
## An Update of Medicine

JUNE 29, 2013
DOUBLE TREE BY HILTON HOTEL
JFK, NEW YORK

3 HOURS OF AMA PRA CATEGORY 1 CME

# 3rd Annual Reunion & CME 2013

# SIR SALIMULLAH MEDICAL COLLEGE ALUMNI ASSOCIATION ABROAD

KAPLAN MEDICAL

# Attention SSMC Alumni Association Abroad:

If you would like to register for any Kaplan Medical Courses, we will be extending our 15% discount only for **SSMC members** until ***July 10, 2013***. Please email nymedadvisor@kaplan.com and make sure to mention that you are a SSMC member to get your discount.

Also, don't forget to check out our free events in July.

**Begin Your ECFMG Application**
Tuesday July 9th @ 6PM – Brooklyn
Wednesday July 10th @ 6PM – Newark
Thursday July 11th @ 6PM – Manhattan
*Learn how to get started and navigate your way through the ECFMG application*

**Top Ten Successful Match Strategies**
Monday July 29th @ 6PM – Brooklyn
Tuesday July 30th @ 6PM – Newark
Wednesday July 31th @ 6PM – Manhattan
*Scores are only the first step. Find out the other key components towards improving your chances in the Match.*

# SSMC Alumni Association Abroad

3rd Annual Reunion and CME

## Final Program

| | |
|---|---|
| 12 noon | Registration |
| 12 -12:45 | Box Lunch will be served for all registrants and their family members |
| 12 - 4 | Children and Family Program (Ball Room) |
| 12 - 12:50 | Symposia for Pre Residents and Students "How to Best Prepare for Residency- Survival of The Fittest" (Narita Room) |
| 12:50 - 4 | CME Program "An Update of Medicine" (Narita Room) |
| 4:00 - 4:15 | "Asset Protection for Physicians" - Jeremy Darstek, Meridian Financial Group, Fort Myers, Florida (Narita Room) |
| 4:30 - 5:30 | Business Meeting open to all general members, Agenda- Review and Amend Constitution, Election of New Executive Committee (Narita Room) |
| 5:30 | Children and Family Cultural Program (Ball Room) |
| 7:00 | Pulse Band Show |
| 7:45 | Dinner |
| 8:15 | Guest Singers |
| 12:00 | Closing |

## EXECUTIVE COMMITTEE

**Habibur Rahman, MD, FCCP**
President

**Faruque Ahmed, MD**
Vice-President

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Treasurer

**Obayedur Khan, MD, FACP**
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**Mohammed Islam, MD**
Cultural Secretary

**Syed Rahman, MD**
Chair, Fundraising

**Esha Khoshnu, MD**
Chair, Expert Forum

### REUNION COMMITTEE 2013

Mohammed Islam, MD *(Chairman)*
Shahin Ahmed, MD *(Co-Chair)*

Magazine:
Sumit Mamun, MD, FACP *(Editor)*

CME Committee
Faruque Ahmed, MD *(Program Director)*
Obayedur Khan, MD, FACP *(Co-Director)*
Shahin Ahmed,MD *(Program Coordinator)*
Esha Khoshnu, MD *(Member)*
Parvez Alam, MD *(Member)*

### REUNION SUB-COMMITTEE 2013

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Mohammad Rahman
Tanjina Mustafa
Sabina Awaal
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Sabbir Siddique
Olia Alia
Ratan Banik
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Ashraf Malek
S.M Monir Mohar
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Fahmina Quader
Farhana Rana
Biswajit Saha

Akm Sarker
Moumita Sarker
Abu Siddique
Mahbubur Siddique
Rumana Sultana
Aminul Islam Sohel

# EDITORIAL

*It is a great honor and privilege to serve as the Editor of the 3rd Reunion Magazine of SSMC Alumni Association Abroad. Our association began its journey 3 years back with a bold and courageous mission. We are happy to see steady strides made with that vision under the leadership of our President and Executive Committee since then. I believe that with broader participation of all of our Alumni we can truly achieve the goal of transforming this organization into one that will make significant changes in the lives of our alumni, current students and trainees of SSMC, and also the needy patients of SSMC and Mitford Hospital.*

*This year's reunion serves as the platform for the First Time that we will have CME Program Sponsored by our Alumni which will provide upto 3 hours of AMA PRA Category 1 credit to participants. Also there will be a Non CME program dedicated to our Pre-residents to help them guide in their pursuit of passing USMLE Exams and provide general guidance with regards to securing a residency position. In this magazine there is a message from our President and Secretary about what we have achieved with our combined effort since the inception of and future direction of our organization. There are pictures of our activites of the past year as well as pictures from our 2nd Reunion. Scientific publications as well as literary articles by our alumni are also included. We have tried our best despite our limitations to make it an enjoyable experience of your reunion.*

*I would like to thank our Executive Committee, Reunion Organizing committee and especially our tireless Secretary, my classmate, Obaydeur Rahman Khan of 11th batch for their help and contributions for this publication.Special thanks goes to Dr. Parvez Alam of 8th batch and Dr. Shahin Ahmed of 12 th batch for without their efforts this publication would not see the light of day. Constructive criticism and suggestions as well as active participation by other alumni are always welcome and will help to make future reunion magazines better and more entertaining.*

***Sumit Mamun**, MD, FACP*

# Message from the President

*Dear Alumni,*

*For the past three years, it has been my great honor to welcome you to our annual reunion. Since we met last year, we have had to endure everything from natural calamities to the loss of close family and friends, to name a few. Thankfully, together we have steered through these difficulties, with patience, perseverance and hope for the future. We continue to offer our prayers, love and financial support to our friends and their families, as well as to all the victims of disasters both natural and unnatural, here and abroad: Hurricane Sandy, Oklahoma City, the children of Somalia, the commercial building collapse in Bangladesh, amongst many others.*

*On a more positive note, to date, we have already distributed more than 200 custom-made white coats embroidered with students' names and the SSMC AAA logo to incoming medical and dental students of our school. With the support of BMANA, we have also donated a defibrillator machine and manikin to Mitford hospital last year. I am grateful to our alumni who travelled to Bangladesh, and organized seminars and CME for our medical school--a service that has been highly appreciated by students, doctors and the administration. It took some time to open an account, but finally we are about to transfer more than $8000.00 to help poor patients buy medicine, especially children in Mitford hospital. We dedicate this fund to our late alumnus,Dr. Shamsul Islam Dollar. With your help, starting this year we will also sponsor a scholarship program to support eight students in SSMC.*

*Having fulfilled all the requirements, our application for 501(c) status is being submitted this week. We are hopeful that we will be approved.*

*I feel deeply grateful to all of you, especially to the members of the executive committee and coordinators of our reunion and CME. Without your hard work and sacrifice, we could not have come this far. But there is lot more for us to do.*

*We must remain deeply committed to finding ways to offer better services to our pre-residents, to support, mentor and guide them through the long challenging years ahead. So far we have been notably weak in this area of our mission.*

*Thank you for your invaluable support and friendship ,and most importantly, despite my many flaws, for allowing me be part of our extraordinary journey together.*

*Welcome dear friends to our third reunion. Wishing the very best for all of you and your lovely families.*

***Habibur Rahman Lulu***

*President*

*Sir Salimullah Medical College Alumni Association Abroad*

# *Message from the Secretary*

*One Year Report Card*

***Obayedur Khan,*** *MD, FACP*
*Secretary*

## *Introduction*

*Since the formation of SSMC Alumni Association Abroad in April of 2011, we have had significant achievements. As a new organization our report card should be considered excellent. Before going into details, I would like to reiterate the Goals and Objectives of our organization-*

**ARTICLE II: OBJECTIVES**

*The purpose and objectives of the Association shall be to*
*a) Promote the best interests of Sir Salimullah Medical College and Mitford Hospital*
*b) Help improve quality of medical education, training and research*
*c) Exchange education and skills*
*d) Improve communication between the college and alumni*
*e) Aid the college in any form for future development*
*f) Sponsor social and professional activities*
*g) Collaborate with existing alumni association of the college*

*Our activities reflect these proposed goals and objectives. Over the last one year we have been very active in various activities as stated below. Although time is a big factor for our members, many have dedicated significant amount of time towards the organization. On behalf of the organization I would like to extend our sincere thanks and gratitude to them.*

## *2nd Annual Reunion 2012*

*The 2012 Reunion was a big success. It took place on July 4, 2012 at the World's Fair Marina in Flushing, New York. We had 54 Alumni along with their families attended. The total attendance was more than 200. From the feedback we received, it was a memorable event for all attendees. A very beautiful publication was one of the highlights of this occasion. This was edited by Dr. Parvez Alam. It was an opportunity to watch many of our SSMC Talents performed during the cultural show. S.I. Tutul performed at the end.*

### SSMC Graduates Looking for Residency

*SSMC Graduates who are now struggling in the USA to get a residency position have been our particular focus. While no one can personally guarantee any direct assistance in gaining a position, we have tried to coordinate efforts to better prepare our graduates to face the reality. Our website has a section dedicated to residency seekers. This page has vast amount of information regarding preparation for residency. Personal advice is now available and easy to get, when sought. In addition Dr. Faruque Ahmed has been assigned as the Chair of Education Committee. Our goal is to improve communication among alumni, which will ultimately improve cooperation and assistance. I understand this may not be enough, but compare this with when there was nothing. We ask that all alumni come forward in this effort.*

### Helping Hurricane Sandy Victims

*Following the tradition of helping others during distress, Alumni Association members went out, on a rainy day, to help hurricane Sandy Victims. On December 16, 2012 we distributed canned food, fine candy, cookies, water, different variety of foods of necessity and 150+ winter clothing to needy families in Far Rockaway area in New York. The following Alumni were in attendance and deserves our heartfelt thanks- Drs. Habibur Rahman, Shaheen Rahman Ranu, Quamrul Islam Ponu, Esha Khsohnu, Syed Jalal and Mujahid Billah. To see them in action on a cold rainy day please visit our website where pictures have been posted. Thanks to those alumni who participated and who helped in this project.*

### Donation to Oklahoma Tornado Victims

*Most recently the severe tornado that devastated Oklahoma caused loss of many lives and properties. Members of SSMC Alumni Abroad once again came forward, and donated five hundred dollars through American Red Cross.*

### Donation for Savar Victims

*The heart breaking news of building collapse at Savar that killed 1500+ garments workers shook us all. We have started raising funds to be donated to victims of Rana plaza. So far we have raised fifteen hundred dollars. We will continue to accept donation for this purpose.*

### Scholarship for SSMC Students

*We have been contemplating scholarships for SSMC Students for some time now. Although this program is not yet implemented, we have explored the process how we can start this. Many of our alumni living in Bangladesh will be assisting us in this process. Drs. S. M. Ali, Khairul Anam, Zakir Hasan are among the alumni involved in this process. We have faced a few administrative obstacles such as how to handle the scholarship fund and distribute them. Hopefully we will soon be able to overcome those and start the process.*

### *Lab Coat for New SSMC Students from SSMC AAA*

*On December 29, 2012 lab coats were presented to all incoming Medical and Dental students during their orientation. During this ceremony, Alumni Abroad members Drs. Faruque Ahmed, Esha Khoshnu and I were present at the New Gallery 1 of SSMC. Dr. S. M. Ali (5th Batch ) of Square Hospital was phenomenal in arranging the lab coats. As you can imagine how difficult it would be in ordering, measuring, collecting and distributing more than 200 lab coats. Dr. Ali did all the ground work for us. We are grateful to him.*

### *Networking and Seminar at SSMC and Mitford Hospital*

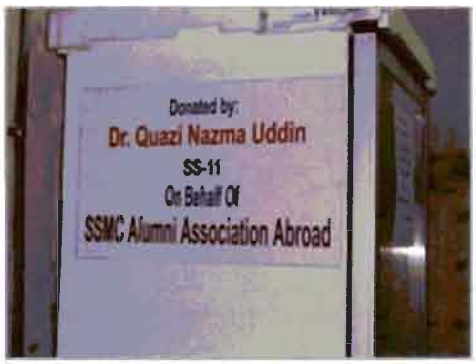
*On December 30, 2012 Alumni Association Abroad organized a Seminar and Networking for Students and Teachers of Sir Salimullah Medical College. The program lasted from 12 noon till 3:30 PM and attended by College Principal Prof. Dr. Dilip Sarker, Teachers, 3rd, 4th and 5th year students. Moderated by me, several of our Alumni Abroad members, who were visiting Bangladesh, presented various topics from primary care, Psychiatry, ALS, Hematology and Oncology, Surgery, Quality Improvement, USMLE and Residency Training in the USA. At the end a lengthy question and answer session took place were students asked many questions. The program speakers were College Principal Dr. Dilip Sarker, Drs. Faruque Ahmed, Esha Khoshnu, Barnali Hasan, Khaja Jashimuddin and Rumana Sultana. Several other Alumni Abroad members were also present including Drs. Shahin Ahmed and Nilufer Sultana.*

### *Pediatric Advanced Life Support (PALS) at Mitford Hospital*

*For the first time ever PALS was arranged at the Mitford Hospital on December 30, 2012. Sixteen Pediatricians from SSMC and Mitford Hospital were trained and certified of PALS. The program was jointly organized by SSMC Alumni Abroad and Bangladesh Medical Association of North America (BMANA). We are thankful to BMANA President Dr. Maksood Chowdhury for taking the interest in this. He also donated a Defibrillator to Mitford Hospital. We are especially thankful to College Principal Prof. Dr. Dilip Sarker and Mitford Hospital Director Brig. Gen. Dr. Zakir Hasan for their sincere interests and cooperation in arranging all the SSMC and Mitford Event.*

### *Networking with Shandani Members*

*During our visit to SSMC, Shandani Members took keen interest and came to meet with our visiting members. They explained their current programs and also presented us with a plaque for humanitarian services that we provide.*




*On behalf of SSMC Alumni Association Abroad Kazi Nazma Uddin donated a refrigerator to Shandani Blood Bank.*

### *Expert Forum*

*Expert Forum consists of Alumni Abroad members of different specialties of medicine. Chaired by Dr. Esha Khoshnu forum members give free medical advice to SSMC AAA members and their family when in need both at home and abroad.*

### *Khaled Shamsul Islam Dollar Fund*

*After the tragic death of Khaled Shamsul Islam Dollar many came forward and donated a total of $8081. We have decided to make a permanent fund with this money to be spent among needy patients in Mitford Hospital.*

### *Conclusion*

*Although, we are a small new organization, we have been committed to serving not only our members, our medical college and hospital but also our society in general. The 3rd Reunion will bring new breezes to these commitments and we hope to continue to get your involvement to serve as we promised.*

*Finally my sincere thanks to all our alumni who worked hard for this reunion, those who silently helped and continue to remain as a source of inspiration, all our patrons, advertisers, donors and well-wishers. Without you we cannot proceed.*

# Message from the Treasurer

*This is another reunion.*
*It has been a sense of optimism, growing up in a family coming together. Our family of SSMC Alumni Association Abroad is about to celebrate 3rdre-union, 6-29-2012. All members are unique: each star shining of its own worth. Some glitters more than others, different color, different form and norm. One cannot compare one another because Almighty endowed all of us with specific virtue and perspective in life.*

*Our infant organization moves forward, inching together. We have gone through different stages of activity: helping the storm victim in the horn of Africa, Oklahoma City, giving Lab-coat to the students, conducting CPR course, donating defibrillator to our mother, Sir Salimullah Medical College. We personally went right to the "Sandy victim" and personally distributed clothing, food, among others. It is an immense joy and feeling. Expert forum is striving to bloom in a full moon.*

*Here we passionately opine, disagree, vet, pretest and, at the end, try to preserve and protect the final resolution. We look forward to alleviate suffering of the poor, ameliorate burden of the unfortunate to ultimately feel the taste of sweetness and the fruit of being a good human being -- rightful citizenry of a society-- in a family. I strongly believe, Almighty gives wisdom and wealth to those who share it with others. In a certain way we all are fortunate to have both, and be in a position to share.*

*May almighty allow us to reach the right destiny.*

***Syed Jalal, MD***
*Treasurer*
*Sir Salimullah Medical College Alumni Association Abroad*

# Message from the Cultural Secretary

*Dear respected members and guests,*

*Welcome to the 3rd Annual Convention of SSMC Alumni Association Abroad. For the last 3 years the Executive committee has worked hard for our organization and now slowly with baby steps the organization is getting larger and more mature.*

*SSMS Alumni has actively worked for Educational activities in SSMC in Bangladesh. We have contributed several times with Financial and other help to individuals, and organizations after natural disasters, and personal loss. Our Alumni has also helped SSMC present students with lab coats and has donated a Refrigerator to Shondhani to help preserve donated blood.*

*This year our Convention will be for much longer time and will start with CME conference for the first time. Please join our CME program and make it a success.*

*Our goal is to expand our membership. I want to encourage everybody to join our effort and be actively involved in SSMC Alumni projects. Together we can make a difference.*

*Last but not least, please perceive SSMC Alumni as your very own and dear organization.*

*Thank You*
***M. Q. Islam,** MD*
*Cultural Secretary and Chairman of Reunion Cultural Committee.*

# Message from the Co-Chair

*Dear members and guests*

*Welcome to the 3rd annual convention of SSMC Alumni Association abroad 2013. I would like to add that the convention, this year, is an example of tireless dedication, activities and efficiency of dynamic members along with all volunteers.*

*I am proud to be a part of this vibrant and energetic Association. An Association, which is ever growing, full of social, cultural and academic activities; open to all. Therefore, I encourage more and more members to get involved as the more we have the better it is for all of us. Allow us to expand with your continuation in unending dedication, volunteering services and donations.*

*I thank all the members and their families for their time and hard work that they put in for the success of this convention.*

*Best regards,*

***Shahin Ahmed,** MD*

*Co-Chair, Reunion Committee and CME Program Co-ordinator*

# We Express Our Sincere Thanks And Gratitude To The Following Sponsors of Our Program

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# Activities

*1st Reunion 2011*


*2nd Reunion 2012*


*2nd Reunion 2012*

*2nd Reunion 2012*

*Sandy Relief*


*Education, Scientific and Network Seminar, SSMC 2012*

*Education, Scientific and Network Seminar, SSMC 2012*

*Education, Scientific and Network Seminar, SSMC 2012*

*ESHA KHOSHNU, M.D.*
1140 BLOOMFIELD AVENUE, ROOM 202, WEST CALDWELL, NJ 07006
Tel 973-575-1107, Fax 973-575-1107

Eating Disorder in Patients with Bipolar Disorder: Is it comorbidity or an episode that leads to Bipolar Disorder?
Background: Eating Disorder is typically treated with antidepressant SSRIs (selective serotonin reuptake inhibitor), as is the Major Depressive Disorder. Bipolar Disorder can present with an episode of Major Depression, yet treatment with SSRI can worsen the treatment outcome and overall clinical course.

***Hypotheses:***

1. Bipolar Disorder can present as an episode of Eating Disorder.
2. Consequently, they can have poor treatment outcome with worse clinical course if treated with SSRI.
3. However, they will have better treatment outcome with proper treatment of Bipolar Disorder with mood stabilizer.

A Case Vignette

I first saw Miss G.Iv. on 03/30/2010; at age 16 years and 6 months, a 5' 8" tall, fairly built, with acne on her face - she looked more mature than her age. On her first visit, she stated, "I really do not know what is the problem, but I get anxious in the middle of the day, get hyped up at night." She stated that she has been diagnosed with Eating Disorder (Bulimic type), a diagnosis that was offered by her therapist who treated her for four years. She reports symptoms of excessive eating, binging, and then purging in excess of two to ten times a day.

She reported crash dieting starting in the fifth grade, which escalated into excessive eating followed by purging, calorie counting, excessive use of the gym and treadmill to lose weight, and she succeeded in becoming 113 pounds at her lowest weight from a weight of 150 pounds.

In her sophomore year, she says that the severity has been to the extent of fainting due to low potassium levels and hypotension requiring frequent visits and treatment in emergency room to balance her electrolytes. She reported having panic attacks, which has lessened in the last two years. She reported having weekly blood tests for electrolytes and is presently within normal limits. She assured me that it would not happen again. Although she has been under the treatment of a therapist for almost four years, she has none at the present time; one day, she walked out from the office of the therapist out of anger and now feeling embarrassed to go back to her. I continued to explore her symptoms further, which revealed decreased focus and attention with a dramatic drop of her school performance from straight A's to B and C grades in recent months. She admitted to having gone days without sleep at night. In subsequent sessions, she described having excessive energy, "craving for movement, stay awake, hyper, constant movement, action, and happiness, and cutting myself, (cutting myself gave me this)."

She also reported, "I was giddy and buzzing on some weird high and have an impulse to throw up food." In her sophomore year, she "graffitied park, shoplifting food, eating it, and then throwing it up, got caught dining and dashing late at night," and then there are times when she would just, "sit at home and cry and have no motivation even to go out."

In describing her symptoms after many months, she stated, "I was depressed before anything started. I hated my-

self. I consciously decide to throw up." She also said, "If I am not anxious, I was just angry, rageful, and snapping at people, yell, scream, and be angry, not care much about anything and then throw up." "This would continue for about 1 ½ weeks and then one day, I would just wake up normal." When I asked about the frequency, she said, "it is never regular and it would go on once or twice a week for three weeks or even once a day." Although she denied hearing any voices, she admitted to hearing her own voice; "at times it would start screaming. It used to be often, but recently, it has been about twice a week." She denied having ever made serious suicidal attempts, but she had made gestures, having constant thoughts of killing herself by hanging or cutting her wrists, four months prior to her first visit with me. She admitted to having cut herself for a long time. She has also taken an overdose of aspirin, up to 7 grams in 15 hours, and was disappointed to find out that it was not a lethal dose. She admitted to using multiple drugs, which included alcohol, marijuana, heroin, cocaine, cigarettes, caffeine, and amphetamines to control her moods and behavior in the past, but never been treated on psychiatric medicine.

Family history was significant for her great-grandfather's suicide and a maternal aunt in treatment with several psychotropics and being on disability. She is the only child. She lived with her parents and was a high school student. She also worked as a waitress and a cashier at Walgreens. She reported that she had good friends a decent family. She denied any history of abuse although she reports being chubby and being called fat starting at the very early age of 7. She denied having ever felt sad or cried about being called fat and never had to defend herself about it.

She was driven to my office by her father for all of her appointments except for the last few visits in June 2011. I initially diagnosed her with Eating Disorder Bulimic type, Eating Disorder Not Otherwise Specified, Polysubstance Dependance in early remission with multiple rule outs, including Anxiety Disorder Not Otherwise Specified, Psychotic Disorder Not Otherwise Specified, Bipolar Disorder Not Otherwise Specified, and Bipolar Disorder with Psychosis. I explained to her the diagnosis and my concern about the possibility of mood swing and the risk of being on antidepressants and SSRIs that are commonly prescribed for Eating Disorders that can potentially worsen the underlying Bipolar Disorder and alter the course and outcome of the treatment and overall clinical outcome. She really did not care about the diagnosis or the treatment and she was willing to take any medication that would not cause weight gain. She adamently decided to only take topiramate and nothing else. On subsequent visits, she reported worsening of concentration and anger, describing it as "mysterious," but she insisted on continuing topiramate as it had lowered her appetite with improvement of the binging and purging behavior. At this time, I confirmed the diagnosis as Bipolar Disorder and had her agree to take lamotrigine. Miss G.Iv. continued having anger and mood swings, even with a dose of 300 milligrams of lamotrigine. Risperidone had no therapeutic response. Although it was hard to convince her to take sodium valproic acid, she agreed as she understood the consequences of her anger, snapping at her teachers, and the disrespectful behavior towards them would jeopardize her education and her future.

She was started on the topiramate on the first day of treatment. Lamotrigine was started in April 2010. Sodium valproate was introduced in November 2010 with improvement but she continued to complain of weight gain and appetite, which was not controlled even with H-2 blocker, so I was bound to stop it in March 2011, four months after it was introduced.

Her concentration continued to decline or not improve with mood stabilization. Clonidine was introduced in March 2011. Although she had some side effects, her concentration improved. Her mood remained fairly stable on

lamotrigine and Clonidine after discontinuation of sodium valproate. My last session with Miss G.Iv. was on June 15, 2011. On that day, she was casually, but neatly dressed. She stated that she would be graduating and leaving New Jersey permanently to go to college out of state, and this was our last session. When I asked about her Eating Disorder, she said, "not at all" but after further exploration, she said, "once or twice a week." She said, "I do not keep track of it. It is not a regular thing." She said, "It became a lifestyle and right now, it is not a lifestyle anymore." Her mood was good, affect was appropriate, and she denied any thoughts of harming herself.

She stated," I gained weight and at an ideal healthy body weight of 145 pounds, but I still struggle to see myself in a healthy way when my standards have been so unhealthy for such a long time. By being treated for my Bipolar Disorder, my eating disorder does not reach such a low point. My minor bulimic tendencies remain, and I consider myself a recovered Eating Disorder patient."

I expressed my pleasure of treating her with a potentially superior treatment outcome. I explained my long-term desire of writing an article on eating disorders in patients with bipolar disorder, and prior disappointments in faiing to complete a treatment course. She enthusiastically gave me permission "even to publish with my full name" if it can help others in the future for proper diagnosis and treatment.

Discussion: It was a pleasure to treat Miss G.Iv. She was not on any SSRIs and was open to try a mood stabilizer. The sessions were long, as she would argue about every clinical opinion I would offer, but at the end would say "Dr. Khoshnu, whatever you think" and accept my recommendations. She was able to finish high school and go to college. I consider that she had potentially a superior treatment outcome with better symptom relief and a better clinical course. Most prior patients with a diagnosis of an Eating Disorder came to my office on SSRIs with poor functioning and poor symptom control. Initially, they would say, "You are the doctor and whatever you say" but in the end, they either did not accept the diagnosis of bipolar disorder or did not follow the treatment recommendations and left my practice. I legitimately remain concerned about the subsequent treatment and overall treatment outcome of these patients with the diagnosis of an eating disorder who might potentially have bipolar disorder.

***Suggestions:***

Future studies are needed –

1. To determine what percentage of Eating Disorders lead to Bipolar Disorders.
2. To explore if Eating Disorders and Bipolar Disorders are comorbidities.
3. To explore if Eating Disorder is an episode that leads to Bipolar Disorder.
4. To compare the treatment outcome and clinical course of patients who are treated with SSRIs for Eating Disorders with the treatment outcome and clinical course of those who are treated with mood stabilizers even if they started having episodes of Eating Disorders.
5. To establish guidelines and develop clinical tools for proper diagnosis of Bipolar Disorder even in the case of onset of Eating Disorder episodes.

# *CASE REPORT*

Sudden Right-Sided Hemiparesis.

***Sumit Mamun,*** *MD, FACP.*

**THE PATIENT**

A 78 Year –old man presented with sudden-onset, right-sided hemiparesis that had begun approximately six hours before. His wife reported expressive aphasia as well.His medical history was significant for hypertension, type 2 diabetes mellitus, and coronary artery disease. The patient also had a history of chronic atrial fibrillation, a left middle cerebral artery stroke in 2010 from which he had made full recovery and stage 3 chronic kidney disease. Six months earlier, the patient's physician changed his prescribed daily warfarin to 75 mg of dabigatran twice daily. He and his wife confirmed adherence to this regimen.

Initial physical examination revealed an irregular pulse with a blood pressure of 162/97 mmHg. Motor strength was 3/5 in the right upper extremity and 4/5 in the right lower extremity. The remainder of his examination, including his speech and mental status, was normal. Admission laboratory values revealed a serum creatinine level of 1.1 mg/dl and corresponding glomerular filtration rate (GFR) between 30 to 50 ml/min. Brain magnetic resonance imaging revealed multiple acute and subacute infarcts involving the territory of the left middle cerebral artery, consistent with recurrent embolic cerebrovascular accident. Magnetic resonance angiography of the head and neck did not demonstrate an alternative source of stroke.

Upon prompt assessment by the neurology team, it was determined that the patient was not a candidate for thrombolysis. Intravenous unfractionated heparin infusion was started, dabigatran was discontinued, and warfarin was reintroduced. The patient's new right-sided hemiparesis persisted, and he was discharged to acute rehabilitation.

**THE DIAGNOSIS**

This patient's diagnosis is a recurrent embolic cerebrovascular accident of presumed cardiac source due to chronic atrial fibrillation. A recurrent embolic event in this high risk patient (CHADS2 score of 5) occurred despite being on anticoagulant therapy with a new direct thrombin inhibitor.

The Randomized Evaluation of Long-Term Anticoagulant Therapy (RE-LY) trial was a non-inferiority trial of warfarin to dabigatran for the prevention of stroke in patients with nonvalvular atrial fibrillation. Dabigatran, given in doses of either 150 mg or 110 mg twice daily, was determined noninferior to warfarin in terms of stroke and systemic embolization. Subsequent subgroup analysis of high-risk patients also suggested similar rates of stroke and systemic embolization with a significantly lower risk of hemorrhage for both 150 mg and 110 mg doses.The FDA approved dabigatran in October 2010 for prevention of stroke in patients with nonvalvular atrial fibrillation at a dose of 150 mg twice a day for patients with a creatinine clearance (CrCl) greater than 30 ml/min, and 75 mg twice a day for patients with a CrCl of 15-30 ml/min.Dabigatran is contraindicated in patients with CrCl of <15 ml/min.

This patient was receiving a dose of dabigatran (75 mg twice daily) that was inadequate for his particular level of renal function.It is also critical to note that the 75 mg dose was not evaluated in the RE-LY trial or in any subgroup analyses, and as such its impact and efficacy upon stroke prevention is unknown.The data regarding dabigatran and other novel anticoagulants continue to evolve; however, this case demonstrates the potential consequences of an incorrect dose and lack of efficacy associated with a dose that was not rigorously studied.This suggests physicians should exercise caution going forward, especially in patients with renal impairment.

**PEARLS**

For patients with nonvalvular atrial fibrillation and chronic kidney disease, warfarin is still the preferred anticoagulant for prevention of embolic cerebrovascular accident.

*P.S. This case report was published in the May,2013 issue of ACP Hospitalist Magazine.Dr. Mamun is from 11th Batch of SSMC and works as a Hospitalist with IPC-The Hospitalist Company in San Antonio,TX.*

# *ORTHOSTATIC HYPOTENSION IN ELDERLY PATIENT*

***Shahin Ahmed***
*North Shore Lij at Glencove*

Case Report: 79-year-old female with severe orthostatic hypotension due to autonomic dysfunction, supine hypertension, and hyperlipidemia who had an episode of syncope which resulted in a C7 fracture. She had a pulse 80 and a blood pressure of 160/88 while sitting and a blood pressure of 120/66 with standing. Her standing blood pressure is 120/88, which is much better than it was before. While she does have occasional dizziness, she has had no further episodes of syncope. Her lungs are clear to auscultation bilaterally. Her cardiac examination revealed a regular rate and rhythm . Her abdomen is benign with no tenderness. Her lower extremities revealed no evidence of edema. Her neurological exam is grossly nonfocal. She appears to be tolerating her current regimen of Pindolol, Midodrine, and Florinef quite well. She has no other neurological signs to suggest that she has either Shy-Drager syndrome or multisystem atrophy.

Therefore, given her improvement, recommend continuing her current regimen of Midodrine, Florinef, and Pindolol at its current doses. She should continue her walking as tolerated and her use of compression stockings. If she continues improving and has no further episode of dizziness, then can start peeling back of her medications, although keeping her on her current dose of Pindolol for now given that that seemed to give her most dramatic improvement in her symptoms.

Discussion: Orthostatic hypotension is a sudden fall in blood pressure that occurs when a person assumes a standing position. It may be caused by hypovolemia (a decreased amount of blood in the body), resulting from the excessive use of diuretics, vasodilators, or other types of drugs, dehydration, or prolonged bed rest. The disorder may be associated with Addison's disease, atherosclerosis (build-up of fatty deposits in the arteries), diabetes, and certain neurological disorders including Shy-Drager syndrome and other dysautonomias. Symptoms, which generally occur after sudden standing, include dizziness, lightheadedness, blurred vision, and syncope (temporary loss of consciousness).

Conclusion: The evaluation and management of orthostatic hypotension must be carried out in the context of the patient's unique clinical circumstances. In some patients, stopping a medication may cause more harm than benefit if the hypotension symptoms are mild.

Orthostatic hypotension may have more than one cause; a patient with mild neurogenic orthostatic hypotension who becomes dehydrated or starts taking a new medication could develop symptomatic orthostatic hypotension. Because orthostatic hypotension is associated with several other morbidities, its diagnosis or onset should prompt the physician to consider other conditions, especially if the patient is elderly.

# রোগ দর্শন

পারভেজ

আধুনিক বিশ্বে যেমন নতুন নতুন জীবানু বাহিত রোগের জন্ম হচ্ছে, তেমনি প্রকোপ বাড়ছে ডায়াবেটিস, উচ্চ রক্তচাপ, হৃদরোগ ও বিভিন্ন রকমের দুরারোগ্য ব্যাধির। এগুলোর মূলে প্রধানত কাজ করছে আমাদের অস্বাস্থ্যকর জীবন যাত্রা। উন্নয়নশীল দেশগুলোতে এর হার মহামারীর আকার ধারণ করছে। উন্নত দেশগুলোতে এখন শিশু-কিশোররাও আক্রান্ত হচ্ছে এসব রোগে। হাজার হাজার বছর ধরে মানুষ বিবর্তিত হয়ে আসছে প্রকৃতির সাথে সামঞ্জস্য রেখে। শত বছর আগে পৃথিবীর লোকসংখ্যা ছিল ১.৬ বিলিয়ন, এখন এসে দাঁড়িয়েছে ৭.০ বিলিয়নের উপরে। আমাদের জীবন যাত্রাও হচ্ছে জটিল থেকে জটিলতর। দ্রুতগতিতে বাড়ছে mental stress, fast food and sedentary life style সমাজে। ভুগছে মানবকূল নানা ব্যাধিতে।

যে রোগ জন্মলগ্নে প্রাপ্ত হয়না, অর্থাৎ non-congenital সেগুলোর মূলে রয়েছে তিনটি কারণ। প্রথমটা বাবা-মায়ের কাছ থেকে পাওয়া Genes (এটা জ্বীন-ভূত নয়, আগে যেটা বিশ্বাস করা হতো)। দ্বিতীয়টা আমাদের পারিপার্শ্বিক অবস্থা (environmental) আর তৃতীয়টা হলো আমাদের ব্যক্তিগত খাদ্যাভ্যাস আর আচার-আচরণ (life-style)। পরের দুটি কারণ আমাদের Genes-কে প্রভাবিত করতে পারে পজিটিভ বা নেগেটিভ ভাবে। এই প্রভাব কাজ করে অন্যান্য Genes-এর সাহায্যে। সুতরাং আমাদের শরীরের একই Genes manifest করতে পারে বিভিন্নভাবে। আপনার স্বাস্থ্য নির্ভর করবে এই তিনের ক্রিয়া প্রতিক্রিয়ার ওপর। এই বিদ্যা হলো epigenetics। পাশ্চাত্যে এই বিদ্যা এখন বেশ গুরুত্ব পাচ্ছে চিকিৎসা শাস্ত্রে। আমার ধারণা এই অজানা রহস্যাবৃত epigenetics হলো সমস্ত বিবর্তনের মূলে। আমাদের জ্ঞান যতই বাড়বে এর সম্বন্ধে, ততই বাড়বে আমাদের রোগ প্রতিরোধ নিরাময়ের উপায়। এ পর্যন্ত মানব শরীরে সর্বসাকুল্যে ২৫,০০০ জীন খুঁজে পাওয়া গেছে, যা দখল করে আছে সমস্ত ডিএনএ-র মোটে ১০ থেকে ১৫ শতাংশ। আমাদের ক্রোমোজমে নিহিত ৮৫-৯০ শতাংশ ডিএনএ-র ক্রিয়াকর্ম এখনও সুস্পষ্ট নয়। যাই হোক, এখন ফিরে আসা যাক মূল বিষয়বস্তুতে।

রোগ-বালাই সব সময় ছিল এবং থাকবে, এতে হতাশ হবেননা। এর ভিতরেই ছোট ছোট সুখ, অল্প-বিস্তর শান্তি খুঁজে নিতে হবে। অসুখ-বিসুখ অনেকটা অর্থ ও সহায়-সম্পত্তির মত। এটা বংশানুক্রমে পেতে পারেন বাবা-মার কাছ থেকে অথবা আপনার ক্রিয়া-কর্মের ফল হিসেবে। প্রথমটা কিছু করার নেই, তবে পরেরটা আপনার উপর নির্ভর করে।

আমাদের শরীর যেমন সহনশীল, তেমনি নাজুকও। সুখের চেয়ে দুখের প্রভাবই বেশী আমাদের জীবনে। কান্না দিয়ে এই জীবনের শুরু। মানুষ নেশা ছাড়া বাঁচেনা। তার একটা অবলম্বন দরকার। সেটাই তার নেশা। একেক সমাজে একেক বয়সে একেক রকম নেশায় আক্রান্ত হয় মানুষ। ঘোরে থাকে সে তখন। ঘোর কাটলে কেউ যায় বিপথে, কেউ পায় নতুন দিগন্তের সন্ধান।

অসুখের ঘোরে থাকলেও একই অবস্থা। পরিমিত খাদ্যাভ্যাস, সংযত আচরণ, পর্যাপ্ত বিশ্রাম, প্রয়োজনীয় ঔষধ সেবন এসবের মাধ্যমে কেউ যায় নিরাময়ের দিকে আবার কেউবা হতাশায় অক্রান্ত হন। আপনাকে প্রথম দলে থাকতে হবে। আরেকটা কথা, শক্তিতে কুলোলে হাত পা ছড়িয়ে খানিকটা exercise করলে আরও ভালো। না পারলে কি আর করা।

খাওয়া-দাওয়ার ব্যাপারে common sense ব্যবহার করবেন। ফলমূল, তরি-তরকারি, tree nuts (অর্থাৎ চীনা বাদাম ছাড়া বাকীগুলো), দুধজাত দ্রব্য, মাছ ও fibre rich খাদ্যসমূহ বেশি করে খাবেন। অল্প খাবেন লবন, মাংস, টিনফুড, ফাস্টফুড ইত্যাদি।

কোন একটা রোগে পড়লে মন খারাপ লাগবে, হতাশা আসবে, হয়তো রাগও লাগবে- এটাই স্বাভাবিক। কিন্তু এগুলো যেন আরোগ্যের পথে অন্তরায় না হয়ে দাঁড়ায়। মনকে শক্ত রাখতে হবে। সাধ্যমতো ভালো চিন্তা করবেন, হাসিমুখে থাকবেন, পরিমিত খাবেন। এতে রোগের অনেকাংশ লাঘব হবে। অযথা মেজাজ গরম করবেননা। এগুলো আপনার ব্রেনের মূল্যবান কোষগুলোর অপূরণীয় ক্ষতি সাধন করে। ব্রেন তার electrical এবং neuro-chemical signals-এর মাধ্যমে শরীরের বিভিন্ন অঙ্গ-প্রত্যঙ্গের কাজ খুব সুক্ষভাবে পরিচালনা করে। তাই ব্রেনের সুস্থতাও অতি কাম্য। চেষ্টা করবেন দুষ্ট প্রবৃত্তি দমন করবার। নিম্নস্বরে কথা বলবেন, সহানুভূতি ও সাহায্যের হাত বাড়াবেন। কখনো হিংসার আগুন জ্বালবেননা কারণ সে আগুনে আপনার ব্রেনের সেল গুলোই পুড়বে। এবার আশা যাক আমার কথায়। প্রায় একান্ন বছর কেটে গেল হেলায় ফেলায়। ছোট বেলায় নীল আকাশে উড়ে বেড়াতাম, মেঘের ভেলায় ভাসতাম। অস্থির ছিলাম বেশ। অনেক স্বপ্ন দেখতাম ভবিষ্যতের। পুঁজির ভান্ডার ছিল শূন্যে ভরা। সমাজের কঠিন বাস্তবতা কখনো আমাকে মন্থর করতে পারেনি। শুন্যের উপর ভরে করে উড়ে এলাম সাত সমুদ্র তের নদী পার হয়ে এই অজানা উপকূলে। বোধহয় সংখ্যাগুলোর মধ্যে শুন্যের জোর সবচেয়ে বেশি। সেটাই ছিল আমার একমাত্র অবলম্বন। তবু মনটা পড়ে থাকে সেই চেনা দেশে। এটাও এক ধরণের নেশা। ঘোর এখনও কাটলোনা।

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ছেলেমেয়েরা পাঠশালায় যায়। তারা ইশিতার চেয়ে বড়। নানা চলে গেলেন দূরের হাই স্কুলে। তিনি সেখানে অংকের শিক্ষক।

পাঠশালা ছুটি হলো তিনটার আগে। এসেই ছুটে গেল ইশিতা ছবি ঘরে। মালা দু'টো এখনও বেশ তাজা। সামান্য নেতিয়ে গেছে তবে সুন্দর শাদা রয়েছে। কাল নাগাদ আরো নেতিয়ে যাবে। বিবর্ণ বাদামী হয়ে যাবে রঙ। ক্ষতি নেই । কাল আরো ফুল ফুটবে, আরো মালা গাঁথবে ইশিতা। অন্তত এই হেমন্তের দিনগুলিতে তো বটে।

সারা বিকেল খেলা-ধুলা, ঝোপে-ঝাড়ে পাকা ফল, গাছের ডালে-আবডালে পাখির বাসা খোঁজে পেতে কেটে গেল। সন্ধ্যায় পড়তে গেল কাছারীতে বড়দের সাথে। পড়া বলতে তো সেই কবিতার বই । বেশ রাত। পড়া শেষ। খাওয়া শেষ। সবার সাথে ইশিতাও এসে বসেছে নানার ঘরের সিঁড়িতে। বাতাসে শেফালী ফুলের সুবার ছড়িয়ে পড়েছে। বাড়ির আর কোথাও কেউ থাকতে চায়না এসময়ে। মামা একটি ডাল নুইয়ে দেখলেন শেফালীর কলি গুলি ফুটি ফুটি করছে। অন্যথায় রাতে এখন দেখা যায়না। মা, খালা, মামারা, ভাই-বোনরা সকলেই উপস্থিত। সুগন্ধে ভারী হয়ে আসা ঠাণ্ডা আমেজ গায়ে মেখে সবাই গল্প করছে। ইশিতা খুশী মনে মায়ের কাছটি ঘেসে বসে শুনছে। হেমন্তের শেফালী ঝরা দিনগুলিতে সে মায়ের কাছ ছেড়ে নানার কাছে ঘুমোচ্ছে। আবার সকালে সে ফুটে ঝরে পড়া শেফালী ফুলের মালা গাঁথবে।

নানা বাড়িতে বেড়ে উঠার দিনগুলিতে সে কত হেমন্তে ঝরে পড়া শেফালী ফুলের মালা গেঁথেছে। তারপর নানা বাড়ির সেই মেঠো পথ ছেড়ে চলে এসেছে ঢাকায়-শহরে। সে কতকাল আগের কথা। ঢাকায় ইশিতা কখনো কোন শেফালীর গাছ দেখেছে কী? তবু তার সৌভাগ্য হয়েছে মালা গাঁথার।

বাসার কাজের ছেলেটা ছোট, নাম তার জয়নাল। এই লক্ষীছাড়া ছেলেটা বারণ না মেনে কোত্থেকে কোত্থেকে ফুল জোগাড় করে এনে ইশিতাকে দিত। কোত্থেকে সে এই ফুল জোগাড় করতো তা স্পষ্ট করে কখনো বলেনি। বোধকরি কারো বাড়ির দেয়ালের বাইরে রাস্তায় ঝরে পড়া ফুল সে কুড়িয়ে আনতো ইশিতার জন্য। ইশিতা মহা আড়ম্বরে বকা দিয়ে সেই ফুল নিত। যখন যা- বেলী, বকুল গোলাপ, শেফালী.....।

শেফালী হলেই ইশিতা মালা গাঁথতো। জার্মানী যাবার আগে শেষ যে মালাটি গাঁথলো সেটি গলায় পরে সে একটি ছবি তুললো। ইশিতা কী বুঝতে পেরেছিল ছোট্ট বেলার অঢেল সেই শেফালী এখন কত বিরল? নানা বাড়ির সেই গাছটাও এখন আর নেই। এক ঠাণ্ডায় সেটি মরে গেছে। তার আগে অনেক দিন থেকে গাছটিতে ফুল আর তেমন ফুটতোনা।

আর আজ? নিতান্ত মৃতপ্রায় দু' একটি শেফালী ফুল সে দেখেছে বনানী কবরস্থানে। কোন সৌভাগ্যবান মৃত ব্যক্তির কবরের কাছে ছোট্ট গাছটিতে নিস্তেজ ঘোলাটে শাদা বিবর্ণ প্রায় ফুলগুলি। মৃত ব্যক্তিটি যেন ফুলগুলিকে ধরে রেখেছেন তাঁর বুকে। শেষ নিঃশ্বাস দিয়েও যেন ফুলগুলিকে রক্ষা করতে চান।

ইশিতার স্মৃতিতে শেফালী ফুল আজো সেই প্রথম দিনের মতোই পরিপূর্ণ, সতেজ, শাদা, সুগন্ধী। স্মৃতির কোঠরে আগলে ধরে কি শেফালীকে অবলুপ্তির করাল গ্রাস থেকে রক্ষা করতে পারবে ইশিতা?

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Patient's Name: _____ Date _____

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**MRI**
☐ With Contrast ☐ Without Contrast
- ☐ Brain
- ☐ Pituitary
- ☐ IAC
- ☐ Posterior Fossa
- ☐ Orbits
- ☐ TMJ
- ☐ Sinuses
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Soft Tissue Neck
- ☐ Chest
- ☐ Abdomen
- ☐ MRCP
- ☐ Pelvis
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Extremity
- ☐ Other: _____

**CT SCANNING**
☐ With Contrast ☐ Without Contrast
- ☐ Brain
- ☐ Posterior Fossa
- ☐ 3D Skull
- ☐ Pituitary
- ☐ Sinuses
- ☐ Orbits
- ☐ TMJ
- ☐ Mastoids
- ☐ Soft Tissue Neck
- ☐ Chest
- ☐ Lung Interstitium/Bronchiectasis
- ☐ Abdomen
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ CT Angiogram
- ☐ Musculoskeletal

_____
_____
_____
_____

**SONOGRAPHY**
- ☐ Abdomen Complete
- ☐ Right Upper Quadrant Limited
- ☐ Kidneys / Bladder
- ☐ Pelvis
  - ☐ Transvaginal
- ☐ Obstetrical Evaluation
- ☐ Breast
- ☐ Thyroid
- ☐ Testes
- ☐ Prostate
- ☐ Carotid Doppler
- ☐ Deep Venous Extrmity Doppler
- ☐ Arterial Doppler
  - ☐ Upper
  - ☐ Lower
  - ☐ Right
  - ☐ Left

**NUCLEAR MEDICINE**
- ☐ Bone Scan (TcMDP)
  - ☐ Whole Body
  - ☐ Limited View
  - ☐ (Specify Area)
  - ☐ 3 Phase (Specify Area)
  - ☐ Spect (Specify Area)
- ☐ Thyroid Uptake &Scan (I-123)
- ☐ Liver / Spleen Scan (Tc S.C.) Spect
- ☐ Hepatobiliary Scan (Tc HIDA)

**BONE DENSITY**
- ☐ Bone Densitometry

**GENERAL X-RAY**
- ☐ Skull
- ☐ Sinuses
- ☐ Chest
- ☐ Ribs
- ☐ Abdomen
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Shoulder
- ☐ Humerus
- ☐ Radius/Ulna
- ☐ Elbow
- ☐ Hand
- ☐ Hips
- ☐ Femur
- ☐ Knee
- ☐ Tibia/Fibula
- ☐ Ankle/Foot
- ☐ Other

_____

**CARDIOLOGY**
- ☐ Thallium - Treadmill
- ☐ Thallium - Pharmacological
- ☐ Myoview - Treadmill
- ☐ Myoview - Pharmacological
- ☐ Treadmill Stress Only
- ☐ Ejection Fraction / MUGA
- ☐ Echocardiogram

**MR ANGIOGRAPHY**
- ☐ MRA Carotids
- ☐ MRA lower Extremity
- ☐ MRA Brain
- ☐ MRA Renal
- ☐ MRA Abdomen

**MAMMOGRAM**
- ☐ SCREENING
- ☐ DIAGNOSTIC
- ☐ SPOT VIEWS

Patient Clinical Hisptory: _____

_____

_____

R/O Dx: _____

_____

## DIRECTIONS

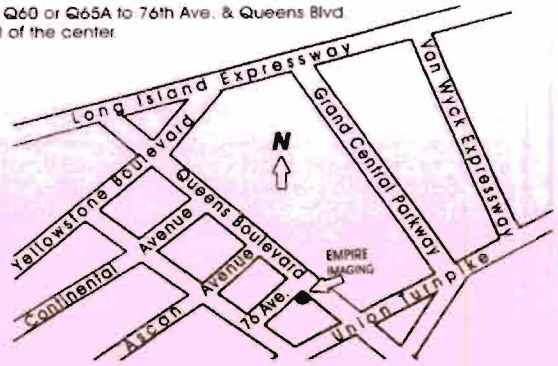
**FROM MANHATTAN:** Grand Central Parkway to Queens Boulevard
Proceed North on Queens Boulevard to 76th Avenue

**FROM LONG ISLAND:** Grand Central Parkway to Queens Blvd., proceed West on left lane or express lane; on Queens Blvd. second light make left on 77th Ave., proceed two blocks to Austin St. Make Right on Austin St., Proceed another two blocks and make a right on 76th Ave. The center is at the corner of 76th Ave. and Queens Blvd.

**FROM LONG ISLAND EXPRESSWAY:** Take exit to Queens Boulevard East
Center is at the corner of 76th Avenue & Queens Blvd.

**MASS TRANSIT:**
**SUBWAY.** Take the "E" train to Union Turnpike. Walk 4 blocks to center, or, take the "F" train to 75th Ave. Walk one block to center. Center is at the corner of 76th Ave &Queens Blvd.

**BUS:** Take the Q60 or Q65A to 76th Ave. & Queens Blvd.
Stop is in front of the center.




## PREPARATION OF EXAMINATIONS

**PELVIC ULTRASOUND:**
Two hours prior to the exam, empty bladder. Within first hour drink 24 oz of water Do not empty bladder. Bladder must be full for examination.

**ABDOMINAL ULTRASOUND:**
Have a non-fatty dinner the night before appointment. Nothing by mouth starting 5 hours prior to the exam.

**M.R. SCAN (MAGNETIC RESONANCE):**
Nothing is required unless specifically directed. Nothing by month 3 hours prior to the exam. If sedated, please bring a friend or family member to drive you home.

**C.T. SCAN:**
- Brain or chest study Inform office if you are Diabetic & taking Glucophage.
- Abdomen and/or pelvis study - Nothing by mouth starting 5 hours prior to your appointment. Inform office if you are Diabetic & taking Glucophage.

Please Note if you have had prior studies of the same body part or organ, please bring all films and reports with you.

MRI contraindications, Cardiac Pacemaker, Aneurysm clip (s) in brain, Ear implants, Metal Objects or Fragments.

Any patient who requires contrast with CT must have a Bun & Creatinine prior and bring lab's with them.

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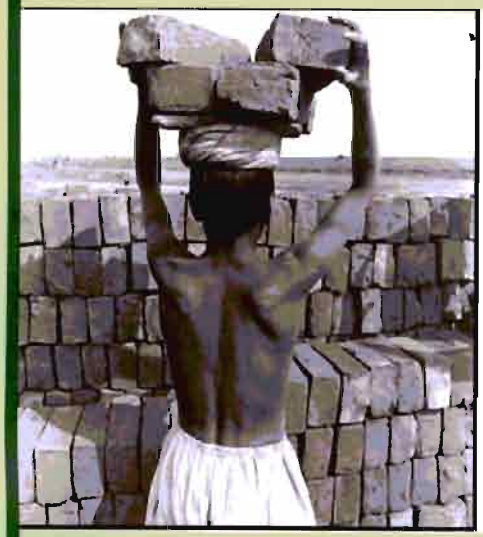

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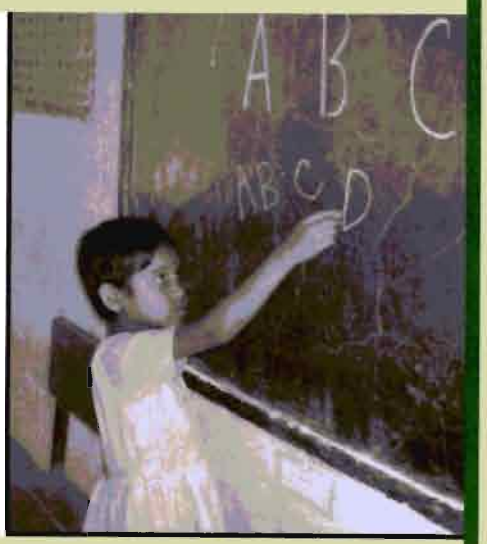
www.distressedchildren.org

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