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SAT, 11TH DEC. 2010
EDUCATIONAL PROGRAMME FOR POST GRADUATE STUDENTS/RESIDENTS

SUN. 19TH DEC. 2010
RNTCP – TB WORKSHOP

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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.
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PresidentSpeak...

IMPOSSIBLE IS WITHIN REACH!!

Dear Friends,

It is indeed with great pleasure and satisfaction that I am writing to you today. IMA Mumbai West is shining, and shining like a great star on the horizon of Indian Medical Association. We always knew that we had it in us to excel, but never knew that we can surpass our wildest imagination in achievements.

And why not? Our Managing committee members, various chairmen, office bearers and Trustees have truly shown their might and commitment to take IMA Mumbai West forward on the path of progress! Kudos to all of them!!

October once again saw a plethora of activities. It is mind boggling what our chairmen can think, act and do! Pick of the month was of course our Annual Conference. Dr. Lekha Pathak started the ball rolling with an unforgettable first day on 24th October at one of the finest venues – Hotel Grand Hyatt, Santacruz. The ambience, conduct, presentations and participation was excellent. The full house got its money's worth. Thank you Dr. Lekha for your wonderful efforts!

Conference rolled on throughout the next week with different themes and subjects. Tuesday saw pathology and investigative branches, Thursday saw some part of Cardiology and Saturday saw miscellaneous and very interesting topics.

This was followed by Sunday IMACON 2010. The leaders in Medicine delivered their presentations to the enormous satisfaction of the delegates. The inauguration ceremony saw the inimitable Dr. Praful Desai delivering the "Dr. Surabhai Sheth Oration" on a very thought provoking topic – "**SCIENCE, MEDICINE, RELIGION - CAN THERE BE A SYNTHESIS**?" in presence of the family of the Late Dr. Surabhai Sheth. Needless to say, he received a standing ovation from the delegates for his oratory and thoughts.

There were many who went beyond their call of duty to make IMACON 2010 successful. Apart from the strong but graceful Dr. Lekha Pathak, Dr. Subodh Kedia excelled as a Co-convenor, Dr. Suhas Patwardhan as a Co-ordinator, Dr. Priti Bhargava with her invaluable inputs, Dr. Sanjay Dudhat with his enthusiasm, Dr. S. K. Joshi with his commitment and Dr. Deepak Jumani with his skills as an audiovisual expert. Others who chipped in with their "valuable" inputs were Dr. Jayant Gandhi, Dr. Intwala, Dr. Nitin Shah and Dr. Ronak Shah. Dr. Jayesh Lele as an experienced and invaluable Convenor lent them good support as usual. Hon. Secretary Dr. Ashok Balsekar, and other office bearers were pillars of strength along with our Trustees. All the Conference committee chairs were outstanding and proved beyond doubt why our branch is such a leader in CME activities. Their organizational skills were there for everybody to see and appreciate. Thank you my friends! It is because of you that our branch is functioning like a well oiled machine with its highest outputs!

Our major sponsors also need a grateful mention – Emcure, Dr. L. H. Hiranandani Hospital and Dr. Reddy's Laboratory. The list of other sponsors is endless and we are extremely thankful for their participation in our conference activities.

All the above with the quiet but efficient support of our office staff – Seema, Sunita, Aparna, Sandeep, Alam, Hirji and others has made our branch the Numero Uno in conducting our CME activities.

This year, we have instituted a new award for those who have given their invaluable "Service Above Self" for IMA Mumbai West. This was the unique "Friend of IMA" Award. We were honored by conferring this prestigious award to Dr. Lekha Pathak, Dr. Jayesh Lele and Dr. Bakulesh Mehta. They are indeed "Jewels" in our crown and we are indebted to their inputs from time to time for our branch.

There were of course other excellent programmes for our members. Among them, "Diwali

Swaraprabhat" saw an unforgettable performance by Dr. Anita Bapat-Patel and her friends. The songs were memorable, rendition flawless and conduction spellbinding. The full house once again said it all! Kudos to Dr. Rohini for giving such a programme for our branch!

MASTACON at Nashik followed. We were bestowed with numerous awards as a branch for our exceptional activities. There were lots of personal appreciations for individual members (the list is elsewhere in this bulletin). Our felicitations are due for all these members for excelling at the state level. We wish you all the luck friends and our best wishes for your future progress at this level.

All this was possible because all these individuals have taken their tasks seriously and with lot of commitment for our Branch. It is important to realize that welfare of our branch must have a priority while taking any decision regarding any issue because we are here due to our branch, we excel because of our branch and our continued progress is unthinkable without participation from our branch. Utopia is many times illusory, but in the right context and right perspective, it is not impossible to achieve!

"It is only when we try to search the limits of the possible that we suddenly realize the achievement of the impossible!!"

Life is indeed a funny experience!

Warm Regards,

DR. B. M. INAMDAR
President, 2010-11

ANNOUNCEMENTS

Messaging Service is made available for members at a nominal cost of '. 750/- only. Maximum number of words sent will be 30. Send your message to Hon. Secretary, Dr. Ashok Balsekar (98205 35802). The message will be transmitted to all the members of IMA – Mumbai West, whose cell no is available with the office.

Second transmission of the same message will cost Rs 500/- only.

Payment by crossed cheque in favour of "IMA – Mumbai West".

Those members and their family members who have participated in **MUMBAI – MARATHON 2011**, are requested to assemble in IMA Building, Juhu on **SATURDAY, 04TH DECEMBER 2010, at 7.00 am** for orientation, co-ordination and for planning training sessions under the guidance of Dr. Avinash Thakurdesai.

Sports Sub Committee invites applications from members of our branch, who are interested to play "Season Ball Cricket".

I.M.A. – Mumbai West will participating in a Cricket Tournament during season 2010 – 2011.

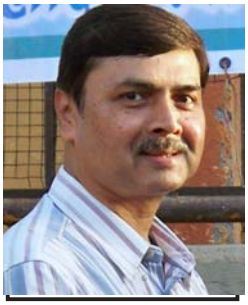
Contact : **DR. RAHUL NADKARNI** (98207 04726)

VIIITH EXHIBITION OF RARE BOOKS, 'ONCE UPON A TIME'

BOMBAY NATURAL HISTORY SOCIETY (B.N.H.S.) jointly with rotary club of Bombay seacoast has organised an exhibition of rare and precious books at hombill house, opposite lion gate, shaheed bhagatsinh marg, fort from 11th December till 17th December, everyday from 11 am till 5 pm. Most of the books on display on display are 100 to 200 years old. The books will be on Indian wild life, Indian history, Mumbai, history of western india, Kashmir, Tibet etc. the books are from the collection of BNHS and also few books from the collection of Dr. Ashok Kothari, our life member and also Hon. Secretary of BNHS. There will be 170 years old rare books on human anatomy on display. The exhibition will be inaugurated on 10th December, by Kalyan Banerjee, rotary international president elect (2011 – 2012).

Those who want to visit the exhibition or display rare books or antiques may contact Dr. Ashok Kothari on 9833476773 or 2649 4535 (clinic)

DR. ASHOK BALSEKAR
Hon. Secretary



Hon. Secretary's Desk...

Dear Colleagues,

All is not well in a medical world from the perspective of IMA. IMA – HQ, Hon. Secretary General & President are suspended by MCI for six months and therefore cannot practice for that duration. This action is taken because they were the signatories of a contract with MNCs to endorse their product, which allowed the companies to use the name and the logo of IMA on their products. Here, I am worried on two counts. Number one, the two doctors who were suspended were only the executives and were executing the order passed by members of the central council, which in turn was working & doing what they did, for economic health of the association. Number two, if the association cannot endorse products, what is the status of "Educational Grant" a psendonym for sponsorship provided by pharmaceuticals for CMEs and Conferences ? If CMEs and conferences do not become self sustaining activities, delegates & participants of CMEs will have to pay the delegate fees thro' their nose, and as is well known, cost of education going northwards, each one of us will have to pay at least ten times more than what we are paying now. As one of our past presidents used to say. "There are no Free Lunches in this World !" So, friends, brace yourselves for difficult times ahead. And don't even think about not getting yourself updated in continuous medical education. If you think, knowledge is expensive, try ignorance !

Now, some good news to lift up your spirits. Though rowdy & uncivilized behavior of some of our members at state council meeting at MASTACON was nothing worth shouting about, feelings of shame got drowned in the feelings of pride the next day, when branch won prizes after prizes and many of our members occupied chairs of authority in IMA – MS, during the installation ceremony.

Another good news is that IMA – MS office stays in our premises for the next 3 years, thanks to concerted efforts of our president and other members who spoke in favour of keeping the office at the same place.

It is a matter of great pride for our members that our branch will be sharing the same address as the state office. In the long run, it is going to be a platform for our members who have ability & aspirations to go to HQ. and who knows? President IMA - HQ may be a member of IMA – Mumbai West ! That's a dream of every member of our branch. Nothing wrong in dreaming, isn't it ? Unless you dream, how will you make efforts to make them come true ?

Post conference & post Diwali, December will be a quiet month, comparatively speaking. RNTCP – TB Workshop and post graduate lectures are the only CMEs apart from regular weekly CMEs.

An innovative programme "Treasure Hunt", planned by Sports Sub Committee, Chairperson – Dr. Hiren Ambegaonkar failed to invoke much enthusiasm amongst our members and had to be cancelled due to lack of enough number of entries. We had to do some introspection why can we not motivate people to partake in extracurricular activities. Or is it that mass depression is pervading throughout our member community.

Whatever be the case; we need to wake up from a deep slumber and realize that there is a life beyond medicine.

Long Live IMA !

DR. ASHOK BALSEKAR
Hon. Secretary
drag_bal@yahoo.co.in

G. P. FORUM

C.M.E. PROGRAMME FOR GENERAL PRACTITIONERS

Every Tuesday
at 02.30 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
07.12.2010	Opportunistic Infections (Lungs) in HIV/AIDS	Dr. Salil Bendre
14.12.2010	Clinical Approach to Back Pain – I	Dr. Pradumna Mamtora
21.12.2010	Bedside Clinic (Sujay Hospital)	Dr. Raveshia
	Approach to Swellings in the Neck (IMA - Lupin Hall	Dr. Parthiv Sanghvi
28.12.2010	Clinical Approach to Back Pain – II	Dr. Pradumna Mamtora
04.01.2011	Anti Angina Drugs	Dr. Mahesh Shah

WEEKLY SCIENTIFIC PROGRAMME

Lectures on Every Thursday
at 02.30 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
02.12.2010	First Line ART & HIV Prophylaxis	Dr. George Oommen
09.12.2010	Pregnancy & HIV	Dr. Ira Shah
16.12.2010	HIV in Paediatrics	Dr. Rashid Merchant
23.12.2010	Newer Vaccines – A Stitch in Time Saves Nine	Dr. Jagruti Sanghvi
30.12.2010	**New Year - Holiday**	

- **WORKING LUNCH WILL BE SERVED FROM 01.30 PM TO 02.30 PM BEFORE EACH CME.**
- **CGP & IMA Members who have paid Annual Fees : FREE**
- **C.G.P. & IMA MEMBERS : ₹ 100/- (NOT PAID ANNUAL FEES).**

EACH LECTURE CARRIES A CREDIT OF 1 HOUR EACH FOR FCGP EXAMINATION.

DR. B. M. INAMDAR President
DR. ASHOK BALSEKAR Hon. Secretary
DR. PRITI BHARGAVA Asst. Director of Studies
DR. RONAK SHAH Asst. Secretary
IMA - Mumbai West C.G.P. Sub Faculty

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IMACON-2010 – A Report

Keeping in line with a number of other unique events this year, our XXIIND **ANNUAL SCIENTIFIC CONFERENCE-IMACON 2010** was also unique in ways more than one.

-it was spread over eight days (24th Oct. to 31st Oct.2010)

-it was held at two different venues
-it was accredited by MMC

Venue for the first day of the Conference (24.10.10) was the Conference Hall of Hotel Grand Hyatt, at Santacruz (E). Distinguished, learned speakers mesmerized all by the knowledge they shared. In the pre lunch (morning) session Dr. Sunil Bichile, Dr. Nilesh Shah, Dr. Lekha Pathak delivered very practical talks on their respective subjects. Significance of using Chirally pure molecules as drug formulations was explained by Dr. P. Bhandari.

The first day of the conference was memorable for the venue and ambience, solely due to the efforts of Dr. Lekha Pathak. Thank you for your assistance, Dr. Lekha!

In view of 24th October being World Obesity Day, the post lunch session was dedicated to this subject.

Dr. Jayshree Todkar Dr. Poonam Shah and Dr. Shashank Shah put in good team effort on the role of bariatric surgery in combating Obesity.Of particular interest was the Physiological basis of Bariatric Surgery. The day ended with a talk on a very relevant topic-'Breast Cancer - From Palliation to Cure'. This talk was delivered by Dr. Sandeep Goyale.

Venue for subsequent CMEs of the conference was our own premises of IMA MUMBAI WEST.

Three Pre Conference CMEs were held. Pre Conference CME –I, on 26th October 2010, was dedicated to the subject of PATHOLOGY. Pre Conference CME –II, on 28th October 2010, was witness to two talks of great practical significance- Follow up of Angioplasty Patients by Dr. Darshan Jhala and Genetic Tumour Markers And Hereditary Cancers by Dr. Avinash Deo. Pre Conference CME – III, on 30th October 2010, was marked by excellent presentations. Talks on Counseling In Cancer Patients and Counseling In HIV AIDS reflected the significance of emotions/spirituality

as major part of human health. Both, Dr. Sandeep Goyle and Dr. Rajashree Intwala dealt with this very efficiently. Dr. Jayshree Shah made her talk on Hepatitis C very receptive by case presentations. The concept of Coblation Surgery, new to many from the medical fraternity, appeared promising as it was dealt by Dr. Vikas Aggrawal.

The final day - 31st October 2010, was a grand, full day event, witnessing a number of luminaries and a large number of delegates gracing the occasion. The day began by a talk on HIV AIDS by renowned HIV AIDS specialist -Dr. Jehangir Sorabjee. Neither the audience nor the Session in charge wished to put a stop to the talk even as it went well

beyond the scheduled time! It was followed by an equally engrossing and informative talk by Dr. N .H. Banka.

Inauguration of the Conference followed with President Dr. Bal Inamdar, the trustees and other office bearers lightening the lamp signifying knowledge. Presidential address was followed by felicitation of Dr. Bakulesh Mehta and Dr. Jayesh Lele as 'FRIENDS OF IMA' for their long standing and selfless services rendered to the cause of IMA.

This award has been instituted at our branch from this year –a brainchild of President Dr. Bal Inamdar.

This year's 'DR SURABHAI SHETH ORATION' was delivered by Eminent Onco Surgeon Dr. Praful B. Desai. He spoke on-'SCIENCE, MEDICINE, RELIGION-CAN THERE BE A SYNTHESIS'. The gist of his talk-whatever skills and knowledge we may acquire, if we try to act God we are losing our sense of spiritualism and are no longer human but like robots or any other machine that functions only as logically programmed and with no sense of feeling, a mind without a heart. He strengthened his beliefs with a number of quotes.

The talk was an apt tribute to late Dr. Surabhai Sheth. Mrs. Sunita Sheth and his children graced the occasion.

The stream of knowledge flowed with talks by Dr. J. J. Dalal, Dr. Ajay Mahajan, Dr. Reena Nair, Dr.B. K. Smruti, Dr. Pankaj Deshpande, Dr. Ajit Vaze, Dr. Jayant Gandhi, Dr Kalpana Sarangi - each doing justice to her/ his respective talk.

Dr. C. T. Thakkar Oration was awarded to Dr. Jagdip Upadhyaya for his presentation on "Euthanasia."

The conference ended on a happy note with delegates taking back memories of the conference a useful delegate gift and forthcoming Diwali festival to look forward to!

Excellent coordination between various conference committee members and apt moderation by chairpersons and Session in charge of various sessions ensured a smooth and well conducted Conference.

Dr. Deepak Jumani has already gone down in the annals of IMA MUMBAI WEST for his excellent and committed efforts in handling the audiovisuals throughout the conference, year after year.

Finally, all our sponsors of IMACON 2010 deserve special thanks for their participation. Our office staff also deserves a special pat on the back for their unflinching back office support.

DR. PRITI BHARGAVA
Asst. Director of Studies
IMA – CGP Sub Faculty

DEEPAWALI SWARAPRABHAT - an unforgetable program

Deepawali morning on Sunday, 07th November 2010, dawned on IMA- Mumbai west, with the melodious tunes of song "Jyoti Kalash Chhalake" from film "Bhabhiki Chudiyan" sung by Dr. Anita Patel. A group of music loving doctors "Swatchhanda" presented Hindi film songs sung by Dr. Anita Patel, Dr. Satyjit Upasani and the musical family Dr. Yogendra Javdekar, Dr. Savita Javdekar and their son Dr. Alap Javdekar. Excellent compering was done by none other than Dr. Anil Brado. Who says doctors can only treat patients?

Deepawali without Diyas, Aakash Kandils, Flowers and Rangolies is unthinkable so did IMA have all these adornments. The Rangoli exhibition in the side room was the creation of the artists-Dr. Chhaya Desai, Dr. Manjiri Inamdar, Dr. Rohini Badwe, Dr.Hansa Shah, Mrs.Nanda Kamble and Mrs.Sushama Karyakarte.

Almost 150 members attended, decked in traditional attire. Dr. Urmila Garg and Dr. Sanjeev Shah were awarded prizes for best dressed female and male resp. at the hands of best dressed office bearer Dr. Niranjan Vaidya.

Delicious breakfast was sponsored by our own Amantran caterers. Members returned home with happy memories and with a promise to attend similar celebrations next year.

DR. ROHINI BADWE
Chairperson
Cultural Sub Committee

INFORMATION, EDUCATION & COMMUNICATION SUB COMMITTEE - A Report

Awareness lecture was organised on the topic of **"AWARENESS OF TB, Malaria, Dengue Leptospirosis, Chickungunia and Universal Preventions, Post Exposure Prophylaxis"** on **THURSDAY, 11TH NOV. 2010** at M. W. Desai Hospital, Govind Nagar, Malad (E) from 11.30 am to 01.30 pm.

Lecture was given by Dr. Pratibha Thoravade. Sister (Mrs.) Shobha Waghmare & Lab Technician from MDACS Dept. Mr. Sachin Padhye.

It was attended by 50 Staff including sister incharge, nurses, ward boys, ayabai and sweeper. Programme was followed by distribution of snacks to all.

We thank Dr. Kamlesh Gandhi and Mr. Krishna Kokate for helping in organizing this programme.

DR. PRATIBHA THORAVADE
Chairperson—Information, Education & Communication

GERIATRIC CELL – A Report

On Sunday, 14th November 2010, a Medical Health Check up Camp was held by Geriatric Cell of IMA – Mumbai West at 'Sneha Bandhani' an Old Age Home at Taluka Sudhagad, Dist – Raigad, Near Khopoli.

Health checkup was carried out for 55 senior citizens who stay at Sneha Bandhan itizens ranged from 70 years to 95 y

The team compr
1) Dr. Chhaya De Dr. Dattaben Shah
4) Dr. S. D. Tejw Dr. Devangi
7) Ms. Sushila
Technicians San

Diwali festival distributed sugarless sweets to the senior citize – Mumbai West.

DR. CHHAYA DESAI
Chairperson , Geriatric Cell Sub Committee

MEMBER'S WELFARE SUB COMMITTEE - A Report

Member's Welfare Committee had organised a weekend trip to Nashik, Shirdi & Trambakeshwar on 19 - 21 November, 2010. An air-conditioned 17 seater bus was arranged for transportation. The group started from IMA building at 7 a.m. on 19th November & reached Nashik at around 11a.m.The stay was arranged in hotel Ginger, managed by Tata group. All the participants were given rooms with LCD TV, A.C & 24 hour hot water facilities. The rooms were allotted on twin sharing basis. On 19th November the lunch was arranged at the Mastacon venue & banquet dinner at Dr. Vasant Rao Pawar's farm house. On 20th the group left the hotel early in the morning for darshan of Shirdi Saibaba.VIP entry passes were arranged for the whole group, so that no one had to stand in the queue for long. In fact few senior citizens in the group could avail the darshan for two times. On 21st November, Sunday the group visited Trimbakeshwar temple & back in Mumbai by 7 p.m. in the evening. All in all, it was wonderful exprience.

Dr. Mehul M Bhatt
Chairperson, Member's Welfare Sub Committee

MEDICAL EDUCATION SUB COMMITTEE
of
INDIAN MEDICAL ASSOCIATION - MUMBAI WEST
Presents

"EDUCATIONAL PROGRAMME FOR POST GRADUATE STUDENTS / RESIDENTS"

Day & Date : SATURDAY, 11TH DECEMBER 2010
Time : 06.30 pm onwards
Venue : I.M.A. Hall, I.M.A. Building, Behind Chandan Cinema, J. R. Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

PROGRAMME

TIME	TOPIC	SPEAKER
06.30 pm - 07.00 pm	Registration	
07.00 pm	Welcome Address & Inauguration	Dr. Balkrishna M. Inamdar
07.00 pm - 08.00 pm	Sleep Apnoea	Dr. Salil Bendre Consultant Chest Physician
08.00 pm - 09.00 pm	Current Trends in Diabetes Management	Dr. Rahul Tambe Consultant Physician
09.00 pm - 09.15 pm	Discussion	
09.15 pm	Vote of Thanks	Dr. Rashmikant Sanghvi / Dr. Sanjay Dudhat
09.15 pm onwards	Dinner	

▶ **REGISTRATION FEES: FREE BUT PRIOR REGISTRATION IS A MUST.**

FOR REGISTRATION CONTACT : MS. APARNA / MS. SEEMA / MS. SUNITA
IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. B. M. INAMDAR	DR. ASHOK BALSEKAR	DR. RASHMIKANT SANGHVI	DR. SANJAY DUDHAT
President	Hon. Secretary	Chairperson	Co-Chairperson

WOMEN'S WING SUB – COMMITTEE of IMA- MUMBAI WEST
presents **FREE INFORMATIVE TALK BY VERSATILE PERSONALITY**
MRS. SANDHYA ADITYA KAUSHIK on

1) "HAND WRITING ANALYSIS"
Do you know when you write or sign; unknowingly you disclose much more about yourself, than you want to? It is a method of identifying, and evaluating a person's nature and personality.

2) "HOW DO TAROT CARDS WORK?"
It helps you define your position in life and help you find new directions in which to move forward.

We welcome you all to attend these talk and take back a few tips to discover your greatest gifts for the new year, realize your potential and achieve success in your life and work.

on **FRIDAY, 17TH DECEMBER 2010** at **02.30 pm**
Venue : IMA Hall, IMA Building, J. R. Mhatre Marg, Behind Chandan Cinema
J.V.P.D. Scheme, Juhu, Mumbai - 400 049.
Registration : FREE but **Must** by **15th December 2010**
FOR REGISTRATION CONTACT : **MS. APARNA / MS. SEEMA / MS. SUNITA**
IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. BALKRISHNA M. INAMDAR	DR. ASHOK BALSEKAR	DR. BHAVNA PATEL
President	Hon. Secretary	Chairperson

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IMA - CGP SUB FACULTY
of
INDIAN MEDICAL ASSOCIATION - MUMBAI WEST
Presents

"RNTCP – TB WORKSHOP"

Day & Date : SUNDAY, 19TH DECEMBER 2010
Time : 09.30 am onwards
Venue : I.M.A. Hall, I.M.A. Building, Behind Chandan Cinema, J. R. Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

PROGRAMME

Time	Topic	Speaker
09.00 am – 09.30 am	**Registration**	
09.30 am – 09.40 am	Welcome Address	Dr. Balkrishna M. Inamdar
09.40 am – 12.30 pm	Session – I	Dr. Manisha Bidaye
12.30 pm – 01.30 pm	**Lunch**	
01.30 pm – 04.30 pm	Session – II	Dr. Anil Pachnekar Dr. Satish More
04.30 pm	Vote of Thanks	

- **REGISTRATION FEES : FREE BUT PRIOR REGISTRATION IS A MUST.**
- **MMC Accredation has been applied for.**
- **Charges MMC Credit hours (For the Accredited CME Rs. 50/-)**
- **Applicable to all IMA Member desirous of credit hours**

FOR REGISTRATION CONTACT : MS. APARNA / MS. SEEMA / MS. SUNITA
IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

DR. PRITI BHARGAVA
Asst. Director of Studies

DR. RONAK SHAH
Asst. Secretary

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

We appreciate your feedback !!

Dear President Dr. Balkrishna,

Wishing you a Happy Diwali and Bright New Year.

Multi congratulations for your well deserved **"President's Special Felicitation Award"** and a basketful of awards like **"Best Bulletin Award", "The Best CGP Sub Faculty of IMA Award"** and **"Best Bulletin Award"** from **IMA – Maharashtra State**. I am sure that under your leadership, the Association will continue to make excellent progress in all the avenues.

With warm regards, Yours sincerely,

Dr. Krishnakant B. Bhargava

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

ANNOUNCES FOR THE FIRST TIME

"EMERGING STARS OF MEDICINE" CONFERENCE

APPLICATIONS ARE INVITED FROM ELIGIBLE CANDIDATES

FOR

IMA MUMBAI WEST CITATION OF "EMERGING STARS OF MEDICINE"

ELIGIBILITY FOR APPLICANTS :

1. Age less than 45 years;
2. Residing/practicing between Bandra to Dahisar;
3. Member of IMA Mumbai West will be given preference;
4. Must be successful in private practice or institutional practice;
5. Must be known as an expert in his/her chosen field of medicine;
6. May have done pioneering work in medicine;
7. Should submit two (2)recommendations from peers/teachers about the veracity of his/her application;
8. Should submit his/her **"JUSTIFICATION FOR APPLICATION"** in a one page format (not more than 300 words);
9. Should submit application in hard copy and soft copy to IMA Mumbai West along with proof of all the educational qualifications (Xerox copies);

All the applications will be scrutinized by the selection committee of IMA Mumbai West and final results announced in December / January "medical image". **Final number of awards will be decided by the selection committee but will not be less than three (3).**

Successful applicants will be given **a prestigious IMA Mumbai West citation of "EMERGING STARS OF MEDICINE"** and will be invited to speak in the above conference on their chosen topic.

KINDLY APPLY IN TRIPLICATE TO ...

IMA - MUMBAI WEST, IMA BUILDING, J. R. MHATRE MARG, BEHIND CHANDAN CINEMA,
J.V.P.D. SCHEME, JUHU, MUMBAI – 400049 . Tel. : 26206517, 65235579
EMAIL: imamumbaiwest@gmail.com, imamumbaiwest@yahoo.com

LAST DATE FOR APPLICATION : WEDNESDAY, 15TH DECEMBER 2010

DR. BALKRISHNA M. INAMDAR
PRESIDENT

DR. ASHOK BALSEKAR
HON. SECRETARY

FOR THE FIRST TIME
IMA – MUMBAI WEST MEDICAL EDUCATION SCHOLARSHIP

IMA – Mumbai West Branch announces **Medical Education Scholarship of ₹. 25,000/- (. Twenty Five Thousand only)** to economically challenged, sincere in studies and deserving Final M.B.B.S. Students.

Students desiring to apply can contact the IMA office for details. (Criteria and application form attached)

Last Date for Application 31st December 2010.

This is a very good opportunity to avail of education scholarship for needy students. Kindly contact any such student that you know and inform him/her about this scholarship.

The students would need to furnish following details:
Title: Mr. / Miss / Mrs.
Name:
Address:
Date of Birth:
Gender:
Seat No/Roll No:
Date of joining the institute: ₹
Father's Name:
Father's profession:
Mother's profession:
Family Income:
Total no of earning members in family:
Educational Details:

Qualification	Institute Name & City	University Name & City	Period (From – To) dd/mm/yyyy	Student ID / Reg.	Student ID / Reg.
3rd MBBS					Not applicable
2nd MBBS					
1st MBBS					
12th / equivalent					
10th / equivalent					

Scholarships, Sponsorship, Prizes:

CRITERIA FOR SELECTION OF MEDICAL EDUCATION SCHOLARSHIP

- Should be from Seth G. S. Medical College, Topiwala National Medical College & Lokmanya Tilak Medical College & Grant Medical College.
- Should be Final M.B.B.S. student,
- Family income less than Rs. 2 Lacs per annum,
- Should have proven record of consistent performance,
- Shortlisted candidates need not be rank holders,
- Highest scorer amongst the shortlisted candidates will have added advantage,
- Should be Indian national residing within territorial limits of Mumbai west (i.e. between Bandra & Dahisar)
- Should be recommended by respective institute's committee ,
- Repeaters are not eligible for grant,
- Equal opportunity will be provided to right candidate irrespective of Religion, Caste, Creed or Sex
- The decision of the IMA – Mumbai West grant committee will be final and binding on all.

AWARDS AND ACHIEVEMENTS by Our Branch at MASTACON 2010, at Nashik

Congratulations ! Congratulations !! Congratulations !!!

• IMA MAHARASHTRA STATE AWARDS •

IMA - MUMBAI WEST BRANCH Receives

- **"BEST BIG BRANCH AWARD" :** in BIG BRANCH CATEGORY, in IMA–Maharashtra state
- **DR. J.S. SIKCHI AWARD** for "THE BEST SUB FACULTY OF IMA CGP" for Consecutively the Fourth Year.
- **BEST BULLETIN AWARD** jointly with IMA – Mumbai Branch.

ACHIEVEMENTS

- **President's Special Felicitation Award - 2009-10 - Awarded to**
  i) Dr. Balkrishna M. Inamdar ii) Dr. Akil Contractor
- **Appreciation Awards for Selfless Service – Awarded to**

i) Dr.Jayesh M. Lele ii) Dr. Deepak Jumani iii) Dr. Niranjan R. Vaidya iv) Dr. Shailendra C. Mehtalia

- Ex. President & Senior Veteran Leader of our branch **DR. KANTILAL M. DAVE** of Goregaon (W) was honoured with prestigious **"LIFE TIME ACHIEVEMENT AWARD"** from **IMA Maharashtra State** in recognition his selfless and invaluable contribution at branch State & HQ level in various capacities.
- Our Imm. Past President **DR. JAYESH LELE** has been elected unopposed for the prestigious **"HON. SECRETARY"** of **IMA– MAHARASHTRA STATE BRANCH** for the year 2010 - 2011.
- Our Hon. Joint Secretary **DR. PARTHIV SANGHVI** has been elected unopposed for the prestigious **"HON. JOINT SECRETARY"** of **IMA – MAHARASHTRA STATE BRANCH** for the year 2010 - 2011.
- We congratulate following leaders of our branch who got elected in CWC

  - Dr. Bakulesh S. Mehta - Dr Akil Contractor - Dr. Anil Suchak - Dr. Niranjan R. Vaidya
- Our hon. Treasurer, **DR. NIRANJAN R. VAIDYA,** has been elected as a Member of the IMA Standing Committee on Political Liaison for 3 years.
- Our Trust Board member **DR. ANIL SUCHAK** has been elected as a member of IMA - MS Standing Committee (building).

This is a moment of glory for our branch. We are very proud of these achievements.

DR. BALKRISHNA M. INAMDAR — President

DR. ASHOK BALSEKAR — Hon. Secretary

Guest Editorial...

Dear Friends,

It is my proud privileged & honor to be the guest editor for this special issue of Medical Image on "Dermatology". At the outset I would like to congratulate the editorial team of image for choosing Dermatology special issue. Dermatology by definition is 'the study of skin & its ailment' or in broader way "a branch of science which not only treats".

Skin but also internal medicine diseases like AIDS which manifest on skin. That is probably the reason why skin is also known as the mirror of internal disorders.

Friends! medical science has been progressing day in & day out & Dermatology is no exception. Over a period of last 3 decades I have seen Dermatology progressing from simple diagnosis to complex syndrome from scabies to AIDS, from simple microscopy to electron microscopy, simple skin biopsy to immuno florescence & special staining & lastly but not the least simple electro cautery to complex LASER, The later is able to treat successfully so many complex diseases like Nevus of Ota, Port wine stain, café au lait spot etc. which were once upon time in curable. This has resulted in proving the old saying wrong that skin diseases are not curable.

Skin is composed of three layers ; epidermis, dermis & sub cutaneous tissue. The epidermis the outermost layer, is formed by an ordered arrangement of cells known as keratinocytes, whose basic function is to synthesize keratin, a filamentous protein, but serves as protective function. The dermis is a middle layer. Its principal constituent is the fibrillar structure protein collagen. The dermis lies on the panniculous, which is composed of lobules of lipocytes .

In this special issue I have made a humble attempt to discuss the common skin ailment which we see day in and day out in our routine clinical practice of medicine.

Acne is a common skin ailment which affects more than 80 % of the youth.

Though a self limiting ailment leads to very severe ugly scars if not treated in time.

The second topic on hair which is a dead structure has great cosmetic importance especially for the ladies. The loss of hair is known as alopecia while the excess is known as hypertrichosis or hirsutism if a female has male type of hair growth.

As mentioned earlier skin is a mirror of internal diseases. One of the most dreaded diseases of mankind ***Acquired Immune Deficiency Syndrome [AIDS] has*** its first symptoms on

from this there are many diseases, malignancies, & viral measles, varicela have their on skin .

on pigmentary disorders. This ded to discuss on Facial Hypo etails.

be very keen to receive your se articles. If I get positive feedback I would be very glad , if negative I promise to improve in my next attempt as an editor.

Thanking you,

DR HARESH TIMBADIA
MD skin Mumbai
drtimbadia@gmail.com
Phone 28021012 / 28052069
Mob. : 9930764112

ACNE

DR HARESH TIMBADIA
MD (Skin)

Acne vulgaris (commonly called **acne**) is a common skin condition, caused by changes in androgen [sex hormone]stimulation. It is characterized by noninflammatory follicular papules or comedones and by inflammatory papules, pustules, and nodules in its more severe forms. Acne vulgaris affects the areas of skin with the densest population of sebaceous follicles; these areas include the face, the upper part of the chest, and the back. Severe acne is inflammatory, but acne can also manifest in noninflammatory forms.

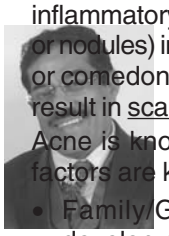
Acne occurs most commonly during adolescence, affecting more than 89% of teenagers, and frequently continues into adulthood. In adolescence, acne is usually caused by an increase in male sex hormones, which people of both genders accrue during puberty. For most people, acne diminishes over time and tends to disappear—or at the very least decrease—after one reaches one's early twenties. There is, however, no way to predict how long it will take to disappear entirely, and some individuals will carry this condition well into their thirties, forties and beyond.

The face and upper neck are the most commonly affected, but the chest, back and shoulders may have acne as well. The upper arms can also have acne, but lesions found there are often keratosis pilaris, not acne. Typical acne lesions are comedones, inflammatory papules, pustules and nodules. Some of the large nodules were previously called "cysts" and the term *nodulocystic* has been used to describe severe cases of inflammatory acne.

Aside from scarring, its main effects are psychological, such as reduced self-esteem and, according to at least one study, depression or suicide. Acne usually appears during adolescence, when people already tend to be most socially insecure. Early and aggressive treatment is therefore advocated by some to lessen the overall impact to individuals.

Causes of acne

Acne develops as a result of blockages in follicles. Hyperkeratinization and formation of a plug of keratin and sebum (a microcomedo) is the earliest change. Enlargement of sebaceous glands and an increase in sebum production occur with increased androgen (DHEA-S) production at adrenarche. The microcomedo may enlarge to form an open comedone (blackhead) or closed comedone (whitehead). Whiteheads are the direct result of skin pores becoming clogged with sebum, a naturally occurring oil, and dead skin cells. In these conditions the naturally occurring largely commensal bacteria *Propionibacterium acnes* can cause inflammation, leading to inflammatory lesions (papules, infected pustules, or nodules) in the dermis around the microcomedo or comedone, which results in redness and may result in scarring or hyperpigmentation.



Acne is known to be partly hereditary. Several factors are known to be linked to acne:

- Family/Genetic history. The tendency to develop acne runs in families. For example, school-age boys with acne often have other members in their family with acne as well. A family history of acne is associated with an earlier occurrence of acne and an increased number of retentional acne lesions.
- Hormonal activity, such as menstrual cycles and puberty. During puberty, an increase in male sex hormones called androgens cause the follicular glands to grow larger and make more sebum.
- Inflammation, skin irritation or scratching of any sort will activate inflammation.
- Stress. can cause an acne flare.
- Hyperactive sebaceous glands, secondary to the three hormone sources above.
- Bacteria in the pores. *Propionibacterium acnes (P. acnes)* is the anaerobic bacterium that causes acne. In-vitro resistance of *P. acnes* to commonly used antibiotics has been increasing.
- Use of anabolic steroids

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- Exposure to certain chemical compounds. Chloracne is particularly linked to toxic exposure to dioxins, namely Chlorinated dioxins.[citation needed]
- Chronic use of amphetamines or other similar drugs.

DIET : NO ROLL TO PLAY IN CAUSATION OF ACNE

HYGIENE : Acne is not caused by dirt. This misconception probably comes from the fact that blackheads look like dirt stuck in the openings of pores. The black color is not dirt but simply oxidized keratin.

TREATMENTS

AIMS

- Normalising shedding into the pore to prevent blockage
- killing *Propionibacterium acnes*
- anti-inflammatory effects
- hormonal manipulation

A combination of treatments can greatly reduce the amount and severity of acne in many cases. Those treatments that are most effective tend to have greater potential for side effects and need a greater degree of monitoring, so a step-wise approach is often taken. There are a number of treatments that have been proven effective:

A Topical bactericidals

Benzoyl peroxide may be used in mild to moderate acne. Bar soaps or washes may also be used and vary from 2% to 10% in strength. In addition to its therapeutic effect as a keratolytic benzoyl peroxide also prevents new lesions by killing *P. acnes*. Unlike antibiotics, benzoyl peroxide has the advantage of being a strong oxidizer and thus does not appear to generate bacterial resistance. However, it routinely causes dryness, local irritation and redness.

Topical antibiotics : Externally applied antibiotics such as erythromycin, clindamycin or tetracycline kill the bacteria that are harbored in the blocked follicles. While topical use of antibiotics is equally as effective as oral use, this method avoids possible side effects including upset stomach and drug interactions, but may prove inefficient to apply over larger areas than just the face alone.

Oral antibiotics : Oral antibiotics used to treat acne include erythromycin or one of the tetracycline antibiotics (tetracycline, the better absorbed oxytetracycline, or one of the once daily doxycycline, minocycline, or lymecycline). However, reducing the P. acnes bacteria will not, in itself, do anything to reduce the oil secretion and abnormal cell behaviour that is the initial cause of the blocked follicles. Additionally the antibiotics are becoming less and less useful as resistant P. acnes are becoming more common. Acne may return soon after the end of treatment—days later in the case of topical applications, and weeks later in the case of oral antibiotics. Furthermore, side effects of tetracycline antibiotics can include yellowing of the teeth and an imbalance of gut flora, so are only recommended after topical products have been ruled out.

It has been found that sub-antimicrobial doses of antibiotics such as minocycline also improve acne. It is believed that minocycline's anti-inflammatory effect also prevents acne.

Hormonal treatments

In females, acne can be improved with hormonal treatments. The common combined estrogen/progestogen methods of hormonal contraception have some effect, but the antiandrogen, Cyproterone, in combination with an oestrogen is particularly effective at reducing androgenic hormone levels. but a newer oral contraceptive containing the progestin drospirenone is now available with fewer side effects than Diane 35 / Dianette. Both can be used where blood tests show abnormally high levels of androgens, but are effective even when this is not the case. Along with this, treatment with low dose spironolactone can have anti-androgenetic properties, especially in patients with polycystic ovarian syndrome.

If a pimple is large and/or does not seem to be affected by other treatments, I prefer to administer an injection of cortisone directly into it, which will usually reduce redness and inflammation almost immediately. This has the effect of flattening the pimple, thereby making it easier to cover up with makeup, and can also aid in the healing process. Side effects are minimal, but may include a temporary whitening of the skin around the injection point; and occasionally a small depression forms, which may persist, although often fills eventually. This method also carries a much smaller risk of scarring than surgical removal.

Topical retinoids

A group of medications for normalizing the follicle cell lifecycle are topical retinoids such as tretinoin, adapalene, and tazarotene. Like isotretinoin, they

are related to vitamin A, but they are administered as topicals and generally have much milder side effects. They can, however, cause significant irritation of the skin. The retinoids appear to influence the cell creation and death lifecycle of cells in the follicle lining. This helps prevent the hyperkeratinization of these cells that can create a blockage. Topical retinoids often cause an initial flare up of acne and facial flushing.

Oral retinoids

A daily oral intake of vitamin A derivative isotretinoin over a period of 4–6 months can cause long-term resolution or reduction of acne. It is believed that isotretinoin works primarily by reducing the secretion of oils from the glands. Isotretinoin has been shown to be very effective in treating severe acne and can either improve or clear well over 80% of patients. The drug has a much longer effect than anti-bacterial treatments and will often cure acne for good. The treatment requires close medical supervision by a dermatologist because the drug has many known side effects (many of which can be severe). About 25% of patients may relapse after one treatment. In those cases, a second treatment for another 4–6 months may be indicated to obtain desired results. Occasionally a third or even a fourth course is used,. The most common side effects are dry skin and occasional nosebleeds (secondary to dry nasal mucosa). Oral retinoids also often cause an initial flare up of acne within a month or so, which can be severe, it is recommended that patients have blood samples taken and examined before and during treatment. In some cases, treatment is terminated or reduced due to elevated liver enzymes in the blood, which might be related to liver damage. Blood triglycerides also need to be monitored. However, routine testing are part of the official guidelines for the use of the drug in many countries. Some press reports suggest that isotretinoin may cause depression but as of September 2005 there is no agreement in the medical literature as to the risk. The drug also causes birth defects if women become pregnant while taking it or take it while pregnant. For this reason, female patients are required to use two separate forms of birth control or vow abstinence while on the drug.

Microdermabrasion comes from the dermabrasion. Microdermabrasion is a more natural skin care that is a gentler, less invasive technology for doing an exfoliation on the skin. The goal of the microdermabrasion is to eliminate the superficial layer of the skin called the epidermis. The microdermabrasion is done to eliminate some of the corneocytes. MDA helps minimizing or eliminating scars, blotchiness and stretch marks. MDA makes use of Aluminium Oxide crystals which causes sup exfoliation of skin. Today's time this is one of the BEST treatment to remove acne scars & it very much cost effective .

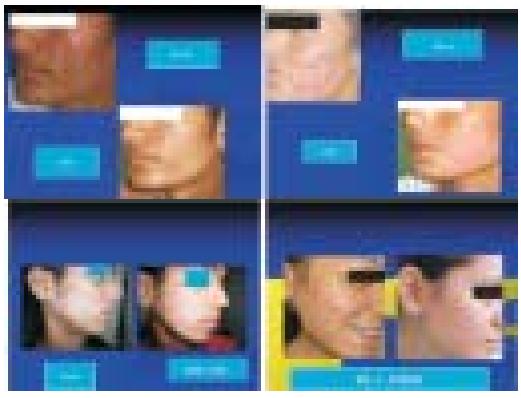
Subcision is a process used to treat deep rolling scars left behind by acne or other skin diseases. Essentially the process involves separating the skin tissue in the affected area from the deeper scar tissue. This allows the blood to pool under the affected area, eventually causing the deep rolling scar to level off with the rest of the skin area. Once the skin has leveled, treatments such as laser resurfacing, microdermabrasion or chemical peels can be used to smooth out the scarred tissue.

LASER TREATMENT : Intensed Pulse Light

Laser surgery has been in use for some time to reduce the scars left behind by acne, but research has been done on lasers for prevention of acne formation itself. The laser is used to produce one of the following effects:

- to burn away the follicle sac from which the hair grows
- to burn away the sebaceous gland which produces the oil
- to induce formation of oxygen in the bacteria, killing them

I use intense pulsed light in addition to the medical line of treatment, it not only shortens the course of the treatment but also prevents scarring.



SKIN IN SYSTEMIC DISEASE

DR. CHITRA S. NAYAK
Associate Professor, Dermatology
BYL Nair Ch Hospital & TN Medical College

The skin is the largest organ of the body. It can be affected in various systemic diseases while diseases with widespread systemic involvement can have systemic involvement.

Systemic diseases with cutaneous involvement include, systemic lupus erythematosus, systemic sclerosis, xanthoma, sarcoidosis, paraneoplastic syndromes among others.

Skin diseases with systemic involvement are erythroderma and lepra reactions.

Endocrine system: Various endocrine disorders have myriad cutaneous manifestations of which diabetes and thyroid disorders are most often encountered in practice.

A vast spectrum of manifestations is seen in diabetics. Acanthosis nigricans consists of velvety plaques seen on neck and in intertriginous areas and is seen in diabetics. It is a marker of insulin resistance andwhen seen in non-diabertics, warns of future diabetes risk. Bacterial infections like furuncles and carbuncles and genital and cutaneous candidiasis are more common in diabetics. About 50% diabetics have shin spots which are initially dull red macules which later turn dark and atrophic. Spontaneous, painless, non-inflammatory bullae in acral areas are seen in diabetics. Reduced joint mobility and waxy skin are seen in long standing diabetics. Diabetic neuropathy may cause trophic ulceration of soles. Dryness of skin on extremities is a common feature in diabetics. Acquired perforating disorders are seen as itchy hyperkeratotic papules mainly on legs and may be mistaken for folliculitis. Necrobiosis lipoidica diabeticorum consists of yellowish orange atrophic plaques on legs, especially shins.

Thyroid disorders are not uncommon in the populace. Skin changes are seen in both hyper and hypothyroidism. In severe hypothyroidism, myxedema develops where the skin coarse and dry simulating ichthyosis. Diffuse hair loss and loss of outer third of eyebrows is seen. Hair becomes coarse and brittle with breaking of free edges of nails. Carotenemia is a feature causing yellowing of skin, better appreciated on palms and soles. Coldness of hands and feet, hair loss and dry skin may be the only symptoms of mild hypothyroidism.

Thyroid acropachy is seen in Graves' disease and less commonly in hypothyroidism and consists of digital clubbing and soft tissue swelling of hands and feet. Pretibial myxedema may start as non-pitting edema and later form plaques and nodules. In hyperthyroidism the skin is warm, moist, smooth with palmar erythema and facial flushing. Hair is thin and fine and there is non-scarring diffuse alopecia with concave nails in hyperthyroidism. Bronzing of skin is also seen.

Hypoparathyroidism amy lead to dry, scaly and thickened skin prone to dermatitis. Hair is thin, fragile with patchy alopecia. Nails are atrophic, brittle with horizontal ridging.

Hyperparathyroidism, both primary and secondary (due to chronic renal failure) can lead to very severe severe pruritus which may be relieved by parathyroidectomy.

Adrenal gland disorders: In Cushing's syndrome (hyperadrenalsim) the skin is thin, fragile, with purpura and striae. Truncal obesity, moon face, buffalo hump with acne, hirsutism and acanthosis nigricans are other features. In primary Addison's disease (hypoadrenalism) there is generalized brown-black diffuse pigmentation with accentuation of normally pigmented areas like creases, flexures.

Renal diseases: Renal failure due to any cause leads to dry, pruritic scaly skin with a tendency to develop purpura or ecchyoses on minor trauma. The skin looks pale and yellow due to anemia and accumulated urochrome and carotene pigments and edema. High blood urea levels may reflect as deposition of urea on nose and malar areas, the "uremic frost". Acquired perforating dermatosis and hair loss from limbs due to rubbing and scratching is seen. Nephrogenic fibrosing dermatopathy with reddish discoloration of distal half of nails (half and half nails) may be seen.

Gastrointestinal disorders: Dysphagia may be seen in dermatomyositis. Gastrointestinal bleeding may occur in Peutz-Jeghers' syndrome (perioral lentigenes with intestinal polyposis), hereditary hemorrhagic telangiectasia, Ehlers-Danlos syndrome and pseudoxanthoma elasticum. Abdominal pain may be a precursor of herpes zoster of abdominal dermatomes. It is also seen in angioedema, porphyria, mesenteric vasculitis in Henoch-Schonlein purpura andcollagen vascular diseases, polyposis of Peutz-Jegher and Gardner syndromes and neurofibromatosis.

Common skin changes in liver disease are icterus, telangiectasis, xanthelasma, spider nevi, loss of secondary male hair growth, purpura, striae and palmar erythema. Clubbing and white nails are seen in biliary cirrhosis.

Skin and internal malignancy: Many internal malignancies have tell-tale cutaneous signs. Paraneoplastic manifestations are skin changes seen either preceding, concurrent with or after treatment of internal malignancies.

The following are skin changes seen with underlying malignancies: Exfoliative dermatitis with lymphoproliferative diseases, acanthosis nigricans with adenocarcinoma, Sweet's syndrome with acute myelogenous leukemia, nodular fat necrosis with pancreatic carcinoma. Dermatomyositis in older patient may have underlying breast or gastrointestinal malignancy. Acquired ichthyosis may be associated with lymphoproliferative disorders. Sister Mary Joseph nodule is an umbilical metastasis from gastrointestinal, pancreatic, ovarian, endometrial or breast cancer. Necrolytic migratory erythema consists of expanding rings of superficial vesicopustules or scaly plaques over face, trunk or flexures and is associated with glucagonoma syndrome (glucagon secreting pancreatic tumour) which also manifests weight loss, glucose intolerance, anemia and glossitis. Erythema gyratum repens is a characteristic gyrate serpiginous erythema associated with underlying malignancies. Acquired hypertrichosis lanuginose consists of sudden growth of profuse downy hair with underlying lung or colon cancer. Erution of multiple itchy seborrheic keratosis with an underlying malignancy is called Leser=Trelat sign. Trousseau's sign (migratory thrombophlebitis) has an underlying pancreatic carcinoma. Paraneoplastic pemphigus is associated with lymphoma or lymphocytic leukemia.

Xanthomas are lesions produced by collection of lipid in dermis. They may be Planar (flat), popular, nodular, tuberous or tendinous (associated with tendons and to be differentiated from rheumatoid nodules). They usually signal an underlying hyperlipidemia.

Fig. 1: Trophic ulcers in a diabetic with sensory neuropathy on the feet.

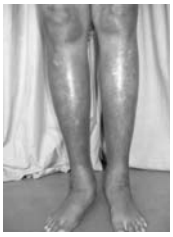


Fig 2:
Pretibial myxedema

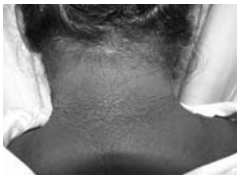


Fig. 3:
Acanthosis nigricans

IMA CGP REQUESTS THE MEMBERS TO FOLLOW CERTAIN GUIDELINES TO HELP US TO HELP YOU

- Prior registration for CME – must (upto 12 noon).
- Registration for accreditation at CME venue will close 10 mins. after talk begins.
- Accreditation desiring delegates should be seated in the hall by 10 mins. after CME begins.
- Feedback forms will be made available after felicitation of speaker.
- Feedback form has to be submitted subsequent to the CME on the same day.

HYPOPIGMENTED LESIONS ON FACE

DR. VIDYA KHARKAR, M.D, D.V.D
Professor (Dermatology)
Seth G.S. Medical College &
K.E.M. Hospital, Mumbai.

Introduction : Hypopigmented lesions on face are a very common condition seen in day to day practice They are very disturbing to the patient . Repigmenation takes some time after the primary disease is treated and so counseling is an important part of its management

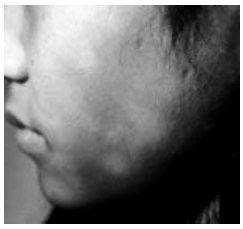
Common causes

1. Pityriasis alba
2. Post inflammatory hypopigmentation
3. Vitiligo
4. Leprosy
5. Pityriasis versicolor
6. Nevus depigmentosus
7. Nevus anemicus
8. Ash leaf macule

1. Pityriasis alba

Introduction - Pityriasis alba is a nonspecific dermatitis of unknown etiology that causes erythematous scaly patches. These resolve and leave areas of hypopigmentation that slowly repigment to normal. It is commonly seen in young children. Exact etiology is not known. It is commonly associated with atopic dermatitis.

Clinical features - Initially mildly erythematous ill-defined patches of size 1cm to 2cms are seen. Erythema later subsides completely to leave areas of hypopigmentation with or without fine scaling. So later, few asymptomatic or slightly itchy light colored ill defined flat round to oval patches are usually around 2-3 cm in diameter, are commonly seen on cheeks.



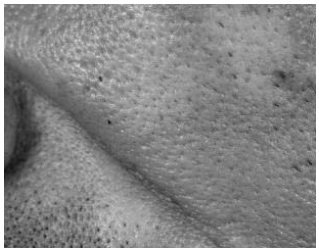
Multiple hypopigmented macules

Treatment- Counseling the parents regarding benign nature of the disease is important. Mild topical steroids such as hydrocortisone1% can used for short duration. Topical 0.1% tacrolimus ointment may be indicated only after other treatment options have failed. Moisturizing creams are the main stay of treatment. The lesions disappear over a period of time without any permanent hypopigmentation. Camouflage can also be done till repigmentation occurs.

2. Post inflammatory hypopigmentation

Introduction- It is seen in all age groups, all sites, and in variable size and shapes. It can occur after a consequence of multiple diseases.

Clinical features- Few to multiple hypopigmented macules or patches seen on affected area with ill defined edges. The primary lesion might be observed along with the hypopigmented patches. Woods lamp examination does not show any accentuation of the lesion



Hypopigmented patches

Treatment- Controlling the primary disease is important in order to prevent new patches.
Post inflammatory hypopigmentation tends to resolve after few months.
Placental extract, topical psoralens, UVB, UVA are also used with variable success.

3. Vitiligo-

Introduction- Vitiligo is an acquired hypopigmentary disorder of the skin and mucous membranes, and it is characterized by circumscribed depigmented macules and patches. It is an extremely common disease with multiple genetic and environmental associated factors. All age groups are affected. Multiple mechanisms including autoimmune, neuronal, free radical damage are important.

Clinical features- The most common form of vitiligo is a hypopigmented or depigmented macule or patch surrounded by healthy skin. The macules are chalk or milk-white in color, and lesions are well demarcated which get further enhanced on Wood's lamp. Lesion can be of any size and shape. Vitiligo lesions may be localized or generalized, with the latter being more common than the former. Localized vitiligo is of

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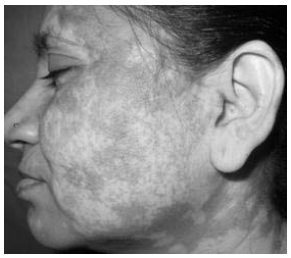
mainly 3 types- focal, segmental, mucosal. Generalized vitiligo may be acrofacial, vulgaris and mixed.It is important to make out whether it is stable or unstable vitiligo. Trichrome vitiligo has an intermediate zone of hypochromia located between the achromic center and the peripheral unaffected skin. Leukotrichia means -depigmented hair is associated with poor prognosis and delayed repigmentation.



Multiple confluent hypo and depigmented macules and patches

Treatment- No single therapy for vitiligo produces predictably good results in all patient. Treatment must be individualized. Unstable vitiligo has to converted to stable vitiligo first, with the help of topical and/or oral immunosuppresants and immunomodulators with antioxidants.. Various topical drugs are then used for repigmentation.

Medical management includes, topical and oral steroids, topical and oral psoralens, UVB, UVA antioxidants, topical calcineurine inhibitors, placental extracts and topical growth factors.

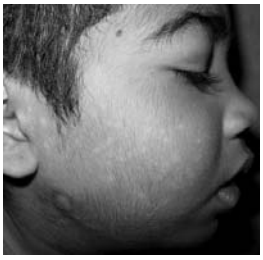
Surgical modalities mainly includes micropigmentation, punch grafting, suction blister grafting and melanocyte-keratinocyte culture and grafting.

4.Pityriasis versicolor (syn. Tinea versicolor)

Introduction- it is a superficial fungal infection caused by M.furfur which causes hypopigmented to hyperpigmented macules on face, chest and back. The organism is a normal resident flora on skin.

Clinical features- Hypopigmented to hyperpigmented scaly round to oval macules of size ranging from 1mm to few cms. Lesions might be mildly itchy. Hypopigmented macules around hair follicles are also seen. Patients with positive family history show higher rate of recurrence and longer duration of disease.

Woods lamp examination shows golden yellow fluorescence and light scraping of the involved skin seen under the microscope reveals the spores and the hyphae.



Well defined round to oval hypopigmented macules

Treatment- Patients should be informed that tinea versicolor is caused by a fungus that is normally present on the skin surface and is therefore not considered contagious. Recurrence is a common problem. Repigmentation takes a few months after eliminating the infection.

Selenium sulfide lotion is liberally applied to affected areas of the skin daily for 2 weeks; each application is allowed to remain on the skin for at least 10 minutes prior to being washed off. Topical clotrimazole1% and miconazole 2% for 4 to 6 weeks have commonly been used with good success. Luliconazole1% has low MIC values which can be used in resistant cases. Weekly applications of any of the topical agents for the following few months may help prevent recurrence. Antifungal dusting powder can to be used liberally during the day.

Oral therapy is also effective for tinea versicolor and is often preferred by patients because it is more convenient and less time consuming. Fluconazole given as a single 150- to 300-mg weekly dose for 2-4 weeks. Itraconazole is usually given at 200 mg/d for 7 days. Ketoconazole is less commonly used due to its side effects.

5. Leprosy

Introduction- Leprosy is endemic in India since ancient times. Multiple manifestations and deformities due to skin and nerve involvement are seen. Hypopigmented lesions are commonly seen in leprosy.

Clinical features- Ill-defined hypopigmented macules and patches with xerotic surface and loss of hair are mainly seen. Sensation is usually impaired or lost. Loss of temperature sensation occurs first. The lesions gradually increases in size and number. There is thickening of the cutaneous nerves

Diagnosis- AFB staining mayl show the presence of M. lepra bacilli . Biopsy of the lesion will show granulomatous infiltration in the dermis and of the nerve

Treatment- MDT-MB for 1 year for multibacillary and MDT-PB for paucibacillary type of leprosy to be given. Isolated treatment of patches for repigmentation is usually not attempted.

Ref

6. Nevus depigmentosus

Introduction- The term nevus depigmentosus (achromic nevus) should probably

be used to describe the majority of children with one or two hypopigmented macules and no other signs of neurocutaneous disease.

Clinical features- Most commonly it presents as localized poorly demarcated white patches that tend to be in a dermatomal pattern. In most of the patients, the lesions are not completely achromic but are hypopigmented and resemble splashed paint. The individual lesions are permanent.

Hypopigmented patches in a dermatomal pattern

Treatment- There are no effective therapies for repigmenting this nevus.

7. Nevus anemicus

Introduction - Nevus anemicus is an uncommon congenital disorder in which there is usually a solitary asymptomatic patch that is paler than the surrounding normal skin. Nevus anemicus is also known as a pharmacological nevus.

Clinical features - Nevus anemicus is often misdiagnosed as an ash leaf macule as they present with an asymptomatic pale macule or patch that has been present since birth and grows with the child. Wood lamp examination demonstrates the presence of normal pigment. Rubbing the area results in erythema from vasodilatation in surrounding normal skin, while the lesion remains unchanged.

Treatment- No approved therapy is available for nevus anemicus.However, camouflage is generally helpful & other treatment is not needed.

8. Ash leaf macule-

Introduction- They are hypopigmented macules that are ash-leaf shaped, oval at one end and pointed at the opposite end. They are most commonly seen in association with tuberous sclerosis.

Clinical features- Ash leaf macules are usually present at birth, and most commonly located on the trunk, but can also be found occasionally on the extremities and face. On the posterior trunk, their long axes are in a transverse direction, whereas on the extremities they are cephalocaudal. Sometimes, ash leaf macules are subtle & can only be detected with a Wood's lamp. These macules are often the first cutaneous sign of tuberous sclerosis, and this diagnosis should be strongly suspected in patients with three or more ash leaf macules. The ash leaf macule may be seen in the general population; therefore it is not considered to be the most criterion for tuberous sclerosis diagnosis.

Treatment- There is no treatment for either the hypopigmentation or the underlying disorder.

Conclusion : Hypopigmented lesions on face are a common feature in day to day practice. Accurate and early diagnosis is very important for its management.

REGISTRATION FOR TB RNTCP WORKSHOP

TB RNTCP WORKSHOP on **SUNDAY,19TH DECEMBER 2010** will be held at IMA premises from. 9.00 a.m. onwards. Twenty (20) delegates will be registered on first cum first serve basis. Members practicing in slum area will be given preference.

Registration will be accepted from 10th December 2010 onwards.

DR. PRITI BHARGAVA
Asst. Director of Studies IMA – CGP Sub Faculty

REGISTRATION FOR BED SIDE CLINICS

Bed Side Clinics on Tuesday, 21st December will be held at Sujay Hospital at 2.30 p.m. onwards. Thirty (30) delegates will be registered on first cum first serve basis. (Delegates incapable of standing for long hours, please excuse.)

Registration will be accepted from 10th December 2010 onwards.

Members who did not attend Bed Side Clinics at Nanavati Hospital will be given preference.

DR. PRITI BHARGAVA
Asst. Director of Studies IMA – CGP Sub Faculty

DISORDERS OF HAIR

ATUL DONGRE, UDAY KHOPKAR

Department of Dermatology, KEM Hospital &
Seth GS Medical College, Mumbai

In today's cosmetically conscious communities, a full head of hair is every man or woman's envy. Although hairs protect head from the physical factors like trauma and exposure to harmful sunrays, they immensely enhance the natural beauty of a person. Hence, decrease in hair density or hair loss can have tremendous psychosocial impact on the life of an individual, especially women.

Normally there are around 1 lac hairs on the scalp. Hairs are formed by the hair follicles which pass through 3 different phases of hair cycle i.e. anagen, catagen and telogen. The hairs which are in growing phase are known as anagen hairs. Telogen hairs are resting hairs which are going to be shed while catagen hairs represent a transition stage from anagen to telogen. Out of these 1 lac hairs on scalp, about 100 are shed every day. The hairs which are normally shed are in telogen phase.

ALOPECIA :

Loss of previously existing scalp hair is termed as alopecia. It may be permanent (scarring) where hair follicles are completely destroyed by the pathology and there is no chance of hair re-growth. Most of these conditions are associated with deep inflammations that destroy follicles. In temporary (non-scarring) alopecia though the hairs are shed, the hair follicles are not lost so re-growth of the hairs can occur. On clinical examination it is possible to differentiate between these two patterns. Examination of the bald area with a lens reveals follicular openings without hair shafts in cases of non-scaring alopecia whereas follicular openings are absent in areas of scarring alopecia.

Alopecia may be patchy where localized areas of hair loss are seen on the scalp or it may be diffuse where no patches of hair loss are visible but there is generalized decreased density of hair. Alopecia accompanied by signs of inflammation like redness, swelling, pus formation or scaling are known as inflammatory alopecia and are commonly caused by fungal infections (tinea capitis) or bacterial infections of the scalp (folliculitis). Alopecia where there is no sign of inflammation is known as non-inflammatory alopecia.

1. Causes of patchy or localized hair loss:

Cicatricial:

1. Discoid lupus erythematosus
2. Lichen planus
3. Tinea capitis (inflammatory, kerion)
4. Bacterial infection (deep folliculitis)
5. Traumatic alopecia e.g. mechanical, thermal burn, chemical burn

Noncicatricial:

1. Alopecia areata
2. Tinea capitis (noninflammatory)
3. Bacterial infection (deep folliculitis)

2. Causes of diffuse or generalized hair loss:

Non cicatricial:

1. Androgenic alopecia
2. Telogen effluvium
3. Systemic diseases e.g. thyroid disorders, systemic lupus erythematosus
4. Drug induced alopecia e.g. colchicine, antithyroid drugs, chemotherapy agents, high dose vitamin A
5. Iron deficiency anemia, protein energy malnutrition
6. Diffuse alopecia areata
7. Senile alopecia
8. Hair shaft defects

Cicatricial:

1. Traumatic alopecia e.g. mechanical, thermal burn, chemical burn
2. Autoimmune disorders e.g. systemic lupus erythematosus, lichen planus

Investigations in hair disorders: Though most of the hair disorders can be diagnosed clinically, a few special investigations may be required in cases which are in early stage or where the presentation is atypical or more than two disease conditions exists in the same individual. Such

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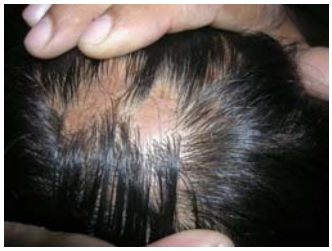
procedures help the physician to arrive at an accurate diagnosis and to know the prognosis.

1. Wood's lamp: Some of the fungi causing tinea capitis fluoresce under wood's lamp which can be helpful to differentiate from bacterial infection of scalp.
2. KOH mount: Hair and scales obtained from the lesion are mounted in KOH solution and observed under microscope to visualize fungal elements.
3. Hair pull test: About 60 hairs are pulled from the scalp. If telogen hairs are more than 10% then it indicates telogen effluvium.
4. Trichogram: Plucked scalp hairs are examined under microscope and analyzed for number of anagen and telogen hairs
5. Photo trichogram: A small area of scalp is trimmed and photos are taken on day 1, 4 and 7 to monitor for the hair growth. Trichscan is an instrument that is used to make a photo trichogram in a standardized fashion with the help of image analysis software.
6. Dermatoscopy (Folliscopy): Scalp and hairs are analyzed with the help of special instrument known as dermatoscope to differentiate various hair diseases.
7. Scalp biopsy: A small tissue of the skin is removed from the scalp and after laboratory processing and staining observed under microscope.
8. Thyroid function tests, estimation of serum ferritin levels are helpful to rule out thyroid disorder and iron deficiency as causes of diffuse hair loss.



Scarring alopecia- Complete loss of hairs & no follicular openings are seen.

SCARRING ALOPECIA (Cicatricial alopecia, permanent alopecia):

In scarring alopecia as hair follicles are lost permanently no follicular openings are visualized on clinical examination. Most of the conditions causing scarring alopecia are associated with deep inflammations that destroy follicles. History and examination play an important role in arriving at a diagnosis. Sometimes, biopsy is necessary to reach a diagnosis and may reveal the cause.

Treatment consists of arresting the progression of disease by identifying the cause and treating it. Since no regrowth of hair can occur once follicles are lost, surgery is the only means of cosmetic correction. If patients are not ready for surgery then artificial hairs can be used for to improve cosmetic appearance of the scalp.

DIFFUSE ALOPECIA:

Diffuse loss of hair is one of the commonest complaints in dermatology. In this kind of alopecia no bald patch is visible, so it is common for the doctor to underestimate the severity of the complaint. No signs are obvious except in the very severe cases where slight scarcity of hair ("diffuse thinning") is visible.

The commonest cause of diffuse hair loss in women is telogen effluvium. Another common and reversible cause of diffuse alopecia is androgenic alopecia which can be seen in both men and women. While androgenetic alopecia affects women with family history of alopecia, telogen effluvium follows some stressful precipitating event a few months earlier. Positive of history of thyroid disease, nutritional deficiency or drug ingestion is helpful in identifying these causes of diffuse hair loss. Senile alopecia affects the elderly beyond the age of 60 years. 1

ALOPECIA AREATA:

It is an autoimmune disorder which manifests as patchy loss of hair due to sudden precipitation of a group of hair follicles into telogen (resting phase). It is commonly seen in young adults and in children. Clinically, well circumscribed round patches of hair loss are seen without any signs of inflammation. The bald skin is hairless, smooth and on examination with a lens reveals openings of follicles, indicating that this is a non-scarring alopecia. At the margins of patch broken stubs of hair can be seen which can be easily plucked with fingers in active lesions. Apart from the scalp other sites like beard, mustache, eyebrows, eyelashes and axillae may be involved. In severe cases whole scalp involvement leading to complete baldness termed as alopecia totalis or loss of hair over the whole body termed as alopecia universalis can occur.

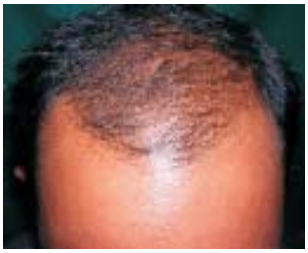
Spontaneous regrowth of hair may be seen in a few cases. Potent topical steroids or intralesional steroids (e.g. triamcinolone) are effective in most of the cases. Topical minoxidil solution, 2-5%, applied twice daily can also be tried.

Unresponsive or severe cases like alopecia totalis or universalis or rapidly progressing cases

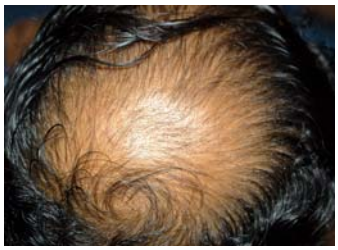
requires specialized treatment modalities for which an expert opinion of a dermatologist should be sought. Systemic steroids are not generally indicated in alopecia areata because of their serious side effects and a very high relapse rate on stopping of steroids. However they can be only tried only to prevent the spread of a rapidly evolving alopecia areata threatening to become total.

ANDROGENETIC ALOPECIA (Common Baldness, Male Pattern Baldness):

This is the commonest cause of alopecia. It is a nonscarring, non inflammatory diffuse type of alopecia where androgens and genetic predisposition play an important role. It is transmitted as an autosomal dominant trait. During childhood and adolescence period the scalp hairs are normal and alopecia becomes manifest usually around age of 20 years with gradual, diffuse loss of hairs especially from the frontotemporal and vertex area of scalp. In initial stages recession of the hairline in temporal and frontal areas is seen followed by appearance of alopecia over vertex. Initial sign is thinning of hair shafts and later increase in number of short and fine hairs. As the condition progresses, there is further frontal and temporal recession and a patch of baldness on the vertex becomes more obvious. In advanced stage the vertical, frontal and temporal areas of baldness coalesce leaving only the parietal and occipital hair intact.



Androgenic alopecia- Decreased density of hairs with recession of hair line in temporal and frontal area



Androgenic alopecia- Decreased density & thinning of hairs involving the vertex

Androgenic alopecia can also be seen in women (female pattern hair loss). In genetically predisposed women, it presents as a partial diffuse hair loss beginning during the twenties or thirties. However, this rarely leads to bald patches. As compared to androgenic alopecia in males the frontal hairline is usually preserved in females.

Therapy:

Topical minoxidil, 5-10% solution for male and 2% for females, to be applied twice a day helps to arrest further hair loss and improves hair thickness if used for 6-12 months and is the effect is maintained only if minoxidil is continued. Finasteride, a 5 alpha reductase inhibitor, is useful in a dose of 1 mg / day orally in males. Surgical options like hair transplant give good cosmetic results in advanced cases but are expensive. Surgery is advised only when hair loss has been stabilized.

TELOGEN EFFLUVIUM:

Is a commonest cause of diffuse hair loss in females. Normally the hairs which are shed as a physiological process are telogen hairs. In telogen effluvium the telogen hairs are shed in excess. Hair loss is abrupt diffuse and generalised, usually seen after 3 months following stressful events like febrile episodes especially persistent high fever (malaria, typhoid, tuberculosis, etc.), surgery, major trauma, difficult labour, emotional stress, crash diet. In times of stress, many (but not all) anagen follicles are precipitated suddenly into telogen. Since most telogen hair are shed only when a new anagen hair pushes the old hair out, it takes about 3 months (average duration of telogen) for the hair fall to be noticed. Since most of the hairs are still in anagen, visible thinning of scalp is unusual. Reassurance that the hairs are going to regrow spontaneously is most important.

TRAUMATIC ALOPECIA:

Hair loss due to mechanical stresses on hair shaft is termed as traumatic alopecia. It may occur to due to pulling, plucking or pressure.

Traction Alopecia:

Prolonged traction on the hair may lead to their breakage resulting in alopecia. Such kind of alopecia is seen in girls or women who tie their hair bands very tightly. The alopecia is seen either as a recession of the hairline at the scalp margin or as small ill-defined patches at the margins with short broken hair. It may be sometimes seen in males who grow and tie their hair of scalp (pony tail). Change of hair styling with relief of the traction solves the problem.

Trichotillomania (hair pulling tick):

Trichotillomania is usually seen in children or young women who, consciously or subconsciously, twist and pull at their hair. Clinically irregular patches of alopecia which shows broken stubs of hair of varying lengths is seen. A history of a habit of twisting and pulling of scalp hair is usually diagnostic and stoppage of hair pulling habit leads to regrowth of hair.

Pressure Alopecia:

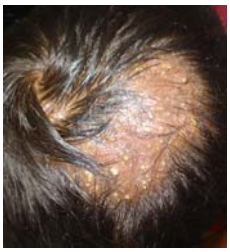
Persistent pressure on the one part of scalp leads to loss of hair in that area. In case of newborns it is seen over the occipital area. In adults it is seen in comatose patients or in patients who have undergone surgery under general anaesthsia. It is non-inflammatory, non-scarring type of alopecia and is completely reversible.

HAIR SHAFT DISORDERS:

Hair loss may uncommonly result from breakage of hair shafts. This may happen due to genetic defects in hair shaft strength or due to external trauma. Repetitive trauma due to frequent use of a strong shampoo, due to rapid drying of hair with a hair drier, due to use of a rough comb, hair bleaching or straightening procedures can damage the hair shafts. However, in such cases, hair loss is not severe enough to cause patches of baldness. Cessation of trauma leads to gradual regrowth of hair.

INFECTIONS CAUSING ALOPECIA:

Fungal and bacterial infections affecting scalp are common in children and can lead to scarring or non-scarring alopecia.



Tinea capitis- Hair loss and swelling studded with pustules

Tinea capitis: Non –inflammatory scaly patches with partial hair loss is common presentation. Hairs within the patch are fragile and lusterless. Such a non-inflammatory tinea capitis does not lead to scarring alopecia and treatment with oral antifungal agent is effective. Inflammatory tinea capitis (kerion) presents as painful swelling on the scalp studded with pustules and hair loss. Such lesions are uncommon in clinical practice and may lead to scarring alopecia even after treatment with oral antifungal. Oral antifungal agents like griseofulvin, terbinafine and fluconazole given for 4-6 weeks are effective.

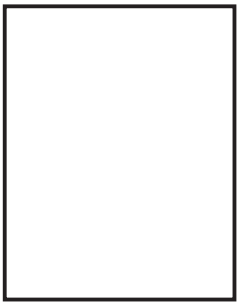
Bacterial infections:

Superficial folliculitis presents as grouped tiny follicular pustules with a narrow rim of redness. There is involvement of upper part of the follicle and pustule formation so that such a lesion heals without follicular scarring (permanent loss of involved hair).

Deep folliculitis involves the whole length of the follicle and heals with loss of hair follicle resulting in scarring alopecia. Reddish follicular papules and pustules are seen clinically.

Treatment with oral antibiotic agents like ampicillin, amoxicillin, cefadroxil, erythromycin, azithromycin with or without local application of antibiotics is effective in both the varieties.

Conclusion: Alopecia is a common complaint in day to day practice. Accurate diagnosis and treatment of alopecias, with timely referral to an expert dermatologist, will help to relieve anxiety and improve the quality of life of many with hair disorders. It may not be out of place to mention here that dermatologists are trained to take care of hair diseases during their 3 year curriculum and have wide exposure to common and uncommon causes of hair loss. It is common for patients in India to think of trichologists as doctors who have specialized in treatment of hair diseases. However, most trichology courses do not require MBBS degree for entry into this field. Hence, caution in needed in choosing your hair specialist.



FOR YOUR HEART STRINGS ONLY

Dear Friends!

Like me,you too can recall those days when many of us used to dream of saving a lakh of rupees to ensure a comfortable life. Then very soon a time came when people found that a minimum of 10 was essential to secure a better future, and the figure soon rose to 50 and then people found that there was no novelty in being a lakhpati and there were requirements to the tune of crores to buy a house, and take care of old age and many other needs. The figure kept on increasing and the destination of security kept on getting pushed further away, and we kept on working blindly thinking that achieving that would certainly bring security of a comfortable future.

Recently, I have been interacting with two great gentlemen. One who owns a bungalow and lives in a posh hill colony. He lives alone, with both son & daughter been married off and wife living abroad. He is all alone in his vast home, supported by servants. On entering his home he is received by servants and also seen off by them. He owns around 100 crores of assets and almost 20 lakhs of running income per month. He craves for company of people and even a cup of tea or half an hour chat with someone is of immense value to him.

Second gentleman was honest to admit to me that at his age of 65, he has wealth which is sufficient enough for his next few generations. He has lived his life working very hard to earn money and he has developed an expertise in that mission in an unmatched way in his circle of relatives and friends. God also has been kind enough to him by fulfilling all his financial missions. He owns innumerable properties in various cities. But sadly for him and his wife, they don't know how to kill time. They have no hobbies, nobody to talk to, no relative willing to invite them, or be guest in their palatial house.Now at this age and loaded with immense wealth, this couple craves for some one to talk to them, spend some time with and entertain them, but alas most of the relatives have moved on.

The above mentioned two gentlemen have really made me learn a lot of valuable lesson. I would not have learnt as much from any book as much I have learnt from them and their lives. Whatever dreams we may have of accumulating wealth for old age, and howsoever we may share the popular vision that apna paisa hi apne kaam aata hai.aur kuch nahi, one can see here that one's own money also does not guarantee a happy, secure and settled life. Money cannot and does not bring that happiness which friends and relatives alone bring to us.

All through our life, most of us blindly earn money and leave behind all relatives, friends, and every important relationship. We keep on accumulating figures, and keep on losing key people who could nourish and nurture us, make our life lively and happier. And we do so, since everyone around us is also doing so. We do so hoping that this is the right and only way to ensure long term happiness and most of us hit the hard reality of our life when we have money and other material assets but an extremely excruciatingly hanging sword is the feeling of loneliness which kills us every moment and any amount of money is useless in reducing that pain. What is needed as remedy is PEOPLE. Friends, relatives, well wishers and all these should not be remembered only late in life, rather they need to be taken care of as early in life, cultivated, nourished by us.

Wise people wake up in time, take charge and look around and revive dying relationships, rekindle the fire of emotions in vital relationships. And you are going to do that exactly from this moment onwards. There are many relatives and friends whom you have not called or talked to for months or perhaps years. When will you call them? After your departure or now!! Then do so right away with the Buddha's smile of wisdom on your face. Wish you A HAPPY LIFE hereafter.

Your feedback are valuable at drrajivanand@gmail.com or 9820064768

DR.RAJIV ANAND