JUNE 2009 VOLUME NO. 33 ISSUE NO.3

MEDICALIMAGE

Monthly Bulletin of **INDIAN MEDICAL ASSOCIATION** - MUMBAI WEST
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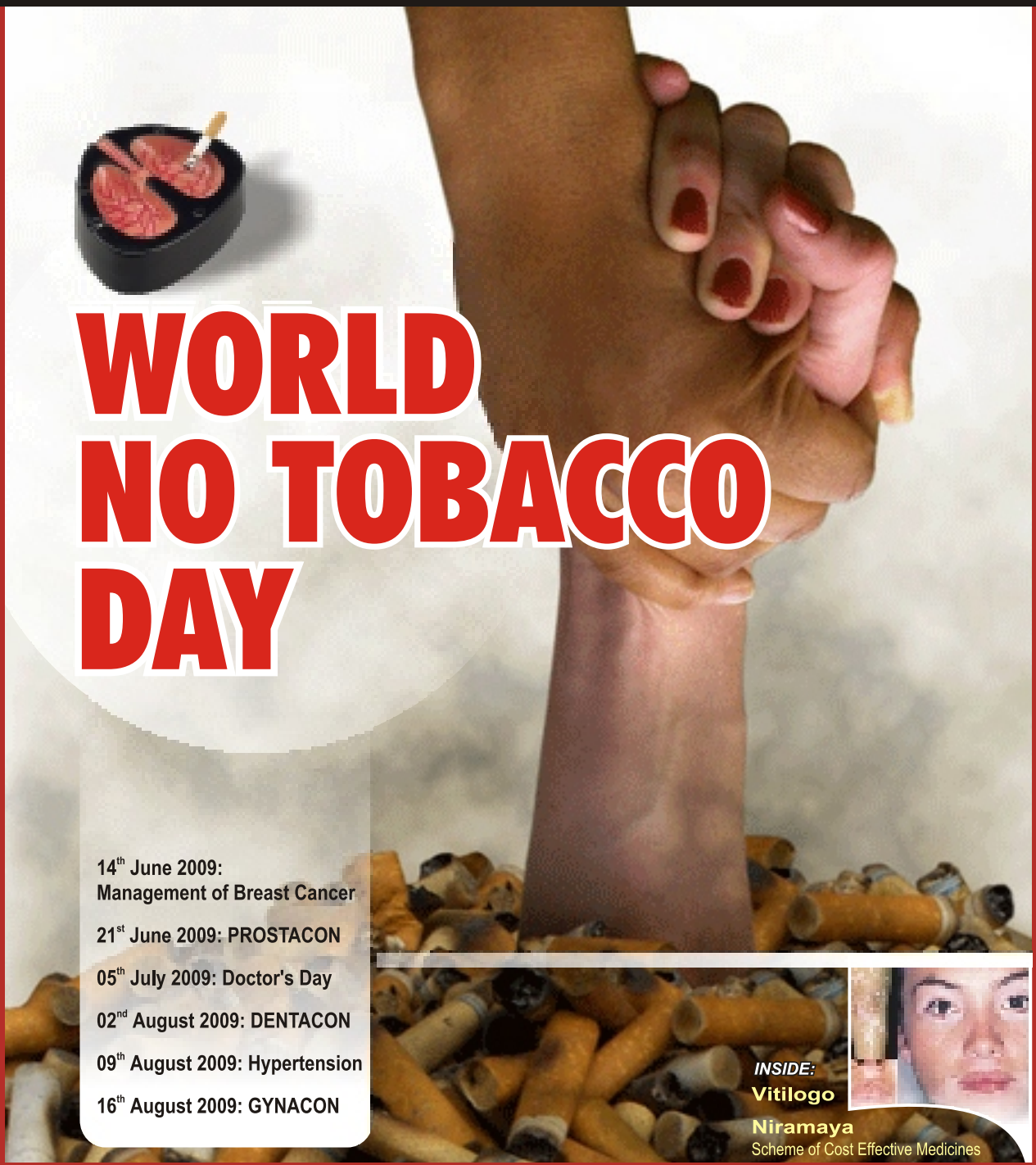

WORLD NO TOBACCO DAY

14th June 2009:
Management of Breast Cancer

21st June 2009: PROSTACON

05th July 2009: Doctor's Day

02nd August 2009: DENTACON

09th August 2009: Hypertension

16th August 2009: GYNACON

INSIDE:

Vitilogo

Niramaya
Scheme of Cost Effective Medicines

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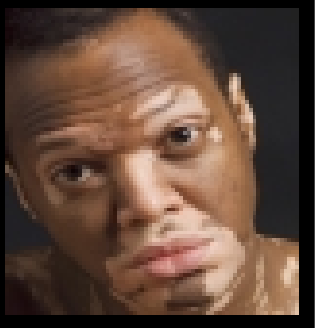

Medical Image : Published by **Satish Sinnarkar,** of **Campaign Masters** on behalf of the **Indian Medical Association - Mumbai West** and printed by him at **Unity Art Offset**, 302, Wadala Udyog Bhavan, Wadala, Mumbai-31.

Contact for write-ups, articles, interviews and advertisements : **Editor - Dr. B.M. Inamdar,** I.M.A. Bldg., Behind Chandan Cinema, J. R. Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.
Office : 2625 4368 / 6523 5579 Fax : 2620 6517
E-mail: imamumbaiwest@yahoo.com

Advertisement cheques to be drawn in favour of IMA Mumbai West

Please get your IMA Mumbai West **IDENTITY CARD.** Identity Card shall be mandatory for future events.

UPDATE YOUR DATA

Your stamp size Photograph

Name .....
Residence Address .....
.....Telephone .....
Clinic Address .....
.....Telephone .....
Mobile ..... Blood Group .....
Email ID/s. ..... Date of Birth .....

Send sms to 9819812996 or email to : drjayeshlele@yahoo.com

Dr. S.K. Joshi
Hon. Secretary

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

I.M.A. Bldg., Behind Chandan Cinema, J. R. Mhatre Marg, J.V.P.D. Scheme,
Juhu, Mumbai - 400 049.
Office : 2625 4368 / 6523 5579 Fax : 2620 6517
E-mail: imamumbaiwest@yahoo.com • Website : www.imamumbaiwest.com

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Dr. Dua Atul	2887 6186	2886 6446	9820140533	Dr. Shetty Umesh	5694 1610	2670 3639	98201 37779
Dr. Gupta Sanjay	-	2628 2243	98202 32606	Dr. Tiwaskar Mangesh	2848 6588	2808 2713	98200 67424
Dr. Joshi Kaushik	2888 8236	2880 2792	98922 80527	Dr. Vaid Zubin	2628 5700	2674 0082	98212 31939
Dr. Kalambi Suresh S.	2679 6556	2683 5719	98191 62278	Dr. Vaidya Niranjan R.	-	2646 2122	93204 42122
Dr. Kamdar Bipin	2612 6699	5691 9933	98200 26093	Dr. Vora Agam	28924811	2893 0010	98200 70054

MUMBAI - WEST SUB FACULTY OF IMA - CGP

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Asst. Secretary	Dr. Bhargava Priti	-	2633 0653	98338 87603

MUMBAI - WEST CHAPTER OF IMA - AMS

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Asst. Secretary	Dr. Patel Heena M.	2682 3179	2620 2392	93222 38372

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From the Hon. President's desk.....

"The 1st announcement brochure for MASTACON 2009 delegates is almost ready and shall be send to all the members from our branch ,CWC members, other state council &state executive members of IMA Maharashtra state, prominent branches as well as various leaders from state. Please reserve your seats to avoid last minute rush as we have limited seats."

Dear Friends

IMA is now the talk of entire Maharashtra, and I am sure after the MMC elections results were seen the entire panel walked in with the thumping majority. It is now history that probably first times in the recent years MMC elections were held as physical voting and all our candidates were elected. Our panel will not only ensure smooth running of the MMC and it shall improve the confidence of doctors as well as serve a very good link between the patients and our doctors

Last month at our branch we could arrange WORLD VITILIGO DAY, Dr Timbadia gave very good lecture. We also arranged WORLD NO TOBACO DAY on 31st May, Sunday. Normal CME activities on Tuesday and Thursdays continued well.

We have started working with all the faculties who are helping us to arrange Grand scientific conference MASTACON 2009. The 1st announcement brochure for MASTACON 2009 delegates is almost ready and shall be send to all the members from our branch ,CWC members, other state council &state executive members of IMA Maharashtra state, prominent branches as well as various leaders from state. Please reserve your seats to avoid last minute rush as we have limited seats.

Our DOCTORS DAY shall be observed on 5th July being Sunday. MEDICINE UPDATE 2009 and grand musical evening shall be attraction in the evening. We are also felicitating dignitaries from different walks of life.

Dr Nilesh Shah and Dr Rawal, for the first time arranging Contract Bridge tournament at our premises around August Sundays, please participate and encourage them. After grand revival of our sports activities last year they have planned many such tournaments this year.

Dr Kalambi our chairperson for the Geriatric cell called on meeting with the officials with various neighboring senior citizen clubs to get their involvement in our cell activities. The 1st ever such meeting was very successful well attended. We could get their feedback on various events as well their needs. We are in the process of staring GERIATRIC COUNCELLING at our premises which will serve as ongoing regular feature all throughout the year.

Dr Kusum Doshi and Dr Akil Contractor are working on DENTAL CONFERENCE, DENTACON 2009, this year on 2nd August . Please mark your calendar. Dr Rashmikant Sanghvi is working hard to arrange 1st programme for the AMS chapter on 21st June.

Our entire managing committee Chairpersons from sub committees and various Chairpersons forms MASTACON 2009 are really putting efforts to give variety of events and innovative lectures. But your presence will make all the difference SO PLEASE REGISTER FOR THE CONFERENCE at the earliest.

Your feedback shall be great help.

JAI HO

DR JAYESH LELE
E mail : drjayeshlele@yahoo.com
Cell ; 981 981 2996

WEEKLY SCIENTIFIC PROGRAMME

Lectures on Every Thursday at 2.30 p.m. sharp

Venue : **Lupin CME Auditorium**, IMA Building, J. R. Mhatre Marg, Behind Chandan Cinema, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

DATE	TOPIC	SPEAKER
04.06.2009	Councelling for Deaddiction	Dr. Ashok Balsekar
11.06.2009	Relationships in Medical Practice	Dr. Ramesh Mehta
18.06.2009	Treat to target with insulin & monitoring	Dr. Manoj Chawla
25.06.2009	Prevention of micro vascular complications in diabetes	Dr. Rajiv Kovil

G. P. FORUM - ADDITIONAL C.M.E. PROGRAMME FOR GENERAL PRACTITIONERS

Every Tuesday at 2.30 p.m. sharp

Venue : **Lupin CME Auditorium**, IMA Building, J. R. Mhatre Marg, Behind Chandan Cinema, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

DATE	TOPIC	SPEAKER
02.06.2009	GERD & Asthma	Dr. Salil Bendre
09.06.2009	Newer trends in vaccination	Dr. Y. K. Amdekar
16.06.2009	Newer Anti Diabetic Drugs	Dr. Vinod Gidwani
23.06.2009	World Stroke Day	Dr. Shirish Hastak
30.06.2009	Stress urinary in incontinance - New advances	Dr. Udhav Raj

- **We highly appreciate and thank the following pharmaceutical companies for sponsoring our weekly CMEs Programmes:**
  1) M/s. Cipla Ltd. for Dr. Prashant Chhajed 's lecture on 19.02.2009.
  2) M/s. Intas Bio Pharmaceuticals Ltd. For Dr. Reetu Jain lecture on 16th April 2009.
  3) M/s. Eli-Lilly Co. Pvt. Ltd. for Dr. Rakesh Nair lecture on 23rd April 2009.

- WORKING LUNCH WILL BE SERVED FROM 01.30 PM TO 02.30 PM BEFORE EACH CME.
- CGP & IMA Members who have paid Annual Fees : (CGP:Rs.750/- & IMA:Rs.1000/-) Free.
- CGP & IMA Members : Rs. 50/- (Not Paid Annual Fees) (Weekly Lectures).

Each Lecture Carries A Credit of 1 Hour Each For FCGP Examination.

Dr. Jayesh Lele President | **Dr. S.K. Joshi** Hon. Secretary | **Dr. Subodh Kedia** Asst. Director of Studies | **Dr. Priti Bhargava** Asst. Secretary

IMA - Mumbai West C.G.P. Sub Faculty

From the Hon. Secretary's desk.....

"Doctors Day is fast approaching. It is scheduled on Sunday 5th July 2009. We are committed to deliver you an excellent Doctors Day Programme. We will have CME, felicitation of dignitaries followed by entertainment programme & grand dinner as per tradition of our branch. Please do attend in large numbers & encourage us."

At the outset I profoundly thank you for your kind gesture of responding to our request & turning up for voting on 26/04/2009 in large numbers at MMC elections in spite of scorching heat. This rightly proves that we stand united and the result all the 9 members of our panel won with great majority. In fact, first highest 9 vote drawers were of our panel of 9 members out of total 39 contestants.

Our parliamentary elections are also over by now. The results are also out. We respect the mandate of world's largest democracy. We heartily congratulate & wish incoming honorable PM & his team all the best in their contribution to our Nation's peace, prosperity & bright future.

Mercury is also rising very sorely this year & we have started feeling this & other ill effects of global warming, Vehicular Pollution, de-forestation & indiscriminate use - rather abuse - of natural resources like water are some of the main reasons for this. I must strongly urge senior member of our branch & leading tree lover & environment lover - Dr. Ashok Kothari & other like minded members to organize programmes of planting for more tree saplings in coming monsoon season. I assure them full co operation & co ordination on behalf of our branch.

Doctors Day is fast approaching. It is scheduled on Sunday 5th July 2009. We are committed to deliver you an excellent Doctors Day Programme. We will have CME, felicitation of dignitaries followed by entertainment programme & grand dinner as per tradition of our branch. Please do attend in large numbers & encourage us.

We are also organizing seminars on Prostatic disorders & CA - Breast this month.

We owe a lot to the society. Most of us have graduated from municipal or government run public hospitals. Whenever there is occasion we must try & reciprocate our gratitude in the form of offering our services to the poor & needy people by way of participation & organization of free medical check up campaigns, health awareness programmes & similar activities. Keeping this in mind, our branch proposes to start FREE GERIATRIC COUNSELLING CENTRE at our branch premises on every Wednesday in the afternoon. Aim of this centre is to listen to our senior citizen & help them to vent out their problems / feelings / grudges etc & guide them in proper direction. Most senior citizens usually complain that nobody including their doctors, does not listen to them & their problems/feelings/ grudge etc are remaining with them only. We would definitely expand this centers activity in the event of good response, Members who are interested to volunteer their services & help us in this noble cause may please come forward & give their names to our office. It is pity that many of their works are held up inspite of having enough money in the observe of manpower or proper advice.

Mastacon 2009 preparations are in full swing. Please register for the same. As you are aware it is scheduled on 13th to 15th of November 2009 at our branch premises. I invite members to associate & involve in the organizing of the conference with various departments of their preference like registration, fund raising, hotel accommodation for delegate coming from out station, catering etc. I reiterate that we are committed to offer you an excellent & memorable conference this year.

I end with my prayers to almighty God to bless us with gift of timely & adequate rains in coming monsoon.

With best regards,

Dr. S. K. Joshi
Hon. Secretary
joshisatishchandra@gmail.com

IMA - CGP MUMBAI WEST SUB FACULTY OF
INDIAN MEDICAL ASSOCIATION - MUMBAI WEST BRANCH

has great pleasure in inviting you to

"MANAGEMENT OF BREAST CANCER"

Day & Date : SUNDAY, 14TH JUNE 2009 • Time : 09.30 a.m. to 12.15 pm
Venue : IMA Lupin Auditorium, IMA Building, J. R. Mhatre Marg,
JVPD Scheme, Juhu, Mumbai - 400 049.

PROGRAMME

Topic	Topic	Speaker
09.30 am - 10.00 am	Registration & Breakfast	
10.00 am - 10.15 am	Welcome Address Inaugural Address Introduction	**Hon. Secretary - Dr. S. K. Joshi** **President - Dr. Jayesh Lele** Dr. Subodh Kedia
10.15 am - 10.45 am	Mammography	**Dr. Yojana Nalavade,** Consultant Sonologist
10.45 am - 11.15 am	Benign Breast Diseases & Newer Trends in Surgical Management of Breast Cancer	**Dr. Sanjay Sharma,** Surgical Oncologist, Raheja, Bombay & Lilavati Hospitals
11.15 am - 11.45 am	Auditing Emerging Technologies for Radiotherapy in Breast Cancer	**Dr. Nagraj Huilgol**, Radiation Oncologist Nanavati Hospital
11.45 am - 12.15 pm	Medical Management of Breast Cancer	**Dr. Nilesh Lokeshwar,** Medical Oncologist, Raheja, BSES MG & Joy Hospitals
12.15 pm	Vote of Thanks.	Dr. Priti Bhargava
12.15 pm	Lunch	

MODERATOR : DR. PARTHIV SANGHVI

REGISTRATION CHARGES : FREE

REGISTRATION A MUST TO MAKE PROPER ARRANGEMENTS
EARLY BIRD LUCKY DRAW PRIZES for members who register by 09.30 am

FOR REGISTRATION CONTACT : MS. APARNA / MS. SEEMA / MS. SUNITA
IMA - OFFICE TEL. NO. 2620 6517 / 2625 4368

EDUCATIONAL GRANT BY M/S. GSK ONCOLOGY

DR. JAYESH LELE
President

DR. S. K. JOSHI
Hon. Secretary

DR. SUBODH KEDIA
Asst. Director of Studies

DR. PRITI BHARGAVA
Asst. Secretary

IMA - Mumbai West C.G.P. Sub Faculty

Editorial

Communication

Dear Friends,

Some time back, I came across a very instructive story. Especially for Medical profession, it highlights our resistance to be open with our patients or even amongst ourselves! The story runs like this …..

She said, Hello, darling, I'd like to talk with the person who gives the information regarding your patients. But, I don't want to know if the patient is getting better, or doing like expected, or worse. I want to know all the information from top to bottom, from A to Z!'

The voice on the other end of the line said, "That's a very unusual request....What is the patient's name and room number?"

She said, 'Yes, darling! I'd like to know the information about Sarah Finkel, in Room 302.'

He said, 'Finkel, Finkel. Let me see. Feinberg, Farber, Finkel. Oh, yes. Mrs. Finkel is doing very well. In fact, she's had two full meals, her blood pressure is fine, her blood work just came back as normal, she's going to be taken off the heart monitor in a couple of hours and if she continues this improvement, Dr. Cohen is going to send her home Tuesday at twelve o' clock.'

The woman said, 'Thank God! That's wonderful! Oh, thank God! Her test came back normal, she's getting off the heart machine in a couple of hours you say. Oh! that's fantastic, darling! And she is being released tomorrow at twelve o'clock! I'm so happy to hear that! . . . That's wonderful news!'

The man on the phone said, 'From your enthusiasm, I take it you must be a close family member or a very close friend!'

She said, 'What close family or friend? I'm Sarah Finkel in 302! **Cohen my doctor tells me nothing!**"

"Tell me what you would like to read in our bulletin, whether you liked any article or presentation of our branch, whether you would like to improve or modify any of them, whether you have any opinion about our bulletin or our branch etc. etc. etc….
Friends, let us be more interactive, more communicative and more responsive for a better cohesive relationship. Remember, it is OUR branch and OUR bulletin!!"

This story is so piquant that it is important for all of us to take note and learn from it. Same thing is applicable for bulletin editorship! I sometimes feel like "Sarah Finkel" when I find that there is no feedback from any of you! And imagine we have 2800 + strong membership! So, my sincere request to you to communicate with me. Tell me what you would like to read in our bulletin, whether you liked any article or presentation of our branch, whether you would like to improve or modify any of them, whether you have any opinion about our bulletin or our branch etc. etc. etc….

Friends, let us be more interactive, more communicative and more responsive for a better cohesive relationship. Remember, it is OUR branch and OUR bulletin!!

Warm Regards,

Dr. B. M. Inamdar
bminamdar@gmail.com,
9833054054

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST
IMA - AMS BRANCH CHAPTER

presents

"PROSTACON"

Day & Date : SUNDAY, 21ST JUNE 2009. • Time : 06.30 pm onwards
Venue : IMA - Lupin Auditorium, I.M.A. Building, J. R. Mhatre Marg, Behind Chandan Cinema, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

PROGRAMME

Topic	Topic	Speaker
06.30 pm - 07.00 pm	Registration & Tea / Coffee	
07.00 pm - 07.15 pm	Welcome Address Inaugural Address Lighting The Lamp	Hon. Secretary - Dr. S. K. Joshi President - Dr. Jayesh Lele Chief Guest – Dr. Shrikant Badwe
07.15 pm - 08.45 pm	1) Tricks to Evaluate Symptoms - BPH & CA Prostate. 2) State of the Art – Minimally invasive Urology & Uro-Oncology Surgery	**DR. ANUP RAMANI** MCh, DNB, MS, DNB, Chief Surgeon & Director, Breach Candy, Lilavati, Jaslok Hospitals
08.45 pm - 08.50 pm	Vote of Thanks	Dr. Rashmikant Sanghvi
08.50 pm onwards	Dinner	

FREE BUT COMPULSORY ADVANCE REGISTRATION.

KINDLY REGISTER EARLY TO AVOID DISAPPOINTMENT.

REGISTRATION LIMITED TO 150 DELEGATES ON FIRST CUM FIRST SERVE BASIS.

EARLY BIRD LUCKY DRAW PRIZES FOR MEMBERS WHO REPORT TILL 07.00 P.M.

DR. JAYESH LELE
President

DR. S. K. JOSHI
Hon. Secretary

DR. RASHMIKANT SANGHVI
Chairman

DR. HEENA PATEL
Asst. Secretary

IMA - AMS Branch Chapter

MASTACON 2009

INVITATION

Dear Colleague,

You will be delighted to learn that the Maharashtra State Annual conference (MASTACON 2009) is to be hosted by the Mumbai West (Bombay West Suburban Branch) of Indian Medical Association. MASTACON will be held on 13th, 14th, and 15th November 2009 at the prestigious IMA Building J. R. Mhatre Marg, J.V.P.D. Scheme, Behind Chandan Cinema, Juhu, Mumbai - 400 049.

In inviting you to this Gala Event, we are extremely confident that your stay in the pleasant climate of Mumbai in November would be truly memorable.

We have arranged a series of advanced C. M. E. Programmes with Guest Orations, Symposia and Seminars that will interest everyone of you. A Public Health, Trade Exhibition & Banquet will be added features to provide the necessary.

There will be scores of LUCKY Draws and a excellent delegate Gift for all.

You are aware that we have been the proud recipient of the Best Branch Award for our C.M.E. Programmes, and we will leave no stone unturned in giving you the best conference.

The relevant Registration form and details are enclosed in this brochure.

If you are likely to be with us at the conference, please inform, so as to enable us to send you the next communication on time.

Should you need us to arrange for your accommodation and stay while in Mumbai, please do not hesitate. Let us know the range of hotel tariff, which would suit your requirements. We will try our best to let you know the possibilities. There will be a dormitory type of accommodation which can be provided on first come first served basis.

Sincerely,

Dr. Anil Suchak	**Dr. Jayesh Lele**	**Dr. Akil Contractor**	**Dr. S. K. Joshi**
Organising Chairperson	Co-organising Chairperson	Organising Secretary	Co-organising Secretary

TENTATIVE PROGRAMME

- **FRIDAY, 13.11.2009**
  - IMA Maharashtra State Executive Meeting.
  - IMA Maharashtra State Council Meeting.
  - Conference from 02.00 pm onwards.
- **SATURDAY, 14.11.2009**
  - Conference from 09.00 am to 05.00 pm
  - Conference Inauguration programme.
  - Installation of IMA – MS, President and his team for the year 2009 – 2010 from 06.00 pm onwards.
  - Banquet from 08.00 pm onwards
- **SUNDAY, 15.11.2009**
  - Conference from 09.00 am to 04.00 pm
  - Valedictory function.
- **CONFERENCE HIGHLIGHTS**
  - Renowned faculties addressing the conference.
  - Visit to state of the art hospital
  - Live relay of various hospital procedures.
  - Numerous lucky gifts, draws & surprise prizes.

PLEASE REGISTER EARLY

CHARGES FOR MASTACON 2009
(IMA – MAHARASHTRA STATE ANNUAL CONFERENCE 2009)
TO BE HELD ON 13TH - 15TH NOVEMBER 2009
AT OUR BRANCH PREMISES.

- IMA delegates : Rs. 750/- up to 30th September 2009
- IMA delegates : Rs. 1000/- from 01st October 2009
- Spouse / Children : Rs. 200/- (only Banquet on 14.11.2009 at 08.00 onwards

DR. ANIL SUCHAK	DR. AKIL CONTRACTOR	DR. JAYESH LELE	DR. S.K.JOSHI
Organising Chairman	Organising Secretary	Organising Co-Chairman	Organising Co-Secretary

IMA – CGP CME FEES FOR THE YEAR 2009 - 2010

ANNUAL FEES:

This includes Sunday's CME Programme, all mini conferences,
Weekly CMEs on Tuesdays & Thursdays.
(These does not include MASTACON)

a. IMA - CGP Members of our branch	: Rs. 750/-
b. IMA - Members of our branch	: Rs. 1000/-
c. IMA Members of other branches	: Rs. 1500/-
d. Eligible Non - Members	: Rs. 3000/-
e. Annual CGP Fees + Mastacon Fees	: Rs. 1500/-

SURPRISE GIFT FOR THOSE WHO PAY
ANNUAL CGP + MASTACON 2009 FEES

CHARGES OF IMA - CGP LIFE MEMBERSHIP

We wish to draw attention of newly admitted life members of our branch that revised charges for IMA – CGP Life Membership are as follows with effect from 1st January 2009

1) IMA – CGP Life Membership **Rs. 1000/-**
2) IMA – CGP Quarterly Journal life time subscription **Rs. 1000/-**

IMA – CGP ANNOUNCEMENT

F.C.G.P. Examinations to be held in October 2009 & April 2010.
Interested candidates for details contact IMA office or CGP office bearers,
Dr. Subodh G. Kedia & Dr. Priti Bhargava.

DR. JAYESH LELE	DR. S.K.JOSHI
President	Hon. Secretary

AN APPEAL

PLEASE SUPPORT OFFICIAL CANDIDATE OF OUR BRANCH

DR. BAKULESH S. MEHTA

FOR THE POST OF

PRESIDENT OF
I.M.A. - MAHARASHTRA STATE BRANCH
(2009-2010)

DAY AND DATE OF ELECTION:

SUNDAY, 09TH AUGUST 2009

Report of
" WORLD ASTHMA DAY " on Tuesday, 2nd May 2006

IMA – CGP sub faculty of our branch had organized an interesting & interactive programme of on the occasion of **"WORLD ASTHMA DAY"** on **Tuesday, 05th May 2009**.

Hon. Secretary Dr. S. K. Joshi welcomed the speaker & delegates. President Dr. Jayesh Lele inaugurated the programme. **Leading Chest Physician Dr. Sanjeev Mehta** addressed the audience excellently on the topic of **"CHALLENGES ON ASTHMA"** covering many practical aspects in the management of the asthma.

This programme well attended by more than 125 members & was highly appreciated.

We appreciate and thank M/s. Cipla – Respiratory Division for their kind gesture of extending educational grant toward this programme.

Bridge Is Falling…

Hi !

Dear friends, let me try to re-introduce a nice and lovely game of cards known as Contract Bridge back into the world of few medico brothers esp. members of I.M.A.

In past we all practically played or learned a little 'bout contract bridge during our college days. But later we all got so much involved in our busy schedule that we forgot it being an antidote for Alzheimer's disease.

Definitely it challenges our skills and tickles a few grey cells of the brain and I personally think that our fraternity is generously blessed with these grey cells. But unfortunately this game is dying…

To begin, Every pack of cards has 52 cards and is made up of 4 colours set viz Spades, Hearts, Diamonds and Clubs in the descending order of bridge world.

Each colour set has 13 cards.

Spades and Hearts suits are called Major suits. Diamonds and Clubs are Minor suits.

Every set has Ace, King, Queen, Jack(4 high cards) and 9 other cards.

To make things easy Ace is granted 4 hcps,

King = 3,

Queen = 2,

Jack = 1.

(Hcps = high card points)

So there are total 40 hcps in every pack of cards.

Usually it is seen that to make any contract of game level minimum 25 hcps for 3NT, 4 Spades, 4 Hearts is required i.e. game in major suits and or NT (no trumps contract).

To make game contract in minor suits i.e. Diamonds and Clubs 27-29 hcps suffices coz these games are 5level games viz 5Diamonds and 5 Clubs contracts.

For Small Slam , 6level = 33 hcps and Grand Slam, 7 level = 37 hcps are a must between the two partners.

When a pair bids any contract eg. 1s/1h/1nt/ 1d. They have to make 6+1 = 7 tricks out of 13 cards dealt to each player.

Like wise 2 level is 6+2 = 8 tricks,

3 level = 9 tricks,

4 level = 10 tricks,

5 level = 11 tricks,

6 level (Small slam) = 12 tricks,

7 level (Grand slam) = All 13 tricks!

By now you must have understood that games bid are 3NT, 4Spades and 4 Hearts, 5 Diamonds and 5 Clubs. Rest all contracts are called part games eg. 1, 2, 3 Spades or1, 2, 3 Hearts or 1, 2, 3, 4 Clubs or 1, 2, 3, 4 diamonds etc.

Part contracts get lesser imp's or mp's than a contract bid of full game. These imps or mp's depends on the vulnerability too of the players.

Imps (international match points), mp(master points) which are then totaled upto V.P.'s (Victory points) depending upon the type of games played, whether Duplicate Contract Bridge or Master Pairs, etc.

We also need to understand that same deal of cards are rotated on all the tables and which ever pair gets the most imps/mps/vps is the ultimate topper.

Bridge is played by 4 players or a pair of 2 partners each. They are named for convienience sake as the directions of their seat viz. South, West, North, East.

Here, North and South are partners for the game. In the same way West and East are partners too.

The Dealer is granted a right to open the 1st call of bidding. He can also to choose to pass if no adequate hcps dealer holds. Then his L.H.O.(left

hand opponent) gets a chance to call his bid. The bidding goes clockwise until 3 consecutive passes are made and that last bid is the final contract which the pair has to attain within their recourses

It is really a game of intelligent communications between the partners by process of bidding as per certain systems of biddings developed world over. There is no place for cheating ! Every opponent can ask even in international tourneys the bids made by partner and right answer is expected or one can get disqualified too if misguided!

It is a game I suggest you play only if one has passion for it.

Winning or losing a contract is not very crucial because sometimes a pair loses too and still gets imps/mps/vps. It is called as sacrifice bid. I understand that all these vocabulary bounces for beginners but as it turns into one's avocation, one kinda gets really hooked to bridge.

Few Systems of biddings used world wide are Goren bids, Precision bids, Super precision bids, strong clubs, S.A.Y.C., 2/1 bids, Ambra bids, Blue moon clubs, Zar bids etc etc.

The most popular is Sayc and 2/1 according to what I've notice people playing all over the world. In India/Eastern Countries many players prefer Precision biddings.

Every bidding system has it's own set of rules to open a bidding and to respond by his partner. Also interference bids are expected from opponents too. So, one must know exactly what his partner has (in hcp strength) when he opens a bidding or he could have passed his round of bidding. The responses are also ruled by certain sets of conditions depending on the hcps the responder has.

Next time, I hope to bring in S.A.Y.C. as it is the easiest bidding sys. and used all over the world.

Ciao

Dr. Dhruv B. Rawal

FORTH COMING EVENTS

1) Scientific programme of **"Medicine Update 2009"** on the occasion of **"Doctor's Day"** on Sunday, 05th July 2009 from 02.00 pm to 06.00 pm. The programme includes update in various fields of Medicine.
2) Doctor's Day Programme from 06.30 pm onwards wherein prominent celebrities from different walks of life will be felicitated. This will be followed by Cultural Event.
3) 2nd August : DENTACON
4) 2nd August : Contract Bridge Tournament
5) 9th August : Hypertension
6) 16th August : GYNACON 2009

CLASSIFIEDS

PREMISES FOR SALE

Nursing Home, as per new laws BMC approved, 1st floor, area 4770 sq. ft., Separate Staircase, 5/6 parking, under and overhead tank, Marve Road, Malad (W). For sale, Contact : 66924209

The World No Tobacco Day

The World No Tobacco Day is a unique global event established to call attention to the impact of tobacco use on public health and to effectively reduce individual tobacco dependence.

The theme of World No Tobacco Day 2007 is “Smoke free Insides” and focuses on 100% smoke-free environments as an effective measure to protect the public – including women and children, and people at their workplaces – from exposure to secondhand tobacco smoke.

The main messages of this year’s WNTD include the following:

* Second-hand tobacco smoke kills and causes serious illnesses.

* 100% smoke-free environments protect workers and the public from the serious harmful effects of tobacco smoke.

* Most people in the world are non-smokers and have a right not to be exposed to other people's smoke.

* Smoke-free environments are good for business, as families with children, most non-smokers and even smokers often prefer to go to smoke-free places.

* Smoke-free environments provide the many smokers who want to quit with a strong incentive to cut down or stop smoking altogether.

* Smoke-free environments help prevent people – especially the young – from starting to smoke.

Mohit
ADV

FOR YOUR HEART STRINGS

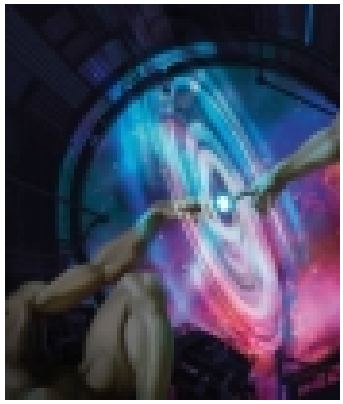
Dr. Rajiv Anand

YOU ARE THE GREATEST MIRACLE YOURSELF!

Dear Friends! Most of us have myriads of notions about our powers or whatever achievements we have made in matter of money,property,name or fame but very few realize that all these are possible due to a wonderful amazing gift of life to us by some higher power.This gift with a name tag on it is the greatest miracle ever existed.If you find it difficult to believe it ……read the following and pinch yourself to accept the reality.

- Every minute a new you is being created when 3 billions cells are discarded by your body, brain and nervous system. And these discarded cells are replaced by equal no of new cells to build up a new you!
- This entire great miracle happens under the direction of subconscious mind, which is part of the infinite mind which is THE connection between us –the limited /finite to infinite whom some of us call God/Allah/Christ of whatever name, but essentially endowed with infinite power and knowledge which is constantly guiding our life building and life controlling subconscious mind.
- Not only that our same subconscious to infinite mind connection also organizes and regulates all other function of the body, like keeping our heart beating uninterruptedly for more than 100,000 times in a day. That means 40 Millions heartbeats in a year, nearly three billion pulsations in a lifetime of 70-80 years.
- Interestingly all this happens without our knowledge, intervention, wish or direct control and also noticeably without any repair, replacement, day to day care or cleaning. Let us think for a while and marvel at the power that controls this.
- Going further we need to get a pleasant shock by learning that we have vascular channels including big and small arteries,vassels,veins of different sizes making 60,000 miles in length, through which 100 gallons of blood is being pumped at the rate of 2 gallons per minute.
- In just one minute each blood cell make about 2-3 rounds of whole circulatory system in the body, and makes 75000 to 2,50,000 round trips in its lifetime. If all these RBC could be ordered to stand up in a line, the length of this queue will be 31,000 miles. In the second we inhale, we lose 30 Lakhs of RBC which get replaced in another second.
- Do we know that that in every cell of our body, each second 100,000 chemical reactions take place and if we want to know how many it will sum up for whole body ……be ready to calculate beyond all calculators …..The figure which will come by multiplying 100,000 reactions with 70-100 trillions cells which makes our body, whose name we know as Dr Patel, Mehta, Kapoor or Anand.
- Are we controlling all this or some bigger intelligence than us is? Some startling recent findings have been that intercellular communication is faster than even the speed of light. And all this happens within us with least awareness. Much to our dismay, ironically we are not controlling anything within our OWN BODY ITSELF, leave aside the ego of controlling anything or anyone outside.

Dear Friends! Let us shed all our egos and pride and accept the existence of a great power flowing through us, all around us, within us as part of every thought, word and actions. This realization can make us a better human being, father, mother, son, daughter and also a good doctor. Let us surrender that` I ` for a while and experience that great power, cherish what a great miracle we are and we need to be indebted to bigger power for that.



To be continued……..

Any feedback is welcome at drrajivanand@gmail.com,or 98189266862 ■

Hon Secretary Dr S K Joshi inaugurating Pediatric Update

Hon. Secretary Dr. S K Joshi and Dr. Akil Contractor choosing Lucky Dip prizes

Pediatric Update - Guest speakers from Kokilaben Dhirubhai Ambani Hospital

Hon. Secretary Dr. S K Joshi lighting the lamp - World Asthama Day 2009

Hon. Jt. Secretary Dr Alka Mehta - World Asthama Day 2009

Well done, Dr. Suhas Pingle on winning MMC elections.

ACHIEVEMENTS !

- Miss. Srishti Subodh Kedia, daughter of our life member Dr. Subodh G. Kedia scored 93% in ICSE std. 10th Examination held in March 2009.
- Miss. Shefali Azad, Grand daughter of our life member Dr. Sarala Azad scored 94% in CBSE std. 12th examination held in March 2009.
- Master Divesh Kishore Jumani, son of our life member Dr. Kishore Jumani scored 93% in ICSE std. 10th examination held in March 2009.
- Master Pararth Paresh Shah, son of our life member Dr. Divya Paresh Shah, has secured First rank in Maharashtra and fourth rank in ALL india merit list of IIT JEE 2009 exams.

Congratulations !
We are proud of you ! it up !

Dr. Jayesh Lele
President

Dr. S. K. Joshi
Hon. Secretary

Maharishi Dadhichi Hospital

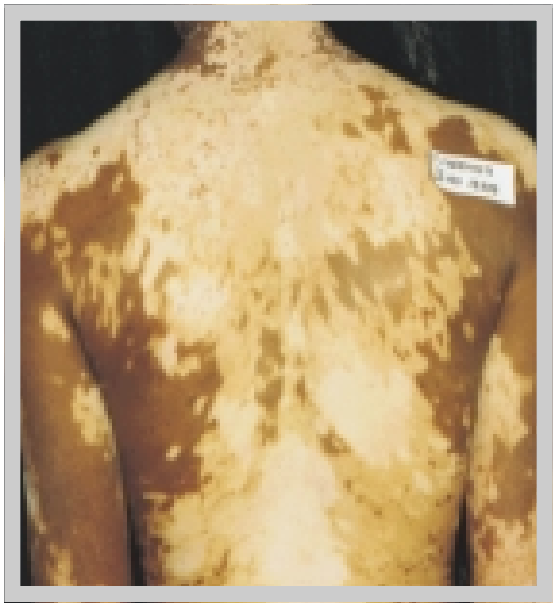
VITILIGO

Vitiligo is a specific, common, often heritable, aquired disorder charachterized by well-circumscribed milky-white cutaneaous macules devoid of identifiable melanocytes. It carries a risk of ocular abnormalities, particularly, iritis, and a significant risk for vitiligo-associated disorders, particularly thyroid disease but also diabetes mellitus, Addison's disease, and perncious anemia.

The term *vitiligo* was probably derived from the Latin word *vitium* ("blemish") and the suffix *-igo,* Vitiligo is a specific entity that many view as a systemic disease with extracutaneous manifestations involving the endocrine and neurologic systems.

Psychosocial Implications of Vitiligo

Vitiligo, particularly in brown and black peoples and in white persons who can tan deeply [*skin phototype (SPT)* IV], may be a psychosocial disaster.



In South India with dark population it is considered as "White Leprosy".

Precipitating Factors

Vitiligo patients can often attribute the onset of their disease to a specific life event or crisis, or illness. Many can relate it to loss of a job, death of a close family member, an accident, or a severe systemic illness. In some the onset follows a physical injury such as a cut or abrasion; this development of vitiligo congruent with a site of injury is referred to as the *Koebner phenomenon* and is characteristic of at least a third of those with vitiligo. Many patients related onset to sun exposure; this may cause koebnerization in predisposed individuals.

Clinical Features

Typical Macule of Vitiligo

The typical vitiligo macule has a chalk or milk-white color, is round to oval in shape, has slightly brushed to fairly distinct often scalloped margins, measures from several millimeters or many centimeters in diameter, and usually lacks other epidermal changes (Fig. 89-4).

There are several variations on the typical vitiligo macule, however.

Trichrome vitiligo refers to the presence of an intermediate color; this is a uniform tan coloration that is a narrow to broad interface between the normally pigmented skin and the typical vitiligo macule.

There may be one, several, or up to hundreds of macules that may be small to large in size, even in a single patient. As vitiligo naturally evolves over time, the macules enlarge, coalesce, and impart a scalloped appearance to the interface of the normal and vitiligo skin.

Types of Vitiligo

The following types represent the most characteristic patterns of vitiligo, namely, focal, segmental, generalized, and universal.

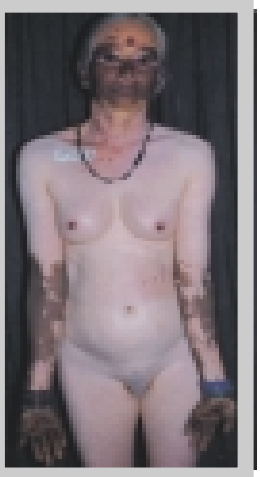
Focal vitiligo is an isolated macule or a few scattered macules; by vague convention the macules are limited in both size and number. Twenty percent of children with vitiligo have the focal pattern.

Segmental vitiligo is characterized by unilateral macules in a dermatomal or quasidermatomal distribution. This should be considered a special type of vitiligo that has a stable course and is un-

likely to be associated with thyroid disease or with other vitiligo-associated diseases. Segmental vitiligo tends to be earlier in onset and more stable than generalized vitiligo and is not familial. Involved patients are unlikely to develop remote or contralateral lesions. Koebnerization is not characteristic. Five percent of adults but more than 20 percent of children with vitiligo are found to have this pattern. The trigeminal area is the most common single site of involvement (>50 percent); the neck and trunk are involved in 23 and 17 percent, respectively. Up to 13 percent may have multiple sites of involvement. Nearly half are associated with poliosis (white hairs, see below). In various studies, from 5 to 28 percent of patients have been noted to have the segmental pattern.

Generalized Vitiligo

It is the most common type of vitiligo and is characterized by few to many widespread macules. These macules are often symmetrically placed and involve extensor surfaces; the most common extensor surfaces include interphalangeal joints, metacarpal/metatarsal interphalangeal joints, elbows, and knees. Other surfaces involved include volar wrists, malleoli, umbilicus, lumbosacral area, anterior tibia, and axillae.



Peri Orificial

Vitiligo macules may be periorificial and involve the skin around the eyes, nose, ears, mouth, and anus.

Periungual involvement may occur alone or with certain mucosal surfaces (lips, distal penis, nipples); the latter is lip-tip vitiligo. Acrofacial vitiligo involves distal digits and periorificial facial areas. Universal vitiligo (vitiligo universalis) describes such widespread vitiligo that there are few remaining normal macules of pigmentation; this type has been associated with the multiple endocrinopathy syndrome.

The general array of macules is often remarkably symmetric, sometimes seemingly mirror image, but asymmetry is not unusual. koebnerization i.e. development of iso morphic lesion at the site of trauma occurs in many individuals. Mucosal involvement is not infrequent; the genitalia, nipples, lips, and gingiva may be involved. Involvement of the palms and soles, once considered rare, can now be said to be rather common, though often unapparent without Wood's lamp examination, particularly in a fair-skinned individual. There are enough differences between segmental and generalized vitiligo to suggest fundamental differences, even as far as pathogenesis. Although segmental vitiligo is only one-fourth as common as generalized vitiligo, or less, patients with segmental vitiligo tend to be younger at onset, to stabilize within the first year, not to koebnerize, not to have a positive family history, and not to have a history of vitiligo-associated diseases.

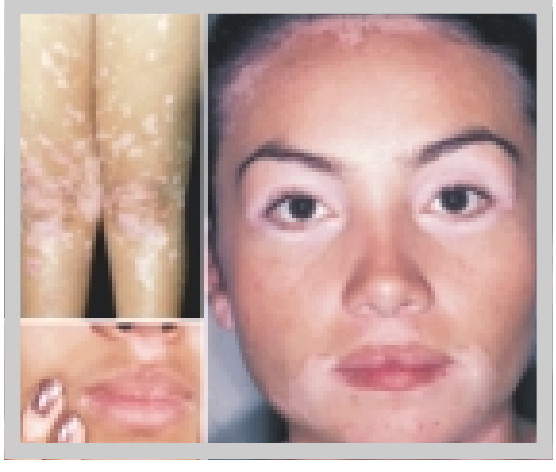
Other Cutaneous Abnormalities

Vitiligo may be associated with leukotrichia, prematurely gray hair, halo nevi, and alopecia areata.

Depigmented hairs are commonly found in isolated vitiligo macules; leukotrichia (poliosis) has been reported in 9 to 45 percent of vitiligo patients. Extensive white hair may be a marker for poor prognosis in repigmentation, but this may not apply for very small macules.

Aside from macular **leukotrichia**, premature graying of hair (canities) occurs in up to 37 percent.

Halo nevi appear relatively commonly. There may be one to many halo nevi. Confluence of these



lesions in the stage of disappearance of the nevus leaves a typical vitiligo-like macule with scalloped borders.

Alopecia areata has been reported in up to 16 percent of vitiligo patients. Three cases of alopecia universalis and extensive to universal vitiligo have been seen at the Massachusetts General Hospital. These have been associated with thyroid disease, multiple autoantibodies, and hypoparathyroidism.

Ocular Abnormalities

Vitiligo patients may have iris and retinal pigmentary abnormalities. Careful examination has revealed choroidal abnormalities in up to 30 percent and evidence of iritis in 5 percent. Visual acuity is normally unaffected.

Otic Abnormalities

Rare association

Systemic Disease Associations

*C*ertain abnormalities, particularly of the endocrine system, are found with significant frequency. Thyroid disease, particularly hyperthyroidism, hypothyroidism, Graves' disease, toxic goiter, and thyroiditis, may be found in up to 30 to 40 percent but not thyroid carcinoma. However, it is hypothyroidism that is most likely to become increasingly prevalent with age, particularly in women. In a study of 18 vitiligo patients over the age of 50, seven were found to have evidence for thyroid disease; Diabetes mellitus, both juvenile and adult-onset types, occurs in 1 to 7.1 percent of vitiligo patients, and, conversely, vitiligo occurs in 4.8 percent of diabetic patients.

The incidence of Addison's disease in vitiligo is said to be 2 percent Pernicious anemia, although uncommon, occurs with increased frequency in vitiligo patients. Among those with pernicious anemia, vitiligo has been documented in 1.6 to 10.6 percent. The multiple endocrinopathy syndrome is found particularly among those with extensive vitiligo. Among 26 such cases reported by 1979, 20 had thyroid disease, 15 pernicious anemia, 10 Addison's disease, 9 diabetes mellitus, and 2 gonadal dysfunction. Chronic mucocutaneous candidiasis, hypoparathyroidism, and alopecia areata are part of this syndrome. Among 68 patients with *autoimmune polyendocrinopathy-candidiasis-ectodermal dystrophy (APECED)*, vi-

tiligo occurred in 13 percent of cases.[36]

Histology

There are no identifiable melanocytes present. Established vitiligo macules evaluated by standard histologic techniques, monoclonal antibodies, polyclonal antibodies, or electron microscopy are consistently devoid of melanocytes. There are no histologic findings diagnostic of vitiligo. However, in the dermis, lymphocytes are present in the upper dermis in evolving macules and in inflammatory vitiligo. Melanin may be present in dermal macrophages in darker skin types.

Pathogenesis

An undisputable fact surrounding the pathogenesis of vitiligo is that there are no melanocytes present in the fully evolved white macules. So the pathogenesis centers around a mechanism for the destruction of melanocytes.

Traditionally there have been three hypotheses to explain vitiligo; the neural hypothesis, the self-destruct hypothesis, and the immune hypothesis.

The *neural hypothesis* theorizes that there is liberated from nearby nerve endings a neurochemical mediator that is melanocytotoxic. Support for this hypothesis is derived from numerous clinical observations; namely, the appearance of vitiligo in neurologically compromised skin, vitiligo sparing paralyzed limbs, vitiligo associated with viral encephalitis, and vitiligo with multiple sclerosis and Horner's syndrome. Melanocytes and nerve cells are both neural crest–derived.

The ***self-destruct hypothesis*** theorizes that certain tyrosine analogues and intermediates (dopa, dopachrome, 5,6-DHI) in melanin synthesis are known to be toxic to melanocytes. Melanocytes appear to have an intrinsic protective mechanism that eliminates toxic melanin precursors. Disruption of this labile mechanism could permit accumulation of indoles and free radicals destructive to melanocytes. The self-destruct or chemical hypothesis postulates that such intermediates or metabolites in melanin synthesis accumulate in excess to destroy melanocytes. Activation of the melatonin receptor could also lead to disordered regulation of melanogenesis with resultant melanocyte destruction.

Clinical support arises from observations of chemical leukoderma in which parasubstituted phenolic compounds, which are structurally similar to tyrosine, result in a vitiligo-resembling leukoderma in which melanocytes have been destroyed. That not all exposed workers are affected suggests an inherent inability of the skin of certain individuals to neutralize those melanocytotoxins.

The association of vitiligo with **autoimmune disease**, the presence of inflammatory changes in the skin, and the detection of autoantibodies have suggested an immunologic basis for vitiligo. The *immune hypothesis* suggests an aberration of immune surveillance is destructive to melanocytes.

Clinical support for the immune hypothesis includes the presence of lymphocytes in the dermis of early lesions, the presence of circulating autoantibodies in many patients and the associations with halo nevi and certain autoimmune diseases

Diagnosis

The diagnosis of generalized vitiligo in a patient with progressive, acquired chalk-white macules in typical sites is normally straightforward. Few such acquired conditions are so patterned and symmetric as vitiligo can be. Wood's lamp

examination may be required to visualize macules in patients with lighter SPTs and to identify macules in sun-protected areas.

The differential diagnosis of generalized vitiligo includes the following:

Chemical leukoderma: History of exposure to certain phenolic germicides, confetti macules

Leprosy: Endemic area, anesthetic macules, off-white color

Lupus erythematosus: Atypical distribution, inflammation, atrophy, positive immunofluorescence

Melanoma-associated leukoderma: Different distribution, may disappear completely, may have melanocytes

Mycosis fungoides: Unpatterned, off-white to milk white, diagnostic biopsy

Piebaldism: Congenital, white forelock, stable, large hyperpigmented macules, different distribution

Pityriasis alba: Slight scaling, fuzzy margins, off-white color, ill-defined border

Postinflammatory hypomelanosis: Off-white macules, ill-defined border, history of psoriasis, eczema, etc. in same areas

Tinea versicolor: Fine scales with fluorescence under Wood's lamp, positive KOH

Tuberous sclerosis: Congenital white macules, occasional segmental and confetti macules, stable

Segmental vitiligo is confined to one unilateral dermatomal or quasidermatomal distribution and the following should be excluded:

Nevus depigmentosus: Unusually congenital, stable to progressive, hypomelanotic as opposed to amelanotic

Tuberous sclerosis: Usually associated with typical white macules or confetti macules elsewhere, hypomelanotic not amelanotic

A solitary white macule or several white to off-white macules often present the most challenge, for either may be the presenting stage of any of the evolutionary processes listed above. Most likely alternative diagnoses include the following:

Idiopathic guttate hypomelanosis: Porcelain-white macule, discrete margins, may be slightly depressed

Leprosy: Endemic area, anesthetic plaque

Pityriasis alba: Fine scale, indiscreet margins

Postinflammatory hypomelanosis: Off-white color, history of corresponding rash

Tinea versicolor: Fine scale, raised margins, positive KOH

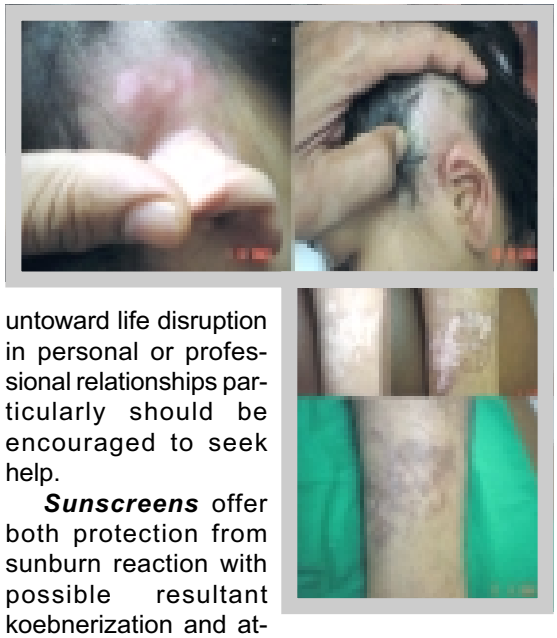
Once the diagnosis has been established, testing for thyroid disease (TSH) and, in high-risk patients, for vitiligo-associated diseases is indicated.

Natural Course

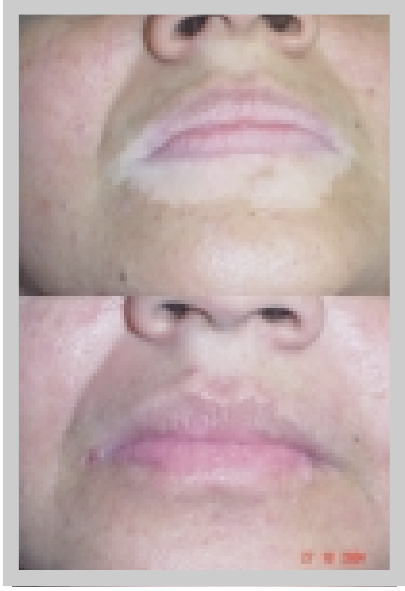
The natural course of vitiligo in the end is unpredictable. Focal vitiligo, though stable for a time, may be a precursor of generalized vitiligo vulgaris. The natural course of common vitiligo vulgaris is often one of abrupt onset, followed by progression for a time; then, a period of stability follows and may last for some time, even decades. This may later be followed by a period of more rapid evolution later in life. Total spontaneous regression is rare, and evolution to vitiligo universalis is unusual though not rare. The most common course is one of gradual evolution of existing macules and periodic development of new ones. Segmental vitiligo, on the other hand, is usually very stable. The period of evolution is often less than a year, after which there is little extention or regression; significant spontaneous repigmentation is unusual. An occasional patient may also develop vitiligo vulgaris, but this too is unusual.

Treatment

While there are several options in the management of vitiligo, most patients require **reassurance** and an understanding of their affliction. In an increasingly sophisticated world, many patients present with a certain level of knowledge of their options. All patients should be encouraged to use sunscreens to protect the vitiliginous areas, reassured that the use of **cosmetic coverup** is perfectly acceptable, and should be educated about the benefits and risks of attempts at repigmentation and depigmentation.



Professional counseling should be offered those particularly distressed over their appearance. Patients suffering untoward life disruption in personal or professional relationships particularly should be encouraged to seek help.



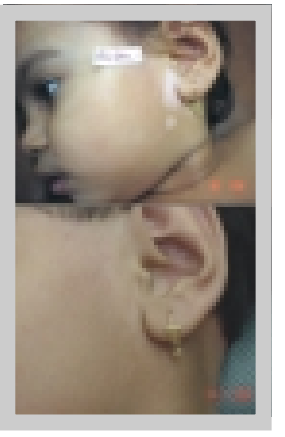
Sunscreens offer both protection from sunburn reaction with possible resultant koebnerization and attenuation of facultative tanning of normally pigmented skin; were the latter to be successful, the contrast between the vitiligo macules and the normal skin would remain as minimal as in the winter months or as on habitually unexposed areas of skin. Opaque sunblocks with a *sun protection factor (SPF)* over 30 and containing ZnO and/or TiO2 are the most suited to these dual purposes (see Chap. 138).

Repigmentation involves any attempt to reverse the depigmentation and to reestablish normal pigmentation in established macules of vitiligo. All current attempts should be viewed as treatments or quasi-remissive techniques and not as a cure.

Current available options include

Topical glucocorticoids for limited vitiligo, **topical PUVA** for focal and segmental types, **PUVA-grafting-PUVA** for refractory segmental vitiligo or stable vitiligo vulgaris, and **oral PUVA** for segmental or generalized vitiligo. All forms of treatment require a certain commitment from patients and should be under-

taken with the full understanding of the advantages and limitations of each approach



Topical glucocorticoids have proven effective for isolated macules in some cases, but overall results tend to be disappointing. Hydrocortisone may be used for isolated macules in sensitive areas such as the face and axillae and for children. **More potent topical steroids are generally more successful.** However, with the most potent topical steroids, the approach should be daily application for 3 weeks, skip a week and repeat to avoid local glucocorticoid side effects. If there has been no response after 2 months, treatment should be abandoned. If treatment is to be continued, monitoring every 2 months for signs of atrophy is prudent; irreversible striae may develop on the legs in as little as 4 months of continuous treatment. Topical steroids may be used in conjunction with other modalities.

Topical PUVA is indicated for isolated small macules (1 to 2 percent of the body surface, occasionally up to 5 percent) and involves application of a dilute solution of 8-MOP followed by artificial UVA. Since topical 8-MOP is highly phototoxic and since this phototoxicity may last up to 3 days, use of topical PUVA requires a well-informed, reliable patient and a specially trained and experienced dermatologist.

Oral PUVA is the most practical effective treatment for affected patients who are over the age of 10, who have widespread vitiligo, and who find no other option is satisfactory. Oral PUVA carries much less risk of phototoxicity than topical PUVA.

Results of numerous studies have demonstrated the effectiveness of PUVA for vitiligo Ultramicronized 8-MOP (0.25 mg/kg) was found to give excellent results Outdoor treatments may generally be used in warm climates when there is adequate sunlight for a sustained treatment

course. Trimethylpsoralen is generally preferred because of its comparably low phototoxicity; 5-MOP, where available, is a reasonable option. Outdoor and indoor PUVA should be considered equally effective.

There is a 50 to 70 percent likelihood of substantial repigmentation of the face, neck, trunk, upper arms, and legs, mucosal and acral macules respond poorly if at all. Neither age of onset, chronologic age, duration of vitiligo, sex, nor presence of vitiligo-associated disease is necessarily predictive of response.

Numerous ***surgical techniques*** have been reported to be successful in repigmentation Regardless of the surgical technique, **segmental vitiligo is the best candidate for surgical intervention.**

Vitiligo,which always carries the risk of koebnerization, may be considered in those cases in which the vitiligo has been stable for some time (2 years is suggested). In most cases, pretreatment with PUVA will establish those islands of inapparent melanocytes capable of repigmenting an area and thereby define sites that have no ability to repigment (and thereby need melanocyte grafting). The minigrafting test described by Falabella et al.**66** is particularly useful in predicting success (or failure) in minigrafting of stable vitiligo; in all patients the results demonstrate to the patient the expected cosmetic appearance of the graft and donor sites. The patient and the doctor together then may decide if proceeding with extensive grafting will likely be satisfactory.

Vitiligo,which always carries the risk of koebnerization, may be considered in those cases in which the vitiligo has been stable for some time.

Various surgical techniques have been described. Transplantation of cultured autologous melanocytes to depigmented macules has led to excellent results but the method is tedious. Up to 6 to 8 months were required for an excellent color blend. The grafts were generally stable over the 1 to 2 years of follow-up. Falabella reported even the dorsal hands could be successfully grafted. Cryostorage of excess cultured melanocytes is a source of melanocytes for future procedures in a patient.

Minigrafting with 1- to 2-mm punch grafts may be the most practical for isolated small macules. Placement of four 1.5-mm grafts per square centimeter is a practical technique; pigment spread beyond the graft site should be visible within a month. PUVA may be required to complete the repigmentation. Hyperpigmentation and pebbling may be observed but generally will reverse over time. Patients with stable vitiligo without koebnerization seem to be the best surgical candidates; reversal of leukotrichia has also been observed.

New therapies ***Multivitamin therapy*** (folic acid/vitamin B12,/vitamin C) has been reported to show repigmentation particularly in children. ***Melagenina*** (placental therapy) has generally proven disappointing outside of Cuba where it was first described;

311-nm UVB [Narrow Band UVB] is most successful treatment in my experience of over two & half decade ; however, while the ease of acute sunburn reaction with this therapy may limit its use, chronic phototoxic changes and hyperpigmentation are much less likely. It is safe

in children & even pregnant women

Depigmentation is another optionfor the unification of skin color in those with extensive vitiligo Bleaching, which implies destruction of residual melanocytes with *monobenzylether of hydroquinone (MBEH)* 20% cream is a generally permanent, irreversible process. Application of MBEH may be associated with satellite depigmentation; therefore, MBEH cannot be used selectively to bleach just limited areas of normal pigmentation; the risk of distant and remote macules of depigmentation is very real. Thus, neither the extent nor the area of depigmentation can be controlled. MBEH should not be used just to reduce normal pigmentation (as with hydroquinone) or for isolated macules (without accepting the risk of remote depigmentation). Successful bleaching with MBEH requires twice daily application for 2 to 3 months before improvement is observed and 9 to 12 months before complete depigmentation is achieved. Up to 50 percent of patients may complain of erythema, dryness, burning, and pruritus, particularly on the face; these symptoms may be diminished by reducing the frequency of use or by mixing the MBEH with an emollient.

Between 90 and 95 percent of patients will be fully bleached in a year. Maintenance applications are not required. However, although this depigmentation is normally considered to be irreversible, periodically following sun exposure an occasional patient will observe focal repigmentation, which requires reapplication of MBEH for a month or more. Assiduous avoidance of midday sun and routine use of high SPF opaque sunblocks usually minimize this risk. There have been no long-term untoward effects from the use of MBEH.

Treatment of Vitiligo in Children

Reassurance is most effective. Thyroid dysfunction should be ruled out Sunscreens and cover-up are still the initial steps. The next is topical steroids, which may take weeks to be initially effective. In certain cases of limited vitiligo, topical psoralens may be considered. Oral psoralens may be considered after maturity of the ocular lens can be reasonably assured (about age 10). The specifics of each approach are the same as for adults.Narrow band UVB is found to be the most effective in my practice. ■

NIRAMAYA

Scheme of cost effective Medicines

NIRAMAYA is a scheme undertaken by a team of passionate ctizens with a deep desire to cater to the basic needs of weaker economic section of our society in the area of healthcare.

Niramaya scheme was conceptulized with the two-fold objectives of providing-

> Creating a system for ensuring a low cost but effective medicines to economically weaker section of the society.

> Creating awareness among consumers about the price differential within the medicines available to them.

Gradually ,a small initiative undertaken by a few motivated individuals has resulted in a large movement to contribute to this nobel and worthly cause.

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- MD Medicine GMC, Nagpur 1980
- Ex. President, IMA Arvi Branch.
- Trainer on HIV/AIDS by IMA, NACO, CLINTON FOUNDATION.
- Managing Committee member of Social Security Scheme.
- Hon. Secretary RED CROSS Society, Arvi Branch.
- Pioneer in fight against Electropathy at District, State & National levels.
- Founder member of **"Niramaya"** a low cost medicine scheme launched by IMA Arvi. (www.niramayaarvi.com)
- Life Member, Rotary Club of Gandhi City, Wardha

We welcome you to join this initiative and to contribute in your own way to make this mission possible and make our nation a healthier place to live in.

Mission

To encourage and create awareness among Doctors, Chemists and patients regarding the use of cost effective drugs and ensure availability of such drugs to the poor thereby making healthcare affordable to them

Introduction

Suicides among farmers have been increased in last 6-7 years in India, particularly in Vidarbha region of Maharashtra and more so in Wardha district. On this hot topic there are discussions among government machineries, administrators, politicians, electronics and print medias to find out the causes behind suicide of farmers, and to suggest remedies to prevent suicides

After a detailed survey of affected families of these farmers, it is observed that one of the major cause is huge loan. Major amount of this loan is used on health expenditure. Amongst the

Expenditure on health 60-70% goes for the purchase of medicines.

Looking at cost of medicines, it is further observed that same drugs costs differently , when sold by different companies. This variation takes place anywhere from 2 to 200 times. So, if treating doctor prescribes standard low cost medicines it will decrease the huge expenditure of a poor farmer on health

Therefore the doctors and chemists at Arvi under the guidance of dynamic IAS lady officer Smt. Gunjan Kinnu decided to form a scheme to provide low cost effective standard medicine. This is “NIRAMAYA”.

After detailed study of availability and comparative cost of drugs a preliminary list of commonly used drugs with their cost is prepared . Thus we got a ready reference which compares the cost putforth by different companies. While selecting the drugs of the company having low cost, reasonable care has been taken about the standard, quality and effect of same drug,this is “NIRAMAYA.”

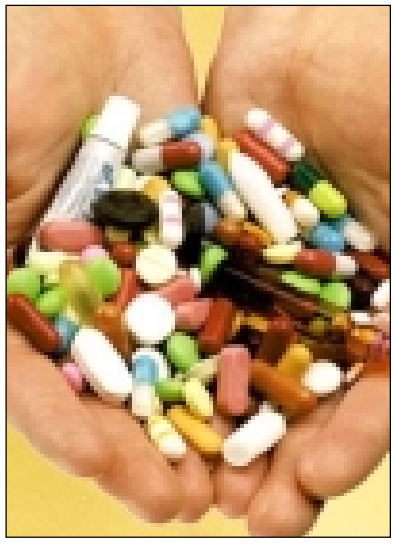
Examples Of Drug Price Difference

1. Mikacin			
Mikacin	- 250	Aristo	35.00
Mikacin	- 500	Aristo	65.00
Mikastar	- 250	Mankind	23.00
Mikastar	- 500	Mankind	35.00
2. Amoxicillin+Clavulinic Acid			
Augumentin	625	GSK	40.10
Clavum	625	Alkem	20.00
Bestomox	625	Bestochem	17.00
Moxiikimd CV	625	Mankind	15.00
Inj. Augumintin	1.2 Gm	GSK	182.10
Inj. Clavum	1.2 Gm	Alkem	99.00
3. Inj. Ceftazidine 1 Gm			
Inj. Fortum	1 Gm	GSK	384.00
Inj. C-Zid	1 Gm	Emcure	105.00
4. Tab Atenelol			
Tab Aten	50	Zydus-Cadila	2.78
Tab Tenomac	50	Macleods	1.13
Tab Ziblok	50	FDC	0.52

These differences are observed in near about in all drugs prescribed.

From above study, our Aims and Objectives are :

1. To help them to complete their prescribed course of medicine under their budget.
2. By completing prescribed course - disease will be cured or kept under control acc to nature of disease.
3. To provide effective low cost medicines to farmers and poors.
4. Thus the ultimate aim of NIRAMAYA is to curtail down the heavy expenditure on health.
5. This will definitely help in decreasing the incidence of suicides among farmers and poors (as it is one of the cause among other for suicides) - ensures good HEALTH and PEACEFUL Society



After successful launching the "NIRAMAYA" scheme in Arvi Taluka. We have launched this movement in Wardha district. This scheme got the momentum and introduced all over Maharashtra though IMA. Niramaya is also introduced in meeting of president secretary meet at IMA New Delhi.It is appreciated and accepted by all IMA State branches. Niramaya is also accepted by Govt. Of India for Study as a WARDHA MODEL

FAQ

1. How low cost medicines are different from high cost Medicines

The medicines used for treatment of a particular disease are manufactured by different companies under various brands. Typically these medicines which are prescribed to treat a disease offer similar contents.

All the branded medicines are manufactured under quality control as laid down by Food and Drug Authorities (FDA). Many times such medicines differ in cost dueto various reasons like expenditure incurred by the company on medical research, royalty payment, brand value, direct distribution cost, types of molecules used for manufacturing medicines, targeted income etc.

2. Are these low cost drugs equally effective?

The effectiveness of drugs does not depend on price . The doctors prescribing the drugs to patients take in to account contents of drug to ensure its effectiveness to the patient. Also efectiveness of a drug differ from patient to patient.

3. Does low cost drug causes any side effects?

Many medicines cause side effects on the health of patients, Sometimes we name them as hypersensitivity, allergy or in common term we say "Reaction". Side effects on account of any medicines would depend on the contents of medicines and its appropriatenesss to the patient. Mostly , tolerance of the patient and his reactivity towards the drugs in the form of response are mainly responsible for the side effects.

Hence, it is recomended that the medicines are always taken with the consultation of doctor.

4. Why only few companies are listed under low cost drugs?

The list of drugs are indicative and is based on the information currently available with us. The process of identification of low cost drugs will be continued and the list will be updated on an ongoing basis.Therefore any company offering standard similar drugs will be included in the list of NIRMAYA. In short , the window of Niramaya is open for all those companies which are providind low cost effective standard medicines or drugs.

5. Why doctors should prescribe NIRAMAYA?

Many patient do not have adequate resources to take care of high health expenses , mainly arising on account of costly medicines.This results in incomplete treatment to patient which does not yield any meaningful results. In order to reduce this burden, the scheme NIRAMAYA is the best solution to benefit the needy patient ,

N.B.- More Details and drug list are available on web site- www.niramayaarvi.com

Dr. Arun B. Pawade
President IMA MS

Tobacco Health Warnings

Tobacco is the leading preventable cause of death. More than 1.2 million people die every year in South-East Asia Region due to tobacco use. The wide-spread use of tobacco products in the Region has resulted from unrestricted use of marketing tools by the tobacco industry, the addictive nature of nicotine and the lack of knowledge about the harmful effects of tobacco products among tobacco users and non-users in the form of second-hand tobacco smoke. The lack of regulation of the tools of a product that kills half of its users has exposed the population to the misinformation of the tobacco industry about the suitability of their products.

The WHO Framework Convention on Tobacco Control (FCTC) in its Article 11 mandates that countries should enact effective measures to ensure appropriate health warnings on tobacco products packages. It also says that these health warnings should be rotating, large, clear, visible, legible and include pictures or pictograms and occupy at least 50% or more and no less than 30% of the principal display areas. The third session of the Conference of the Parties (COP), held in Durban, South Africa in November 2008 also adopted guidelines for implementation of Article 11 which provide detailed information for countries to effectively implement their obligations in relation to Packaging and Labelling of Tobacco Products. In addition, the MPOWER Policy Package promotes effective tobacco health warnings as an intervention under its one of the six policies - “Warn about the dangers of tobacco”.

Comprehensive health warnings about the dangers of tobacco use play a vital role in changing its image, especially among adolescents and young adults. Text and pictorial health warnings are useful to communicate the health risks of tobacco use, provoke more thought about the health risks of tobacco use and have a greater emotional response and generate increased motivation and intention to quit. They are particularly effective in communicating health effects to comparative low literate populations, children and young people.

Call to policy-makers

- Promote your country's accession to the WHO Framework Convention on Tobacco Control, whose Article 11 guidelines lay out the elements of effective tobacco health warnings.
- Use the MPOWER package — specifically, the "W", which stands for "Warn about the dangers of tobacco" — to counter the tobacco epidemic and to help countries meet their commitments under the WHO Framework Convention on Tobacco Control.
- Require by law that all tobacco products display large picture warnings about the harm caused by tobacco and its many other negative consequences.
- Build on the experiences of other countries to craft the most effective warnings and implement them for the greatest possible impact.
- Base your decisions on impartial scientific evidence, not on the claims of the tobacco industry. Tobacco companies oppose strong health warnings, particularly those with pictures. The arguments they use against health warnings are false and should not be relied upon.

Call to civil society and nongovernmental organizations

- Advocate for picture-based warnings on all tobacco products.
- Campaign for and help to develop and implement laws that require picture-based warnings on tobacco products.
- Act as a watchdog to monitor tobacco-industry packaging strategies and compliance with statutory warnings.
- Evaluate and share information about the effectiveness of picture warnings.

Call to the public

- Demand your right to know the truth — the whole truth — about the dangers of tobacco use and exposure to second-hand tobacco smoke.
- Let everyone know that you support picture warnings.

ADVT. TARIFF OF "MEDICAL IMAGE" FOR IMA Mumbai West MEMBERS	Page	For IMA Members		For Other Advertisers	
		Colour	B/W	Colour	B/W
	Back Cover Page on Art Paper	10,000/-	-	14,000/-	-
	2nd Cover Page on Art Paper	8,000/-	-	12,000/-	-
	3rd Cover Page on Art Pager	7,500/-	-	12,000/-	-
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	Ordinary Half Page	3,000/-	2,000/-	6,000/-	5,000/-
	Ordinary Quarter Page	2,000/-	1,200/-	4,000/-	3,000/-
	Gate Fold	18,000/-	-	20,000/-	-
	Centre Double Spread	16,000/-	12,000/-	18,000/-	-

CLASSIFIED ADVERTISEMENTS ONLY FOR IMA MEMBERS

Tariff for classified advertisements

Members are welcome to send personal announcements in the above column.

Charges for the same will be as under:

For Members: Minimum charges Rs.300/- up to 25 words. Every additional word at Rs.8/- per word. Maximum 45 words only.

1. Life members are entitled to 20% concession for BLOCK advertisements in ordinary pages.

2. The tariff for 6 monthly and annual insertions will be applicable provided the matter is not changed and full payment is made in advance.

3. The material for printing should be sent to our office on or before 15th of the previous month.

4. The cheque should be drawn in favour of "I.M.A. - Mumbai West Branch".

FOR PRIVATE CIRCULATION ONLY

••• FACILITIES AVAILABLE IN OUR PREMISES •••

1) Ground floor hall — Sitting Capacity 300
2) Lupin Auditorium — Sitting Capacity 150
3) Lawn — Sitting Capacity 200
4) 2nd Floor Hall — Sitting Capacity 200
5) 4 Self Contained Air Conditioned Double Bed Rooms
6) Terrace — Sitting Capacity 200

For details contact our office.

Dr. Jayesh Lele, President

Dr. S.K. Joshi, Hon. Secretary