

Nepalese Doctors' Association UK

Established 1985



NDA Journal/Souvenir

22nd

Annual Conference

20 - 22nd July, 2007

HILTON ABERDEEN TREETOPS

ABERDEEN

Nepalese Doctors' Association (UK)

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

Executive Committee Members 2005-2007

Dr. Madan Sharma	Chairman
Dr. Anil Tuladhar	Vice-chairman
Dr. Rajendra Pandey	General Secretary
Dr. Ramesh Khoju	Treasurer
Dr. Milan Kumar Piya	Joint Secretary
Dr. Siri Gautam	Member
Dr. Shabin Joshi	Member
Dr. Prem Rai	Member
Dr. Keshar Lal Shrestha (IPP)	Member

Local Organising Committee for this AGM 2007

Dr Prasanna and Leela Gautam
Dr Prasima Shrivastav
Anita Shrivastav
Meena Gautam

Editorial Policy

NDA Journal is published annually from the material provided by doctors, their family members and friends in the UK and abroad. Both medical and non medical articles are welcome. Medical articles should be original, properly referenced e.g. Vancouver style. Interesting case histories and abstracts of articles published in other journals are also accepted. Non-medical articles should be interesting, informative, impartial, non-political and if possible linked to Nepal and Nepalese cultural heritage. **Articles, both medical and non-medical should be brief and concise, and should preferably not exceed 1500 words (although exceptions will be made at**

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

Notice to the contributors:

Material for publication should be typed clearly in double space and submitted preferably electronically as a word attachment well in time for publication. The editorial board reserve the right to reject any article they deem inappropriate. It also is not responsible for not publishing articles submitted late.

Advertisements:

Advertisement rates are according to the site and size of the advertisement. Details can be obtained from the editorial board.

An NDA Newsletter is published in February/March every year to update members and their families on the association's activities. It also publishes news and achievements of the members and their families. This is now being published on the website and also being sent via email. For those who would like a copy of the newsletter sent via post, please contact Dr Milan Piya or any of the executive committee members.

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Editorial

Shakespeare wrote, "If music be the food of love, play on." Dr Dharma Shakya in his article *Watering the Seeds of Love* writes of his experience with the Venerable Thay and describes a different food of love. Dr Chuda Karki, in his article *Yoga - Review of Pranayama and Ashanas*, has described Yoga based on Swami Ramdev's teaching which he intends to demonstrate for everyone in the AGM. Yoga would lead to a healthy life, but so would Dr Satyan Rajbhandari's *10 Steps to Healthy Living*, a simple guide to staying healthy. The *Recipe for Vegetable Pakoda* by Hind Vaidya is a less healthy option, but definitely tasty.

In *Romania- An Illuminating Venture into Eastern European Healthcare*, Dr Siri Gautam describes the disparity in healthcare delivery in different hospitals in Romania. This reminds me of the disparity of healthcare in various parts of Nepal. Dr Prasanna Gautam has written *A Cervical Grip*, a tale of his experience in a hospital in Dharan in Eastern Nepal a long time ago. Having been to medical school in Dharan in a large teaching hospital, it is difficult to imagine what it was like back then when he was one of only a few doctors. Hind Vaidya, in *Thoughts Crop Up in My Mind*, has described coincidence... or is it?

The NDA has funded a *Study on Prevalence of Hypertension in Dhulikhel Municipality*, the preliminary abstract of which is published here by Dr Rajendra Koju *et al*. Dr Ramesh Khoju has written *Snakebite in Nepal: The Role of the Anaesthetist*. I think this is very important, having seen people die of respiratory failure in Eastern Nepal. Mr Pukar Shrestha and friends have shared their experience in *Renal Transplant Program in a Developing Country-A Need and a Challenge*. Dr Dhiraj Tripathi, as every year, gives us an article on liver disease in his article on *Hepatorenal Syndrome*.

There are poems written by our young contributors Cara Laxmi Pathy, Taya Rai (*Away With the Wind*) and Pramesh Khoju Shrestha (*Numbers*). I have included a poem *Darkness?... Brightness* that I wrote after watching the movie *Amistad* when sick slaves were thrown overboard a ship chained to an iron ball.

There is a report of the Psychiatry Section of NDA which seems to be very active under the Chairmanship of Dr Arun Jha. Feedback from the last AGM has been compiled by Dr Dhiraj Tripathi.

I cannot finish without congratulating Dr Raghav Dhital for his great achievement of being awarded an OBE. And I would like to end by thanking all the contributors, and also all those who have helped me edit this journal. Have a great AGM!

Milan Piya, Editor

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CHAIRMAN'S MESSAGE

It gives me great pleasure in welcoming you to the 22nd Annual General Meeting of the Nepalese Doctors Association (UK). This year's location at the Hilton Treetops Hotel in Aberdeen will hopefully provide delegates and their family with an enjoyable and memorable time.

I would like to thank the executive committee again this year, without their hard work it would not be possible to run the organisation. My special thanks to Dr Rajendra Pandey for his commitment to the association, Dr Anil Tuladhar his work on the website and correspondences with NARIC, Dr Shabin Joshi for the charity work, Dr Ramesh Khoju for sorting out our accounts, and Dr Milan Piya for publishing the journal and newsletter.



This year again, we have had a problem for our junior colleagues. It has been brought to our notice that medical graduates from universities in Nepal are not being awarded HSMP visa points on the grounds that UK NARIC, the agency responsible for determining whether a foreign university degree is equivalent to UK MBBS degree, considered that the Nepalese university degree are not equivalent. This is in spite of degrees in India, Pakistan, Bangladesh and Sri Lanka being recognised. We wrote to NARIC on 21st March 2007 asking for clarification but are still awaiting their reply.

Political situation in Nepal is still not peaceful. People were hoping for peace after last year's JANA ANDOLAN II, but there are a few problems coming one after another. Let us hope all the political parties come together to bring peace in Nepal.

Dr Raghav Dhital has been conferred Order of British Empire (OBE) by Her Majesty the Queen in recognition of his contribution towards UK – Nepal relations. NDA (UK) would like to heartily congratulate Dr Dhital, one of our founder members, on his memorable achievement.

On behalf of the executive committee, I would like to thank all of you for giving us the opportunity to serve you for the past 2 years. I would like to give my special thanks to our organising chairpersons Dr Prasanna Gautam and Mrs Dr Leela Gautam for selecting this marvelous venue and their hard work.

Dr Madan Sharma
GP, Manchester

Nepalese Doctors Association (UK) Annual report of the General Secretary 2006/2007

It is my pleasure to welcome you again to the 22nd AGM being held at Aberdeen. As you all know the AGM is the most important event in our calendar and I have no doubt that this event over the years has helped bind us together. This year we are unfortunately missing the participation of our junior colleagues who are affected by the new regulations which have adversely affected their training. The NDA Executive committee has written to the BMA's International Doctors Action Group and also to UK NARIC (National Recognition Information Centre) to express our dissatisfaction.

The past year has been eventful for positive reasons. The Executive Committee met twice, at Manchester and Middlesbrough. These meetings were attended by local NDA members too. Our agenda included the current AGM, charity, finance, membership, website and the new visa regulations affecting graduates from Nepal.

Dr Khoju, the Treasurer has continued his good work. His active persuasion has resulted in an increase in paid membership to 92 about half of which are life members. Our accounts are transparent, simplified and up to date. Dr Shabin Joshi, NDA's charity coordinator organised a programme under the banner of the NDA in Kathmandu which was well attended by dignitaries. He handed over donations for charities in Nepal which was well appreciated. We have also responded to a request by Hospice Nepal, who is doing a praiseworthy work under difficult circumstances, by making a donation recently. Dr Anil Tuladhar has been instrumental in improving the website further. He has been providing our members with up to date information regarding our activities. The extensive information published on the website regarding new regulations concerning junior doctors is very useful and commendable. I would also like to thank Dr Milan Piya for finding time from his busy schedule to bring out an impressive journal again.

I am ending four years as General Secretary of the NDA. I would like to take this opportunity to thank Chairman Dr Madan Sharma and all the members of the Executive Committee for their invaluable support. I look forward to handing over to the new General Secretary who I am confident will bring new ideas and enthusiasm to take our work further.

Finally, I would like to thank Dr Prasanna Gautam and his team who have worked hard to make this AGM a successful one. I do hope you will return with happy memories of Aberdeen.

Dr Rajendra Pandey, MRCPCCh
GP, Middlesbrough

Executive Committee



From Left to Right:

Dr Shabin Joshi, Dr Ramesh Khoju, Dr Milan Piya, Dr Rajendra Pandey, Dr Anil Tuladhar, Dr Madan Sharma, Dr Prem Rai, Dr Siri Gautam, Dr Keshar Lal Shrestha

NDA NEWS

Congratulations to Dr Raghav Prasad Dhital for being awarded Order of the British Empire (OBE)

Dr Ramesh Khoju, Consultant Anaesthetist, Bronglais General Hospital, Aberswyth, Wales

Dr Ananda Chapagain, SpR Renal Medicine

Dr Mohan Thapa, SpR Acute Medicine

Dr Shiv Gurung, Final FRCA

Dr Dip Raj Rai, MRCS

Dr Nanu Acharya, MRCP

Dr Sankalpa Neupane, MRCP

Dr Nawaraj Subedi, MRCP

Dr Sabina Pahari, MRCPCh

Dr Samridhi Bharadwaj Padhe, MRCPCh

Dr Ava Acharya, MB ChB, University of Bristol 2007

Meena Gautam, LLB Glasgow University

Also, congratulations to all the young doctors who got a job in the new MMC system amid all the chaos regarding MTAS.

And, best of luck to the rest for round two.

New Arrivals

Dr and Mrs NR Joshi on the birth of their granddaughter

Dr Arun and Meena Jha for the birth of their grandson

Dr Gunjaman and Jyoti Sherchan on the birth of their grandson

Drs Sarju and Tara Shrestha on their baby boy

Dr Sangeeta and Anurag Sharma on their baby girl

Drs Bhuma and Ilias Karantonis on their baby boy

Bhubi and Renate on their new baby boy Kian Arun Vaidya.

Wedding Bells

Eva Gautam and Ross Aitken

Sophie Dhungana and Ayush

Dr M Mahaseth and Dr Rabita Duku

Dr Nawaraj Subedi and Dr Samridhi Bharadwaj Padhe

Mr Yuvraj Agrawal and Dr Jyothi Karuwa

Condolence

Dr Binode Dhungana and family for the loss of his mother

Dr Gauri Shrestha and family for the loss of her father

Sanita Malla Rajbhandari and family for the loss of her father

Shaila Joshi and family for the loss of her father

Dr Anil Tuladhar and family for the loss of his mother

Other News

Divaker and Pravaker Hamal (twins) came 6th in the whole of the UK in the under 9 National UK English Primary School Chess Association Chess championship. (Grandsons of Dr PB Hamal and sons of Abhinna and Dr Arati Hamal.)

Farah Panesar won a local competition to design a Christmas card, and her design was used by the local council as their featured design for all their Christmas cards.

Shabeena Panesar was runner-up in the BBC national schools competition for design a sticker for malaria awareness week. She received a trophy from John Craven of Newsround and has appeared in the local newspaper. Farah and Shabeena are daughters of Dr Anokha and Jitender Panesar, and granddaughters of Dr PB Hamal.

Romania – An illuminating venture into Eastern European Health Care

May 15-19th 2006, Salaj Hospital, Zalau, Romania. Dr Siri Gautam, Sunderland

I have always been interested in international child health. Being a paediatric SpR in the UK, I was quite keen in taking the opportunity given to me by a charity organization to explore the paediatric services in Romania.

Before heading to Romania, my main impressions had been of wandering gypsies and a previous historically rich culture. I had no preconceived ideas about the health care system there. I went with an organization MSR (Medical Support Romania) to assess the paediatric department including accident and emergency. The organisation existed for relief of sickness in Eastern and Central Europe.

Before heading there, I thought the following would be important: training, guidelines & protocols, looking at all departments, equipment, patient profile, and local demographics & needs. However, once I got there, I realised that I needed to put a lot more thought into how the local system ran and what resources they had.

Historical Perspective of Romania

From 1916-1918, Romania fought on the Allied side, acquiring several territories with Bucharest being known as “Former Paris of the East”. The 1930s Fascist movement led to the dictatorship of King Carol II being established. In 1941, Romania fought against USSR with Germany, but switched sides towards the end of the second world war. A Soviet backed government was installed in 1945.

In 1965, Nicolae Ceausescu (who is notorious for the significant demise of the country), the then Communist party leader, pursued a health policy independent from Moscow. These included, blood transfusions to pregnant women, (leading to wide spread HIV-existence of this was denied throughout Ceausescu’s time), banning of abortion and contraception; > 5 kids benefits and > 10 kids free, childless couples-higher taxes; and sex education prohibited. Secret police pervaded society - Securitate knew everything which led to a “don’t speak” culture. Urban and rural systematisation occurred and properties were removed from owners and people were relocated to rural areas. 1985-1986 saw the slow demise of Ceausescu’s communist regime - Food shortages and powercuts led to a national uprising in 1989. In 1989, Ceausescu and his wife tried to leave but were caught and executed on Christmas day 1989, and the National Salvation Front was established.

More than 100,000 orphaned children living in horrific state institutions were discovered.

In the 1990s, there were several changes in leadership, and an economic reform programme started in 1997. Despite these changes, there has been ongoing poverty. And as you are all aware, Romania along with Bulgaria has joined the EU since January 2007.

Health in Romania

For the last decade, more than half of all Romanians have said that their biggest fear is sickness. They think accessibility to medical services is limited, they fear they do not have enough money to get treated.

The number of abandoned children according to UNICEF was 4000/year on maternity wards, and 5000/year in paediatric hospitals in 2005 alone, resulting in stays as long as 6-7 months. Surprisingly, these are similar to figures from Ceausescu’s time. 1483 children are now in state institutions compared to 7483 in 1997. HIV/AIDS is also a significant problem.

Bribery estimated at \$1 million in health care is ongoing. 1 of 5 doctors willingly accepts payments! It is suggested that this is a ‘hangover’ from former communist regimes. Low wages and public acceptance of the necessity of informal payments leads to ready acceptance - some professionals asking for payment directly!

The system is a mixture of private and public health care. There are also cheaper alternative therapies including salt mines/hydrotherapy in natural springs which some people are prescribed to go to for two weeks at a time! The salt mines are very deep but are said to be good for respiratory illnesses.

The problems also include debts of hundreds of millions of dollars. Hospital suppliers and pharmacies go on strike regularly. Health care used to be free. Pharmacies run out of treatment and simple things like bandages very easily. A new legislation is bringing in a different Basic Package, but patients have to pay for any extra tests.

Zalau and Kaluj

Zalau and Kaluj are towns in Romania, in Transylvania. As I flew into Budapest the magnificent buildings of the old Hapsburg Empire could be viewed from the plane. Our onward journey was by taxi into Romania. We left the beauty of modern Budapest and entered the vastness of countryside Romania, whose roads were full of large potholes that the driver had to swerve to avoid. We passed through many small villages on our way to Zalau where the majority of our time would be spent. On reaching Zalau, we noticed the tower grey apartment blocks of the old communist regimen with no indication of the former wealth of this country. The people were very hospitable and keen to help, the hospital which was a district general public hospital was right next to a multicoloured private hospital. During our stay in Romania, we did venture into another town Kaluj, which had amazing buildings of a past empire. It was a university town with well equipped hospitals and good amenities and beautiful hilly areas surrounding it. The doctors seemed more content in Kaluj in comparison to Zalau where many were demoralized and overworked with limited resources in a very dilapidated hospital.

Salaj Hospital, Zalau

There were 33,170 paediatric attendances in A&E with 11,925 admissions in a year, but with only 2 Consultants who were resident on-call in a one in two (I couldn't believe it) and 2 GP trainees only. The burden of the work was done by the consultants, with consultants going to A&E to see paediatric patients straight off. There were only 2 large paediatric wards. Many clinical conditions were lumped together, with a lot of patients being inpatients for two weeks which was surprising as a lot of management here in the UK has quite a high turnover and short hospital stay. Many children were receiving intravenous treatment when oral would have been sufficient, and surprisingly many children were very well looking. Equipment was a problem with only one portable nebuliser which children would come out to use in turn!

Hygiene was a major issue with No Handwashing occurring between patients – not surprising, as there was no soap or towels in some bays! Patients with gastroenteritis were next to respiratory and nephrotic patients. There was a recently appointed infection control chief who was to make changes.

Outpatient system was bizarre with no appointment system. Patients would turn up with a GP letter and queue, and if no further space was available for an appointment, they would return home and re-attend to queue again another day.

On the neonatal unit, there was one ventilator and it was rarely used. Delivery suites which were recently refurbished had resuscitaires though no equipment to resuscitate newborn babies. Some abandoned babies were present though we were informed that the gypsies usually returned after some months to claim their children.

Bribery and lack of trust in the health care system, possibly a 'hangover' from the old communist regime was quietly talked about or feared - not sure which. Patients did not trust medical staff, and shopped around and paid more and more for a second opinion. A surgeon drunk when at work was suspended briefly then reinstated.

Alleged bribery quotes: "I won't wake you up if you don't pay", "You may need further input so attend my private clinic", "You need this doing so it will cost this much", "Waking during an operation - pay more to feel no pain", and "Gift to doctor as delivery was very good". To alleviate lack of trust in the system, lay people have been employed by MSR as patient representatives. New rules have been put in place by the government to combat the pervasive nature of bribery.

Conclusions

We had several recommendations for the team in Zalau, such as importance of handwashing, cheaper alternatives for treatment, an improved outpatient system and other recommendations which at times felt difficult to establish due to lack of resources, morale and willingness to change.

What I personally learnt was that EU 2007 was fast approaching. Corruption is rife though I did not see it myself. Fear is palpable. The doctors I met were very hard working and clinically excellent, though they had limited resources and were poorly paid. Those in the teaching hospitals had state of the art equipment and worked in a very nurturing

environment. The disparity between the two types of hospitals surprised and shocked me - one felt like a war zone with overstretched overworked doctors, the other felt like a high tech dream with plenty of eager health professionals.

Lack of funds and different priorities was making basic health care difficult to achieve. Suppression of ideas and enthusiasm was making people leave the health profession. I realized that it is necessary to try and work within the system the government has given. Though at times this seems impossible, there is usually no choice!

I learnt that it is imperative to determine the social set up and public health care system in order to make an eventual impact. I was surprised by the remarkable difference within one country of basic health care, though the experience made me appreciate the NHS more despite the irrevocable changes that are happening within it. At least everyone is entitled to free health care and we have basic resources that we can rely on being available.

Poems by Cara Laxmi Pathy

Age 9

1.
A mother is something
That money cannot buy.
They help you with your homework
Comfort you when you cry.
And in my opinion,
(I think you might have guessed.)
For me you are truly
The mother that is BEST!
P.S. When I have tears to shed ,
I want to share them with you in bed.

2.
Thank you for the things
You do,
Each & every day.
Thank you for bringing
Happiness
In each and every way.
Thank you for giving
Me sisters,
Thank you for
Giving me fun.
What I want to say
IS: "IREALLY LOVE
YOU, MUM!"

Two Poems written by Cara and written on cards she gave her mother Risu on Mother's Day. Cara is the granddaughter of Dr Subarna Shrestha.

Watering the Seeds of Love

Dr Dharma Shakya, Slough, Berkshire

“When my father came to visit us from Paris we were so happy. I was happy. My children were happy. On the night before he was suppose to leave he told us he was going to take early retirement so that he could spent more time with us. We were very pleased and excited to hear him say that. Unfortunately, he never woke up. He died in his sleep. I was devastated. My children were devastated.”

This was the story recounted by a young American-Vietnamese mother during Dharma discussion on the second day of retreat. My wife and I had joined a week long summer retreat with venerable Thich Nhat Hanh (Thây) – a Vietnamese Zen meditation master in August 2006 at Plum village in France. On the second day of the retreat there was a Dharma discussion in the afternoon in our group. The discussion started with the sisters leading our group asking us what were our expectation? What brought us to the Plum Village?

There were 16 people in our group from seven countries - Denmark, Sweden, USA, UK, France, Vietnam and Nepal. One lady from Denmark opened the discussion saying that she had stayed in Plum Village about 10 years ago and had found it very comforting and inspiring. She was very sad about her father’s impending death and had come specifically to learn to say goodbye compassionately to her dying father, who was in the terminal stage of cancer. She then started to cry.

This set the mood for the whole group. An American lady told us that she was having difficulty with her sister. She had very much wanted to see her sister and her nephews. She had tried very hard but so far she had failed in her effort. Even though she had breast cancer, her sister’s attitude towards her had not changed. She had come to Plum village to get inspiration to overcome this current impasse with her sister.

Hearing this, the lady who recounted the above incident of her father’s unexpected death told the group that she found listening to one of the Thây’s tapes helped her enormously. She had come to USA from Vietnam with her younger sister about 15 years ago. She was married and had two children. A few years later she started having problems with her husband. Her younger sister also blamed her for every thing that went wrong in her life. On top of all this, she had to look after her mother. Now that her father was dead ,she felt helpless and came from Paris to live with them.

She suggested, listening to this tape might give her inspiration. It was about a young couple from Paris who were having difficulties in their relationship. She told us she had listened to this tape over and over again. This gave her inspiration and confidence to deal with her problems which at first seemed insurmountable. As if to answer our questions, Venerable Thây recounted this story the next day in the upper hamlet.

After these heart rendering stories, the reasons given by others for attending seemed trivial. Some said they came to France to see Thây because he was not visiting USA in 2006. Others said they have heard so much about Thây that they wanted to spend time in Plum village, have personal experience and learn from him.

The next day we went to Upper Hamlet which was about a half hour drive from new hamlet to listen to Thây’s talk, and to participate in walking meditation. Plum village in France was divided into three hamlets - **upper, lower and new hamlets**. We stayed at new hamlet. Venerable Thây gave a talk in French which was translated simultaneously into English, Italian, German, Spanish, Vietnamese etc. We stayed with the English speaking group.

I. The greatest gift parents could give to their children:

The first session was aimed at children, their families and others and he spoke in simple and practical language about the greatest gift parents could give to their children i.e. ‘Their own happiness’. “If parents are happy their children will be happy as well. If there is no peace and harmony between the parents there will be nothing parents could offer to their children. They can not give what they do not have”. He emphasised the importance of cultivating four sublime states of mind - the Brahma Vihara (heavenly abode) for our own and our children’s happiness i.e. Maitri (Loving Kindness), Karuna (Compassion), Mudita (Joy) and Upekkha (Equanimity/balanced view). Children left the hall after this to play outside.

II. Love needs food – nothing can survive without food:

In the second half of the session he told us a story about a young Vietnamese couple living in Paris to illustrate the above point.

Buddha said – love needs food, nothing can survive without food.

There was a difficulty between a couple who were living in Paris. They were living in French culture. In the beginning there was great love. After marriage they were happy for some time but it did not last long. They did not know how the situation came apart. They did not know how to bring back that happiness. The wife did not find any joy in cooking for her husband or in doing housework. She did not find happiness on hearing her husband’s footsteps coming home from work. The husband also no longer felt happy when he came home. There was no happiness at all. Without love life became unlivable.

One day the young woman was at home on her own. She did not work because her husband’s salary was enough for both. She opened a closet and suddenly saw a beautiful Vietnamese cookie box in which she had saved her love letters, magnificent letters her husband had written before they were married. She smiled. Out of curiosity she opened the box and took out a letter and read it. Some thing happened inside her while reading this letter. She really felt better in her body and mind. The language in the letter was truly the language of love. When she read this letter she watered the seeds of love. She felt refreshed. Since she felt good she took another letter and read it. After this she took the whole box down, sat in the kitchen table and read one by one all fifty of them, sweet letters full of love. Her husband did not use this type of language any more. Her prince charming who had used this

type of language was no longer there. Yet he was there somewhere. She remembered the man she had married.

She also used to write similar letters to her husband. After reading these letters she was revived and had a desire to write a letter and started with 'Darling' using the same language she had used before. Her husband had not read the letter but she already felt better. Before reading these letters it was impossible for her to write this type of letter. The seeds of love were still there. Her prince charming was still there but buried with layers of sufferings. The seeds had not been watered for so long that they had dried up. When she read these letters it was like watering a barren land. The seeds of love had chance to grow. She put the letter in an envelope and left it on the table of her husband's study.

"In Buddhism we speak of consciousness in terms of seeds. We have all sorts of seeds - seeds of happiness, seeds of love, seeds of understanding, seeds of despair, seeds of hatred etc. The name given to this type of seeds is 'totality of consciousnesses. It is like the earth containing all types of seeds. If they are watered, they will have a chance to grow."

Love and happiness in the past did not last because they did not know how to maintain it. They had become dry. When she read those letters she could hear that young man. She was capable of writing this kind of letter after having read 50 letters. Even if you did not save love letters, it was still there in the depth of your consciousness. You could read them mentally and water them.

"We should not underestimate our capacity to love. It is still there in the depth of our consciousness. It is possible to revive the love that is the teaching of the Buddha. Suffering can be used as a compost to make a beautiful garden. Suffering can be very useful. We can use it to transform our life."

That morning that lady had practised watering positive seeds of love and happiness. "In Buddhism we practice watering the seeds. In Plum village we practice selective watering. We water seeds of love, understanding and compassion. We do not water seeds of hatred and despair. One hour of practice of watering can make a big difference."

That evening her husband came home and told her that he had to go to New York. He did not notice any changes in his wife. They were used to him travelling from work. It did not matter because she was not happy at home, and he was not happy at home. A couple of days later her husband called her from New York and told her he had to stay a few more days in New York. She told him in sweet voice full of love, "Of course you can stay in New York if it is necessary, but please come home as soon as possible." A few hours later her husband rang back. He had recognised something has changed in his wife's way of speaking. They had not spoken like this for a long time. There was always a kind of bitterness in her voice. Now it was full of love. He arranged to come back home quickly.

When he came home she knew he would go straight to his study. He stayed there in his study for a long time and was very quiet. He had found his beloved again. He had rediscovered his sweetheart by reading this one letter. "Love is an art. It depends on you. It begins with you. Do not wait for the other person to change."

Both people were responsible for their situation. "Watering the seeds of love in you can water the seeds of love in the other person. Transformation in one person can bring transformation in the other person. To bring change you do not have to wait for the other person to change. The change in you will be able to bring changes in others. This is for sure. If you change, transformation in the other person is only a matter of time."

Each of them was reflecting deeply in what they had done. They had not been skilful in maintaining their love. "Sometimes you say you can kill two birds with one stone. I will say one can save two lives with watering seeds in one person. Everything is there. Nothing is lost. We must not become the victim of despair." "I wish everyone good practice."

Everyday Venerable Thây gave equally inspiring talks. The monks and nuns from Plum village organised equally inspiring activities. Plum village with its peaceful surrounding; kind and compassionate attitude of monks and nuns had a profound effect on us.

However, not everyone felt that way. There was a young lady from Sweden who found it boring. She had come because her boyfriend had liked the place when he came in 2005.

But for the rest of us in our group, after a week of staying together, we really felt we knew each other very well and felt that we were a family unit. We exchanged our e-mails and other contact details and were very sad to leave. We had invitations to visit Denmark, USA and France from members of our group. We had gone on package holidays for longer periods but had never made this type of bond.

When we left the Plum village, monks and nuns prepared packed lunches for each of us to take with us in our journey. We were touched with this gesture of kindness.

As I have mentioned before this was a family retreat. There were many families with their children who stayed more than a week. There were about 100-150 children in the retreat. About seven hundred people representing 47 nationalities of different faiths like Christians, Hindus, Sikhs, Muslims etc. attended the retreat.

On the last day during question and answer session, one Muslim lady asked Thây if he would be willing to conduct such a retreat for Muslim leaders of Europe. To which he replied it would be difficult to arrange but if it could be arranged he would be happy to conduct it. If you could organise such a retreat not only for Muslims but include other faith groups as well, it will give you an opportunity to show to the world that "Islam is a truly peaceful religion."

One more pleasant surprise was waiting for us. We went to buy some DVDs of talks from previous days but we did not have enough Euros and they did not have facilities for debit/credit cards. So the gentleman selling these told us "you write down what you want in the order form and send the money from England." The total came to 45 Euros. When I asked him "will you post the DVDs to us once you get the money?" He said "No, No," you take them now and send the money once you are in the UK'.

I did not believe what I was hearing, but it was the truth!

Renal transplant programme in a developing country: A Need and a challenge

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Overview

End Stage Renal Disease (ESRD) is a common problem encountered in developed as well as developing countries around the world. Conventionally, management of ESRD is Renal Replacement Therapy (RRT) in the form of haemodialysis or peritoneal dialysis as a short-term measure, with renal transplantation as a more definitive treatment option⁽¹⁾. Estimated worldwide dialysis population is greater than 1.1 million and the figure is expected to reach 2 million by 2010.⁽²⁾ Over the last 5 decades and especially after the ‘Cyclosporine era’ in the nineties, renal transplantation has become the mainstay of management of these patients. Safer surgical techniques and the introduction of novel immunosuppressants, to help with the management of mismatches, has resulted in graft survival rates and improved overall outcomes, with dramatic reduction of morbidity and mortality in the transplant population.⁽¹⁾ Nevertheless, “*de novo*” setting up of a renal transplant unit is still a great challenge and requires a multidisciplinary approach, with close co-ordination and co-operation between a number of specialists.

The programme is run by a dedicated team of Transplant surgeons, Nephrologists, Urologists, Specialist Anaesthetists, Transplant co-ordinators, Immunologists, Histopathologists, Microbiologists and Radiologists. Other supportive staff like Transplant Nurses, Dieticians and

Physiotherapists plays an equally important role in the overall success of the renal transplant programme.

The transplantation process starts with patient selection which is primarily done by the nephrologists as they deal with all the renal failure patients. Once suitable candidates for the renal transplant waiting list are identified, transplant co-ordinators play an important role in organizing further investigations, counseling and formulate action plan for the actual transplant procedure. Full assessment and pre-operative workout are summarized in Table 1.

Finally it is the transplant surgeon and anaesthetist’s responsibility to assess for fitness for transplant operation, with particular focus on cardiovascular status of the potential transplant recipients. This is of great importance since in the ESRD population, the incidence of hypertension and ischaemic heart disease is estimated to be as high as 60% and 40% respectively.

After the transplant operation, the kidney function is closely monitored in terms of biochemistry, urine output and other clinical parameters. Central venous pressure and blood pressure monitoring are very important after the renal transplant to ensure good blood flow to the transplant kidney. Perfusion of transplant kidney is confirmed the following day with either Duplex ultrasound or DTPA renal scan. Close biochemical level monitoring of immunosuppressants like Cyclosporine or Tacrolimus or Sirolimus is done every alternate day or so in early period and less frequently in the later period when the graft function become stabilized.

Successful outcome will not be possible without an appropriately trained team. Before and after the operation, the ward staff must be experienced to deal with general care

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Table 1: Workout and assessment of potential transplant recipients

TOPIC	ASSESSMENT TOOLS
Overall fitness	Full medical examination BM, Glucose, Random Glucose Full Blood Count, Clotting screen Serum biochemistry
Cardiovascular	ECG, Exercise ECG and/or exercise thallium scintigraphy or stress echocardiography in patients with a low exercise capacity. Coronary angiography, CT or MRI
Peripheral Vascular disease	Duplex sonography Pelvic radiography Angiography, CT or MRI
Infection	HBV, HCV, Tuberculosis, CMV and Treponema Pallidum Full medical assessment for foci of infection
Typing	ABO Typing HLA typing Cross matching
Psychological	Able to consent Compliance with therapy

of the patients including fluid and pharmacological management as well as provision of dialysis. Indeed, the immediate postoperative period might be a stormy one – possible bleeding, infection and rejection are the most serious complications.

Almost all live donor transplants achieve “excellent” graft function.⁽²⁾ However, only 30 to 50% of cadaveric transplants achieve this result. The outcome is best with the live donor renal transplant followed by cadaveric and then by Non Heart Beating Donor (NHBD) transplants. 1-year graft survival rates are 95% and 90% for living and cadaveric donor grafts, respectively, with rates of 90% and 80%, at 5 years. Renal allograft half life was 11.6 years for cadaveric transplants and 22.8 years for well matched liver donor transplants.^(1,3,4-7)

Delayed graft function accounts for 10-50 % of kidney transplants⁽²⁾. Renal vascular thrombosis which usually occurs in early post op period ranges from 0.5 to 8% and is the worst complication leading to graft loss. Surgical complications in early post transplant days include bleeding, wound infection, lymphocele and haematoma. Urinary leak from ureterovesico anastomosis site is another important transplant related complication in early postoperative period.^(1,2, 8-12)

As in any form of organ transplantation, rejection is an important and specific complication of renal transplant which usually occurs in the early stage with possible devastating consequences. The overall rejection rate in renal transplant is 20%.⁽²⁾

Complications specific to immunosuppression are increased risk of infection anywhere and post transplant lymphoproliferative disease (PTLD). Skin cancers and Lymphomas are the common malignancies that can occur in post transplant patients.

Late complications include stenosis of renal artery anastomosis leading to hypertension and graft failure, stricture of ureteric anastomosis leading to hydronephrosis and chronic allograft nephropathy (CAN) which leads to a gradual deterioration in graft renal function. Main reasons for CAN are cyclosporine toxicity, or chronic rejection.^(1,2)

Table 2: Demographics of renal transplants for 2006

Transplant Procedure	Number
Adult Kidney Transplants	82
Paediatric Kidney Transplants	9
Simultaneous Kidney Pancreas Transplants (SKP)	6
Pancreas after Kidney (PAK)	1
Total	98

One year mortality rate is about 5% of which 40% has been ascribed to cardiovascular diseases and 30% to infectious complications.⁽²⁾

An experience in Renal Transplant Center, Freeman Hospital

Though a renal transplant unit in a developed country is well established in terms of service, standard and outcome, an example can be seen as a model for any center in the developing world.

In the year 2006, the Freeman Hospital Renal Transplant Unit in Newcastle Upon Tyne, UK, carried out 98 transplants (Table 2 and Figure 1). The mean age of renal transplant recipients was 43 years (range 4 to 68). Male to Female ratio was 1:1.

At up to 1 year follow up, 93 / 98 transplant grafts are functioning. 15 patients had Delayed Graft function (DGF) needing more than one session of dialysis after transplant. 4 patients had early rejection requiring treatment with high dose pulsed methylprednisolone.

Regarding immunosuppression, our unit has the policy of giving IL2 blockers as an induction immunosuppressant just before starting implant. Methylprednisolone 500mg IV is given when the vascular clamps come off after the anastomosis. Then the recipients are maintained on different immunosuppressant depending upon the HLA type and cross matching. The hospital has its own protocol of immunosuppression. We prescribe steroid based immunosuppression along with antimetabolite (Azathioprine for live donor and cadaveric donor transplants; and Mycophenolate Mofetil for NHBD transplants) and Calcineurin Inhibitor (Cyclosporin or Tacrolimus for NHBD transplants and poor HLA mismatch patients), The regime for NHBD transplant is slightly different in the sense that they are subjected to a randomized trial for either Sirolimus or Tacrolimus when serum creatinine comes down below 350.

Indications for renal transplant biopsies are delayed graft function, static or deteriorating renal function as measured

Table 3: Results of transplant biopsies in post-transplant patients

Biopsy result	Number of cases
Acute Tubular Necrosis (ATN)	15
Acute Cellular Rejection (ACR)	6
Acute Vascular Rejection (AVR)	5
Antibody mediated rejection	2
Calcinosis	1
Normal	6

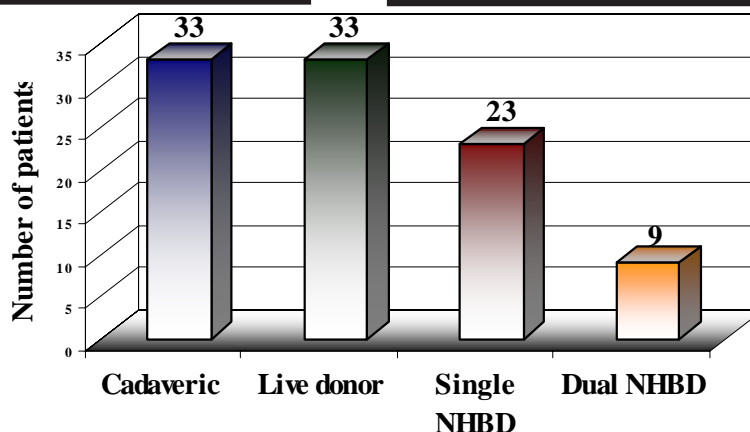


Figure 1: Demographics of donor kidneys for 2006

by failure to decrease or increase in serum creatinine or decrease in urine output. A total of 35 biopsies of the transplant kidney were done for impaired graft function the results of which are shown in Table 3.

Out of the 35 patients having biopsies of the transplant kidney, 9 patients were treated with high dose pulsed Methylprednisolone alone, 1 had Anti-Thymocyte globulin (ATG). 1 had ATG + Plasma Exchange (PE) combined treatment, 2 had ATG + PE + Steroid combined treatment, 2 had intravenous Immunoglobulin and 1 had a parathyroidectomy. No action taken in 19 patients. 6 patients needed repeat biopsies. Of these, 2 had ACR, 2 had ATN and reports were not accessible in 2 patients. 1 needed ATG + FFP + PE combined treatment, 1 had high dose pulsed Methylprednisone, whereas 2 were managed without any medical intervention but data could not be accessed on two patients.

Complications were comparable to data from other regional centers within UK and are depicted in detail in Table 4. In all, 11 patients required further surgical intervention for hydronephrosis (4), lymphocele (2), bowel obstruction (1), intra-abdominal abscess (1), and bleeding (1). One patient required pancolectomy for uncontrolled C. Difficile infection and one patient required removal of the failed graft due to rejection.

The mortality was 4%. Of the 3 transplant recipients: One died of sepsis and CVA, one of Post Transplant Lymphoproliferative Disease (PTLD) with bleeding and Sepsis and no cause were identified at postmortem in the third case. The fourth death was a patient with simultaneous kidney and pancreas transplant who died following arterial anastomotic bleeding secondary to fungal infection.

Context in Nepal

Nepal, an underdeveloped country with more than 25 million population is without any transplant facility in the country yet. Those who can afford to go to neighbouring India have

to spend about £4000-8000 for the procedure. Furthermore, the country's hard hit economy has been further troubled by increasing incidence of ESRD. While the government has been trying to start the transplant programme for the last 5 years or so, it has not been possible despite technical and financial support from WHO.

To attain good results in renal transplantation, a multi-disciplinary team approach is crucial. This requires qualified and highly trained medical and nursing staff which involves a significant initial investment in training and it adds to the cost of immunosuppression and medical therapy. Over the years, most units have developed their own immunosuppression protocols. It is always good to have every unit's own policy to suit its patients. However, we should not forget important factors to be considered while designing an immunosuppression protocol - efficacy, side effects and cost effectiveness. Modern immunosuppressants are very effective in preventing rejection but their high cost limit their use particularly in developing countries.

Infrastructure development has been a challenge and Nepal is in shortage of properly trained manpower. Transplant law has been another hurdle on the programme because of the rule which render the donor surgeon prosecuted if the donor dies within 1 year even when the cause of death is not transplant related.

Equally important in the context of Nepal, because of various cultural reasons, a cadaveric donor programme is a distant possibility. So, a comprehensive live-donor transplant programme should be a starting point. While in Europe cadaveric donation is still the norm, with only 20-25% of live-donor transplants, this trend has been already reverted in the US where over 50% of kidneys come from live-donors. Thus, the advantages of live-donor transplantation (early graft function and overall graft survival) add to the intrinsic characteristics and culture of our country. Once it runs successfully, cadaveric donor and Non Heart Beating Donor (NHBD) programme can be gradually acceptable to the people in order to increase the donor pool.

Table 4 Post-operative complications

	Complications		Number of cases	
Medical complications	Infections	UTI	4	
		Chest infection	3	
		C. Difficile diarrhea	3	
		Septicaemia	1	
Cardiovascular		MI	1	
		AF	1	
		Hypotension	1	
		Post transplant diabetes	2	
		Upper GI bleed	2	
		Skin rash	1	
		Deranged LFT	1	
Surgical Complications	Collection / Abscess Wound related	Infections / dehiscence	6	
		Haematoma	7	
			2	
			Urine leak	2
			Peritonitis	1
			Small bowel obstruction	1
			Intra-abdominal bleed	1
			Pancreatic fistula	1

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The Hepatorenal Syndrome: What's new in 2007?

Dr Dhiraj Tripathi¹, MD, MRCP

Introduction

Hepatorenal syndrome (HRS) is a clinical condition arising in patients with advanced liver disease and portal hypertension. Sherlock, Popper and Vessin in the 1950's emphasised the functional nature of the syndrome and its dismal prognosis. There is a marked decrease in glomerular filtration rate (GFR) and renal plasma flow in the absence of other identifiable cause of renal failure. Marked abnormality in systemic haemodynamics occurs, with activation of endogenous vasoactive systems. Recent revisions to the definitions and current therapy will be discussed (Salerno, Gerbes, Gines, Wong, Arroyo GUT 2007)

Pathogenesis of HRS

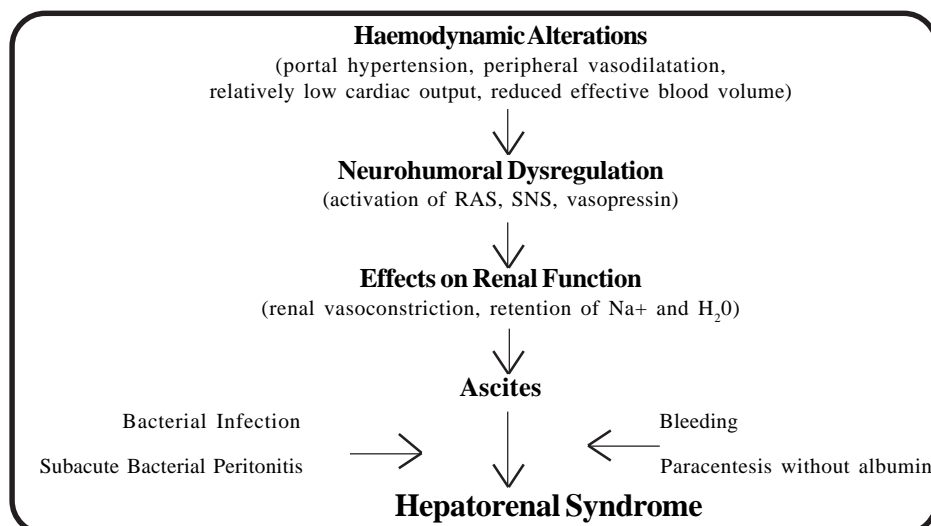
There is disturbance in systemic haemodynamics in portal hypertension; mainly splanchnic vasodilatation leading to a reduction in the systemic vascular resistance (SVR). Local nitric oxide production in the splanchnic circulation leads to resistance to vasoconstrictors. The hyperdynamic circulation results with arterial hypotension and initially a high cardiac

output (CO) state. There is increased activity of vasoconstrictor systems in cerebral, muscular, renal and possibly cutaneous circulations eg. endothelin 1 (ET-1), renin-angiotensin system (RAS), sympathetic nervous system (SNS), and arginine vasopressin (AVP). In end stage cirrhosis insufficient CO (possibly exacerbated by cirrhotic cardiomyopathy and reduced preload from arterial underfilling) and renal hypoperfusion results in the hepatorenal syndrome. The role of precipitants has recently been studied, especially spontaneous bacterial peritonitis (SBP), gastrointestinal bleed, and large volume paracentesis (LVP).

Definition of HRS

Recently the definitions have been revised by the International Ascites Club following a consensus meeting in 2006. Main changes include: (1) removal of creatinine clearance; (2) inclusion of renal failure in the presence of infection without septic shock; and (3) removal of minor criteria. The International Ascites Club revised diagnostic criteria for HRS are as follows:

Pathogenesis of HRS



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1. Cirrhosis with ascites.
2. Serum creatinine >133 $\mu\text{mol/L}$ (1.5 mg/dl).
3. No improvement of serum creatinine (decrease to a level of 133 $\mu\text{mol/L}$ or less) after at least two days with diuretic withdrawal and volume expansion with albumin. The recommended dose of albumin is 1 g/kg of body weight per day up to a maximum of 100 g/day.
4. Absence of shock.
5. No current or recent treatment with nephrotoxic drugs; Absence of parenchymal kidney disease as indicated by proteinuria >500 mg/day, microhematuria (>50 red blood cells per high power field), and/or abnormal renal ultrasonography.

Clinical types of HRS

There are 2 types defined below. Type I HRS prior to the use of vasoconstrictor therapy was universally fatal.

Type 1 HRS

1. 100% increase in serum creatinine reaching a value greater than 226 $\mu\text{mol/L}$ in less than 2 weeks (GFR typically < 20ml/min).
2. Spontaneous or often there is a precipitant (SBP)
3. Reversibility possible without liver transplantation.
4. Cardiac dysfunction and splanchnic vasodilatation
5. Prognosis without therapy is abysmal, with a median survival of 2 weeks.

Type 2 HRS

1. Moderate and steady decrease in renal function not fulfilling criteria for Type 1 HRS (creatinine 133 -226 $\mu\text{mol/L}$).
2. Typically associated with refractory ascites.
3. Better survival than type 1 HRS with a median survival of 6 months.

Therapy for HRS

Vasoconstrictors and Albumin

Current therapeutic strategies are aimed at reducing splanchnic vasodilatation via vasoconstrictors such as vasopressin analogues (terlipressin and ornipressin) and α -adrenergic agonists (midodrine, nor-adrenaline). Terlipressin, the most studied agent leads to a response in up to 65% of patients, but HRS will recur in 20% of these responders (although retreatment is often effective). Albumin is important and can counteract underfilling; albumin may also result in arterial vasoconstriction by binding to vasodilators. Albumin is better than terlipressin alone. There are relatively few RCT's and less experience with type 2 HRS. A recent Cochrane review found that terlipressin reduced mortality by 34%.

Transjugular intrahepatic portosystemic stent-shunt (TIPSS)

TIPSS has been widely utilised for the management of the complications of portal hypertension in particular variceal haemorrhage and refractory ascites. However, the use of TIPSS for HRS has been little studied, with less than 100 patients in the literature. No studies were randomised or controlled. Most studies were in patients with type 1 HRS. There are reports of suppression of the RAS with improvement in of renal function. The use of TIPSS in patients who responded to albumin and vasoconstrictors resulted in increased chance of long term survival in one study with up to 2 years survival. The exact mechanisms are unclear; the relief of portal hypertension and diversion of blood to increase cardiac output and central blood volume has to be balanced against the potential for hepatic ischaemia. At this present time the use of TIPSS for HRS outside of clinical trials is controversial and should be reserved for select groups of patients.

Liver transplantations for HRS

HRS is a strong indication for liver transplantation. After initial reduction GFR improves to 30-40 mL/min at 1-2 months and persists at a reduced level probably due to a degree of nephrotoxicity from immunosuppression. Thirty five percent require long-term dialysis. Post transplant outcome is worse than other groups of patients with more preserved renal function (60% vs 70-80% 3 year survival). One study showed better outcome using terlipressin and albumin pre transplantation. Efforts to improve renal function pre transplantation are paramount.

Prevention of HRS

In SBP, IV albumin (1.5 g/kg b.w. on the first day plus 1 g/kg b.w. on the third day) leads to a 66% reduction in risk of HRS compared with antibiotics alone. There is improved survival (10% vs. 33%), with evidence of marked suppression of the RAS. There are also beneficial effects on systemic haemodynamics.

Summary and final recommendations

Below are the up to date recommendations from the International Ascites Club.

Type 1 HRS

1. The first line of therapy is the use of vasoconstrictors combined with albumin (either salt poor albumin 20% (20g albumin per 100ml) or human albumin solution (4.5g albumin per 100ml))
2. Terlipressin 0.5-1mg 4-6h, doubled every 2 days if >25% decrease in creatinine to 12mg/day); stop if < 50% drop in creatinine after 1 week, or no reduction in 3 days. If response, treat for a maximum of 14 days with particular attention to ischaemic side effects.
3. Albumin (1 g/kg of body weight day, to a maximum 100g, followed by 20-40 g/day.) Discontinue if albumin concentration is >45 g/L and in case of pulmonary oedema. Central venous pressure monitoring is not mandatory, but careful physical and radiological monitoring of the cardiopulmonary function is recommended.
4. Patients with partial or no response to vasoconstrictors may be treated with TIPSS.
5. The sequential use of vasoconstrictors plus albumin and TIPSS in suitable patients is an interesting idea deserving further investigation.

Type 2 HRS

1. There is no definite data to support the use of vasoconstrictors in these patients.
2. TIPSS can be used to improve refractory ascites, which is often associated with type 2 HRS. Data on the effect of TIPSS on survival is still insufficient.

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Thoughts Crop Up in My Mind

Hind Vaidya

Donna moved to Great Ayton after her early retirement. She was a good friend of mine and the Head Teacher of Breakon Hill Primary School where my children used to go. It's not that far from Middlesbrough. However, it made a difference, and we had not seen each other for a while.

It was Saturday evening in December when I went to visit Donna in her new home in Great Ayton. I followed the instructions that she gave me by telephone. As soon as I passed the Great Ayton town Centre, I had to turn left and drive down a narrow bending road and turn third right. Only one house in a huge space! Nearby was a stable. Lots of logs were stacked in front of the house.

I opened the wooden gate and rang the door bell. Donna opened the door, "Hello my dear, so nice to see you." We hugged. "It's nice to see you Donna," I said. "Did you find your way ok?" she asked while showing me the way to the sitting room along the hall. "Yes, no problem. Followed your instructions." Donna's husband, Allen (a retired biology lecturer), was watching TV. "Hello dear, how are you?" he asked with a smile, his attention on David Attenborough who was explaining how the crabs migrate every year in Christmas Island. Nature program, one of my favourites too. "Just a few minutes left, a beautiful program" he said, still watching.

Both seemed to be enjoying their early retirement taken last April. They had been looking after their two year old grand daughter, who was playing with a teddy next to her grandpa. She looked at me, I smiled and said hello, but she looked surprised and shy and went to cling to grandma's skirt.

Donna and I sat on chairs by the fire place. Allen had added some more logs. We had tea with scones and talked about our children. So far so good. After tea, I looked through the window. It was already dark. I saw big trees in the back yard. "What a nice area, very quiet and peaceful," I said.

"Oh yes. We love it here," both said at the same time. "You should come here in summer. We will walk through the moor land and the woods. You will love it. A variety of heather with scattered Crowberry and Bilberry are eye-catching. Moths, dragonflies and butterflies abound too." "The Woods provide shelter for badgers as well as a wide range of birds such as the tree creeper, wood peckers, and owls" Allen added. "I will certainly come, it will be really nice," I said. "Darling, can you show Hind around our house, Jane is tired, I'll let her sleep." Donna picked up her grand daughter, "Come on sweetheart! Mommy will soon be home."

Allen showed me the kitchen and said that they had recently installed new units. "This is my mother's house. We bought a small bungalow for her in the village. I visit her most days" "How old is she?" I asked. "She is 78." He looked at his mum's picture on the wall. "She is keeping well." "She is very brave. Back home we stay together," I said, smiling. "So I've heard. That's brave too," he said.

Then he took me upstairs and showed me the bathroom and master bedroom. "This is Emma's room." He opened the door. I saw something flying inside the room and came out.

"Oh! Not again. An owl's in. The window's open!"

Allen seemed alright. He started to talk to the owl, "why do you have to come inside? You make too much noise at night. Can't you stay in the tree in your own place?"

The owl was sitting on the top of the table looking at him constantly with large fixed eyes and a round face. He went close, got the owl in his hand and let it fly out of the window which he then closed.

My skin crawled. This brought back half forgotten memories of the dark beliefs I had heard in my childhood. Stories of owls as creatures of magic, mystery and evil are known. William Shakespeare's three witches use an owl's wing as a charm. I have also heard that if an owl lands on the roof of your house, it foretells the death in the family. Also they are the agents of witches and the devil. On the other hand, there are stories about the owl being the wisest of birds.

I am not really superstitious. I like bird-watching, but, I never came across an owl inside the house. After that, I lost my interest in looking around the house. Those big steady eyes of the owl were still in front of me.

We went down. Donna had an album in her hand waiting to show me the photographs of their holiday in Spain. I went through the album. The pictures were nice and beautiful, but my mind was occupied by that owl. I told myself that I would not be able to stay in such an isolated house.

"You are very friendly to that owl" I said to Allen.

"Owls are harmless creatures, why not?" he replied

"Owls are watchmen of the night. They feed on small animals and insects, and are useful in pest control," he continued.

"I still don't like the eerie call of an owl in the middle of the night," Donna interrupted.

"Owls are disappearing. We have to protect them," said Allen. The door bell rang, Allen responded. It was Emily to collect her daughter.

* * * * *

It had been a nice evening with Donna and Allen. Back at home, I lay in bed and remembered the owl. After all, owls are no longer a sign of misfortune. They are active at night and hunt for food as we do in the day time. I fell asleep and in my dream I saw my late father, late uncle and auntie. I had a good conversation with my father about my children and about my studies. I was with him in his room. He was working on stamps as he used to do. My father was worried about my brother's long lasting bad cold.

My alarm clock woke me up and I was amazed that I'd seen my late father in my dream, and had a long conversations. It looked so real and true. It did not occur in my dream that he was already dead. Once when I was about 8 or 9 years old, I saw my grandma in my dream, I knew that she was dead and I was running away from her. That had been a nightmare.

A few days later, I heard of the sudden death of Donna's mother-in-law. Thoughts crop up in my mind. Was it a coincidence?

Snakebite in Nepal: The Role of the Anaesthetist

Dr Ramesh Khoju, FRCA

Introduction

Snakebite is an important cause of death and a common, but neglected public health problem in many districts of Nepal, particularly 23 districts in Terai and inner Terai region. Of the 21 species of venomous snakes living in Nepal, the most common species that are found in Terai region includes Cobra, Krait and Green pit viper. Hospital based studies showed that most envenomed patients had signs of neuro-toxicity. The in-hospital mortality amongst those exhibiting signs of neuro-toxicity was reported as 22%-27% (1, 2). A retrospective study of snake bite in children at Lumbini Zonal Hospital reported that 47% of children had respiratory distress (3). The main cause of death, due to neuro-toxicity is respiratory failure. So, immediate ventilatory support is paramount. Anaesthetist can play an important role in supporting airway and introducing artificial ventilation of the snakebite patients with respiratory failure, critical care management, and in airway skill training to other health care professionals and community members.

Magnitude of the problem and Epidemiology

In the late 1980's, it was estimated by WHO that more than 20,000 people are bitten by snakes and 1,000 people die from snakebite each year in Nepal (4). The statistics of "poisoning cases" in Nepal obtained from 'Annual Report 2001/2002' shows that snakebite poisoning accounts for 26.4% of all reported poisonings (5). A community -based survey in 3 districts of eastern Nepal reported annual incidence of snake bite and mortality due to snakebite were 1162/100,000 and 162/ 100,000 respectively and is the highest in Asia (6). The national case fatality rate (CFR) was 19% in the year 2000, while that of 10 hospitals of eastern Nepal ranged from 2.6% to 58 % (7). Data, published by different hospital based surveys showed that snake bite was more frequent between the ages of 11- 40 years and in males(3, 8,9,10).

Snakes of Nepal

In Nepal only 77 species of snakes have so far been identified and 21 species are poisonous. All snakes of poisonous family belong to *elapidae* and *Viperidae* (11). The family *elapidae* includes Cobra, Krait and coral snake, while *viperidae* includes viper and pit vipers.

Table1. Snake ID and Clinical Features

	Cobra	Krait	Russell's Viper
Local pain/ Tissue Damage	YES	NO	YES
Ptosis/ Neurological Signs	YES	YES	YES
Haemostatic Abnormalities	NO	NO	YES
Renal Problems	NO	NO	YES
Response to Neostigmine	YES	NO?	NO?
Response to Anti-snake Venoms	YES	YES	YES

Snake venoms and clinical features

Depending upon the snake, the effects can be local or systemic (Table1). Local effects are mainly due to the action of phospholipases A2 and metalloproteinases. In elapid snake bites, neuro-toxicity is a typical consequence due to the effect of neurotoxins in neuromuscular junctions. The neurotoxins are pre-synaptic i.e. phospholipases A2 that damage nerve endings, initially releasing acetylcholine transmitter, then interfering with release, or post-synaptic: these peptides compete with acetylcholine for receptors in the neuromuscular junction and lead to curare-like paralysis. These toxins cause progressive descending paralysis, which may become life-threatening when bulbar and respiratory muscles are involved. Systemic effects in viperid snake bite, due to the procoagulant enzymes, include spontaneous haemorrhage, disseminated intravascular coagulopathy, and cardiovascular shock secondary to hypovolaemia, vasodilation, and direct effects on the myocardium.

Management of Neuro-toxicity and the role of anaesthetist

Early administration of antivenom prevents respiratory paralysis after elapid snake bite. Patients with the evidence of respiratory insufficiency after neurotoxic venom poisoning require rapid intubation and artificial ventilation. Recently, respiratory support with non invasive ventilation in a snake bite poisoning has been reported (12).

Anticholinesterase agents may help to reverse neuromuscular dysfunction caused and may accelerate recovery. Neostigmine: 50-100 mcg/Kg 4hrly (or continuous infusion) or Edrophonium: 10mg in adult or 0.25mg/Kg in children over 2 minutes (with Atropine or Glycopyrrolate) have been advocated.

Circulating volume repletion and vasopressors are used for treating hypotension, dialysis for renal failure, antimicrobials and tetanus toxoid for infected wounds and surgical debridement for necrotic wounds.

Anaesthetists are frequently involved in airway maintenance and introducing artificial ventilation of snakebite victims with respiratory insufficiency, resuscitation and further critical care management, or management of anaphylaxis due to anti snake venom. In peripheral hospitals immediate availability of the

Table2. Role of the Anaesthetist

1. Respiratory Support and critical care management
2. Training:
 - i) In the community:
 - Basic life Support training for community members
 - ii) To health care professionals (casualty officers, paramedics):
 - Advanced Airway Skills and Artificial Ventilation
 - Advanced Life Support
3. Involvement in setting up national guidelines with multidisciplinary team

anaesthetist is not always possible. So, advanced airway skill and artificial ventilation training to other health care professionals, including casualty officers and paramedics is essential. Anaesthetist can also play an important role in advanced life support training. Basic life support training in the community can reduce the death due to respiratory arrest following the snakebite (Table 2)

Conclusion

Snake bite is a major, but neglected public health problem in Nepal. In hospital mortality due to neurotoxicity is very high following the Elapidae snake bite. The main cause of death, due to Neuro-toxicity is respiratory failure. The anaesthetist can play a vital role in respiratory support, critical care management, life support training and setting up guidelines in the management of snake bite victims.

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Study on Prevalence of Hypertension in Dhulikhel Municipality

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Abstract

Introduction: Hypertension is increasing in middle and low income countries. There aren't many studies on prevalence of hypertension in Nepal. Previous studies in rural/semi-urban Nepal showed a prevalence of 5% and 19%. This study aims to find out the prevalence of hypertension in Dhulikhel municipality, a semi-urban area of Nepal.

Method: This is a cross sectional study. Systematic random sampling of households was done from voters list, and all the members more than 18 years of age were included in this study. They were interviewed and their blood pressure was measured twice using mercury sphygmomanometer in standard method in their home. The average blood pressure was taken for the study. Hypertension was defined as systolic blood pressure of 140 mmHg and/or diastolic blood pressure of 90 mmHg, and/or people already on antihypertensive treatment.

Results: Total number of the study population was 796. Among them 490 (61.6%) were female and 306 (38.4%) were male with age ranging from 18 years to 88 years (mean 48.41±17.38). Overall prevalence of hypertension was 28.9% (male 28.8%, female 29%). The prevalence was increasing with age (11.1%

in <30 years to 44.8% in >70 years). 29.1% were in Pre-hypertensive group according to the JNC 7 classification (Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure).

Conclusion: This study shows that the prevalence of hypertension is high in Dhulikhel municipality, semi-urban area of Nepal.

Limitation: Hypertension was diagnosed with single occasion measurement of blood pressure. More female populations were studied because male populations were mostly out of home.

Keywords: Hypertension, Blood Pressure, Prevalence, Nepal

Study done by Dhulikhel Hospital and Society for Healthy Heart

Notes

Not the complete results.

Full analysis will be done after completing the 2 wards still undergoing.

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A Cervical Grip

Dr Prasanna Gautam, Aberdeen

‘Not a mark!’ exclaimed Nirmala, the midwife. ‘Not a mark!’ exclaimed Nirmala, the midwife.

Elated, I struggled in vain to keep a straight face. The midwife was unaware that I had never before applied an outlet forceps without any expert supervision or assistance. Yet it had turned out to be a near perfect application. It was pure fluke!

‘Thank you’ I said and looked at the newborn. There was a mere faint linear mark over one cheek which would not bruise. It was pink and moved all the limbs; a beautiful baby boy. He cried weakly at first, more like the meow of a disoriented kitten. Naturally his wails became louder and piercing in protest. He had been unceremoniously grabbed by the head and hauled from the comfortable, soft and warm womb of his mother. He made fists in the air and screamed loudly again.

‘I do not think he is thanking me’, I thought.

‘Welcome to our world’, I said to him.

Nirmala knew that I had many patients waiting and offered to finish up with the baby and his mother. Grateful for this support, I hurried back to the outpatients’ clinic.

I was first drawn to the case when the girl, barely sixteen, had not been able to deliver spontaneously. It was her first pregnancy. She had arrived at the hospital about an hour earlier after over two days spent in labour. The village midwife could not cope and in desperation, had set her on a bullock cart to journey twenty five miles to our hospital.

The agonising screams of each contraction had heralded her arrival at the hospital. Nirmala examined the poor girl and started an intravenous infusion of dextrose solution. Once the contractions stopped, exhaustion consumed her and the sobs of pain diminished. The girl had low blood pressure but the foetal heart rate was satisfactory. The head had crowned nicely but she was just unable to push. Nirmala therefore decided that outlet forceps would be necessary to assist the birth.

I was busy in the outpatients’ clinic when Nirmala came to explain the situation. Both Leela and Pushpa, the other two doctors, were away from Dharan that day. Leela looked after the obstetrics and gynaecology patients. I would assist her when she needed help. I did all routine medical work. Pushpa being the senior doctor, a chest specialist and with huge private practice, saw mostly chest patients and dealt with hospital administration. On this occasion I was on my own.

Nirmala was a highly trained and experienced midwife. If it were not for her, Leela would never be able to cope with the work load. So I had no reason to doubt her assessment.

The trouble was that I had never conducted a delivery with forceps.

On route to the labour room, my mind was rapidly delving into the deep recesses of my brain trying to resurface all the memorised information about forceps delivery. It was sheer coincidence that outlet forceps delivery had been the subject of my final year obstetric viva exam in 1969. First, the examiner had asked me the indications. When I had blurted all the conditions, she had asked me to identify the instrument from among the several gadgets laid in front of her on that huge desk. I had picked up the instrument and held each half on either hand.

‘Go on, apply the blades’, she had instructed, pushing a latex pelvis towards me. I did as requested and locked the blades.

‘Now pull out the baby’, she had said.

The textbook procedure was to use both hands, first down, then towards you, and then up towards your chest in a smooth half elliptical arc. I did just that to the smiles of the examiner. I later discovered that she had given me the highest marks for that viva voce examination. Now, five years later, I needed to be certain that I had retained these skills.

“Can you do this in real life?” A frightened untrained young doctor asked himself. I had no choice but to do it and find out.

I could see that Nirmala had made an accurate assessment. Unfortunately, I also found that the foetal heart rate had begun to slow down. There was no time to send her 50 miles to Dr Thapa, the gynaecologist at Biratnagar Hospital. I had no time to waste if the baby was to be saved. I washed, gloved and gowned and perched on a stool facing the birth canal as an expert. I must have appeared as a confident, well experienced obstetrician about to perform a routine forceps delivery. In truth I was shaking in my sandals and silently praying to every deity that I could remember. Miraculously, the procedure was a success. The gods must have guided my hands.

I left Nirmala to continue with the rest of the delivery and hurried back to the Outpatients. The joy of conducting a normal routine delivery is exquisite. The fact that I had been able to intervene with forceps in the nick of time and save the baby made me feel like bursting with joy. I wanted to shout from the rooftops and sing and dance. I wanted to celebrate. But I had to control all these emotions and focus on the rest of my work. It was a hot day in May. I bore the heat until I finished the last of the patients. It was now time to look at the patients in the ward before going for lunch. It was past one pm. I was beginning to feel hungry. A cold glass of beer while waiting for food to be served would be most appropriate and welcome, I thought to myself. Fate, however, had other plans in store.

Nirmala appeared again. She had administered one shot of ergometrine to the new mother but the placenta had not separated. She had tried gentle pulling and put her hand inside but had been unable to feel any point of separation of the placenta. The bleeding had not stopped. She wanted me to assess the patient and perhaps do the manual evacuation.

Aside from a brief internship in a busy labour room, I had very little obstetrics experience. All I could do was perform episiotomies and suture them again very well. I could not remember ever having done a manual evacuation of placenta. I did not know how. I did not tell this to Nirmala. What would be the point?

‘Can we send her to Biratnagar Hospital?’, I asked hopefully. ‘Not really, her people have left’, she explained. The farmer with the bullock cart had to go back to his village for some urgent business. Her mother-in-law is here but we have no transport to send her to Biratnagar. We will have to do whatever we can.’

Back to the labour room again I went. I saw the poor girl totally exhausted looking pale and with a rapid weak pulse. The haemorrhage was significant and she was nearly in shock. I changed the infusion drip to a normal saline. Donning a pair of gloves I examined her. The cervix was still open. The stump of the umbilical cord was hanging out whilst its proximal end disappeared into the uterus. A bimanual palpation squeezing the uterus from above produced about an ounce of dark blood. She was bleeding profusely.

I was making these observations with only half of my brain. The other half was desperately trying to remember the causes of non separation of placenta, post partum haemorrhage and its treatment. I was sure that I could not operate. I had to find a way to treat her medically and mechanically. What was I supposed to do?

I gave her one more shot of ergometrine, then scrubbed, gowned and gloved. Very gently, I inserted my hand into the uterine cavity. I felt all over for a breach in the placental attachment but could not find one. Something gripped my wrist as though preventing me from exploring it any further. It then dawned unto me that the cervix was beginning to contract. The uterus was still flaccid. If I removed my hand, the cervix would close and all the blood would accumulate inside the uterus. Placenta was still attached firmly. The woman would surely die. All these possibilities flashed through my mind. I panicked.

‘Oh Dantakali, guide my hand’, I prayed silently.

The cervical grip over my wrist had become quite firm. I decided to give her a third shot of ergometrine in the hope that the uterus would somehow contract. It was a dangerous drug with horrible toxic effects but I could think of no other drug that would stimulate the uterus in such a manner. I felt that I had no choice. I kept my hand within the womb and waited. About five minutes later I decided to dig gently with my fingers along the placental border. At last a breach was found. I inserted my little finger and gently advanced it into the breach. I began to break the adhesions. I was also gently pressing upon the body of the uterus from above with my left

hand.

The cervix now responded more violently, gripping my right wrist in a vice. My fingers, however, were still mobile, and this was my primary concern. I continued. My little finger began to hurt. The hand started to get mild cramp. But I had to continue until all of the placenta had been separated. It took a long time to separate. At last, I could not feel any adherent portion. The whole of the placenta must have separated. I had to get the whole thing out quickly otherwise it would complicate matters further.

I grabbed as much of the placenta as I could and tried to pull my fist out of the body of the uterus. It was impossible. The cervix had become too tight and narrow. I tried gently increasing the force of pull, yet still there was no give. I had to let go of the placenta. I barely managed to pull my hand out. The cervix was virtually closing in front of my eyes.

The umbilical cord provided a little hold and, hoping that that would not snap, I began to pull at it gently. Slowly, it brought the placenta. I examined it. It had a few raw surfaces over some of the cotyledons from where the villi had deeply penetrated into the uterine wall. It was probably only a partial placenta accreta. She would have needed hysterectomy if it had been a complete accreta. I breathed a sigh of relief.

‘She should not bleed much any more. Leela can assess her tomorrow’ I told Nirmala, wiping my brow with the folds of the surgical gown. I started to massage my wrist. I could have never imagined that the cervix could grip with that intensity. The new mother was lying almost comatose with exhaustion and relief. The baby was neatly tucked away in a small cot. He was not shouting or making fists now that he had reconciled with his predicament. It was all peaceful. Nirmala beamed at me again. A young mother had been saved.

My legs were shaking and I felt totally drained. I still had the ward round to do. I walked out towards the inpatient block. The cold beer would have to wait.

Notes:

Accreta, a type of abnormal placenta (afterbirth)

Cervix, the neck of the womb

Cotyledons, segments of the placenta, afterbirth

Crown, when the scalp on the baby’s head first appears into the birth canal

Dantakali, the legendary goddess who protects people of Dharan

Episiotomy, a small slitting of the skin surgically to widen the birth passage

Ergometrine, a powerful drug given to stimulate contraction of the womb

Hysterectomy, an operation to remove the womb

Placenta, afterbirth

Post partum haemorrhage, a condition of excessive bleeding after the birth of a baby

Suturing, sewing

Umbilical cord, the cord that joins the baby’s navel to placenta in the mother’s womb

Uterus, the womb

Villi, fingerlike processes which help the afterbirth to remain firmly attached to the womb

10 Steps to Healthy Living

Dr Satyan Rajbhandari, Chorley

The three keys to healthy living are eating the right food, being active and regular medical check ups. A healthy balanced diet contains a variety of types of food. These include lots of fruit, vegetables and starchy foods such as wholemeal bread and wholegrain cereals; some protein-rich foods such as meat, fish, eggs and lentils; and some dairy products. Physical activity is a good way of using up extra calories which helps control your weight. People who exercise regularly have a much lower risk of premature death through heart attack. This is because exercise helps to increase good cholesterol, regulate blood pressure and improve circulation. Similarly if you are above 40 you are at risk of developing diabetes, high blood pressure and heart attack. Therefore you need to have a regular health check up and treat these problems as soon as they develop. Early detection and good control of these diseases will help you lead a normal life.

Here are 10 tips for healthy living.

1. Choose healthy snacks

Choosing the wrong snack is the most common reason why people put on weight. Being overweight can cause diabetes and other health problems. Looking at 100 gram servings, a vegetable samosa contains 252 Kcal and Walker crisps contains 525 Kcal. Why not choose a healthy alternative like an apple (56 Kcal) or banana (153 Kcal). Remember your five portions of fruit or vegetables per day!

2. Know your calorie requirement

The amount of calories you need depends upon your age, sex, height, body weight and activity level. An average man needs between 2000 – 2500 Kcal and a woman needs 1500 – 2000 Kcal every day. Anything more will accumulate as fat and anything less will lead to weight loss. If you eat one extra samosa everyday, you will put on about 11kg additional weight in one year. Similarly if you stop eating a 25 gm packet of crisp daily for one year you will loose about 6 kg in weight.

3. Do not skip meals

Regular meals are important to lose weight as more energy is used to digest several small meals than food eaten all at once. Missing meals doesn't help you lose weight and it isn't good, because you can miss out on essential nutrients. Research shows that eating breakfast can actually help people control their weight. This is probably because when you don't have breakfast you are more likely to get hungry before lunch and snack on foods that are high in fat and sugar, such as biscuits, doughnuts or pastries. So why not go for a bowl of wholegrain cereal with some fruits and a glass of fruit juice for a healthy start to the day?

4. Know your fats

The major kinds of fats in the foods we eat are dietary cholesterol, saturated, unsaturated, and trans fatty acids. All of these raise blood cholesterol except unsaturated fats, which lower cholesterol. A high level of cholesterol is a major risk factor for coronary heart disease and strokes. All fat, whether they are good or bad, have very high calorie and if you want to lose weight, their intake should be limited.

Unsaturated fats are better, especially if used instead of the other fats. Polyunsaturated oils are always liquid even in the refrigerator, and are better at lowering cholesterol than monounsaturated fats. Common sources of polyunsaturated fats are safflower, sesame, soy, corn and sunflower-seed oils, nuts and seeds. 'Vanaspati Ghee' which is widely used in Nepali cooking involves the change of a liquid oil, naturally high in unsaturated fatty acids, to a more solid, more saturated and unhealthier form. Therefore, it is much healthier to cook with vegetable oil rather than 'Vanaspati Ghee'.

Here are a few tips to cut down fat:

- ◆ Choose lean cuts of meat and trim off any visible fat.
- ◆ When you're choosing a ready meal or buying another food product, compare the labels so you can pick those with less total or less saturated fat.
- ◆ Measure oil for cooking with tablespoons rather than pouring it straight from a container.
- ◆ When you're making sandwiches, try to use reduced-fat spread and spread it thinly.
- ◆ Choose lower fat versions of dairy foods like semi-skimmed or skimmed milk, reduced fat yoghurt, lower fat cheeses.
- ◆ Use low fat yoghurt in your cooking. This will reduce the need for oil or cream in the recipe.

5. Every little exercise helps

Becoming active benefits your health and helps you lose weight. Moderate exercise for half an hour 5 times a week can bring enormous health benefits like preventing diabetes. At any age, increasing your daily activity, even by a small amount, can make a huge difference. Here are various ways you can be active.

Walk! Get off the bus or train a stop or two before your destination, park in the furthest space in the car park, avoid lifts, and walk to the local corner shop for your newspaper or milk. You can do housework, garden or play with the kids. Try a sport! They all help burn calories. 15 minutes of brisk walking will burn 60Kcal extra i.e. 3 kg weight loss in a year!

Don't watch too much television. Sedentary activities like watching television or using the computer means you burn a lot less calories. 2 hours of television a day will retain 120Kcal (6 kg weight gain per year) and if you nibble on 50 gram Bombay mix in that time you add 12kg weight to a total of 18 kg weight gain per year!

Approx Calories Burnt By 75kg Person In 1 Min (Kcal/min)

Brisk Walking	4	Swimming	6
Running	8	Aerobics	4
Yoga	2	Dancing	3
Hoovering	3	Gardening	3
Watching TV	1	Sleeping	1

6. Eat less salt

Too much salt can raise your blood pressure which can lead to heart disease and stroke. Three-quarters of the salt we eat comes from processed food, such as some breakfast cereals,

soups, sauces, and bread. Remember, bottled pickle and ready meals have very high salt content. You should not take more than about a teaspoonful of salt every day. This is not a large amount, especially when you consider that 75% of the salt we eat is already in everyday foods. If you are not sure, look at food labels. Babies and children need even less salt.

7. Carbohydrate, Fibre and Sugar

Carbohydrates give energy and are an important component of your food. Carbohydrate can be in the form of sugar, which gets absorbed very fast or starchy food which is absorbed slowly. Starchy foods such as bread, cereals, rice, pasta and potatoes are a really important part of a healthy diet. Try to choose wholegrain varieties which contain more fibre and calcium, iron and B vitamins. You also digest wholegrain foods more slowly so they can help make you feel full for longer and help you avoid snacks.

South Asian people eat too much refined sugar in the form of sweets such as Laddoo, Halwa, Gulab Jamun, Jalebi, etc. These sweets have very high content of sugar and fat so should be avoided or reduced. Having sugary food and drinks can often cause tooth decay, especially if you have them between meals. Cutting down will also help reduce your weight.

Tips for cutting down

- ◆ Have less sweets. Start by taking half your normal amount and reduce it further.
- ◆ Instead of fizzy drinks and juice drinks, go for water or unsweetened fruit juice (remember to dilute these for children). If you like fizzy drinks then try diluting fruit juice with sparkling water.
- ◆ Try to reduce adding sugar to your tea or coffee. One teaspoon of sugar contains 25Kcal and if you stop adding sugar, you will lose 5 Kg in weight in a year if you usually drink 4 cups daily.
- ◆ Try a low-fat spread, sliced banana, or low-fat cream cheese instead of jam or butter.
- ◆ Choose wholegrain breakfast cereals.

8. Fast food, Takeaway and Eating Out

These are all high in fat, calorie and salt content so avoid as far as possible. On average one burger or standard curry takeaway dish contains about 450 Kcal. You need to add further calories to account for accompanying chips, naan or fried rice. Why don't you make a sandwich or chapatti wrap with interesting fillings such as leftover meat/vegetables with salad? You don't even have to cook for it!

When going out for a meal on special occasions, drink water, diet soda, or unsweetened tea or coffee instead of regular soda or alcoholic beverages. This will save a lot of calories. Share a starter and a dessert with a friend. Stop eating when you are full — listen to the cues your body gives you. Do not be shy to take the remainder of your meal home as you have already paid for it. This can serve as a second meal the next day. (Two meals for the price of one!) Look for items on the menu that are baked, grilled, dry-sautéed, boiled, poached, or steamed. These cooking techniques use less fat in the food preparation and are generally lower in calories.

9. Know your potential health problems

If you are South Asian in origin, you have high risk of developing diabetes and heart disease, even higher if someone in your family has such problems. Early detection

and treatment of these conditions can control these diseases and help you lead a normal life. You should have a health check up every two years between ages 40 and 49, and yearly after 50 even if you are healthy.

10. Drink plenty of fluid

Water makes up about two-thirds of our body weight and it is important for this to be maintained. Therefore you should drink approximately 1-2 litres (6 to 8 glasses) of fluid every day, and more in hotter climates or when exercising. One of the first signs of dehydration is feeling thirsty. You may have headaches, lack of concentration, be irritable and pass dark coloured urine. As mentioned above, some drinks may have high sugar content with high calorie and may also damage your teeth. Similarly tea and coffee are also fluid but they have caffeine which is a mild diuretic causing body to make more urine.

Milk and water are the best source of fluid.

Recipe for Vegetable Pakoda

(Tarkariko Pokora) Hind Vaidya

Ingredients:

- (a) ½ lb (250 g) broccoli, cut into thin slices, discard stalk
- 1 medium onion, cut into thin slices
- 3-4 mushroom, cut into thin slices
- 200 g (1 pack) bean sprouts
- ½ red pepper thinly sliced
- 2 potatoes, peeled and grated
- 2 spring onions, roughly chopped
- 1 tbs chopped fresh coriander leaves
- (b) 1 egg
- 1 tsp salt
- 1 ½ tsp tandoori powder
- ½ tsp turmeric powder
- ¼ cumin powder
- ¼ whole cumin seeds
- 3 tbs sesame seeds
- 2 tbs vegetable oil
- ¼ chilli powder
- (c) 1 ½ cup gram flour
- 2 tbs water
- (d) Vegetable oil for deep frying

Put all the chopped vegetables in a mixing bowl (a). Add all the ingredients from (b) and mix it well with a wooden spoon. Add gram flour and mix it all. Flour will just coat the and loosely bind the vegetables. Add water little by little as batter should not be runny. This is the pakoda with more vegetable than the batter.

Put oil about 1 ½ inch deep in a frying pan and heat. As soon as oil starts to fume, drop in a table spoonful of mix in. Fry them until they are light brown. You may need to turn once. When they are done, remove with a perforated spoon. Drain and put in a tray lined with a kitchen paper. Repeat the process with rest of the mixture.

Transfer all pakoda in a serving dish and decorate with lettuce leaves and cucumber slices around. Serve with green sauce, sweet and sour sauce and yogurt sauce. You can accompany with pappadum and serve as snacks with drinks or as a first course individually.

Serves 4-6

Yoga - Review of Pranayama and Ashanas

Dr Chuda Karki

Yoga is an ancient science and way of life which has been described and based on the personal experiences of the sages.

The word yog or yoga comes from the Sanskrit word “yuj” meaning to yoke, join or unite with the source of our being. It is the union of all aspects of an individual: body, mind and soul.

Pranayama is the science which imparts the knowledge related to the control of Prana, life energy force, that deals with breathing.

Breathing is one of many exercises for pranayama.

Breath is the fly-wheel of the body machine. Breath is the portal of entry for control of the autonomous nervous system and mind.

The philosophy of yoga is sometimes pictured as a tree with 8 branches.

1. Pranayama (Breathing exercises)
2. Asana (Physical postures)
3. Yama (Moral behaviour)
4. Niyama (Healthy habits)
5. Dharana (Concentration)
6. Pratyahara (Sense withdrawal)
7. Dhyana (Contemplation)
8. Samadhi (Higher consciousness)

There are several types of yogas including hatha yoga, karma yoga and bhakti yoga.

I would like to share with you my experience of yoga based on Swami Ramdev's teaching. Swami Ramdev has promoted yoga as a part of health awareness and health living campaign and simplifying yoga and bringing it to the common man. His vision and objectives are:

1. To make a disease free world through a scientific approach to yoga.
2. To establish a new world health organisation.
3. To establish prana (breath) as medicine for the treatment of all diseases.
4. To propagate pranayama as “free” medicine across the globe.
5. Making the world peaceful and tranquil place by using yogic techniques.

Yoga has been practiced for thousands of years but the credit goes to Baba Ramdev who has given a new birth to yoga by bringing it to the public and benefiting people across the globe. He has revolutionised yoga and has brought awareness of the benefits of yoga in curing diseases and improving health. His extensive teachings are outlined in his books entitled ‘Yog Its Philosophy and Practice’ and ‘Pranayama Its Philosophy and Practice’. You may also wish to visit www.pypt.org and www.divyayoga.org.uk for the up to date news and events and information.

SWAMIRAMEDVJI'S YOG: THE WAY TO GOOD HEALTH

Healthy living through yoga and pranayama

Having attended the first U.K. Shivir conducted by Swami and undergone a Teacher Training Programme in Haridwar taught by Baba himself. I will briefly outline and share my experience with you. The regime consists of seven breathing exercises (Pranayama) seven asanas (Physical postures) and light exercises. By correctly undertaking these breathing exercises, oxygen is pumped to each cell of the body revitalising each organ of the body. By breathing out, you are also cleaning each part of the cell, and hence the organ affected.

We are hoping to do some demonstration in the practice of pranayama and asana at our NDA meeting in Aberdeen.

PRAYANAMAS

SOME RULES FOR PRAYANAMAS

1. Select a clean and quiet place for doing pranayama either outdoors or indoors.
2. Sit either in padmasanas, sidhdhasana, or bajrasanas whichever you find convenient. The seat or the cloth which you use must be a non-conductor of electricity.
3. Act of respiration has to be only through the nose and not through the mouth.
4. Pranayama should be performed 4-5 hours after taking food. It is best to practice pranayama in the morning after finishing daily routine acts. In the beginning pranayama should be done for 5-10 minutes gradually the time may be increased to half or an hour.
5. Keep your mind calm and composed. Take breaks if you feel tired.
6. Practice of Pranayama should be done slowly without any haste, with confidence and prudence.

TYPES OF PRAYANAMAS

1. Bhastrika Prayanama: Sit in a comfortable meditative position. Breathe in through both the nostrils forcefully till the lungs are full and the diaphragm is touched. Breathe in and out forcefully. Those suffering from high blood pressure or heart disease should not do this pranayama at a fast rate. Diseases like cold ,allergies, asthma, sinus problems can be cured. Lungs become strong and health is improved. This pranayama also calms the mind and is helpful in awakening of Kundalini Chakra.
2. Kapalbhati: Kapala means forehead and bhati means light, hence kapalbhati refers to that exercise which makes the forehead luminous. In this pranayama attention is given to the act of forceful exhalation. Do not try to inhale, concentrate only on exhaling (as if you're trying to expel a foreign body lodged in your nostril). You can put your hands on your tummy to ensure it is tucked in while you're exhaling the air forcefully. Other simple way to ensure you are doing this pranayama correctly is to say “ha” while closing the mouth. This pranayama should be done about one stroke per second. Try

to do it for 5 minutes at the beginning and then at 5 minutes intervals gradually building up to 15 minutes. You can do light exercise in between if you feel tired. At the beginning you may feel little pain in the back or abdomen but this will disappear after a few days of doing this exercise. This pranayama causes blood to gush down your abdomen and then to your head which makes one feel light and luminous. This pranayama is beneficial in overcoming obesity, in reducing blood sugar, hypertension etc. It also helps organs in the abdominal cavity which tends to function more efficiently if this exercise is carried out regularly. It also strengthens the intestines and improves digestion.

3. **Bahya pranayama (with Kapalbhatribandha):** Sit in a comfortable position, breathe out as much as possible. Do (mulabandha, uddyanabandha and jalandharbandha) simultaneously keeping the breath out. Keep yourself in this position for as long as you can. Expel air out touching chin to chest and hold. Squeeze stomach completely inward and hold for a while. Constrict anal and bladder sphincters. When you desire to breathe in do so slowly, unlocking all the bandhas. Begin breathing normally retaining the breath in. Do this 3-4 times.

This pranayama is harmless and helps to calm the mind improves digestion and is beneficial in all kinds of abdominal ailments.

4. **Anulom- vilom pranayama (alternate nostril breathing):** Hold your right nostril with the right thumb and breathe in from the left. Now open the right nostril and close the left nostril with the second and third fingers and breathe out from the right nostril. Again breathe in from the right nostril and close the right and open the left and breathe out and breathe from left nostril and so on. Breathe into the lungs and not into the stomach. Do this pranayama slowly and rest whenever you feel tired doing light exercises in between. Begin for 5 minutes and gradually build up to 15 minutes.

Regular practice of this pranayama has the capacity of cleansing the entire channel through which the Prana flows in the entire body which makes the body healthy, lustrous and strong. Blockage of the arteries of the heart is removed and the circulation improved with the regular practice of this pranayama. Cholesterol is also reduced. Negative thinking is replaced by positive reproachful life. Regular practice will awaken Kundalini chakra.

5. **Nadi Shodhan Pranayama:** Close right nostril and inhale slowly through the left nostril as deeply possible. Retain the inhaled air according to your capacity. Do Mulbandha and Jalandhara bandhas simultaneously. Unlock the bandhas and breathe out completely but slowly through the right nostril. Repeat this exercise as many times as you can.

6. **Bharaamari Pranayama:** Close your ears with your thumbs put your index fingers on your forehead and rest the three fingers on the base of the nose touching your eyes. Now breathe in till your lungs are full of air. Slowly breathe out through your nose humming like a bee with the mental recital of AUM. The vibrations created will stimulate the base of the brain stimulating the hypothalamic area. Try and practice this for 10 minutes daily. It is particularly beneficial in relieving mental tension and stress and to help meditate.

7. **Udgeeth Pranayama/OMKAR JAPA.** Breathe in deeply and chant Om kar OOOOO m (long O and small m) Ah oo ma. Om is a Primordial sound which emits vibrations. The vibrations can work upward from your lower back to the base of the head and awakens the Kundalini Chakra (coiled unspent

energy). The only way to awaken this vast reserve of energy within our body is by regular practice of Pranayama.

8. Other Pranayama which are useful in the cure of diseases are listed below :

Suryabhedhi or Suryang Pranayama, Chandrabhedhi or Chandrang Pranayama, Ujjayi Pranayama, Karna-Rogantak Pranayama, Shitali Pranayama, Sitkari Pranayama, Murcha Pranayama, Plavini Pranayama, and Keveli Pranayama. If you cannot find time, regular practice of Kapalbhatri and Anulom vilom is sufficient to keep you healthy. If you want to cure some of the ailments you may be suffering from I would urge you to refer to Swamiji's book mentioned above and follow his instructions.

LIGHT EXERCISES

Light exercises are recommended for maintaining healthy joints and providing strength, agility and can be done in between pranayama. They can be done individually when you feel tired. These exercises can be started from the eyes and systematically worked down to the toes. Space does not permit me to give details here but will bring some handouts in Aberdeen.

These exercises can be started from and worked down to the lower parts of the body starting from the eyes, neck. There are tailor made exercises for the heart, cervical and shoulder pain, for the elbows, for the hands, cervical spondylolysis and frozen shoulders, for the fingers of the hands, for the stomach and waist, for the knees and hips, for the heels feet and toes. These are beautifully illustrated in Swamiji's book.

ASANAS

Asanas are the postures formed by the practitioner under the guidance of a yoga teacher. There are thousands of different asanas. Regular practice of half a dozen asanas can keep you fit and healthy and also reduce obesity hypertension and diabetes. For those who want details, refer to Swamiji's book. I will be sharing with you some half a dozen Asana which I found easy to master and practice in Aberdeen.

If you are interested in learning about the ancient art of Pranayama (a series of breathing techniques) combined with Asana (postures) and light exercises why not join Mrs. Asha Sharma, Gita Dhital, Anju Karki and me at our NDA meeting in Aberdeen. We will share our experience about Yoga and will be happy to demonstrate some easy steps for you to acquire our ancient art of yoga and Pranayama. We all attended Swami Ramdev's first conference on yoga in the UK. We also travelled to Haridwar and have undergone a Teacher Training Programme conducted by the Swami himself. Unfortunately Mrs Ratna Karki who was the fifth member to be trained will not be with us in Aberdeen. All of us have been practicing Yoga regularly and teaching.

Many ordinary people from all walks of life have benefited by practicing these exercises which do not cost anything except your determination and motivation to learn these techniques, in order to lead a healthy fit and purposeful life.

OM

Psychiatry Section NDA Annual Report 2007

Dr. Chuda Karki, General Secretary
Psychiatry Section NDA (UK)

NDA (UK) Psychiatric Section was inaugurated on 22nd October 2005. The main goals of this section are:

- To provide professionalism and cohesiveness among Nepalese Psychiatrists in the UK.
- To help aspiring Psychiatrists in establishing their careers in British Psychiatry.
- To establish Regional, National, and International Links with other Psychiatrists
- To establish funds to award Psychiatrists making significant scientific contributions and services to Nepalese Psychiatry.

The following were elected office bearers:

- Dr Arun Jha: Chairman
- Dr Shisir Regmi; Vice Chairman
- Dr Chuda Karki: General Secretary

Twelve Nepalese Psychiatrists working in the UK, five of whom are Senior Consultants, attended the inaugural meeting. Dr. Madan Sharma Chairman of NDA, Dr. Afzal Zaved chief guest and Deputy Registrar of the Royal College of Psychiatrist and General Secretary South Asian Forum and Mental Health and psychiatry attended the inaugural meeting along with many other prominent NDA members.

Some Activities and Highlights of the Section:

- 19-21 Jan 2006. Charitable Mental Health Camp organised by Janakpur Red Cross Society and NDA (UK) in Janakpur. Dr. Jha initiated, planned and carried out this camp engaging local Nepalese Psychiatrists. A large number of Nepalese benefited, and the camp got wide positive press coverage.
- 19th March 2006. Executive Committee Meeting.
- 8-10 June 2006. Midland Psychiatric Research Group co sponsored by World Psychiatric Association (WPA). Drs Jha, Regmi and Karki attended this meeting. Activities of NDA were shared.
- NDA AGM Section Psychiatry Meeting 29th July 2006 Watford, attended by eleven Psychiatrists.
- 9th September 2006. A Great Partnership a joint meeting of BIPA, BAPPA, SLPA, BAPA and the Royal College of Psychiatrist was held in London. Drs Jha and Karki attended. NDA Section Psychiatry was welcomed as a new member.
- 17-19 November 2006. Dr Jha attended the 2nd SAARC meeting held in Kathmandu and propose the creation of SAF (Nepal) Chapter.
- 15-19 February 2007. WPA Section on Psychiatry in Developing Countries First International Conference in Lahore Pakistan. Dr Karki and Dr Jha attended. Dr Jha tabled a proposal paper entitled 'SAF (Nepal) Community Mental Health Project 2007'. These far reaching proposals, if adopted will help Nepal modernise its Mental Health Programme.
- 8th May 2007 SAF (Nepal). Dr Jha witnessed the birth of Nepal Chapter at a meeting in Kathmandu. The constitution of Nepal Chapter has now been agreed and affiliated to its International body. Four NDA members have already applied to be Life Members of this Chapter.
- 14-16th June 2007 Midland Psychiatric Research group co sponsored by WPA. Drs Regmi, Karki, Jha and Dhungana attended this meeting along with Dr Shyangwa from Dharan,

Nepal, who had been nominated by our section as 'The Nepalese Psychiatrist of the Year 2006'. He was handed a certificate by the president elect of WPA, Prof Mario Maj at this International meeting. The Section was able to arrange sponsorship for Dr Shyangwa's visit to UK with Dr Jha personally contributing towards a part of the airfare. Visits were organised for Dr Shyangwa to see Psycho geriatric services provided by Dr Jha in St.Albans, Learning Disabilities services provided by myself in Braintree and Adult psychiatric services provided by Dr Regmi in Wolverhampton. We have received very positive feedback from Dr.Shyangwa who found his brief exposure to British Psychiatry very valuable. He is keen to start some joint research Projects with our Section.

- Other activities: Dr Ghana Chapagain, Psychiatrist from Australia, has sent emails appreciating the initiative of this Section and his willingness to cooperate and share views about his many projects in Nepal and Australia.
- The Section has also campaigned and lobbied to create a separate Mental Health Division or directorate within the Department of Health and Ministry of Health in Nepal.
- We have managed to get sponsorship for registration and accommodation for two Nepalese Psychiatrists to attend the first world congress of Asian Psychiatry in Goa in August 2007. Dr Chuda Karki has contributed towards the cost of registration for one aspiring young Nepalese psychiatrist to expose him to an International Psychiatric meeting.
- Dr Jha is hoping to go to Nepal again in September 2007 to continue to work with our colleagues in Nepal to raise awareness of Mental Health at a National level.
- Dr Arun Jha has worked tirelessly and deserves the credit of putting our Section on the International map. He has forged close links with SAF, WPA, PAN and many other bodies. He also maintains close contacts with Psychiatrist in Nepal and travels frequently to Nepal to maintain these links.

Numbers

**Pramesh Khoju-Shrestha
Grade 4, Newcastle upon Tyne**

4...3...2...1

Numbers I love,

I don't know why I love them,

But I just do.

Numbers are great,

You can do everything,

Subtract...Add, Multiply,

Last but not least,

Just divide.

Do anything you want with them,

There are decimals, percentages,

Ratio too,

Don't forget fractions and

algebra too.

Numbers are great,

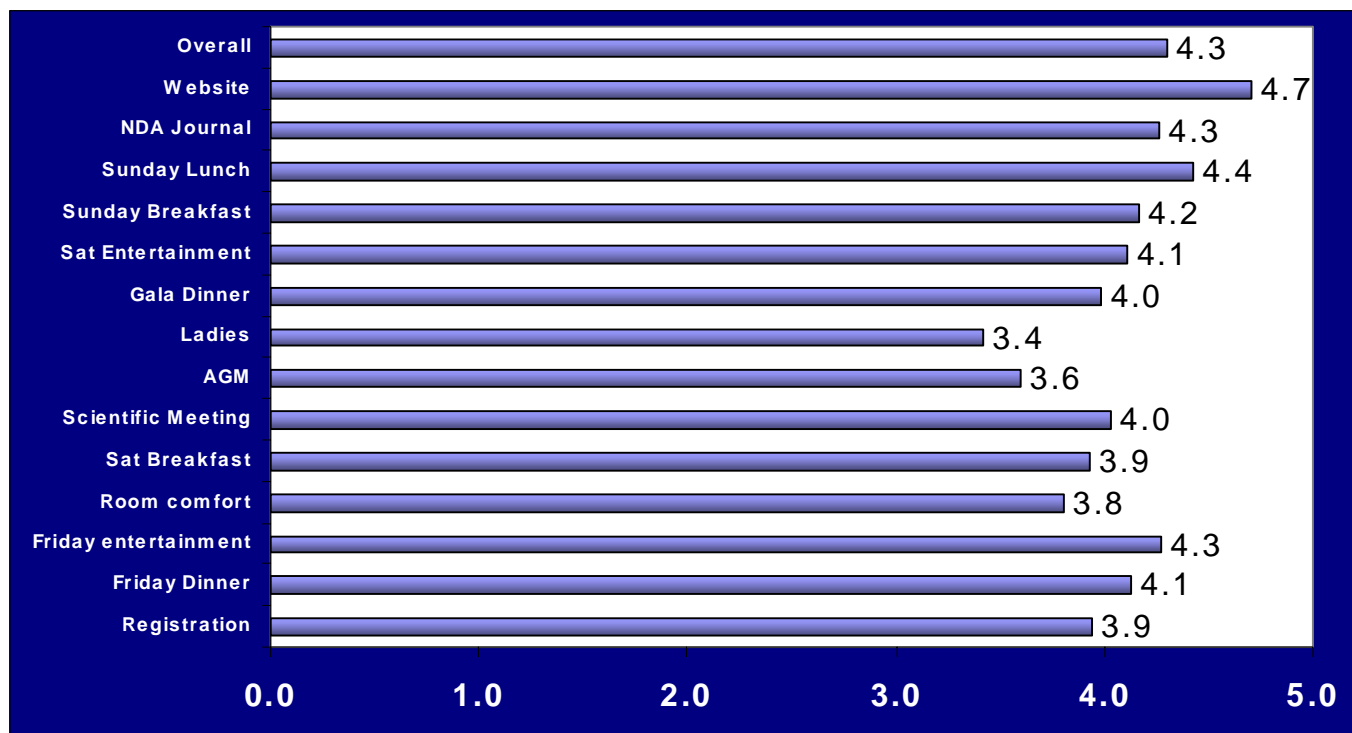
There's no limit to what you do,

So why hate numbers,

They're the best things in the world!

NDA AGM Watford, 2006 -- FEEDBACK

Dr Dhiraj Tripathi, Edinburgh



Feedback Summary

We got a good response with 51 forms returned compared to 44 last year. The overall score of 4.3 is the best yet, and much better than 3.7 last year. The organising committee must be congratulated for all their efforts in making the AGM such a success. Main points from the comments:

1. There was a roughly equal distribution of 18-40 and 40-65 age groups.
2. Of those that expressed a preference (n=20), twelve (60%) would prefer a hotel as the next venue rather than a university. However, a lot did not mind.
3. There was some criticism regarding room comfort relating to noise and the heat.
4. The disco was criticised for being too loud and not including enough Nepali music.
5. Praise for overall organisation, although one or two comments relating to AGM not being well controlled or balanced, and poor timekeeping.
6. Vegetarian dishes came in for one or two negative comments.

Away With The Wind

Taya Rai

Flying, soaring high, spreading my wings and
being what I want to be,
Looking down at the world, at the oceans, at the deserts,
at the jungles and at the people,
If I want to,

Being angry, being fast, being furious and
showing my rage,
or being calm, being light and being elegant,
If I want to,

Sometimes lost in myself but sometimes concentrating
so hard that everything just disappears,
If I want to,

Yes I am strange, I am wild and I am finding it difficult
to explain myself but
What do you think I am. . . ?
Do you give up?

I'll tell you,
I am . . . Imagination!!!!
But I can be anything I want to be
If I want to!

Taya wrote this poem last year when she was 11, and won the Annual Welsh Young Writers Poetry Competition. Well Done!

Please hand in your feedback form this year as well!

N D A (UK) ACCOUNTS --Treasurer's Report 2006/2007

Dr Ramesh K Khoju Shrestha, Treasurer

BANK ACCOUNTS

Currently, NDA has three accounts: **Current & Charity accounts** in Barclays bank, and the **higher interest** account in Alliance and Leicester where the benevolent fund and Life members' fees have been deposited. All the other previous accounts have been closed and money has been deposited in Barclays charity account. Executive committee has also decided to deposit drug company donation money to charity account, not to be used in the running cost of the AGM or other NDA activities.

MEMBERSHIP

Following the 21st AGM's decision at Watford, the ordinary member's fee has been increased to £25.00 and Life member's fee to £250.00. NDA would like to request to update the standing order, if you have not done it yet.

CHARITY FUND

There had been an overwhelming response from members at 21st AGM last year, to contribute towards the charity fund. We were able to collect £2016.00, including raffle sale, for the charity fund. NDA heartily thanks all the members for their kind and generous contribution, and do keep the donations pouring in.

RESEARCH GRANT

This year we also have supported (£432.00) a study on 'Prevalence of Hypertension in Dhulikhel Municipality' in Nepal. Details of the study proposal can be found in NDA web site and an abstract of the preliminary report has been published in this journal.

I am pleased to announce the review of NDA finances, 2001 to 2006 (audited accounts), in two tables on the next page.

Darkness? ... Brightness!

Milan Piya

Darkness, coldness	The chaos above
Creeping around	Hate and violence
Icy fingers	The state of the world
Pull me down	Shows man's incompetence
Eyes can't see	Where man kills man
Vision is blurred	Disrupts harmony
Ears are closed	In the name of God
Nothing is heard	Money or country
Arms thrust	The silence below
Legs kick	Now not so deafening
The futile attempt	To a world of oblivion
To get out quick	This is an opening
The fear of death	Tranquility rules
Looms in front	No one dare disturb
The body gives up	For sound is engulfed
But the mind does not	Only silence can reverb
Waving and kicking	The mind now sees
Fatigue overcomes	What the eyes dare not
Panic seizes and	The light shines down
Desperation comes	Shows what was forgot
The lungs crave	The past flashes by
For that sweet air	Repentance does come
That is not here	As the iron shackles tied to
But was everywhere	an iron ball drags
The hopelessness of hope	The poor soul home, to the
Is now evident	ocean floor.
To live like this	* * * *
Was never meant	

I was inspired to write this poem a few years ago after watching the movie 'Amistad'. Sick slaves on a ship were all tied to a long iron chain which in turn was tied to a huge iron ball that was thrown overboard to drown them.

Charity Report

Dr Shabin Joshi

Money Raised in AGM 2006

Total raffle money raised was £200.

Total money by voting £1816

Grand total raised for charity was £2016.

Pashupati Briddhashram and Paropakar secured the most number of votes i.e. 16 each. NDA doctors' Health camp/projects was third with 13 and Shanti Ashram was close 4th with 11 votes. Four doctors did not submit the promised sum (£100, 25, 10 and 10 i.e. total: £145).

Charity Donations

The charity aspect of the NDA was highlighted in the charity donation programme chaired by the deputy prime minister Mr Amik Sherchan, NMA Chairman Dr Sudha Sharma and other dignitaries, held in Pashupati Briddhashram, Kathmandu on 30th December 2006.

The chief guest donated the following items on our behalf:

1. Four colour television sets (two 21 inches and two 15 inches) and tables for the same to the residents of Pashupati Briddhashram (worth £500).
2. Cash/cheque to Paropakar Organisation (£500).
3. Cash/cheque to Sagarmatha Health Foundation (Ashraya Project) (£300).
4. Cash to Chief Guest's charity Rs 25,000 (~£184) handed over by ex-NMA Chairman Dr Shankar Bahadur Singh Rajbhandari.

The chief guest declared that the extra money (£280) given to his charity would be utilised to build a 'Omawadi Girls Hostel' in a remote village of Okharbot in Myagdi.

NDA (UK) has also donated £500 to Hospice Nepal, a charitable organisation based in Lagankhel, Nepal, and £300 to the Mayor of Dacorum's charity.

NDA (UK) would like to heartfully thank all the members who kindly and generously donated for the cause. Further details of this year's charity and all the charity work of the NDA over the past 22 years is available on the NDA website.

NDA (UK) Accounts

Summary of Income and Expenditure for 2001-2006 (Audited)

	2001	2002	2003	2004	2005	2006
<u>Receipts</u>						
Ordinary members subscription	700	660	600	575	535	765
Life members subscription	0	1,050	1,800	300	0	2,700
Donation by drug companies and members	2,500	1,916	3,396	7,258	5,780	4,889
Money raised from NDA ties/Glass Tankards	80	0	0	0	0	0
Money raised from charity dinner	585	6,281	4,093	0	0	0
Money raised from AGMs	14,064	16,578	11,487	15,450	16,188	19,139
Money raised in charity account	811	9,300	0	0	0	420
Interest Received	107	30	9	8	10	3
Advertising Income	0	0	0	0	0	50
Total Receipts	18,847	35,815	21,385	23,591	22,513	27,666
<u>Payments</u>						
Charity dinner	3,108	2,981	45	1,516	0	0
NDA Conferences expenditure	16,848	16,668	18,030	22,640	21,723	23,853
Printing and Stationery	1,497	1,380	837	260	548	739
Bank charges	0	62	0	0	0	0
Accountancy fees	176	353	0	300	341	353
Sundry	0	70	22	47	0	167
Donations towards charities	0	8,509	2,508	1,000	0	2,310
Total Payments	21,629	30,023	21,442	25,866	22,612	27,422
Surplus(Deficit) of Receipts Over Payments	-2,782	5,792	57	-2,275	-99	244

BALANCE SHEET AS AT 30th of JUNE (2001-2006) (Audited)

	2001	2002	2003	2004	2005	2006
Opening balance as of 1st July	7,762	4,980	10,772	10,715	8,440	8,341
Surplus of receipts over payments	2,782	5,792	-57	-2,275	-99	244
Closing balance as at 30th June	4,980	10,772	10,715	8,440	8,341	8,585
REPRESENTED BY						
BARCLAYS BANK CURRENT ACCOUNT	2,850	9,444	5,293	3,405	3,337	4,648
CHARITY ACCOUNT	811	10	4,104	4,008	4,008	3,367
ALLIANCE & LEICESTER						
MEDICAL BENEVOLENT FUND	1,017	1,017	1,017	1,025	1,028	1,029
GENERAL DEPOSIT ACCOUNT	124	124	124	125	126	126
NDA EDUCATION FUND	39	39	39	39	39	0
NATION WIDE						
CHARITY FUND	130	130	130	130	136	138
LLOYDS						
LIFE MEMBERS	0	0	0	0	0	0
CASH IN HAND	8	8	8	8	8	0
	4,980	10,772	10,715	8,740	8,682	9,308
Deduct :Accrued charges	0	0	0	300	341	723
TOTAL	4,980	10,772	10,715	8,440	8,341	8,585

**Wishing a Successful
22nd Annual General Meeting of the
Nepalese Doctors Association (UK)**

Manhanta Shrestha



Khukuri Lager Beer



**Khukuri Lager Beer now available from:
Manaco Mian, Park Royal**

The Nepalese and British people have long enjoyed a unique friendship epitomised by the noble Gurkha Regiments of the British Army. Their famous fighting knife lends its name to this spectacular beer. Its creation is the harmonious product of original Nepalese recipes, and the brewing traditions of J.W. Lees, one of Britain's oldest Independent Breweries.

Working in partnership, Manhanta Shrestha a native of Katmandu and Head Brewer Giles Dennis, have striven to capture the essence of Nepalese taste and culture, in this superbly smooth premium beer.