CHIEF EDITOR DR. SYED MUBIN AKHTAR

KARACHI PSYCHIATRIC HOSPITAL

BULLETIN (Medical and General Articles) NOVEMBER 2013

World Mental Health Day Program: (L-R) Dr. Syed Mubin Akhtar, Prof Inyat Ali Khan, Prof. Dr. Iqbal Afridi, Prof. Dr. Mazhar Malik(Chief guest) and Prof. Dr. Abdul Basit.

Chief Guest Prof. Dr. Mazhar Malik speaking on the occasion of "World Mental Health Day" Program

Dr. Syed Mubin Akhtar presenting Life Time Award to Prof. Dr. Abdul Basit

Dr. Syed Mubin Akhtar presenting Gift to Dr. Ajmal Mughal

Dr. Syed Mubin Akhtar presenting Gift to Pref. Dr. Iqbal Afridi

Dr. Syed Mubin Akhtar presenting Media Award (Rs. 50,000) to Anum Mashkoor of AB TAK TV

WORLD MENTAL HEALTH DAY 2013

Speaking on the subject of year set for World Mental Health Day 'Problems of Older Age People' (L-R) Dr. Syed Mubin Akhtar, Prof. Dr. Mazhar Malik, Prof. Dr. Iqbal Afridi, Prof. Dr. Abdul Basit, Dr. Ajmal Mughal, Dr. Shahid Mustafa, Dr. Akhtar Fareed Siddiqui & Mr. Syed Salahuddin.

Amongst Guests are Prof. Inyat Ali Khan(c) & Directors KPH Mrs. Kausar Mubin, Ms. Mehjabeen Akhtar, Ms. Mahrukh Akhtar & Syed Haider Ali(2nd L)

About 1000 Doctors & their families attended the program

KARACHI PSYCHIATRIC HOSPITAL

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MONTHLY BULLETIN

(Medical and General Articles)

باہمی اتفاق

حضرت ابو درداءؓ روایت کرتے ہیں کہ رسول ﷺ نے ارشاد فرمایا:

"کیا میں تم کو روزہ، نماز اور صدقہ خیرات سے افضل درجہ والی چیز نہ بتاؤں؟"

صحابہؓ نے عرض کیا: ضرور ارشاد فرمایئے:

آپ ﷺ نے ارشاد فرمایا

"باہمی اتفاق سب سے افضل ہے کیونکہ آپس کی نااتفاقی (دین کو) مونڈنے والی چیز ہے، یعنی جیسے استرے سے سر کے بال ایک دم صاف ہو جاتے ہیں ایسے ہی آپس کی لڑائی سے دین ختم ہو جاتا ہے۔"

(حدیث ترمذی)

Readers are requested to send their articles, comments & suggestions.
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'HIJAMA' ANOTHER QUACKERY

By Dr. Syed Mubin Akhtar

A cure for the perpetual pain in the knee quack takes an ordinary blade and punctures a vein. He repeats the procedure a few times. The punctures the left leg slowly bleed out in a metal tray. This is done for religious reasons as well, since the procedure is considered a Sunnat (tradition of Prophet).

The word 'Hijama' is derived from the Arabic word 'Hajam' which literally translated means 'sucking'. The technique involves the placement of highly pressurised cups on various points across the body. Once the blood accumulates in that area small cuts are made, and creating a vacuum bleeds the person. The theory is "Toxins built up over time are released by the procedure."

Those who carry out the procedure and those who get it done, both claim that Hijama is the cure for all illnesses.

Different points on the body have been pre-determined to cure a variety of illnesses while two specific points at the back of the neck have been determined as Sunnat points.

It is used in patients with complaints like stress and anxiety to more chronic diseases like Parkinson, Alzheimer and Cancer.

Since it is considered a Sunnat, the procedure is granted more legitimacy and a wider audience than other alternative treatments. While most are looking for cure, some people also get it done simply because it is a 'Sunnat' and is said to act as a prevention from illnesses.

Most clinics charge their patients per cup, and in the absence of any regulation, patients can be easily exploited. Like other alternative medicines, this one is considered cheaper than modern medicine. Some places are said to be administering Hijama free of cost, in the name of Allah and because "it's a Sunnat".

Syed TajammulHussain, who turned towards Hijama for back pain highlights there is "a financial element to it. The place I went to charged me 300 per cup and placed a total of eleven cups;

however in Saudi Arabia they only place eight cups on a person."

A major problem with Hijama, as with most alternative medical avenues, is the lack of proper training. Countless videos and training courses can be found online while the equipment too is not difficult to procure, thus making anyone an expert since no prior background in medicine is required. This brings into question various other aspects when treating a patient, such as an understanding of their medical history and complications.

Most practitioners agree with this and while they themselves claim to be fully qualified, they will warn you of others.

Every treatment should have proof that it is effective and that is safe; and also that better (more effective and safer) treatments do not exist. This is now done by comparing two similar groups of patients which are given two treatments, one the treatment that is to be tested and the other a sham treatment i.e. placebo. Unless there is a satisfied difference in getting well in the treatment tested group one cannot say it is effective and usable. The side effect profile of the two treatments, are also to be compared.

As far as using this 'treatment' because it was in use in the prophet's (PBUH) time, one can only say that the prophet used and allowed the latest procedures of the time, and Islam never propagates that a Muslim should use an old treatment when a recent more effective and safe treatment is available.

As far as using this treatment because it is a Sunnat(سنت) i.e. use by the prophet at that, then we should be using other Sunnats too i.e. living in thatched houses, riding on camels and horses, using swords, arrows and spears in war. Let us shun these brick mortar houses, the cars motor cycles, buses and aero planes and equip our army with bows, arrows, swords and spears. Just imagine hhow much Sawab(ثواب) we will get.

EXTREME SOCIAL ANXIETY

If a person suffers from anxiety in the company of others then medicines may halp but more effective is "Systemic Desensitization" and "Assertive Therepy".

A LOVE OF STORY, IN PRINT AND IN THE CLINIC

By Kristina Fiore (MedPage Today)

Poetry isn't the first thing that comes to mind when someone mentions Bellevue Hospital -- that storied, grey monolith of psychiatry and urban medicine -- but there is poetry within those walls, and prose, too. It's found in the Bellevue Literary Review.

And that Bellevue tome is not the only example of medical literature currently circulating. There's also plenty of prose at medical centers affiliated with Yale and Harvard. At the latter, students' literary musings are published in a volume called Third Space -- named for the surgical description of anatomical sites that bodily fluids don't normally occupy.

"It's the idea of a volume in your body that's not seen, that's not in a compartment we talk about day-to-day," said Rena Xu, the Harvard medical student who founded the journal. "Just like a lot of our [written] reflections are things that are there but are unseen or not spoken of every day."

Third Space, which Xu started in 2009 as a first-year medical student, is relatively new to the scene of literary journals affiliated with hospitals and medical centers. It joins a niche carved by heavyweights such as The Healing Muse, ArsMedica, and the Bellevue Literary Review.

The publications accept contributions from doctors, nurses, social workers, trainees, and patients. In general, the medical-literary journals provide an opportunity for reflection - something rare in the "constant treadmill of intense experiences" most doctors face, said Bellevue Literary Review editor Danielle Ofri, MD, PhD.

"Writing ... is a chance to go back to seminal events, dissect them slowly, pull them apart, think about what they really mean," Ofri.

Physicians are, by virtue of their profession, enmeshed in the human condition, so it's not surprising that many are drawn to literature. Indeed there is a long tradition of doctors who write, among them Russian playwright Anton Chekhov, Sherlock Holmes' creator Sir Arthur Conan Doyle, and poet William Carlos Williams. More modern physician-authors include Columbia neurologist Oliver Sacks, Harvard's two New Yorker staffers Jerome Groopman and AtulGawande,

author of the best-selling "The Kite Runner," KhaledHosseini, and Yale's Lisa Sanders.

Moreover, there is an increasing recognition of the value of the reflective process involved in writing as a means of honing a healer's skill. For example, more medical schools are incorporating lessons on bedside manner and empathy into their medical student curriculum, sometimes with the help of a dedicated medical humanities department. And more physicians are seeing the value of "narrative medicine" -- a growing field that puts an emphasis on patient story as part of diagnosis and treatment.

Where Angels Fear to Tread

When Ofri and colleagues at New York University's Bellevue Hospital founded the review, they were navigating uncharted territory. No other hospital or medical center published a journal of literature, and Ofri said their model was an established literary magazine, The Missouri Review, where she'd been published.

Long a proponent of humanities in medicine, Ofri was at the time having her medical students write essays about their experiences, as was her department chair, Martin Blaser, MD, an infectious diseases expert. Both thought a literary journal would be an ideal venue for their collective stack of student work. Blaser signed on as publisher, nephrologist Jerome Lowenstein, MD, took the nonfiction editor slot, and, with seed money, office space, and a part-time administrative assistant granted by the department, the BLR was born in the fall of 2001.

The BLR team had put out a call for submissions in Poets & Writers magazine and the response was impressive -- a flood of nearly 1,000 manuscripts from professional writers with health-related stories to tell.

Now, the BLR gets about 4,000 submissions per year from all perspectives in medicine, but can publish only about 2% of them. "As our publisher likes to say, it's more difficult to get published in the BLR than in the New England Journal of Medicine," Ofri joked.

The journal publishes twice a year, in fall and spring, and is largely funded by subscription and contest fees, Ofri said. The most recent issue, published last spring, was almost 200 pages of fiction, poetry, and nonfiction contributed by physicians, nurses, writers, patients, and others.

In keeping with the publication's tradition of using old Bellevue photographs as cover art, the cover of the spring issue is a picture of late 1930s "motorized ambulances" staffed by hospital surgeons.

The fall issue, which marks the literary magazine's 10th anniversary, will be

commemorated by a reading in October featuring, among others, Paul Harding -- author of "Tinkers," the 2010 Pulitzer prize winner for fiction. The book was published by the review's sister project, Bellevue Literary Press, a natural offshoot that took root in 2005 and is led by Jerome Lowenstein, MD.

Both the Review and the Press are housed on the sixth floor of Bellevue Hospital, in a wing with conference rooms and offices that are lined by bookshelves stacked with back issues of the journal and several copies of "Tinkers" -- the paperback version with the Pulitzer Prize medallion emblazoned on the cover.

Of Physicians and Writers

At the same time that Ofri, Blaser, and Lowenstein were envisioning a new publication, the late poet Bonnie St. Andrews, PhD, was working with clinicians at the State University of New York (SUNY) Upstate Medical University to establish The Healing Muse.

That journal also launched in fall 2001, though at first it was open only to members of the academic community in Syracuse, according to Deirdre Neilen, PhD, who took over as editor of the journal after St. Andrews died of a brain tumor in 2003.

Once the journal established a Web presence in 2004, Neilen says the floodgates opened, garnering international submissions from doctors and patients alike. In addition to publishing medical fiction, nonfiction, and poetry in an annual issue, the journal prints photographs and paintings, often in full color.

In 2004, Allan Peterkin, MD, of the University of Toronto's Mount Sinai Hospital, and colleagues in the department of psychiatry there founded ArsMedica, the first literary journal of medical humanities in Canada.

Peterkin and colleagues shared a love of literature and creative writing, and were able to advance their goals of publishing a semi-annual journal with support from the chief of the psychiatry department and the Mt. Sinai Hospital Foundation.

The journal, which is now partnered with the University of Toronto Press, also publishes pieces from physicians, nurses, patients, and writers. "The goal is to create a literary journal that people want to read, with high-quality poetry, fiction, and creative nonfiction," Peterkin said, adding thatArsMedica also puts an emphasis on publishing visual images - especially photography and painting.

There are several other medical centers that publish literary journals -- some are open to a wide range of submissions, while others serve the creative expression of the center's employees.

The University of Oklahoma's Blood &

Thunder, for instance, puts out an annual issue with a variety of voices, while the University of New Mexico Health Sciences Center's Medical Muse and Hershey Medical Center's Wild Onions showcase employees' works.

Some journals, like Xu'sThird Space, are published online-only, without a print counterpart. These also include Pulse, the literary journal affiliated with the Albert Einstein College of Medicine in New York, the University of Virginia's Hospital Drive, and the Yale Journal for Humanities in Medicine.

A handful of prominent scientific medical journals dedicate a regular page or column to the humanities, including JAMA's "Piece of My Mind" column, CMAJ's humanities section, and Health Affairs' "Narrative Matters," a peer-reviewed, personal essay section dedicated to literary nonfiction.

So many venues exist because doctors "really like to talk about literature and read, much more than lots of people would realize, and more than other people you run into when you just chat with them," said the writer Lee Gutkind, who is often credited with naming the genre of "creative nonfiction," and who has written about -- and encourages writing among -- doctors.

"A physician's life is very similar to a writer's life -- the intense isolation, the feeling of being alone so often, even though there are all kinds of people around you, and especially with surgeons, the method and the craft that you had to use in order to become successful," Gutkind told MedPage Today. He's written about organ transplantation, childhood mental illness, and life inside a children's hospital. He's also edited collections of essays on healthcare, including the soon-to-be-published "Twelve Breaths a Minute," as well as "Becoming a Doctor," a volume of essays by clinicians, to which Ofri contributed.

Perhaps with the exception of those who write only fiction, doctor-authors have to be concerned about patient privacy. Most agree that asking a patient's permission to publish something written about them -- especially if identifying details have been changed -- is sufficient, and most are happy to oblige.

Peterkin even recalled one story in which a pediatrician wrote about a child who was given a poor prognosis when diagnosed with neonatal meningitis. When the writer asked the child's mother whether it would be okay to share the story. She said yes, but wanted to write her own view of the story as well.

Both pieces were published together in an issue of ArsMedica.

Narrative Medicine

There's a growing school of thought that physicians can put their love of

story and their literary talents to work in the clinic. It's called narrative medicine.

Rita Charon, MD, PhD, of Columbia University -- her PhD is in English -- has fostered the growth of the term, and established the nation's first master's degree in narrative medicine at the university. The program's third class, a mix of doctors, nurses, social workers, chaplains, and others, is just about to begin its year-long curriculum.

Charon's short definition of the term is this: "clinical practice fortified with the skills of knowing what to do with stories." She encourages students to be able to enter the narrative world of their patients, and believe in the reality of that world as part of diagnosis and treatment.

"All of us suffer by a restricted notion of what's my job, what's my responsibility," as well as a "constricting notion of what within myself I can put to use in being a doctor."

But putting to use in the clinic the imagination of a creative writer isn't an easy item to bill. Nor do physicians, constrained by tight patient schedules dictated by reimbursement issues, have time to take in all of the backstory.

Charon says sometimes she'll set aside a full hour for the first patient visit to get the full narrative, which enables her to have regularly allotted visits in the future. The cost-efficacy comes further down the line, she said.

One of her patients, for instance, developed a recurrence of breast cancer, and her fears that it would return a third time could not be consoled -- until Charon realized that it was the patient's glimpse of her own mortality that was causing the problem.

"I told her, 'your body probably harbors the disease that's going to kill you. It may be breast cancer, it may not be.' And just saying that made the whole thing different. She felt fine, her worry went away, she stopped bugging the breast surgeon, she relaxed."

Charon said allaying her fears likely cut costs of procedures that the patient would have requested, such as MRIs of the chest wall, and subsequent side effects of the tracer.

Trying to measure the actual benefits of narrative medicine is clearly a challenge. Nevertheless, it is catching on, being incorporated into medical school curricula across the country.

Waid Shelton, MD, of the University of Alabama at Birmingham, has been working to bring narrative medicine to his university, emphasizing reading and writing during student clerkship. Pulse editor and Albert Einstein's Paul Gross, MD, said his clerkship students also have a one-hour session on narrative medicine.

Narrative medicine is not a completely new idea, in the sense that many universities have had established

departments of medical humanities, some for many years.

In some instances, medical literary journals arose out of these departments; in others, the journals came first. The Bellevue Literary Review, for example, ultimately led to a department of medical humanities, as did ArsMedica. On the other hand, The Healing Muse was borne of such a department.

Howard Spiro, MD, an emeritus professor of gastroenterology and current editor of the Yale Journal of Humanities in Medicine, set up the "first or second medical humanities program in the country" in 1983 -- the journal didn't follow until 20 years later.

Spiro laments that medical training today tends to diminish student empathy, even though most start careers in medicine because they are humanists. Evidence-based medicine is partially to blame, Spiro said, since it has squeezed out the importance of the clinician's own experience.

"Emphasis on evidence has changed the whole world of medicine," Spiro told MedPage Today. "Doctors are far more interested in the body than in the mind. The brain we understand quite well, but we need the humanities to help us understand the mind."

Not Just the Facts, Ma'am

Proponents of the medical humanities don't want to diminish the importance of evidence-based medicine. Most would like to see studies that could answer whether elements such as narrative medicine or empathy training can improve patient outcomes.

They've grown used to fielding questions about whether skills like listening and empathy can even be taught.

Charon ostensibly thinks they can, and Gross said, at the very least, these characteristics can be fostered.

While proponents still encounter critics who see their programs as hokey or frivolous, most hold that humanities in medicine are rapidly gaining momentum.

"There's kind of a zeitgeist in medicine involving the teaching of humanities, a wave of people seeing relevance of things like bedside manner, mindfulness, presence, a reflective ability -- this whole notion of narrative medicine and really bearing witness to a person's story," Peterkin said. "All of this is kind of brewing just now."

Gutkind said he doesn't necessarily see an "explosion of awareness" of narrative medicine among the medical community, but acknowledges that the tide is rising slowly and carefully: "They're all becoming more aware that there's more to life than 'just the facts, ma'am.'"

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http://www.medpagetoday.com/special-reports/specialreports/28449

CONFESSIONS OF A CHRONIC CRIER

Tired of being called hysterical, unstable, even manipulative, Taffy Brodesser-Akner sets out to cure a lifelong habit of tearing up at inopportune times.

By Taffy Brodesser-Akner

I am 30 seconds into a discussion with an administrator at my son's daycare when I feel it coming. I have asked her to watch out for another boy who has been biting my son, but she brushes off my concerns. "It's just a phase," she tells me. "It will stop. Besides, the boy who bites is much smaller than your son."

In that moment when I feel ignored, dismissed, infuriated (because, really, what kind of argument is that? Do we dismiss shooters who are shorter than those they shoot?), my cheeks flush, and I start to cry. Mind you, I'm not sobbing. I'm not hiccuping for air. But it doesn't matter. I learned long ago that the sudden appearance of tears turns me into someone who is not to be taken seriously.

I'm a crier. Like many people, I cry at funerals and graduations or when I hear a sad story. The problem is that I also cry when I need to confront someone or when I am discussing anything with a foregone negative conclusion. And I am tired of my inability to contain my emotions; I am tired of feeling like a total mess. So I have decided: It's time to learn to control my tears.

Don't believe people who tell you that you should just "let it out." In everyday human interactions, crying isn't innocuous. While researching this story, I discussed the subject with everyone from academics to acquaintances and learned that there are two distinct groups of people: those who cry too much, and those who are annoyed by them.

Among the latter, the word that popped up most often was manipulative. One researcher reasoned that if children turn on tears to defuse anger, adults surely do, too. And a friend told me about a coworker who seemed to cry to get people off her back. Their stories reminded me of my former boss, who once blurted out that he was tired of being "held hostage" by my tears in budget meetings. (I was eventually replaced by a woman whose neck got blotchy when she was uncomfortable. On meeting days, she wore turtlenecks.)

I'm not trying to be manipulative when I cry-at least not consciously. A 2011 Israeli study published in the journal Science found that female tears contain an odorless chemical that appears to reduce testosterone levels in men; high levels of testosterone are associated with aggression, so one function of women's

tears, it seems, could be to stop men who are on the attack. In those budget meetings where my boss would repeatedly ask me aggressively to justify my spending, perhaps I was only heeding nature's call.

The Israeli study could also explain the resentment my tears provoked, says Helen Fisher, PhD, an anthropologist at Rutgers University: "Once someone cries, the playing field is no longer level. With their testosterone reduced, men feel empathy when perhaps what they wanted to do was get angry."

But no matter the motivation behind tears, they are rooted in sincere emotion, says William H. Frey II, PhD, a neuroscientist at Regions Hospital in St. Paul and the author of Crying: The Mystery of Tears: "I have never been able to get subjects to cry without an authentic emotional trigger." (To create tears in the lab, he has had to resort to screenings of heartbreakingly sad movies like The Champ.) You can't fake tears, which is probably why they're so hard to turn off.

So how do I stop crying at inopportune times (like, say, when I'm discussing my uterus with my obstetrician)?

Some of the experts I interviewed suggested pinching the bridge of my nose, where the tear ducts are, to stop the flow. But I couldn't get my hand to my nose fast enough. And though I received excellent advice about rehearsing nontearful things I might say in a confrontation, such as the one with my son's daycare administrator, that didn't work, either.

Then Jerry Bubrick, PhD, a cognitive and behavioral psychologist in New York City, told me to take a step back-literally. "It's not what the other person says that's causing you to cry," he explained. "It's how you interpret it." I'd never thought of it this way, but Bubrick had hit on something that made sense. I may be frustrated or angry in the moment, but I can decide which insults or slights are worthy of such an outpouring of emotion. Getting to the root of why I well up so easily will probably take a lifetime of therapy, but for now, Bubrick provided me with a practical way to deal with its effects. The trick, he told me, is to remove myself from the drama, even by just a foot, to short-circuit the usual rush of tears.

As I listened to Bubrick talk about the possible effect of something so simple on my mental state, I remembered a study I had come across weeks earlier, suggesting that even our facial expressions can influence how our brains process emotions. Researchers at Columbia University had found that study participants reported having a less intense emotional reaction to a scary video when they didn't frown during the viewing. Was it possible, since I enter most fraught interactions with eyebrows raised and knitted together, mouth pressed into a frown, that my expression might actually be triggering the feelings that lead to tears? If so, could I really cure the crying problem with a neutral face and a single step away from whatever was upsetting me? It seemed unlikely, but I decided to give it a try.

Two days after speaking with Bubrick, I

showed up for a doctor's appointment only to learn that the doctor wasn't in. His assistant cavalierly mentioned, without a trace of apology, that he had meant to cancel my appointment but got distracted. Meanwhile, I had hired a babysitter, blown a deadline, and driven an hour through maddening traffic to get there. I felt anger welling up. But instead of getting flustered, I relaxed my face and took a step away from the counter, which felt only a little weird.

"Are you kidding me?" I blinked, tearless.

And then: "That's incredibly rude."

It was a small victory-but an unbelievably empowering one. For the first time in 25 years, I expressed a strong emotion without dissolving under its weight.

Since then I've been practicing the new technique-in talks with my husband about money, in a minor confrontation with a friend, in meetings with editors. It's sometimes hard to remember to use the tricks in the heat of the moment, but with every tearless encounter I'm gaining confidence that my emotions won't get the best of me. I recently made a follow-up visit to my son's daycare, where I told the administrator I was transferring him to a preschool. When I gave her the news, my eyes were as dry as her heart was cold-and that felt right.

Why Men Don't Cry-at Least Not As Much

Women cry far more often than men: 5.3 times per month on average, versus men's 1.4, according to research by neuroscientist William Frey. Cultural factors are certainly at work-while little boys cry as often as little girls, we know that boys aren't exactly celebrated for their emotional facility. But there are biological explanations as well. When puberty hits and hormones (testosterone in men, prolactin in women) start to flood the body, tear glands begin to develop differently between the sexes, says Frey. As a result, a man and a woman may experience the same level of emotion, but a man's body is less likely to produce tears.

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http://www.oprah.com/spirit/How-to-Stop-Crying-Controlling-Your-Emotions

THE PRESSURE NATRIURESIS RESPONSE TO A PHYSICIAN VISIT IN A PEDIATRIC POPULATION

Mulloy EA, et al

The presence of sodium in urine may help identify children and adolescents with true high blood pressure, as opposed to that caused by anxiety, a small study suggested.

Out of 18 outpatients (ages 10 to 19) who had their urine tested, eight retained a median of 73.5 mg of sodium per hour -- about one-third the amount of sodium in an order of french fries, Gregory Harshfield, PhD.

The "retainers" had a mean increase in systolic blood pressure of 5.4 mmHg during the office visit and seven of them were found to be hypertensive.

The patients who did not retain sodium ("excretors") filtered about 141.6 mg of sodium per hour and showed a small decrease in systolic blood pressure by a mean of 0.7 mmHg.

Harshfield said they didn't identify a cutoff point for when retained sodium might not signal a problem.

"I don't think it's about how much sodium is being retained, but rather the fact that it is being retained at all," Harshfield told.

"It should be a red flag when a child or adolescent is not excreting sodium properly, no matter at what level," he added.

The reported prevalence of white coat hypertension varies according to the definition used and the population studied, according to Marc Lande, MD.

"A reasonable estimate is that about one-third of children referred to a hypertension specialist for elevated blood pressure will have white coat hypertension," Lande, who was not involved in the study.

He called the results of the study "exciting" and consistent with previous work by Harshfield and colleagues. "If confirmed as a useful test, these measures could easily be incorporated into the evaluation of children with elevated blood pressure."

For the study, Harshfield and colleagues collected urine samples and blood pressure readings before and after an outpatient visit to establish baseline and stress values, respectively. Twelve of the patients were black, the rest were white.

Sodium retainers had a mean age of 16 and an average BMI of 30, while sodium excretors had a mean age of 15 and

average BMI of 25.

The study is too small for us to draw any conclusions regarding why retainers had higher BMIs than excretors.

Among the seven retainers who had hypertension, four were African American and three were white.

Sodium retention increases fluid in the blood vessels, which can impact blood pressure. High blood pressure can develop over time if the body can't properly regulate sodium, and is a serious risk factor for heart disease and stroke, Harshfield commented.

Studies of adults have linked sodium consumption with increases in serum uric acid and urine albumin excretion -- "two markers of endothelial dysfunction" -- and have shown an association with uric acid levels and hypertension.

"There is evidence in adults -- with emerging evidence in youth -- that salt sensitive persons may have a higher rate of developing incident hypertension," Elaine M. Urbina, MD, MS,.

Urbina, who was not involved in the Harshfield study, suggested that doctors take a "careful diet history" in young persons with high blood pressure and recommend reducing salt and eating more fruit and vegetables.

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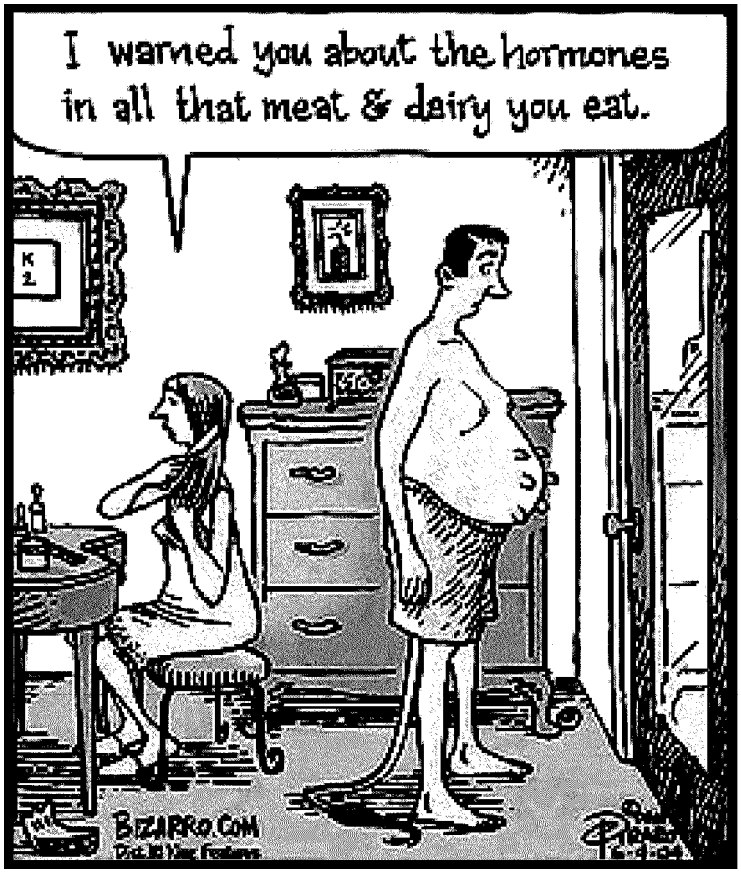
http://www.medpagetoday.com/TheGuptaGuide/Pediatrics/41572?xid=nl_mpt_guptaguide



THE HUMAN URINE METABOLOME

David S. Wishart&Others ..PLoS ONE

"Urine is an incredibly complex biofluid. We had no idea there could be so many different compounds going into our toilets," noted David Wishart.

Wishart's research team used state-of-the-art analytical chemistry techniques including nuclear magnetic resonance spectroscopy, gas chromatography, mass spectrometry and liquid chromatography to systematically identify and quantify hundreds of compounds from a wide range of human urine samples.

To help supplement their experimental results, they also used computer-based data mining techniques to scour more than 100 years of published scientific literature about human urine. This chemical inventory -- which includes chemical names, synonyms, descriptions, structures, concentrations and disease associations for thousands of urinary metabolites -- is housed in a freely available database called the Urine Metabolome Database, or UMDB. The UMDB is a worldwide reference resource to facilitate clinical, drug and environmental urinalysis. The UMDB is maintained by The Metabolomics Innovation Centre, Canada's national metabolomics core facility.

The chemical composition of urine is of particular interest to physicians, nutritionists and environmental scientists because it reveals key information not only about a person's health, but also about what they have eaten, what they are drinking, what drugs they are taking and what pollutants they may have been exposed to in their environment. Analysis of urine for medical purposes dates back more than 3,000 years. In fact, up until the late 1800s, urine analysis using colour, taste and smell (called uroscopy) was one of the primary methods early physicians used to diagnose disease. Even today, millions of chemically based urine tests are performed every day to identify newborn metabolic disorders, diagnose diabetes, monitor kidney function, confirm bladder infections and detect illicit drug use.

"Most medical textbooks only list 50 to 100 chemicals in urine, and most common clinical urine tests only measure six to seven compounds," said Wishart. "Expanding the list of known chemicals in urine by a factor of 30 and improving the technology so that we can detect hundreds of urine chemicals at a time could be a real

game-changer for medical testing." Wishart says this study is particularly significant because it will allow a whole new generation of fast, cheap and painless medical tests to be performed using urine instead of blood or tissue biopsies. In particular, he notes that new urine-based diagnostic tests for colon cancer, prostate cancer, celiac disease, ulcerative colitis, pneumonia and organ transplant rejection are already being developed or are about to enter the marketplace, thanks in part to this work.

The Human Urine Metabolome paper appeared today in PLOS ONE. The word metabolome (which is derived from the words "metabolism" and "genome") is defined as the complete collection of metabolites or chemicals found in a particular organism or tissue. The human urine study is part of a series of studies by researchers at the University of Alberta aimed at systematically characterizing the entire human metabolome. In 2008 the same U of A team described the chemical composition of human cerebrospinal fluid and in 2011 they determined the chemical composition of human blood.

"This is certainly not the final word on the chemical composition of urine," Wishart said. "As new techniques are developed and as more sensitive instruments are produced, I am sure that hundreds more urinary compounds will be identified. In fact, new compounds are being added to the UMDB almost every day.

"While the human genome project certainly continues to capture most of the world's attention, I believe that these studies on the human metabolome are already having a far more significant and immediate impact on human health."

http://www.sciencedaily.com/releases

COFFEE, CAFFEINE, AND RISK OF COMPLETED SUICIDE: RESULTS FROM THREE PROSPECTIVE COHORTS OF AMERICAN ADULTS

Lucas M, O'Reilly EJ, Pan A, Mirzaei F, Willett WC, Okereke OI,

Most people look forward to their morning jolt from coffee, but could that cup of Joe be doing more than keeping us alert? According to researchers from Harvard University, java may indeed have another benefit-that of reducing suicide risk.Dr. Michel Lucas and colleagues leveraged three large studies of US men and women-the Health Professionals Follow-up Study (1988-2008; n=43,599 men), the Nurses' Health Study (1992-2008; n=73,820 women), and the NHS II (1993-2007; n=91,005 women) in which consumption of caffeine, coffee, and decaffeinated coffee was assessed every 4 years by validated food-frequency questionnaires. (Although the researchers looked at caffeine consumption from other sources such as tea, soft drinks, and chocolate, they found the major caffeine source was coffee.) In total, there were 277 deaths as a result of suicide.

In examining the pooled multivariate relative risk, Lucas et al. found that drinking caffeinated coffee actually decreased the risk of suicide. Specifically, drinking at least two to three cups (8 oz) of caffeinated coffee per day seemed to reduce the risk of suicide by about 50% as compared to those participants who consumed 1 or less cup of coffee per day. Lucas and colleagues found only small increases in benefits for drinking more than 3 cups of caffeinated coffee per day.

"Unlike previous investigations, we were able to assess association of consumption of caffeinated and non-caffeinated beverages, and we identify caffeine as the most likely candidate of any putative protective effect of coffee," Lucas said in a press statement.

Previous research has suggested that caffeine boosts such neurotransmitters as serotonin, dopamine, and noradrenaline in the brain, which have mild antidepressant effects. This may be the reason behind the apparent reduced suicide risk. Nonetheless, there are negative effects associated with caffeine, so the researchers cautioned patients and clinicians about large amounts of caffeine intake.

YOUR BOTTLED WATER HAS 24,500 CHEMICALS

By Emily Main for RodaleNews

Paying $2 for a bottle of water may be more convenient than lugging around your reusable one, but that seemingly small price may have a big impact on your health. German researchers found nearly 25,000 chemicals in a single bottle of water, some of which act like potent pharmaceuticals in your body, according to a study just published in the journal PLoS One.

The study's authors purchased 18 different samples of commercially sold bottled water from France, Italy, and Germany. Using various methods of chemical analysis, they tested the water for its ability to interfere with the body's estrogen and androgen (testosterone and other male reproductive hormone) receptors. The researchers threw in a sample of tap water to act as a sort of ringer, and the results were stunning. The majority of bottled waters tested interfered with both kinds of hormone receptors to some degree; amounts as little as 0.1 ounces inhibited estrogenic activity by 60% and androgenic activity by 90%. The latter, the researchers wrote, is equivalent to the hormonal activity of the drug flutamide, a drug commonly prescribed to men suffering from prostate cancer. The tap water didn't exhibit any estrogenic or androgenic activity.

For the second part of the study, the scientists investigated which chemicals were causing the reproductive hormonal interferences. They used another form of chemical detection and discovered the water contained 24,520 differentchemicals. The most hormonally active belonged to classes of chemicals called maleates and fumarates, which are used to manufacture the form of plastic resins used in water bottles. They can also appear as contaminants of other plastic chemicals.

The mere presence of these chemicals doesn't mean that bottled water is going to cause you major lifelong problems, but it is disturbing. Hormonally active chemicals, usually called endocrine disruptors, are known to interfere with the reproductive development of children, but more research is finding that they can also trigger heart disease, diabetes, and infertility, among other problems, in adults. It's concerning that they make it into bottled water, Bruce Blumberg, PhD, of the University of California-Irvine, told Britain's Royal Society of Chemicals. "It is a bit early to make any strong inferences about how detrimental these chemicals will be toward human health," he says, but adds, "It is certain that they are not beneficial."

Carry a refillable nontoxic glass or stainless steel bottle with you wherever you go, and you'll avoid all those problems-and save a fortune, to boot.

More from Prevention: The 6 Best Water Bottles For Your Workout.

PHARMACOLOGICAL INTERVENTIONS FOR SMOKING CESSATION: AN OVERVIEW AND NETWORK META-ANALYSIS

ABSTRACT

Background

Smoking is the leading preventable cause of illness and premature death worldwide. Some medications have been proven to help people to quit, with three licensed for this purpose in Europe and the USA: nicotine replacement therapy (NRT), bupropion, and varenicline. Cytisine (a treatment pharmacologically similar to varenicline) is also licensed for use in Russia and some of the former socialist economy countries. Other therapies, including nortriptyline, have also been tested for effectiveness.

Objectives

How do NRT, bupropion and varenicline compare with placebo and with each other in achieving long-term abstinence (six months or longer)? How do the remaining treatments compare with placebo in achieving long-term abstinence? How do the risks of adverse and serious adverse events (SAEs) compare between the treatments, and are there instances where the harms may outweigh the benefits?

Methods

The overview is restricted to Cochrane reviews, all of which include randomised trials. Participants are usually adult smokers, but we exclude reviews of smoking cessation for pregnant women and in particular disease groups or specific settings. We cover nicotine replacement therapy (NRT), antidepressants (bupropion and nortriptyline), nicotine receptor partial agonists (varenicline and cytisine), anxiolytics, selective type 1 cannabinoid receptor antagonists (rimonabant), clonidine, lobeline, dianicline, mecamylamine, Nicobrevin, opioid antagonists, nicotine vaccines, and silver acetate. Our outcome for benefit is continuous or prolonged abstinence at least six months from the start of treatment. Our outcome for harms is the incidence of serious adverse events associated with each of the treatments.

We searched the Cochrane Database of Systematic Reviews (CDSR) in The Cochrane Library, for any reviews with 'smoking' in the title, abstract or keyword fields. The last search was conducted in November 2012. We assessed methodological quality using a revised version of the AMSTAR scale. For NRT, bupropion and varenicline we conducted network meta-analyses, comparing each with the others and with placebo for benefit, and varenicline and bupropion for risks of serious adverse events.

Main results

We identified 12 treatment-specific reviews. The analyses covered 267 studies, involving 101,804 participants. Both NRT and bupropion were superior to placebo (odds ratios (OR) 1.84; 95% credible interval (CredI) 1.71 to 1.99, and

1.82; 95% CredI 1.60 to 2.06 respectively). Varenicline increased the odds of quitting compared with placebo (OR 2.88; 95% CredI 2.40 to 3.47). Head-to-head comparisons between bupropion and NRT showed equal efficacy (OR 0.99; 95% CredI 0.86 to 1.13). Varenicline was superior to single forms of NRT (OR 1.57; 95% CredI 1.29 to 1.91), and to bupropion (OR 1.59; 95% CredI 1.29 to 1.96).

Varenicline was more effective than nicotine patch (OR 1.51; 95% CredI 1.22 to 1.87), than nicotine gum (OR 1.72; 95% CredI 1.38 to 2.13), and than 'other' NRT (inhaler, spray, tablets, lozenges; OR 1.42; 95% CredI 1.12 to 1.79), but was not more effective than combination NRT (OR 1.06; 95% CredI 0.75 to 1.48). Combination NRT also outperformed single formulations. The four categories of NRT performed similarly against each other, apart from 'other' NRT, which was marginally more effective than NRT gum (OR 1.21; 95% CredI 1.01 to 1.46).

Cytisine (a nicotine receptor partial agonist) returned positive findings (risk ratio (RR) 3.98; 95% CI 2.01 to 7.87), without significant adverse events or SAEs. Across the 82 included and excluded bupropion trials, our estimate of six seizures in the bupropion arms versus none in the placebo arms was lower than the expected rate (1:1000), at about 1:1500. SAE meta-analysis of the bupropion studies demonstrated no excess of neuropsychiatric (RR 0.88; 95% CI 0.31 to 2.50) or cardiovascular events (RR 0.77; 95% CI 0.37 to 1.59). SAE meta-analysis of 14 varenicline trials found no difference between the varenicline and placebo arms (RR 1.06; 95% CI 0.72 to 1.55), and subgroup analyses detected no significant excess of neuropsychiatric events (RR 0.53; 95% CI 0.17 to 1.67), or of cardiac events (RR 1.26; 95% CI 0.62 to 2.56). Nortriptyline increased the chances of quitting (RR 2.03; 95% CI 1.48 to 2.78). Neither nortriptyline nor bupropion were shown to enhance the effect of NRT compared with NRT alone. Clonidine increased the chances of quitting (RR 1.63; 95% CI 1.22 to 2.18), but this was offset by a dose-dependent rise in adverse events. Mecamylamine in combination with NRT may increase the chances of quitting, but the current evidence is inconclusive. Other treatments failed to demonstrate a benefit compared with placebo. Nicotine vaccines are not yet licensed for use as an aid to smoking cessation or relapse prevention. Nicobrevin's UK license is now revoked, and the manufacturers of rimonabant, taranabant and dianicline are no longer supporting the development or testing of these treatments.

Authors' conclusions

NRT, bupropion, varenicline and cytisine have been shown to improve the chances of quitting. Combination NRT and varenicline are equally effective as quitting aids. Nortriptyline also improves the chances of quitting. On current evidence, none of the treatments appear to have an incidence of adverse events that would mitigate their use.

Further research is warranted into the safety of varenicline and into cytisine's potential as an effective and affordable treatment, but not into the efficacy and safety of NRT.

VARDENAFIL IMPROVES PENILE ERECTION IN TYPE 2 DIABETES MELLITUS PATIENTS WITH ERECTILE DYSFUNCTION: ROLE OF TROPOMYOSIN

Zamorano-León JJ & Others AJ.. J Sex Med

ABSTRACT

Introduction: Evidences have been suggested that phosphodiesterase type 5 (PDE5) inhibition promotes vasculoprotective benefits in patients with cardiovascular diseases.

Aim: The aim of this study is to analyze the systemic effect of PDE5 inhibition in type 2 diabetes mellitus patients with erectile dysfunction (ED) determining changes in the expression levels of plasma proteins.

Methods: Seventeen patients with controlled type 2 diabetes mellitus and ED were included in the study. Patients received vardenafil hydrochloride 20?mg on demand during 12?weeks. At the beginning and 12?weeks after vardenafil administration, plasma samples were collected and analyzed using proteomics.

Main Outcome Measures: International Index of Erectile Function-Erectile Function Domain (IIEF-EFD) and plasma protein expression before and after vardenafil administration. Nitrate/nitrite release, PDE5, and soluble guanylatecyclase (sGC) expression and cyclic guanosine monophosphate (cGMP) content in cultured bovine aortic endothelial cells (BAECs).

Results: The IIEF-EFD score was markedly improved after 12?weeks of vardenafil administration. Plasma levels of alpha 1-antitrypsin isotypes 4 and 6 and ?-tropomyosin were decreased, whereas apolipoprotein AI isoype 5 was increased 12?weeks after vardenafil administration. Only ?-tropomyosin plasma levels were inversely correlated with IIEF-EFD score. Tropomyosin has been added to cultured BAECs and after 24?hours reduced the protein expression level of sGC-?1 subunit and decreased the cGMP content. Tropomyosin did not modify PDE5 expression and nitric oxide release in BAECs as compared with control BAECs. Vardenafil (10??g/mL) did not modify sGC-?1 subunit expression in tropomyosin?+?vardenafil-incubated BAECs; however, vardenafil significantly reversed the reduction of cGMP content induced by tropomyosin.

Conclusion: Vardenafil administration improved erectile functionality in controlled type 2 diabetes mellitus patients with ED, which was associated with reduction of circulating plasma ?-tropomyosin levels. Tropomyosin affected by itself the cGMP generating system suggesting a possible new mechanism involved in ED. Vardenafil reversed the reduction effect of cGMP content elicited by tropomyosin in BAECs.

http://onlinelibrary.wiley.com/doi

THE SEXUAL FUNCTION QUESTIONNAIRE'S MEDICAL IMPACT SCALE (SFQ-MIS): VALIDATION AMONG A SAMPLE OF FIRST-TIME MOTHERS

Jawed-Wessel S, Schick V, and HerbenickD.. J Sex Med

ABSTRACT

Introduction:

Changes in sexual function can be difficult to capture, especially when an attempt is made to assess the effects of pregnancy or childbirth on the sexual function of first-time mothers. Commonly used sexual function measures are limited and fail to account for pregnancy or birth in assessment of function.

Aims:

The purpose of this study was to explore the utility of the Sexual Function Questionnaire Medical Impact Scale (SFQ-MIS) in assessing impact of childbirth on sexual function among first-time mothers with infants aged one year or younger.

Methods:

A total of 255 women completed a cross-sectional, web-based survey. Exploratory factor analysis was utilized to assess the factor structure of the SFQ-MIS scores in this sample. Variations in SFQ-MIS scores based upon participant characteristics were conducted to further evaluate the SFQ-MIS scores.

Main Outcome Measures:

SFQ-MIS score was the primary measure of interest. Factors related to pregnancy and childbirth, such as mode of delivery, infant date of birth, last menstrual period, need for an episiotomy or perineal stitches, breastfeeding status, and score on the Perceived Stress Scale, were also assessed in order to further evaluate the validity and predictive capacity of the SFQ-MIS.

Results:

Results indicated one factor that accounted for 58.27% of the variance in impact on sexual function due to childbirth. Cronbach's ? coefficient for all five items was acceptable (0.82). Women who were breastfeeding (P?<?0.05), those who had received perineal stitches after a vaginal delivery (P?<?0.05), and those who reported no sexual activity in the past month (P?<?0.001) experienced significantly greater impact than those who were not breastfeeding, those who had not required stitches, and those who had been sexually active in the past month.

Conclusion:

The SFQ-MIS appears to be a useful and valid indicator of changes in sexual function following childbirth, such as those related to arousal, desire, and orgasm.

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BELIEFS ABOUT PENIS SIZE: VALIDATION OF A SCALE FOR MEN ASHAMED ABOUT THEIR PENIS SIZE

Veale D, Eshkevari E, Read J, Miles S, Troglia A, Phillips R, Carmona L, Fiorito C, Wylie K, and Muir G..J Sex Med

ABSTRACT

Introduction:

No measures are available for understanding beliefs in men who experience shame about the perceived size of their penis. Such a measure might be helpful for treatment planning, and measuring outcome after any psychological or physical intervention.

Aim:

Our aim was to validate a newly developed measure called the Beliefs about Penis Size Scale (BAPS).

Method:

One hundred seventy-three male participants completed a new questionnaire consisting of 18 items to be validated and developed into the BAPS, as well as various other standardized measures. A urologist also measured actual penis size.

Main Outcome Measures:

The BAPS was validated against six psychosexual self-report questionnaires as well as penile size measurements.

Results:

Exploratory factor analysis reduced the number of items in the BAPS from 18 to 10, which was best explained by one factor. The 10-item BAPS had good internal consistency and correlated significantly with measures of depression, anxiety, body image quality of life, social anxiety, erectile function, overall satisfaction, and the importance attached to penis size. The BAPS was not found to correlate with actual penis size. It was able to discriminate between those who had concerns or were dissatisfied about their penis size and those who were not.

Conclusions:

This is the first study to develop a scale for measurement of beliefs about penis size. It may be used as part of an assessment for men who experience shame about the perceived size of their penis and as an outcome measure after treatment. The BAPS measures various manifestations of masculinity and shame about their perceived penis size including internal self-evaluative beliefs; negative evaluation by others; anticipated consequences of a perceived small penis, and extreme self-consciousness.

http://onlinelibrary.wiley.com/doi

PUBLIC MANDATE MASSIVELY STOLEN BY MQM IN NA-256

(From an article by Jamal Khurshidin the News)

Almost 92 percent of the votes cast in NA-256 sent for verification of thumbprints to the National Database Registration Authority (Nadra) have not been verified.

Of the 84,748 votes sent for validation, only 6,815 were authenticated by the Nadra's Automated Fingerprint Identification System (AFIS) i.e. the thumbprints on the counterfoils matched with the data of the citizens registered with the same identity card number in the database.

In a report submitted to the election tribunal that ordered the authentication, Nadra has pointed out that a large number of votes turned out to be bogus owing to invalid computerised national identity card (CNIC) numbers, duplication and out-of-constituency voters.

Pakistan Tehreek-e-Insaf'sZubair Khan had challenged the election result of NA-256, where MuttahidaQaumi Movement's Iqbal Mohammad Ali Khan had emerged victorious with 151,788 votes. The PTI candidate was the runners-up with 69,092 votes followed by the 10-party alliance contender OwaisNoorani, who secured 18,732 votes. The total number of votes cast was 251,399.

But the Nadra report stated that 57,642 votes could not be processed through the AFIS software, which can accurately match fingerprints and verify their authenticity in the database, owing to poor quality.

In the National Assembly constituency, 11,343 votes cast in the general elections on May 11 were either against invalid identity card numbers or had no number mentioned on them. This was observed mainly at polling station no.181, with 770 bogus votes, and polling station no. 161, with 543 fake votes.

Another 1,950 votes failed authentication as someone else had voted against the identity card number mentioned.

One individual voted against multiple registered voters. A man, Waseem Anwar Hussain of Shah Faisal Colony, cast 35 votes from polling station no. 54 against the registered voters.

ShakirZaheer, a resident of City Terrace apartments in Gulistan-e-Jauhar, cast his vote seven times at polling station no.168. At 26 polling stations, the number of votes cast as per the count was greater than the number of used counterfoils received. At 37 polling stations, the used counterfoils received were greater than the number of votes cast.

Another 791 votes were from people not registered in the constituency as ascertained by the CNIC numbers mentioned on the foils. The outsiders mainly voted in polling station no. 57 (43 votes) and polling station no. 58 (31 votes).

As per the identity card numbers mentioned, 5,893 duplicate votes were cast by 2,812 voters. This was mainly done at polling station no. 58 (565 votes) and polling station no. 46 (264 votes).

There were no thumbprints on as many as 314 counterfoils, which were mostly received from polling station no. 178 (66 votes) and the polling station no. 180 (21 votes).

The total number of unverified votes comes to 77,933 out of the 84,748 votes sent for verification.

If the report is proven and accepted by the tribunal, it would raise serious questions about the credibility of the general election results in Karachi, where the MuttahidaQaumi Movement emerged victorious on most of the seats amid allegations of massive rigging, especially by the Imran Khan-led PTI.

Previously, Nadra in its report on voters' verification for the NA-258 constituency in Karachi had found only 2,475 genuine votes against the 32,695 votes sent for authentication.

The seat was won by Pakistan Muslim League-Nawaz's Abdul Hakim Baloch, but his victory was challenged in the tribunal by Pakistan People's Party candidate AbdurRazzaq Raja.

'KALA BUDGET' DEPRIVES KARACHIITES OF RS830M DAILY

Geo News investigative report consists of precise data, surveys, former police officials and bureaucrats' opinions...Residents' blood is squeezed every day through extortion, kidnappings for ransom, street crimes, police excesses

By Geo Investigation Team

The turf war for taking control of the rudderless city of Karachi continues unabated. The blood of residents is daily squeezed through extortion chits, kidnappings for ransom, encroachments, loot and plunder, street crimes, police excessives and other crimes. The residents of the city of lights are deprived of Rs830 million on account of its 'Kala Budget' (black budget).

You must have watched and listened to the yearly budgets of the federal and provincial governments, but 'Geo News' has collected precise data from different investigative reports - surveys by experts, general views, observations by politicians and opinions of former judges, police officials of the IG and DIG level, officials of the civil and military bureaucracy - according to which Karachiites pay Rs830 million in this 'Kala Budget' to official and unofficial rogue elements.

Ten million rupees is being collected as extortion from 550 small and big markets of the city. Those who lead a lavish life out of this black budget are unknown, and the people keep mum afraid to reveal the unknown to save their lives.

Kidnapping for ransom, like bank robbery, in Karachi has become the most lucrative crime for the past few years. Such crimes do not surface because of fear, and the fear of becoming well-known among the criminals. Traders and industrialists are compelled to pay millions of rupees daily on this count. Each kidnapping generates millions of rupees ransom. This money comprises about Rs50 million daily in the 'Kala Budget'.

On the other hand, the parking mafia has marked more than 500 parking areas in the city. Such parking lots generate Rs2.4 million daily by extending parking facilities to citizens illegally. There are more than 55,000 roadside stalls in the bazaars of the city. Each stall pays Rs100 to Rs200 daily to the 'beaters'. About Rs8.25 million are collected daily through this practice, and who pockets this money is not known.

One of the major sources of black money is water theft in the city by the sea. Be it earnings through tankers or water theft through hydrants, Rs100 million is earned by selling 272 million gallons of water daily. Meanwhile, a beat collection of Rs150 million is made each day by 15,000

gambling and narcotics dens across the city.

Encroachers occupied 30,000 acres of government land worth Rs80 billions during the year. Rs14.8 million is generated daily from public transport.

Twenty-five thousand buses, wagons and coaches pay Rs200 to 300 daily. A 'gunda' tax of Rs40 daily is paid by 4,000 Chingchi rickshaw owners' 20,000 auto rickshaw drivers and 7,000, taxis.

Goods transport trucks, containers, and oil tankers each pay between Rs1,000 to Rs3,000 which amounts to Rs7.5 million daily.The state kitty suffers a daily loss of Rs15 million because of power theft. It includes 4,000 to 5,000 'kundas'.

On the medical front, Rs3 million is grabbed from the poor. 20,000 patients daily visit hospitals and they have to pay Rs20 for medical slips.

The people of Karachi are deprived of 40 to 50 motorcycles and 20 to 25 vehicles daily. If at all any vehicle is recovered, it is only structure. The common citizens daily wash their hands of Rs2.5 million on this count.

And not only for the 69 traffic sections, SHOs, in charges of police posts, head muharrar and beat staff, but also tenders of Rs5 million are opened for appointments to district SSP level posts. From a police constable to high authorities, everyone has his share in this game. The data of these billions of rupees monthly auction tells that Rs210 million is made through this exercise daily and has a big share in 'Kala Budget'. The payers of this money get their investment with interest from the public.

NADRA REPORT EXPOSES MQM'S FRAUDULENT MANDATE: JAMAAT-E-ISLAMI

JAMAAT-e-Islami Ameer Syed MunawarHasan said the massive bogus voting in May elections in Karachi revealed by Nadra report on two NA seats has exposed MQM's 90 percent mandate from the port city.

Responding to the revelation on Tuesday, he said bogus votes were cast on large scale in Karachi and Hyderabad on National and Sindh Assembly seats from where MQM had won. He said MQM had been securing false mandate at gunpoint for the last three decades. Security institutions and agencies knew every thing but were not ready to speak out the truth and all past governments had been patronising the MQM. MunawarHasan said, had the constituencies been demarcated afresh and the polls conducted under army's supervision as ordered by Supreme Court Chief Justice, the results would have been quite different. He said in a city where death was looming large, it was difficult for people to vote freely. He said JI had accepted election results only to prevent bloodshed and foil the conspiracies to create anarchy and chaos in the country. JI Ameer was sure that like Karachi seat, the truth

about the rigging all over the country would come out soon.He said situation all over Karachi was the same as had been revealed in NA-256. He said, one or two constituencies where PTI and other parties had been shown as winner, had been left out under the plan to prevent total boycott of the elections. He said if all other parties had boycotted the polls like the JI, the MQM could not have succeeded in its evil designs.

PSYCHIATRIC CONSULTATION BY PHONE, E-MAIL AND SKYPE

***K*arachi** Psychiatric Hospital was established in 1970, and today (2010) has branches in North Nazimabad, Nazimabad and Quaidabad in Karachi as well as a branch in Latifabad, Hyderabad. More than 200 patients come to our hospital daily and the average number of in-patients is one hundred and fifty (150). About 30 professionals, including psychiatrists, graduate doctors psychologists and social therapists work in the hospital to treat the patients. The paramedical and other staff members are almost three hundred (300).Since there are less than four hundred (400) psychiatrists for the whole country of sixteen crore people we feel the immediate need to extend our psychiatric expertise to other cities and villages without actually going there.This we plan to do with the cooperation of the general practitioners and other doctors interested in providing proper treatment to psychiatric patients. We have a sliding scale of fees which people of various financial status can afford.

Patients can also contact us directly for consultation and advice.

The fee can be sent by easy paisa A/c no. 0344-2645552-2, or UBL Omni A/c No. 0344-2645551.

Online bank Account, MCB Bank: Title: Karachi Psychiatric Hospital, A/c No. 1236-662-2.

Meezan Bank Ltd. Title: Karachi Hospital (Pvt) Ltd. A/c. No. 0131-0100001143.

Dubai Islamic Bank. Title: Karachi Hospital (Pvt) Ltd. A/c. No. 0102284001.

The patients can choose the doctor according to the fees they can afford. The phone operators can guide in this matter.

Phone : 111-760-760

Skype ID : kph.vip

For further details please contact C.E.O,

Karachi Psychiatric Hospital

(Tell:021-36603244, 021-36684503,111-760-760)

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Post graduate degree compulsory.

Male / Female

CONTACT

Dr. Syed Mubin Akhtar

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Nazimabad # 3, Karachi

Cell # 03332129177

E-mail: jobs@kph.org.pk

ادارے کی پالیسی کے برخلاف ایم کیو ایم سے نرم رویہ اختیار کرنا کسی حد تک کم کر دیا جس کے کچھ دنوں بعد گورنر سندھ ڈاکٹر عشرت العباد کا فون آیا۔

خاتون صحافی نے بتایا کہ اس کے بعد میں عمرے کی ادائیگی کے لیے سعودی عرب چلی گئی جہاں سے واپس لوٹی تو میرے گھر کو سیکوریٹی فورسز کی بھاری نفری نے گھیرے میں لے رکھا تھا، میں سمجھی کہ شاید کوئی ڈکیتی یا چوری کی واردت ہوئی ہے لیکن گھر میں داخل ہو کر دیکھا تو ایسا کچھ نہیں تھا، میں نے اپنا سیل فون آن کیا ہی تھا کہ اسی لمحہ سپرنٹنڈنٹ پولیس کا فون آیا کہ بھئی آپ کہاں تھیں؟ اللہ نے آپ کو بچالیا ہے، میں راستے میں ہوں اور آپ اب سیکوریٹی کے بغیر گھر سے باہر نہیں نکلیں گی۔ ایس پی کی فون کال کے بعد انٹیلی جنس کے افراد میرے گھر آئے اور انہوں نے ٹیلی فونز کے ذریعے ہونے والی کچھ گفتگو مجھے سنائی جسے سن کر معلوم ہوا کہ چار ٹارگٹ کلرز کو مجھے ٹھکانے لگانے کا ہدف دیا گیا ہے اور انہیں ہدایات کی گئی ہیں کہ اس کاروائی کو ڈکیتی یا رہزنی میں مزاحمت کا رنگ دیا جائے۔

جیسمین منظور کے مطابق تمام انٹیلی جنس ایجنسیاں بشمول آئی ایس آئی، آئی بی اور سی آئی ڈی کی رپورٹ میں مجھے بتایا کہ ان دہشت گردوں کا تعلق لسانی جماعت ایم کیو ایم سے ہے اور یہ رپورٹ وفاقی حکومت کو بھیجی جا چکی ہے۔ روپوش صحافی نے بتایا کہ اس سے قبل ایم کیو ایم کی جانب سے مجھے اس طرح کی دھمکی موصول نہیں ہوئی تھی اور میں یہ ساری بات انٹیلی جنس اداروں کی رپورٹ پر بیان کر رہی ہوں۔ میں نے سب سے پہلے اپنے بھائی کو کینیڈا واپس بھجوایا جبکہ میں والدہ سمیت پاکستان کے کسی نامعلوم مقام پر منتقل ہوگئی۔

میں بہت روئی اور مجھے نہیں معلوم کہ یہ دکھ کے آنسو تھے یا اس بات کی خوشی کہ میرا خاندان زندہ بچ گیا۔ میں نے الطاف حسین سے رابطے کی کوشش کی لیکن ان کی جانب سے کوئی جواب موصول نہیں ہوا جس کے بعد میں نے ایم کیو ایم رابطہ کمیٹی لندن کے انچارج نصرت ندیم سے رابطہ کیا جنہوں نے بہت سکون سے میری بات سنی اور اسے سچ ماننے سے انکار کر دیا۔ حکومت سے بھی مدد کی درخواست کی لیکن اس نے مدد نہیں کی اور مشورہ دیا کہ آپ بلٹ پروف گاڑی استعمال کرنا شروع کر دیں۔

وزیراعظم میاں محمد نواز شریف نے انہیں انرجی کانفرنس میں مدعو کیا تھا جہاں پوار میڈیا موجود تھا اس موقع پر میں نے اپنے اوپر گزرنے والے حالات سے وزیراعظم کو آگاہ کیا لیکن ن لیگ کے صدر نے کوئی جواب نہیں دیا، صرف اس المیہ پر دکھ کرا ظہار کر دیا۔ اس کے بعد وفاقی وزیر داخلہ چوہدری نثار علی خان سے ملی اور ڈائریکٹر جنرل آئی ایس آئی کو بھی بتایا لیکن میری ساری محنت رائیگاں گئی۔ اسی دن میں نے سماء نیوز سے استعفیٰ دے دیا۔ میری ادارے والوں نے کسی ہمدردی کا اظہار نہیں کیا۔ جیسمین منظور کا کہنا ہے کہ میں نہ اپنی سرزمین چھوڑوں گی اور نہ اپنا پیشہ۔ چاہے دہشت گرد ہلاک ہی کیوں نہ کر دیں۔ (جسارت)

متحدہ کے لوگ پریذائیڈنگ افسر کو یرغمال بنا کر ٹھپے لگا رہے تھے

میں نے ٹوکا تو میری شرٹ پھاڑنے لگے، میری والدہ کو زمین پر گرادیا، انٹیلی جنس والوں نے بتایا کہ ایم کیو ایم نے چار ٹارگٹ کلرز کو مجھے ٹھکانے لگانے کا ہدف دیا ہے، نواز شریف نے صرف دکھ کا اظہار کیا

روپوش اینکر پرسن جیسمین منظور کے انکشافات

پاکستان کی معروف خاتون صحافی اور اینکر پرسن جیسمین منظور نے خود ساختہ روپوشی کے بعد اپنے ایک کالم کے ذریعے اس کی وجوہات کا انکشاف کیا ہے۔ خاتون صحافی نے اپنی تحریر میں کہا ہے کہ صحافتی زندگی میں خاتون کے ساتھ بہت بُرا سلوک کیا جاتا ہے۔ میں اس وقت خود ساختہ روپوشی کی حالت میں ہوں، مجھے اور میری فیملی کو جان سے مارنے کی دھمکیاں موصول ہوچکی ہیں۔ میں دنیا کو بتاؤں گی کہ ہم لوگ دہشت گردوں کے ہاتھوں یرغمال ہیں اور یہی دہشت گرد ہماری منزل کا تعین کرتے ہیں۔

جیسمین نے اپنے کالم میں بتایا ہے کہ انہیں حالیہ عام انتخابات کے بعد اس کیفیت سے گزرنا پڑ رہا ہے۔ ان کے مطابق کراچی کے حلقے این اے 250 میں جو ان کا حلقہ انتخاب تھا، اپنی والدہ کے ہمراہ ووٹ کاسٹ کرنے ڈی ایچ اے گرلز کالج پہنچیں، دن کے دو بج رہے تھے، پولنگ اسٹیشن میں سناٹا چھایا ہوا تھا۔ الیکشن کمیشن کا عملہ موجود نہیں تھا، ایک انتخابی امیدوار خود بیلٹ باکس لے کر پولنگ اسٹیشن آیا، میں نے اردگرد کے کمروں کا جائزہ لیا، چند رومز میں انتہائی کم پولنگ ہو رہی تھی جبکہ پریذائیڈنگ افسر غائب تھا، ایک کمرا اندر سے بند تھا جسے دھکا دے کر اندر داخل ہوئی تو دیکھا کہ پریذائیڈنگ آفسر کو یرغمال بنا کر متحدہ قومی موومنٹ کے لوگ بیلٹ پیپر پر ٹھپے لگا رہے ہیں، خاتون صحافی کے بقول میں نے ان سے کہا کہ آپ لوگ کیا کر رہے ہیں جس پر انہوں نے مجھ سے بدتمیزی کی اور قوت کے ساتھ میری شرٹ کھینچ کر پھاڑنے کی کوشش کرنے لگے، اس کھینچا تانی میں دھکا لگنے سے میری والدہ زمین پر گر گئیں۔

جیسمین کے مطابق اس وقت پولنگ اسٹیشن میں دو رینجرز اہلکار تعینات تھے، جن سے انہوں نے مدد طلب کی تاہم وہ انہیں بچانے نہیں آئے۔ اس دوران باہر کی جانب سے کچھ نوجوان میری مدد کو آئے اور انہوں نے ایم کیو ایم والوں کے چنگل سے مجھے نکالا۔ جیسمین منظور کے الفاظ میں سماء نیوز ایم کیو ایم کے حوالے سے سافٹ کارنر رکھتا ہے۔ اس واقعہ کے بعد میں نے اپنے

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KARACHI, PAKISTAN-74600

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WORLD MENTAL HEALTH DAY 2013

Dr. Syed Mubin Akhtar, Prof. Mazhar Malk & other guests visiting stalls set by various pharmaceutical companies

Dr. Syed Mubin Akhtar, Prof. Mazhar Malk & other guests visiting stalls displaying ECT Machine (Manufactured by KPH), Booklets about mental illnesses & items prepared by indoor patients of Karachi Psychiatric Hospital.

WORLD MENTAL HEALTH DAY 2013-CHILDREN ACTIVITIES

Face Painting

Poetry Competition

Children watching candy floss preparation

Guest enjoying Cartoon Character & Jumping Castle