerly “veno-occlusive disease”) and cardiac disorders is excluded.

Epidemiology

Budd Chiari Syndrome remains a rare disease so data regarding its epidemiology is limited. The incidence varies between 0.13 - 0.36 cases per million per year. In Nepal, the disease appears to be at least ten times more common than in the western hemisphere and accounted for 17% of patients presenting with chronic liver disease. Pure HV block appears to be more common in the West and IVC or combined block more common in Asia. Multiple reasons for this variation have been suggested including: malnutrition, recurrent bacterial infections and filariasis. Interestingly in India the rate of pure IVC thrombosis appears to be declining and this may be attributable to improving sanitation and hygiene.

In Asia, males are affected more frequently than females and the median age at presentation is 45 years of age; in Europe females cases predominate and the median age of presentation is younger (35-38 years of age).

Risk factors for BCS

The majority of cases of BCS are acquired rather than congenital. Thrombus formation leads to concentric thickening of the vein wall and subintimal fibrosis. Extension of this process along a vein forms a membrane or fibrous cord.

BCS should be considered the result of multiple hits, where several prothrombotic factors combine to predispose to thrombosis in the liver. At least one thrombophilic disorder is identifiable in 84% of patients and multiple disorders are found in 46%. These disorders are listed in Table 1. Myeloproliferative disorders (MPD) result in excess cell production by the bone marrow and include: chronic myeloid leukaemia (CML), primary myelofibrosis (MF), polycythemia rubra vera (PRV) and essential thrombosis (ET). These disorders are particularly common in patients with BCS and may be overt or occult (occurring with normal peripheral blood counts). Both expansion of plasma volume secondary to portal hypertension and hypersplenism may disguise the increase in blood cells.

Janus kinase 2 (JAK2) mutation results in erythroid precursors that can grow in the absence of exogenous erythropoietin. The JAK2 (V617F) mutation is a diagnostic criterion for MPD in the WHO guidelines. The mutation is a very reliable marker for MPD. Studies have reported a pooled prevalence of 37% in patients with BCS. Among patients with BCS, those with the JAK2 (V617F) mutation had a 10.77 times higher incidence of

MPD during follow-up compared with those without the mutation.

In females, the oral contraceptive pill, pregnancy and the post-partum period have all been associated with BCS. The prevalence of oral contraceptive use in females with BCS is estimated to be up to 50%. The sudden development of abdominal pain and ascites following childbirth should point to the diagnosis. Pregnancy and contraceptive pill use are weak risk factors for BCS and a search for other predisposing factors should occur.

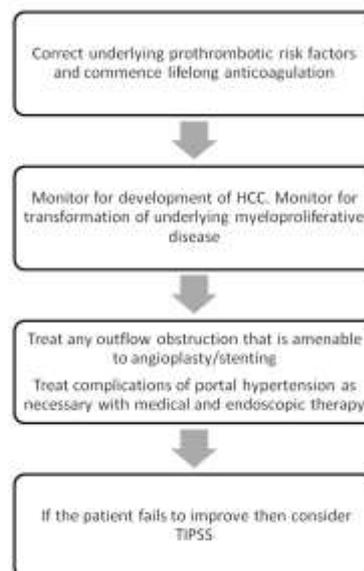
Given the high frequency of underlying haematological disorders in BCS haematological expertise is vital for both investigation and treatment.

Clinical presentation

History & Examination

The median age at presentation is 35 (range 17-76) and two thirds are female. Physical examination findings in BCS are non-specific but ascites is common (84%) as is hepatomegaly (76%). Half of patients have splenomegaly (51%); encephalopathy (10%) and variceal bleeding (8%) are also seen. Abdominal pain is frequent (61%) and in many patients it has occurred over several months. Asymptomatic presentation (in up to 25%) is associated with the spontaneous development of intrahepatic and portosystemic collaterals and a favourable outcome. Rarely patients may present with fulminant hepatic failure, which is an indication for superurgent listing for liver transplantation in the UK.

Figure 1: Stepwise algorithm for management of BCS.



Investigations

There should be a clinical suspicion of BCS in all patients with abdominal pain, ascites or hepatomegaly. Liver function tests are abnormal in the majority but extent of abnormality varies considerably.

The diagnosis of BCS relies on non-invasive imaging and interpretation by an expert radiologist. Doppler ultrasound, CT and MRI are the most commonly used modalities. When hepatic outflow tract obstruction is present they may show dilatation of the vein upstream of the obstruction, endothelial material, no flow signal within the vein and the formation of a collateral circulation. In acute BCS hepatic veins may be enlarged, stenotic or tortuous; in patients with chronic BCS they may be difficult to identify. Less specific signs such as splenomegaly (78%), inhomogeneous liver parenchyma (76%), intrahepatic collaterals (73%), ascites (56%), extrahepatic collaterals (44%) Imaging also allows the differentiation of primary and secondary BCS as it can identify space occupying lesions or tumours infiltrating the hepatic veins or IVC.

Doppler ultrasonography is the initial investigation of choice and has a sensitivity of 87.5%. The left and middle hepatic veins normally join and drain into the IVC separate to the right hepatic vein. CT may be used to confirm the diagnosis following ultrasound, although this modality is limited by false negatives. CT can demonstrate failure of contrast passage through the hepatic veins, the liver may appear mottled or "flea bitten" due to inhomogeneous perfusion. The caudate lobe drains directly into the IVC through a variable number of veins. A compensatory increase in the venous drainage of this lobe occurs in BCS causing hypertrophy of the caudate lobe (which may further narrow the IVC) and relative atrophy of the remaining liver. Splenomegaly and ascites may also be seen. MRI may be used in the setting of renal impairment. Direct venography is now rarely used for reaching the diagnosis.

Liver biopsy is rarely necessary, but may be required to exclude other aetiologies, or when imaging is non-diagnostic and BCS is still suspected. Classical histological features are ischaemic loss of hepatocytes, fibrosis and congestion occurring in the centrilobular region. Chronic congestion may lead to cirrhosis and parenchymal extinction (collapse of the normal architecture and approximation of the hepatic and portal tracts). In patients with concomitant portal vein thrombosis fibrosis is mainly periportal. Coexisting portal vein thrombosis may lead to nodular regenerative hyperplasia. Histological findings do not relate to prognosis, presumably due to the patchy nature of the obstruction and sampling area.

Once the diagnosis is made a search for precipitants should begin (Table 1). The diagnosis of one risk factor should not discourage further investigation. The interpretation of low protein C, protein S and antithrombin levels in the setting of BCS is challenging since these factors are often reduced in liver dysfunction anyway. A reduction in all vitamin K dependent clotting factors suggests hepatic dysfunction; whilst a reduction of a single clotting factor may represent a pre-existing deficiency. A family history of thrombosis and the use of genetic tests assist the diagnosis. It is very important to recognise that MPD may be present in the setting of normal peripheral blood counts.

Treatment and Prognosis

BCS is a rare disorder, and management guidelines are based on level C evidence at best and expert opinion. The majority of patients now receive some form of intervention yet little is known of the natural history of this disease. Initial management involves treatment of the underlying disease followed by a combination of anticoagulation, vascular intervention or liver transplantation.

Anticoagulation

Anticoagulation aims to reduce the risk of further thrombosis and is recommended in all patients unless there is a contraindication, and should be continued indefinitely. There has been no study to determine the best degree of anticoagulation in BCS. The usual practice is low molecular weight heparin (aim for anti-Xa level of 0.5-0.85 IU/mL and monitor platelets) followed by warfarin (target INR of 2.5-3.5) when the patient is clinically stable. There are obvious concerns regarding the use of anticoagulants in the setting of thrombocytopenia, coagulopathy and varices. Bleeding complications are often related to interventions, and anticoagulation should be adjusted prior to any invasive therapies.

Anticoagulation alone may be an option for patients with no signs of on-going hepatic necrosis and diuretic sensitive ascites. After anticoagulation has commenced, all patients must remain under very close medical follow up, since reports suggest that 14% may progress to liver failure and death over a 2 year period. Deteriorating liver function tests or new symptoms and signs related to portal hypertension should prompt rapid radiological re-evaluation and intervention as necessary.

Thrombolysis

The main benefit is with catheter directed thrombolysis in recent thrombus with some residual flow and adjunctive dilatation or stenting. Systemic thrombolysis is less effective. However, thrombolysis is generally not recommended due the bleeding risk.

Radiological interventions

Vascular intervention in BCS aims to relieve hepatic congestion and necrosis. This may be done through balloon angioplasty, recanalisation or stent insertion. Caution should be used in placing a IVC stent as migration to the heart can occur. Care should be taken in selecting the most suitable hepatic vein for intervention. "Spider web" venous collaterals for instance are not suitable for intervention. A percutaneous approach to the hepatic veins may be used when direct access from the IVC is impossible. A wire passed through the hepatic vein can then rendezvous with a snare catheter from the jugular approach and enable balloon dilatation and stent insertion. In 15% of patients concurrent portal vein thrombosis (PVT) occurs. The prognosis in the setting of BCS and PVT is worse than BCS alone and the therapeutic options are more limited.

Portosystemic shunting

Porto-systemic shunt creation is an option for BCS patients who fail medical therapy and who have obstruction that is not amenable to balloon dilatation or stenting. Mesocaval shunts were the most common followed by sided to side portocaval. Surgical shunts are complicated by rates of shunt dysfunction as high as 32%, and are associated high rates of morbidity and mortality. Several studies have looked at the impact of surgical shunting on survival with mixed results. Surgical experience with these procedures is dwindling and they are now rarely performed having been mostly superseded by TIPSS.

Transjugular intrahepatic portosystemic stent-shunt (TIPSS) for BCS using bare metal stents at first was described in 1992. Complications include hepatic encephalopathy, although the risk of hepatic encephalopathy following TIPSS insertion for BCS has been reported to be relatively low at 10%. Injuries to the carotid artery, right atrium, IVC, liver capsule, portal vein, hepatic artery and bile ducts are possible. However, TIPSS is less invasive than surgery and also has the benefit of decompressing the portal system into the suprahepatic IVC allowing an occluded intrahepatic IVC to be bypassed.

Polytetrafluoroethylene (PTFE) stents have reduced the rates of stent dysfunction. TIPSS may be used as a bridge to transplantation and does not interfere with the procedure. It may also be used in more complicated cases such as during pregnancy as the low radiation dose not interfere with intrauterine development. An extended TIPSS with or without thrombolysis can be used in the setting of BCS and concurrent PVT. In 2008 a large (n=124) European multicentre trial reported 1- and 5-year OLT-free survival were 88% and 78%.

Transplantation for BCS

Despite medical therapy and TIPSS clinical deterioration requiring transplantation occurs in 10-40% of BCS patients. BCS represents approximately 1% of patients undergoing orthotopic liver transplantation in Europe. The risk of malignant transformation (which may be increased by immunosuppression) and the natural history of underlying haematological disorders must be considered prior to transplant. Outcomes following transplant are similar to those for other diseases. Anticoagulation is generally started shortly after surgery and continued lifelong.

BCS Prognosis

A number of prognostic indices have been studied in the setting of BCS. However, while these were appropriate for calculating transplant free and invasive free survival, their predictive accuracy was insufficient to be used for individual patients.

Conclusions

Good quality clinical trials are lacking in BCS. Historically the choice of optimal treatment either surgical or endovascular depended on the individual centres' expertise. Outcomes in BCS have clearly improved over the last three decades. In 1985 one year survival of 60% was reported, more recently long term survival of 96% has been reported. Since BCS typically affects younger patients, long term prognosis may be more dependent on the underlying risk factors such as MPD. A stepwise approach to invasive procedures has helped. Patients presenting with BCS are a heterogeneous group. Underlying prothrombotic diseases, location and extent of venous obstruction and the degree of hepatic dysfunction vary. The poor performance of BCS specific prognostic indices when applied to a given patient highlights the need for individualised management. Patients are treated with anticoagulation and progress through angioplasty/stenting, TIPSS and finally transplantation if they fail to improve.

Budd Chiari Syndrome: Key points

- BCS is a rare disorder which may result in liver failure. Management should therefore be in coordination with a liver transplantation unit.
- BCS should be considered in all patients with hepatic dysfunction particularly those with prothrombotic conditions.
- Diagnosis is made by non-invasive imaging in the majority
- The patient should be investigated for underlying prothrombotic conditions.
- Management depends on the location of the hepatic outflow obstruction and the extent of hepatic dysfunction. A stepwise approach is suggested (Figure 1)
- Lifelong anticoagulation is recommended

Table 1: Prothrombotic conditions associated with BCS

Prothrombotic Condition (%)	Investigations
Myeloproliferative disease (49%)	JAK2(V617F) mutation Bone marrow biopsy
Paroxysmal nocturnal haemoglobinuria (19%)	Flow cytometry of peripheral blood cells showing CD55 and CD59 deficient clones
Factor V Leiden (12%)	Factor V Leiden mutation is more resistant to activated protein C and therefore takes longer to switch off clotting. Clotting is tested in the presence and absence of activated protein C to establish if there is resistance. The factor V Leiden mutation (R506Q) may also be identified through molecular analysis
Prothrombin gene mutation (3%)	Molecular analysis for G20210A mutation
Inherited protein C deficiency (4%)	Qualitative or quantitative defect in Protein C. The assay is a generally a functional one and identifies both qualitative and quantitative deficiency
Inherited protein S deficiency (3%)	Qualitative or quantitative defect in Protein S. ELISA for free Protein S antigen. Functional Protein S test also available.
Hyperhomocysteinemia (22%)	Raised serum homocysteine level
Behcet's disease (4%)	Oral ulcers at least 3 times within one year period along with 2 out of the following 4 "hallmark" symptoms: <ol style="list-style-type: none"> 1) Genital ulcers 2) Skin lesions 3) Ocular inflammation 4) Pathergy reaction (papule >2 mm, 24-48 hrs or more after needle-prick).
Antiphospholipid syndrome (25%)	Diagnosis of APS requires one clinical manifestation <ol style="list-style-type: none"> 1) Arterial, venous, or small vessel thrombosis 2) One or more unexplained deaths of a morphologically normal fetus at or beyond the 10th week of gestation and/or 3 or more unexplained consecutive spontaneous abortions before the 10th week of gestation. <p>and one laboratory manifestation on 2 or more occasions</p> <ol style="list-style-type: none"> 1) Anti-cardiolipin IgG and/or IgM 2) Anti-β2 glycoprotein I IgG and/or IgM
Oral contraceptives or pregnancy (33%)	
Ulcerative Colitis (8%)	Colonoscopy if symptoms suggestive
Coeliac disease	Anti-TTG and Anti-EMA antibodies

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Facebook - the pleasant devil: a short communication

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Introduction

Facebook (FB), a social networking website (www.facebook.com), has become an extremely popular and most widely used website in the world for wide range of purposes including social, political, religious and business. Both advantages and disadvantages of engagements in FB are well described, which are largely user-dependant. In this short communication, a historical perspective, advantages, disadvantages and personal perspectives on FB are outlined.

Historical perspectives

The credit for the introduction of FB goes to Mark Elliot Zuckerberg, a computer science and sociology student from Harvard University, who, at the age of 20 (born May 14, 1984), launched FB from his Harvard dormitory room on February 4, 2004. Currently, he has been named among the 100 wealthiest (\$14.7 billion), the youngest billionaire and most influential people in the world by the Time magazine (Person of the year 2010). The revenue is generated mainly through advertisements in the FB, which is worth of several million dollars every year.¹

As of May 2012, over 900 million users were actively using FB and over half of them used FB on a mobile device. FB is available in 70 different languages all over the world. In May 2012, the countries with most FB users were: USA (157.3 million), Brazil (47 million), India (46.3 million), Indonesia (42.2 million) and Mexico (33.1 million). FB has been intermittently banned in countries like China, Iran, Pakistan and Bangladesh based on the anti-Islamic and contents of religious discrimination.² Since its introduction in a basic format, expansion in its utility has been done through introduction of facilities for sending messages, new feeds, chats, gift sending, voice calling and video calling and more lately the introduction of timeline. Users need to register with the website and create a personal profile, add other users as friends for exchange of messages. Several privacy settings are available to allay concerns about privacy so that specific parts of the profile can be made visible to specific group of individuals.

Ivy Lesley Bean (8 September 1905 – 28 July 2010) from Bradford, England is well known for being the oldest person in the world to join the FB at the age of 102 (in 2008) and became an inspiration to the residents of her home. She had 4962 friends on

FB at the time of her death and remained in good spirit until the end.

Advantages

Appropriate use of FB and networking can make positive impact at social and personal levels. FB is free and is being used as the best medium for communication and business promotion. It has helped share and ask public opinion on a particular topic. It has helped unite people with common interest groups thus accruing benefits at professional levels. More importantly, FB can help overcome timidity in some people as contacting people through internet becomes easier for shy people.

FB has helped find and connect old friends and colleagues who had been lost in the past. It allows users to continuously stay in touch with friends and relatives wherever they are in the world, as long there is an access to the internet. Lastly, FB is often used a boredom killer while on vacations and is proved to be useful even to elderly people who are retired from their job.

Disadvantages

Indiscriminate use of FB, including accessibility of personal data, can be associated with severe problems, both at the personal and institutional levels. FB, unquestionably, is addicting, which can lead to significant loss of time and productivity. In May 2011, it was recorded that 50% of British employers had banned FB from their work place because of lower work productivity. FB has led to poor performance among students due to their excessive indulgent and loss of valuable time. There are several reported instances of hacking of FB accounts, replacement of profile pictures with pornographic images, thereby causing severe distress among FB users.

At a social level, continuous contact through FB, may reduce direct communication with each other and can cause increased anti-social tendencies. Some studies have named FB as a source of problems in inter-personal relationships and a cause of divorce and infidelity. FB can even be life threatening as unknown people can track others activities and whereabouts, hence the importance of keeping ones activities private.³

Personal perspectives

I am a regular user of FB for last couple of years and have derived significant benefit from its use. Being involved in a very

demanding profession of transplantation and general surgery with onerous on-call and elective commitments in two specialties of surgery, stress and tiredness, can be very severe inflicting harmful effects on physical and mental health. For sustenance of enthusiasm and interest in one's profession, major distraction for a short period is an essential requirement and FB has served this purpose. It has helped me a lot to recover from exhaustion and start fresh at work. FB has also encouraged me to create and upload pictures, songs and video clips, and helped preserve my basic hobbies, which I have nurtured over last five decades.

I have been successful in keeping in touch with some of my senior colleagues and mentors from overseas through the FB and have been obtaining professional advices on the management of complex patient-related problems, thus benefiting the patients. FB has also helped me to reunite with several of my close friends from medical school, who had been out of touch for last thirty years.

It is true that significant time can be lost, if the FB is used indiscriminately, but grown up people do carry lot of professional responsibilities, so FB should not be a major deterrent in the delivery of duties. I believe, FB can be used positively for personal and professional development purposes and I have no regrets whatsoever.

Conclusions

The use of FB has significant advantages if used with discrimination. On the other hand, it is addictive and can lead to significant loss of precious time, thus causing lowered productivity and poor performance in professional life. It is important to adopt a sensible approach to FB before one becomes a victim of this pleasant devil.

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ABSTRACTS

1. LAT gel use in Sunderland paediatric emergency department 2011-2012.

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In the paediatric emergency department, many lacerations are closed by using steristrips, glue or staples depending on their site, shape, size and alignment. Some need closure using sutures. Previously wounds needing closure with sutures were closed using lignocaine injection for local anaesthetic or the child if too young for this painful procedure was admitted under maxfax for closure in theatre.

We introduced LAT gel (definition below) to improve patient analgesia, reduce admission rates into hospital for wound closure and to provide same day safe treatment, negating the need for general anaesthetic.

Definition

- Lignocaine, adrenaline and tetracaine (LAT) is a topical anaesthetic gel
- Used to anaesthetise dermal lacerations < 4cm in length
- Should be used in preference to injected lignocaine as the local anaesthetic agent of choice in children for lacerations

less than 4cm in length which don't involve digits, other extremities or mucous membranes

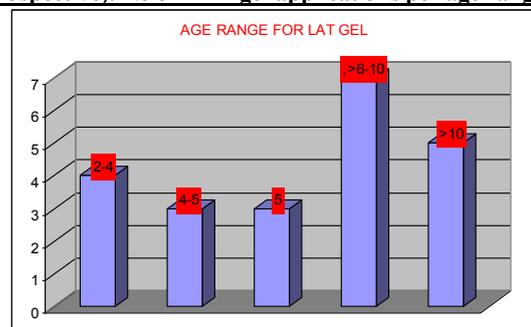
Aim

- Reduce the pain and anxiety felt by children undergoing minor laceration repair and removal of foreign body or grit from wound

Supportive articles

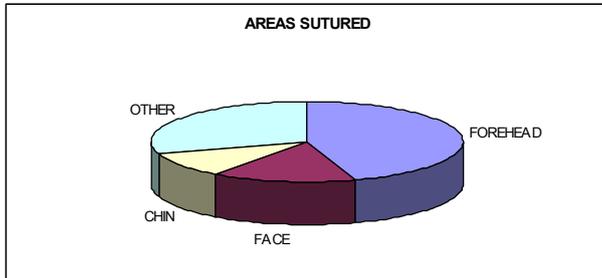
- EMJ:Less painful, reduced tissue distortion, less emotional distress to patient
- BMJ:use in wounds <5cm, similar efficacy to lignocaine injection but less painful to apply

Audit findings (forms filled over a period of 4 months prospective). No of LAT gel applications per age range



The category in the under 5 year age group would have gone to theatre had it not been for LAT gel as in this age range it is difficult to keep a child still to apply lignocaine with a needle. These patients would have been admitted and gone for repair of laceration in theatre. Some of the 6-10 year age range may have gone to theatre too as at this age some children can fear needles a lot.

Areas sutured



The distribution of areas sutured were predominantly on the forehead but included the face, chin and limbs. For lacerations to the forehead, face and chin it is difficult keeping a child still, especially for lignocaine local anaesthetic injection.

Theatre

1/23 – A 2yr 6 month old did have to go to theatre for an eyebrow laceration repair

Ease of administering LAT gel

All health care professionals were satisfied with ease of administration and it's use as a local anaesthetic agent

Parent satisfaction

Most were highly satisfied with LAT gel

Free text comments by staff, including maxfax team

“Easy”

“Bloodless field”

“Avoided child getting upset with a needle”

“Much better than expected”

“Child singing through procedure”

Recommendations

1. Continue to use LAT gel for appropriate wounds to provide good anaesthetic and patient/parent satisfaction
2. Continue to use LAT gel so that a general anaesthetic, an admission to the ward and use of several other resources can be avoided

2. Growth disturbance in newborn babies of women with pre-existing Type 1 or Type 2 diabetes in the North of England

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(This abstract was accepted for poster presentation at Perinatal Medicine Meeting 2011, Harrogate)

Introduction

Diabetes mellitus is the most common pre-existing medical disorder in pregnancy. Fetal growth abnormalities are common complications of diabetes in pregnancy; there is little data on temporal trends in growth disturbance. The main aim of this study was to determine changes in rate of large for gestational age (LGA) and small for gestational age (SGA) in babies of women with pre-gestational Type 1 or Type 2 diabetes (T1DM and T2DM).

Methods

Data were extracted from the Northern Diabetes in Pregnancy Survey, a register of pregnancies in women with pre-gestational diabetes resident in Northern England. We studied 1499 singleton live births delivered 1996-2008, excluding those with congenital anomalies. LGA was defined as birthweight >90th percentile for gestational age and SGA as <10th percentile, corrected for infant sex and parity.

Table 1: Maternal characteristics of diabetic mothers and their newborn babies (N=1499)

Characteristics	Number (± SD)	Percentage
Mean age of diabetic mothers	29±6	
Mean BMI at booking	28.3±6.6	
Type I DM	1164	78%
Type II DM	328	22%
Caesarean section	911	63.1%
Shoulder dystocia	42	3%
Prematurity (birth before 37 weeks of gestation)	545	36.4%
Mean birth weight in gm	3437±755	
Babies with birth weight ≥ 4000 gm	335	22.5%
LGA (Large for gestational age)	702	49.3%
SGA (Small for gestational age)	42	2.9%

Results:

1164 (78%) women had T1DM and 328 (22%) T2DM (Table 1). Mean (SD) birthweight was 3437g (± 755). 335 (23%) babies weighed ≥4000g. The rate of LGA was 49.3% and SGA 2.9% and did not change over time (LGA 50.9%, 1996-2000, 47.7%, 2005-2008; SGA 3.5%, 1996-2000, 2.9%, 2005-2008; p= 0.73). T2DM increased from 8.9% (1996-2000) to 32.1% (2005-2008) (p = 0.01). There was a significant increase in the rate of obesity (BMI at booking ≥ 30) over this period (from 20.9%, 1996-2000 to 37.4%, 2005-2008; p= 0.001). LGA babies were more likely to be preterm (45% vs 29%, p = 0.001), delivered by caesarean section (68% vs 57%, p=0.001), admitted to Special Care (54% vs 40%, p=0.001) and to develop shoulder dystocia (5% vs 1%, p= 0.001) than babies of normal weight for gestational age (Table 2).

Variables	Babies below 10th percentile (SGA) N (%) Total no= 42	Babies between 10th and 90th percentile N (%) Total no= 680 (data available only in 680 subjects)	Babies above 90th percentile (LGA) N (%) Total no = 702	P-value
Prematurity	13 (31%)	194 (29%)	314 (45%)	0.001
Caesarean section	29 (69%)	386 (57%)	477 (68%)	0.001
Shoulder dystocia	1 (2%)	5 (1%)	36 (5%)	0.001
Admission to SCBU	19 (45%)	271 (40%)	376 (54%)	0.001

Table 2: Obstetric procedure and complication in babies with growth disturbance

Conclusions

LGA is the most common growth abnormality of diabetes in pregnancy. Rates of LGA and SGA have not changed over time despite an increase in T2DM. The rising rate of obesity and Type 2 DM present a major challenge.

3. Effect of age or obesity on the short-term and long-term outcomes in living kidney donors: A single centre experience (2001-2009)

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(This abstract was accepted oral presentation at American Transplant Congress Meeting, 2011 and British Transplantation Society Annual Congress Meeting, 2011)

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Introduction

The demographic of the kidney donor population is changing. The proportion of older and more obese donors is increasing. Though the risk of donating a kidney seems to be minimal in carefully selected individuals, there is limited data on the short-term and long-term complications in elderly or obese living donors.

Aims

To evaluate short-term and long-term complications in elderly or obese living kidney donors.

Methods

This study involved a retrospective review of the medical records of living kidney donors who underwent donor nephrectomy from 2001 to 2009. The donor kidney transplant database, hospital records, operative notes, follow-up clinic visits and correspondence from general practice were reviewed.

Results

A total of 237 living donor nephrectomies (laparoscopic nephrectomy 200 and open nephrectomy 37) were performed from January 2001 to December 2009. The mean age at the time of donation was 46.9±10.9 yrs and mean BMI 27.6±3.6. 25.7% of donors were aged 55 yrs or more and 23.6% of donors were obese at the time of donation with BMI ≥ 30. 4.1% of donors aged < 55 compared to 3.8% donors aged ≥ 55 and 4.9% of donors with BMI < 30 compared to 2.4% of donors with BMI ≥ 30 developed Grade 3 complications (The Clavien Dindo Classification) following laparoscopic nephrectomy.

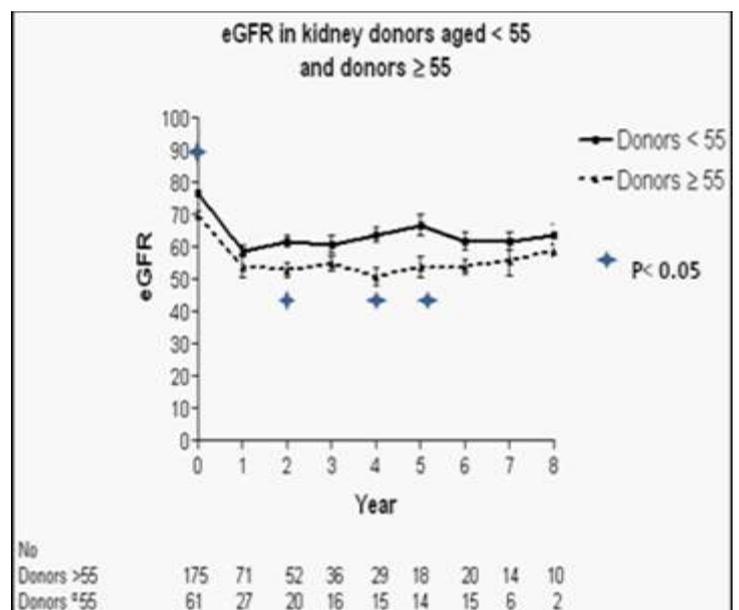
There were no life-threatening complications (Grade 4), post-operative deaths (Grade 5), or conversion to open nephrectomy. The mean duration of follow-up was 46.5 months. A total of 172(73%) patients were evaluated for renal function and blood pressure and we included only those patients who had been followed up for at least 12 months. GFR measured by Cr-EDTA clearance was significantly higher in donors aged <55 vs ≥55 (100 ml/min vs 88 ml/min, p=0.001). In the absence of repeat measures of GFR, we used estimated GFR (4 point MDRD) to assess function. The difference in mean eGFR was 6, 6 and 13 mls/min at 1, 3 and 5 years (p= 0.08, 0.17 & 0.009, <55 vs≥55).

85.2% of donors aged ≥ 55 yrs fit criteria for CKD 3 compared to 56.3% of donors aged < 55 one year post donation. Pre-donation GFR was similar in donors with BMI < 30 and ≥ 30 and the difference in means was 3, 4 and 1 ml/min at 1, 3 and 5 years (p=0.3, 0.4 & 0.9). 62.7% of donors with BMI < 30 developed CKD 3 compared to 69.6% of donors with BMI ≥ 30 at one year.

Hypertension one year post-donation (>140/90 or antihypertensive medication) was present in 17.4% of donors aged < 55 compared to 25% of donors aged ≥ 55 and 15.9% of donors with BMI < 30 compared to 15.2% of donors with BMI ≥ 30. The difference in mean systolic BP between donors aged < 55 and ≥ 55 at year 5 was 5 mm and this difference was 9 mm between donors with BMI <30 & ≥ 30.

Conclusion:

Short-term complications were not significantly higher for older (≥ 55) or obese donors. The high prevalence of hypertension and CKD 3 in older or obese donors highlights the need for long-term follow-up and interventions to minimize cardiovascular risk.



ARTICLE I

Name: The Association shall be called 'Nepalese Doctors Association' in the United Kingdom, NDA (UK) in abbreviation.

ARTICLE II

Aims and Objectives:

- To establish greater understanding and co-operation amongst the Nepalese doctors in the United Kingdom.
- To promote and foster good relations between Nepalese doctors residing in the United Kingdom, doctors in Nepal and other members of Medical profession in the UK.
- To initiate collaboration with similar organisations in Nepal and be of assistance whenever possible.
- To exchange ideas and thoughts in the field of Medicine with fellow Nepalese doctors living in other countries.
- To promote cultural exchange with other groups having similar interest.
- To promote fraternity amongst Nepalese of other walks of life residing in the United Kingdom.

ARTICLE III

Membership:

Clause 1: Full Membership: All doctors and dental surgeons of Nepalese origin residing in the UK for more than one year shall be eligible for full membership of the Association.

Clause 2: Associate Membership: Shall be open to all doctors and dental surgeons in the UK and medical and dental students of Nepalese origin on approval by the executive committee.

Clause 3: Life Membership: Any full or associate member shall be eligible for life membership on payment of fees.

Clause 4: Honorary Membership: To be awarded by the general body to distinguished individuals in recognition of outstanding contribution in the field of medicine and towards Nepalese cause.

ARTICLE IV

General Body

- General body shall consist of all full members of the Association.
- Shall elect office bearers and members of the Executive Committee.
- Accept Annual and Financial reports.
- Shall decide on unforeseen matters arising from time to time.

ARTICLE V

Executive Committee

Clause 1: Composition of Executive Committee

Chairman; Vice Chairman; General Secretary; Treasurer; Joint Secretary; Four Committee members

Clause 2: Functions of Executive Committee

- The Committee shall be responsible for day to day management of affairs of the Association.
- Shall appoint sub-committee and officials as required from time to time.
- Shall accept the resignation of the Chairman when tendered.

Clause 3: Functions of the Office Bearers

Sub-clause I Chairman

- Shall be the official representative of the Association.
- Maintain order and see that the rules are observed.
- Use a casting vote in case of tie.
- Call emergency meetings.
- Accepts resignations of members and office bearers in consultation with the executive committee

Sub-clause II Vice Chairman

- To act as Chairman in the absence of Chairman.

Sub-clause III General Secretary

- Shall be principal executive officer.
- Shall call executive and general body meetings in consultation with the Chairman.
- Shall keep the minutes of all the meetings.
- Shall correspond on behalf of the Association.
- Shall prepare and submit report at the Annual General Meetings.

Sub-clause IV Treasurer

- Shall open a joint Bank Account in the name of the Association with another member of the committee nominated by the committee.
- Shall collect subscriptions and other incomings to the Association.

- Shall be responsible for all financial transactions within the limit imposed by the General Body from time to time on the recommendation of the executive committee.

- Shall maintain a financial record and submit for auditing and present a report at the Annual General Meeting.

Sub-clause VI Joint Secretary

To act as General Secretary in the absence of General Secretary.

ARTICLE VI

Subscriptions

Subscriptions and fees shall be decided by the General Body from time to time on the recommendation of the executive committee.

ARTICLE VII

Meetings

Apart from the general meetings, there shall be at least two executive meetings in a year.

Notice of the forthcoming meeting shall be given at least two months in advance in case of AGM and two weeks in case of an executive committee meeting.

In the event of meeting not held due to lack of quorum, shorter notice on the discretion of the Chairman shall be sent.

Members present at the subsequent meeting shall constitute a valid quorum. Emergency meetings may be called at a shorter notice on the discretion of the Chairman.

ARTICLE VIII

Quorum

A simple majority shall make a quorum at all the meetings of the Association.

ARTICLE IX

Election

The tenure of the executive committee shall be for a period of two years.

No office bearer shall hold the same post for more than four years consecutively. In the absence of general consent, election of the Office Bearers shall be conducted by a secret ballot.

A returning officer shall be appointed to conduct the Election.

Casual Vacancies shall be filled in by Co-Option by the executive committee.

Only full members of the Association shall be eligible to vote and contest in the election.

Vote of no-confidence against any member of the committee or office bearer may be submitted to the committee in writing by at least ten percent of the current membership. Such proposal shall require two third majority consent from amongst the members in the General Meeting to be passed.

ARTICLE X

Amendment and Dissolution

Any proposal for amendment of any article, clause, sub-clause or any other particular point mentioned in the existing constitution must be submitted in writing to the General Secretary. The General Secretary shall submit the proposal to the executive committee and if accepted shall be circulated along with the agenda for the general meeting (annual) to all the members.

Two third majority of the members present at the Annual General Meeting shall be required to pass such proposals.

In the event of non-functioning of the Association, all members shall be duly notified of the dissolution. The existing executive committee shall appoint a Custodian to look after the asset of the Association until such a time, the Association is revived.

NDA (UK) AGM 2012

Metro Centre Marriott, Newcastle-upon-Tyne, UK

Programme

FRIDAY (27th July)

Check in hotel reception, registration and welcome refreshments	15.00 – 17:00
Buffet Dinner (restaurant)	18.30 - 20.00
Evening entertainment	20.00 onwards
Bar open till late	

SATURDAY (28th July)

Breakfast (RARE restaurant)	07.00 -10.00
AGM and Scientific Session (European Room)	09.30- 11.30
Alternative programme (Gymn/Swim/Massage/Steamroom/Fitness Class. Free to see Metro Centre or enjoy company)	10.00 – 12.00
Trip to Newcastle-upon-Tyne Quayside. Explore Newcastle Quayside/the Baltic art gallery/ the Sage <u>Lunch pickup from hotel restaurant at 11.45</u>	12.00- 15.00

Evening Programme

Drinks reception	18.30 - 19.30
Gala Dinner	19.30 - 21.30
Baby sitting (for children 1-6 years)	17.30 – 22.00
Disco/ Entertainment	After Gala Dinner till late
Private bar closes 01.00	

SUNDAY (29th July)

Breakfast (restaurant)	07.00 – 10.00
Scientific Session (European room)	09.30 - 11.30
Dance class	10.00 – 11.30
Checkout	11.30 – 12.00
Lunch (Ponteland Memorial Hall, Darrus Hall)	12.30
Bon Voyage	16.30 onwards