



# INCHES

## Bulletin

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Editor: Dr. Ramesh Subramanian Editorial Board: Dr C H Asrani, Dr Nilesh Baxi, Dr Hemant Patel

### EDITORIAL

I had the opportunity to attend the Diamond APICON held in Mumbai in the third week of January. It was a four day, truly 'mega' conference attended by more than 7500 delegates from different parts of the country and abroad. The CME programme on day 1 featured concurrent sessions at five different halls in different specialities. The conference itself had seven concurrent sessions with talks by a prominent national and international faculty with a host of interactive sessions and workshops. In addition to a banquet there was also a fashion show to boot! What was striking was the blatant presence and sponsorship by the pharma industry. As one of the representatives told me, his company had registered (and sponsored!) 5500 delegates and manned about 20 of the registration counters! At the other end of the spectrum we have the GP conferences where we have to literally run from pillar to post for registering delegates and for sponsorship in spite of the GP's having a larger prescription base! Food for thought indeed! Presented in this issue is compilation of Dr. Ramesh Patankar's talk on "Diagnosis and management of stroke at the bedside" as also the "Current management of Psoriasis" based on Dr. Hema Jerajani's talk at the Update.

**Dr Ramesh Subramanian**  
Editor

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### Hypertension and Brain

#### Effects of hypertension on the vasculature:

- Vasospasm
- Arteriolar constriction
- Hyperplasia of the intima
- Muscular hypertrophy
- Thickening of the blood vessels
- Stiffness of the blood vessels
- Microaneurysms- rupture- hypertensive bleed

#### Effects of chronic persistent hypertension

##### Atherosclerosis of

- Extracranial arteries
- Membranous arteries (deep seated)- This gives rise to lacunar infarcts (small areas of infarcts < 5 mm, not appreciated conventional CT, can be picked up on MRI or CT with 2 mm cuts)

#### CNS presentations of hypertension:

- CNS dysfunction -dizziness, vertigo
- Cerebral infarction
  - Thrombotic stroke
  - Lacunar stroke
- Cerebral haemorrhage
- Hypertensive encephalopathy- (unconsciousness with no focal neurological deficit)

#### Stroke

- Strokes may manifest as
  - Transient ischaemic attack (TIA -focal neurological deficit reversing in 24 hours, amaurosis fugax- total loss of vision in one eye recovering completely, transient numbness of hand)
  - Residual intracranial neurological deficit RIND (lasts longer)
  - Completed stroke
- Cranial nerve palsy and paralysis on the same side indicates cerebral stroke
- Speech defects in cerebral stroke may be due to involvement of the sensory or motor areas
  - Involvement of the motor (anterior) area results in loss of fluency, reduction in the number of words spoken, calligraphic speech, and dysarthria.
  - Involvement of the sensory area results inability to recognize spoken words and incoordinated speech (talking nonsense), loss of names (dysnomia, anomia), repetitions (pallialia),

echolalia). The patient understands commands by showing actions,

- A patient with stroke talking fluently but talking nonsense has sensory aphasia
- Stroke involving the anterior cerebral arteries manifests as acute onset of single lower limb weakness and is seen in about 15-20% of strokes
- Posterior cerebral strokes manifest as hemianopia. In acute PCA strokes weakness is due to oedema in the surrounding cerebral area
- Cranial nerve palsy (ptosis, squint- usually involvement of 2 or more cranial nerves with two or more symptoms of diplopia, vertigo, loss of balance, loss of vision, difficulty in swallowing, change of voice) with paralysis on the opposite side indicates brain stem lesion
- Cerebellar stroke is characterized by incoordination of movements and loss of balance, dysmetria, dyssynergia, adiadokokinesis)
- Anterior cerebral strokes can be reversed within 6 hours of prompt treatment,

Posterior cerebral strokes can be reversed within 12-24 hours if properly managed

### Management

- Urgent CT scan is done as it helps differentiate between ischaemic stroke and haemorrhagic stroke. If CT is inconclusive, MRI may be done later
- Hospitalization of the patient
- Maintain airway
- Intravenous tPA, intrarterial tPA, streptokinase are administered within 3 hours in ischaemic stroke
- Blood pressure control should not be attempted unless the BP is more than 190/105 mm of Hg (WHO). Cerebral autoregulatory mechanism is responsible for the maintenance of cerebral perfusion in response to rapidly changing circulation in the brain. BP with bradycardia is the sign of raised ICT, fundoscopy shows papilloedema. Avoid beta blockers for controlling BP as they mask signs/symptoms of raised intracranial tension
  - The drug of choice is sodium nitroprusside followed by labetalol,
  - Nimodipine can be given even before asking for CT
- Clopidogrel 4 tablets stat with Aspirin 1 tablet is given to patients with ischaemic stroke
- Indiscriminate use of anti cerebral oedema measures should be avoided.
  - Anti-oedema measures are instituted on basis of CT, MRI and fundoscopy findings.
  - Decadron is given in the dose of 1 mg/kg body weight
- Catheterization is avoided as far as possible
- Isotonic fluids are administered if indicated, DNS should be avoided
- Conventional heparin is useful in strokes and is superior to LMW heparin, the advantages are that it

can be stopped when required, reversed with protamine and the cost is low.

*(Based on a lecture by Dr. Ramesh Patankar, Consultant Neurologist, Shushrusha, Lilavati hospitals on Sunday, 16<sup>th</sup>. January 2005 at Hotel Avon Plaza under the joint auspices of INCHEs Health Foundation and Dadar Medicos Brotherhood)*

## PSORIASIS TREATMENT

### Introduction

Psoriasis is a chronic skin disease characterized by accelerated epidermal turnover and hyperplasia. Clinically it manifests as well defined erythematous papules and plaques covered with silvery scales. The lesions are usually symmetrically distributed and are characteristically located on the ears, elbows, knees, umbilicus, gluteal cleft and genitalia. The joints (psoriatic arthritis), nails and scalp may also be affected. The various types of psoriasis are *plaque psoriasis, guttate psoriasis, pustular psoriasis, erythrodermic psoriasis and psoriatic arthritis*

### Treatment of psoriasis

- Treatment is usually effective. The skin becomes less scaly and may then look completely normal
- However relapse is common. Relapse may not occur for many years and sometimes within a few weeks.

### Treatment of localized psoriasis

- *Topical Steroids*
  - They are one of the mainstays for psoriasis therapy.
  - They diminish the inflammation, stop the itching, and help cut down on cellular proliferation
  - They are available as creams, ointments, lotions and liquids, so may be uniquely selected for use on various
  - Drawbacks to steroids are that overuse may lead to steroid atrophy (thinning of the skin) with associated stretch marks, blood vessels known as telangiectasis and even acne
  - Also, there are risks of developing pustular psoriasis or addiction of the area
- *Coal Tar*
  - Coal tar is a black viscous fluid that was first described by Goeckerman in 1925, when it was combined with ultraviolet light for the treatment of psoriasis. It is thought to suppress epidermal DNA synthesis
  - Coal tar is available as an ointment, cream, lotion, shampoo, bath oil and soap.
  - Coal tar is most effective when it is used in combination with other agents, especially ultraviolet B light. Like calcipotriene, coal tar is effective when it is combined with topical corticosteroids. Coal tar shampoo can be used in combination with a corticosteroid scalp solution for the

treatment of psoriasis on the scalp

- *Drawbacks*- Because coal tar is messy and malodorous and can stain clothing, nighttime application is recommended. Patients should be advised to use old bed linens and to wear old pajamas when they are using coal tar. Tar products can cause folliculitis, but they otherwise are generally not associated with side effects
- *Anthralin*
  - Also known as dithranol is an antipsoriatic topical preparation derived from wood tar. It has been available since 1916, but it is a second-line agent because of its irritating and staining properties
  - Anthralin is available in 0.1 percent to 1 percent ointments, creams and solutions. It is generally used on notably thick, large plaques of psoriasis, and therapy is initiated at low concentrations for short periods. The concentration and duration of contact with each treatment is gradually increased, up to a maximum of 30 minutes per application. Anthralin can be combined with ultraviolet phototherapy; this is known as the traditional Ingram regimen
  - Patients should be warned that anthralin has a tendency to stain any surface, including the skin, clothing and bathtub. Its use should be limited to well-demarcated plaques, and it should be applied with a cotton-tipped applicator or a gloved hand. Patients should be warned that normal skin surrounding the psoriatic lesion may become irritated if it comes in contact with anthralin

### Therapy for generalized psoriasis

- *Ultraviolet B (UVB) light*,
  - It has been used for many years, and is highly effective
  - It may cause acute phototoxicity.
  - There are little to no long-term side effects.
  - UVB can be used at home for maintenance therapy
- *Psoralen plus ultraviolet A (PUVA)*
  - The therapy is highly effective; it can be used as maintenance therapy.
  - There is a high risk of acute phototoxicity
  - Long-term risks include high risk of cutaneous malignancy.
- *PUVA*
  - The therapy combines a psoralen drug with UV-A light therapy
  - Psoralen drugs make the skin more sensitive to light and the sun
  - Methoxsalen is a psoralen that is taken by mouth several hours before UV-A light therapy
  - UV-A is light with wavelengths of 320-400 nm. More than 85% of people with

regular psoriasis report relief of disease symptoms with 20-30 treatments. Therapy is usually given 2-3 times per week on an outpatient basis, with maintenance treatments every 2-4 weeks until remission.

- Adverse effects of PUVA therapy include nausea, itching, and burning. Long-term complications include increased risks of sensitivity to the sun, sunburn, skin cancer, and cataracts.
- *Ultraviolet-B (UV-B) and narrow-band UV-B light*:
  - UV-B light is also used to treat psoriasis. UV-B is light with wavelengths of 290-320 nanometers (nm). (The visible light range is 400-700 nm.) UV-B therapy is usually combined with one or more topical treatments
  - The major drawbacks of this therapy are the time commitment required for treatments and the accessibility of UV-B equipment
- *Retinoids* (acitretin -Soriatane)
  - It is moderately effective; it is best for pustular psoriasis.
  - It is a potent teratogen; the use in women of childbearing potential should be avoided.
  - It causes dryness of skin.
  - It may cause elevation of triglycerides.
  - It is known to cause hyperostosis with long-term use.
- *Methotrexate* (Rheumatrex)
  - It is highly effective and can be used on a long-term basis.
  - It should not be used in noncompliant patients or when there is preexisting hepatic disease.
  - It can cause acute or chronic hepatotoxicity, acute neutropenia and pancytopenia.
- *Cyclosporine* (Sandimmune)
  - It is highly effective.
  - Careful monitoring is required.
  - The long-term risk of renal toxicity, which may not be detectable by blood tests, limits long-term use.
- *Frequently used or well-studied combination therapies*
  - UVB plus topical calcipotriene (Dovonex)
  - UVB plus topical coal tar
  - PUVA plus topical calcipotriene
  - PUVA plus retinoids
  - Acitretin plus topical calcipotriene
  - Cyclosporine plus topical calcipotriene
- *Infrequently used or less well-studied therapies*
  - UVB plus methotrexate
  - PUVA plus methotrexate

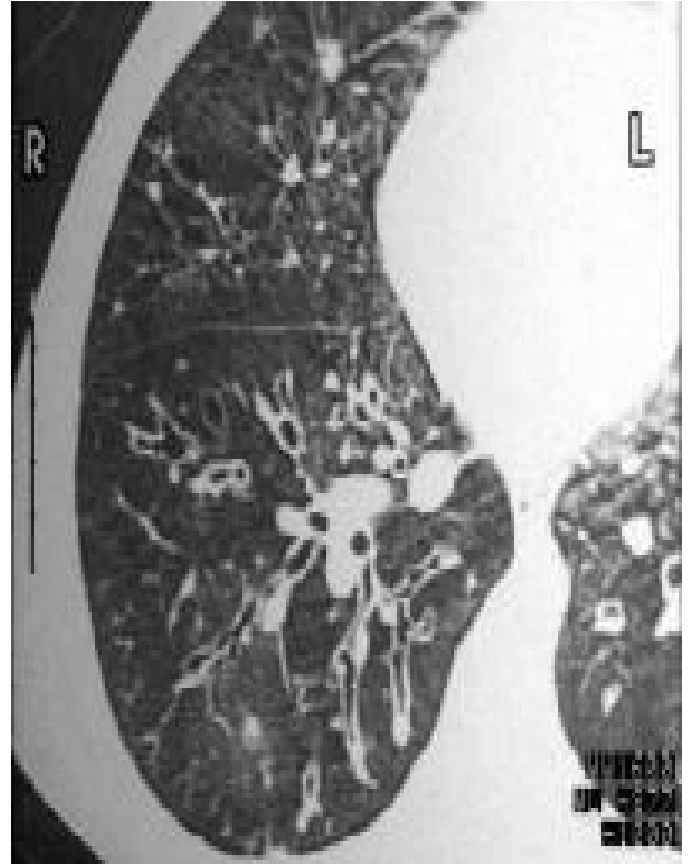
**Know the drug**

**Valacyclovir hydrochloride**

- Valacyclovir hydrochloride is the hydrochloride salt of L-valyl ester of the antiviral drug acyclovir
- After oral administration, valacyclovir hydrochloride is rapidly absorbed from the gastrointestinal tract and nearly completely converted to acyclovir and L-valine by first-pass intestinal and/or hepatic metabolism
- Each caplet contains valacyclovir hydrochloride equivalent to 500 mg or 1 gram valacyclovir
- **Indications and dosage**
  - *Herpes Zoster*:: The recommended dosage for the treatment of herpes zoster is 1 gram orally 3 times daily for 7 days
  - *Genital Herpes*-
    - *Initial Episodes*: The recommended dosage for treatment of initial genital herpes is 1 gram twice daily for 10 days.
    - *Recurrent Episodes*: The recommended dosage for the treatment of recurrent genital herpes is 500 mg twice daily for 3 days
    - *Suppressive Therapy*: The recommended dosage for chronic suppressive therapy of recurrent genital herpes is 1 gram once daily. In patients with a history of 9 or fewer recurrences per year, an alternative dose is 500 mg once daily. The safety and efficacy of therapy beyond 1 year have not been established
  - *Cold Sores (Herpes Labialis)*: The recommended dosage for the treatment of cold sores is 2 grams twice daily for 1 day taken about 12 hours apart
- Side effects include facial edema, hypertension, tachycardia., acute hypersensitivity reactions, headache, dizziness, visual abnormalities., diarrhea. liver enzyme abnormalities, hepatitis. , elevated creatinine, renal failure., haematologic abnormalities, and skin rashes

**Quiz Mania 40**

**Investigation? Diagnosis?**



**Answer to Quiz mania 39**  
**Investigation:** HRCT of the Chest  
**Diagnosis-** Interstitial lung disease

Congratulations to **Dr. Haresh Jumani**  
for correct answer.



# INCHES Health Foundation

## CME for The Power of Knowledge



P D Hinduja National Hosp

Series in Rheumatology  
(with cases)

by Dr C Balakrishnan

9<sup>th</sup>, 16<sup>th</sup>, 23<sup>rd</sup>, 30<sup>th</sup> March 2005

Wednesdays, 2.40 pm to 4.00 pm

The Auditorium 2<sup>nd</sup> floor

PD Hinduja National Hospital. Mahim 400016

Registration: FREE but a Must

*Delegates may get their patients for discussion*

P D Hinduja National Hosp



# INCHES Health Foundation

## OUTSTATION CME

### Turn overleaf for details

### Register Early!



Mediheights

Thursday CME in March 2005 (3.00 to 4.00)

3<sup>rd</sup> Mar - Pelvic inflammatory disease by Dr. Saurabh Dani

10<sup>th</sup> Mar - Cervical Erosion & Prolapse by Dr. Saurabh Dani

17<sup>th</sup> Mar - Menopause by Dr. Saurabh Dani

24<sup>th</sup> Mar - Anxiety Disorder by Dr. Paresh Trivedi

31<sup>st</sup> Mar - Lifestyle Modification by Dr. Rajesh Parekh

MEDIHEIGHTS; Sailee HT Complex, Hindustan Naka.

Opp Ajanta Pharma, Kandivali (W) Mumbai 400067. Ph 28086611

Registration: **FREE** (Only 30 seats) but a **MUST!**

Mediheights

Register with

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# **InCHES Health Foundation**

## **CME for The Power of Knowledge**



### **Out Station CME Workshop** **@ Shahani Holiday Home, Lonavala**

**Sat 12<sup>th</sup> & Sun 13<sup>th</sup> March 2005**

**Join a group of Hard core academically inclined Family Physicians to master some important segments of day-to-day practice**

#### **- UPDATE - Respiratory system**

*(Ac & Chr bronchitis, Bronchial Asthma, COPD, Sleep Apnoea Syndrome, Appropriate use of spirometry, inhalers/ nebulizer)*

*by: Dr P R Prabhudesai - Consultant Pulmonologist*

#### **- UPDATE - URTI**

*by: Dr Divyaprabhat - Consultant ENT Surgeon &*

#### **- LIFE STYLE MANAGEMENT**

*We always recommend lifestyle changes for every chronic illness that we treat. Do we really know what exactly are those advises? Do we implement them in our life?*

*After all, practice is the BEST way to preach!*

**A 2 hour interactive discussion**

**Dr C H Asrani - need of Healthy Lifestyles & relaxation techniques.**

**Dr Asmita Shah - Diet & Nutrition**

**Dr Hemant Patel - What? How? & When? Of Yoga**

#### **ENTERTAINMENT PROGRAMME – SATURDAY WITH DINNER**

**Registration: Rs 1150/- per person only**

**(registration against FULL payment only)**

*includes: to & fro travel, all breakfasts, meals, teas/ coffees, twin sharing accommodation (Self Contained Rooms With Color TV in each room) & CME.*

**Departure: Dadar 7 am 12<sup>th</sup> March 05**

**Return: 13<sup>th</sup> March 05 by 8 pm**