



HEALTHCARE CONSULTANTS ASIA

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Healthy Wealthy

Orthopaedics Insights:
Injury, Syndrome, Management

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ABOUT US

Vision

To be the region's most trusted provider of specialist medical services, delivering accurate expertise and second opinions through a comprehensive network of medical specialists across Malaysia and Asia.

Mission

To uphold and advance our specialist medical advisory standards through global best practices, proactive engagement with clients and partners, and strict credentialing of our specialist panel.

Healthcare Consultants Asia (HCASB) is a trusted subsidiary of Mudah Healthcare. As experts in third-party medical reporting, HCASB specializes in providing detailed and comprehensive medical assessments that help streamline processes and ensure clarity in claims management.

With a panel of over 130 specialist doctors, HCASB is dedicated to delivering accurate and high-quality reports, offering valuable insights and supporting informed decision-making for our clients. Our reports foster fair, transparent resolutions, reinforcing the integrity and efficiency of the claims process.

HCASB is looking forward to continuing our commitment to excellence in medical reporting, making a meaningful impact on the success of our partners in the industry.

From the Desk of Dr. Thiruchelvan

Welcome to the July edition of Healthy Wealthy by HCA

As we progress through the year, our commitment remains focused on advancing patient care through clinical excellence, early intervention, and multidisciplinary collaboration. This month, we are pleased to spotlight the field of **Orthopaedics**, a vital specialty that plays a significant role in the management of injuries and syndromes across a wide range of medical conditions.

July's edition features **our Specialist of the Month, Dr. Lau Chun Liang**, whose expertise in Orthopaedics reflects a strong dedication to delivering comprehensive and patient-centered care. From early diagnosis to surgical management and long-term recovery, his work encompasses a broad spectrum of conditions that impact patients' health and quality of life.

Dr. Lau Chun Liang's insights provide valuable perspectives into the clinical decision-making involved in surgical care. His emphasis on timely detection, evidence-based treatment planning, and injury management is especially relevant in understanding medical necessity, treatment outcomes, and recovery expectations across various surgical conditions. His perspectives offer stakeholders a deeper understanding of patient evaluation, treatment pathways, and the importance of early intervention in achieving optimal clinical outcomes.

I hope you find this month's insights both informative and inspiring. As always, thank you for being a part of our community and for your continued trust in Healthcare Consultant Asia.

Warm Regards,

Dr. Thiruchelvan Balakrishnan

Chief Operations Officer

HCASB



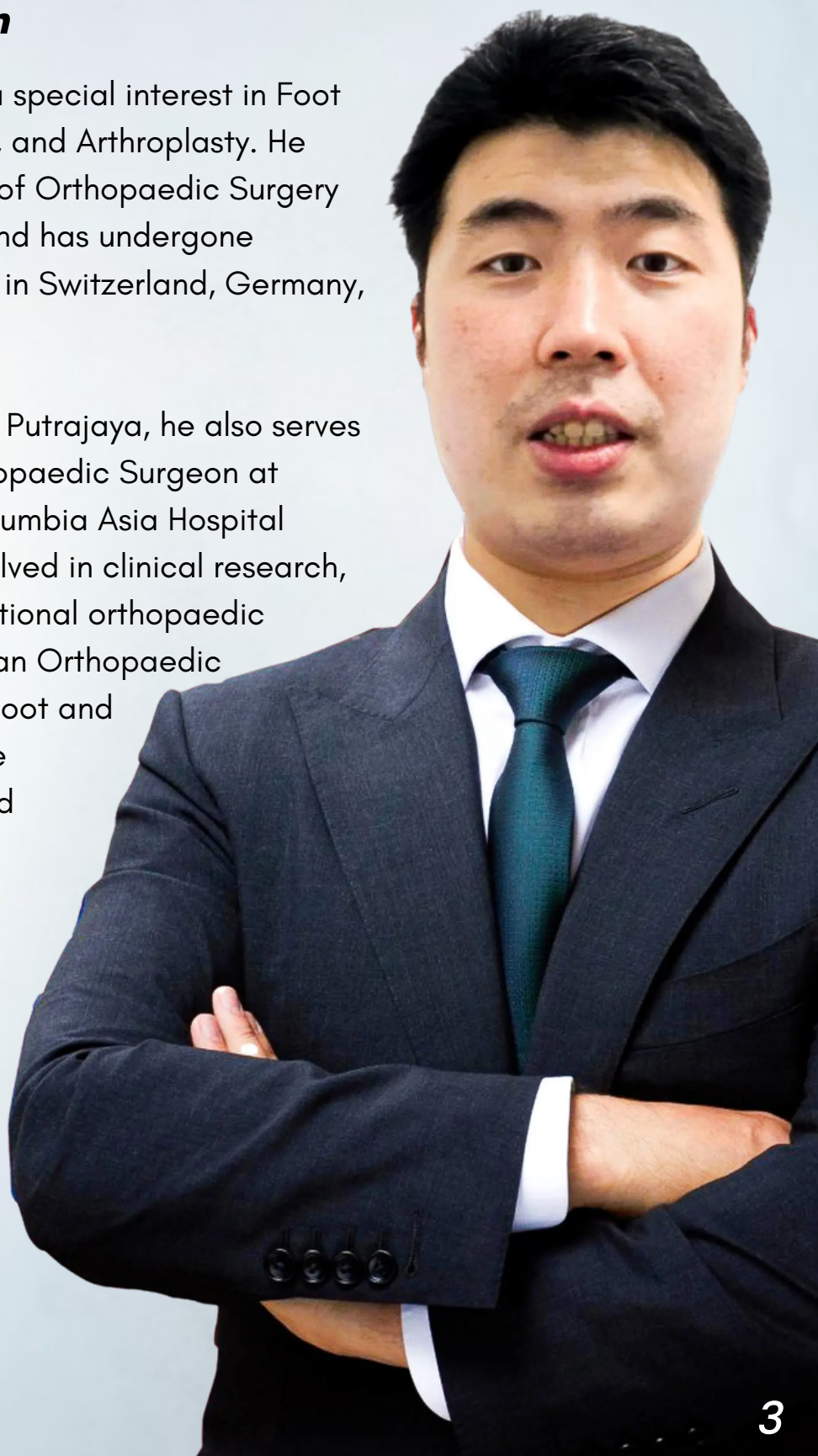
Dr. Lau Chun Liang

Orthopaedics Surgeon

An Orthopaedic Surgeon with a special interest in Foot and Ankle Surgery, Arthroscopy, and Arthroplasty. He obtained his MBBS and Master of Orthopaedic Surgery from the University of Malaya and has undergone advanced subspecialty training in Switzerland, Germany, and South Korea.

Currently practicing at Hospital Putrajaya, he also serves as a Sessional Consultant Orthopaedic Surgeon at Pantai Hospital Cheras and Columbia Asia Hospital Setapak. Dr. Lau is actively involved in clinical research, medical education, and international orthopaedic societies, including the Malaysian Orthopaedic Association (MOA), Malaysian Foot and Ankle Society (MOFAS), and the American Orthopaedic Foot and Ankle Society (AOFAS).

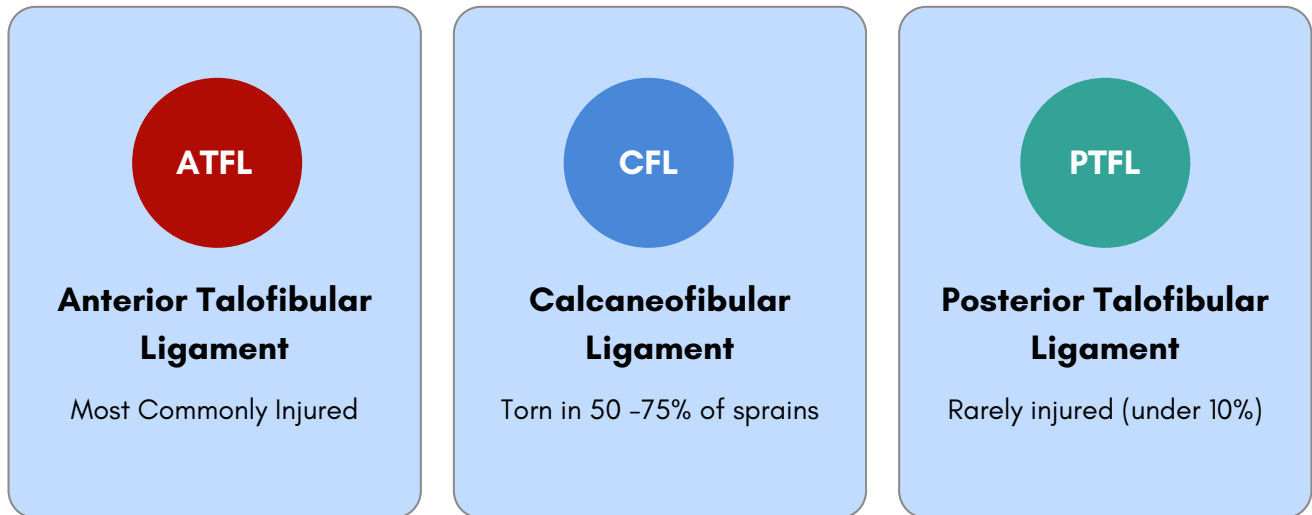
With extensive experience in managing foot and ankle disorders, sports injuries, arthroscopy, and joint replacement surgery, he is committed to delivering evidence-based, patient-centred orthopaedic care aimed at restoring mobility and improving quality of life.



ANTERIOR TALOFIBULAR LIGAMENT INJURY

By Dr. Lau Chun Liang

THE THREE LATERAL ANKLE LIGAMENTS



You are walking along, step off a kerb awkwardly, and suddenly the ankle rolls inwards. There is sharp pain on the outside of the ankle, followed by swelling and bruising. Most people assume it is just a sprain and wait for it to settle. But what actually happened and why does the ankle sometimes never feel quite right again?

The ankle is held together by ligaments. These are tough, rope-like bands that connect bone to bone and stop the joint moving too far in the wrong direction. On the outer ankle there are three. The most important is the Anterior Talofibular Ligament (ATFL). It is the smallest and weakest of the three, and the one that tears in almost every ankle sprain.

What actually tears? When the foot rolls sharply inwards, the ATFL is stretched beyond what it can handle. In a mild sprain, the fibres stretch but mostly hold. In a serious sprain, the ligament tears partly or completely. The result is pain on the outer ankle, rapid swelling, and bruising that often appears a day or two later.

A sprain is not just a bruise. It is a ligament injury and how well it heals depends almost entirely on what you do in the weeks that follow.

How is it diagnosed? A doctor can usually diagnose ATFL injury from examination alone – checking for tenderness over the ligament, testing joint stability, and ruling out a fracture. X-rays come first. MRI is not needed for a straightforward first sprain but becomes important if symptoms persist or surgery is being considered.

Acute Sprain vs Chronic Instability

A single sprain versus the pattern that develops without proper rehabilitation.

ACUTE ANKLE SPRAIN

Single roll or twist of the ankle

Immediate pain, swelling, bruising

Usually settles within weeks

ATFL is the most commonly torn ligament

Most people recover fully with physio

CHRONIC INSTABILITY

About 1 in 5 sprains leads to this

Ankle repeatedly gives way

Persistent pain or wobbling feeling

Avoid uneven ground or sport

Needs dedicated physio or surgery

If your ankle feels wobbly or gives way unexpectedly, do not accept it as normal. It is very treatable and the sooner it is addressed, the better.

About one in five people who sprain their ankle go on to develop chronic instability where the ankle repeatedly gives way, particularly on uneven ground or during sport. The ligament has not healed properly, and the balance sensors inside the joint have been disrupted. Without treatment, this pattern tends to continue and worsen.

Physiotherapy is the treatment. This is not something to try while waiting for a better option. For the vast majority of ATFL injuries, physiotherapy done properly is the treatment. The evidence behind it is clear and consistent across decades of research.

A well-structured programme rebuilds three things the injured ankle loses: strength in the surrounding muscles, proprioception (the ability to sense the joint's position and react fast enough to stop a roll), and coordination for real activities. People who complete a proper programme recover more fully and have fewer repeat sprains than those who rest and wait.

Weeks 1-2

Protect with a brace or boot, control swelling, gentle movement.

Weeks 2-6

Progressive strengthening, balance exercises, walking on varied surfaces.

Weeks 6-12

sport-specific training, agility work, confident return to full activity.

Research About PRP For Ankle Ligament Injury.

What is PRP

Blood is drawn from the patient and spun in a machine to concentrate the platelets.

This liquid is then injected into the injured ligament guided by ultrasound.

Marketed as using your own biology to speed up healing.

What studies found

A few small trials showed slightly less pain in 8 weeks.

By 6 and 12 months, no difference vs physio alone.

A 2024 RCT: PRP was no better than a plain saline (dummy) injection.

The verdict

No proven long-term benefit.

Does not fix the real problem: weak muscles and lost balance sense in the joint.

Not recommended by any major clinical guideline.

Physiotherapy wins.

What about PRP injections? Platelet-Rich Plasma is offered by some private clinics for ankle ligament injuries. PRP is made from the patient's own blood, spun to concentrate the platelets, then injected into the damaged tissue. The concept sounds logical. But the evidence does not support it.

The trials that exist are small and poorly designed. A 2024 randomised controlled trial found patients who received PRP did no better than those given a plain saline injection essentially a dummy. A systematic review in 2024 concluded there is insufficient evidence to support PRP for chronic ankle sprain. Where early studies showed any benefit, the advantage had disappeared entirely by six to twelve months, patients who simply did physiotherapy ended up in the same place. No major clinical guideline recommends PRP for ATFL injury.

There is also a more fundamental issue. Even if PRP reduced pain slightly in the early weeks, it does nothing about why the ankle keeps giving way. Only physiotherapy rebuilds the muscle strength and restores the balance-sensing ability that ATFL injury takes away. No injection can do that. The evidence is clear: PRP does not improve long-term outcomes beyond what physiotherapy achieves. Physiotherapy is safer, better evidenced, and the right treatment.

HOW ATFL INJURY IS TREATED

STEP 1 - IMMEDIATE CARE

Rice + Protection

Rest, ice, compression, elevation. Brace or boot for 2-3 weeks.

STEP 2 - REHAB

Physiotherapy

Strengthening, balance training, range-of-motion exercises, return to sport.

STEP 3 - SURGERY

If physio fails after 3 - 6 months

Brostrom-Gould repair most common, 85%+ achieve good or excellent outcome

WHEN IS SURGERY NEEDED?

Surgery is considered only when the ankle continues to give way despite at least three to six months of dedicated physiotherapy around 10-15% of patients. The Brostrom-Gould repair tightens and reattaches the torn ATFL back to the fibula, reinforced with nearby tissue. Recovery takes around three to four months before returning to sport. More than 85% of patients achieve good or excellent long-term outcomes.

Surgery still requires the same physiotherapy programme afterwards.

The repair restores structure. The muscles and balance sensors still need retraining. There are no shortcuts.

A NOTE ON FOOT SHAPE

Some people have a naturally high-arched or inward-tilting heel that places constant extra stress on the ATFL, making sprains far more likely to recur. Treating the ligament alone may not be enough in these cases insoles, footwear changes, or occasionally a realignment procedure may also be needed.

Quick Reference

LIGAMENT INJURED

The ATFL on the outer ankle torn in nearly every ankle sprain.

MOST COMMON CAUSE

Rolling the ankle inwards during sport or on uneven ground.

HOW IT IS DIAGNOSED

Clinical examination. MRI if symptoms persist or surgery is planned.

FIRST TREATMENT

RICE (rest, ice, compression, elevation) then early physiotherapy.

PHYSIO IS THE ANSWER

Rebuilds strength, balance and coordination backed by decades of evidence.

WHAT ABOUT PRP?

No meaningful benefit over physio. Not recommended by any major guideline.

WHEN SURGERY IS NEEDED

Only if the ankle keeps giving way after 3-6 months of proper physiotherapy.

SURGERY SUCCESS

Brostrom-Gould repair achieves good or excellent results in over 85% of patients.



COMPLEX REGIONAL PAIN SYNDROME (CRPS)

By Dr. Lau Chun Liang



You have had an operation on your foot or ankle or perhaps a fracture and things should be getting better. But instead of improving, the pain is getting worse. The foot is swollen and hot. Even the lightest touch feels unbearable. The X-rays look fine, the wound has healed, yet you are suffering far more than anyone expected. If this sounds familiar, the condition may be Complex Regional Pain Syndrome, or CRPS.

CRPS is a pain condition in which the nervous system continues to generate intense, burning pain long after an injury has healed. It is not imagined the pain is very real but it is out of all proportion to the original problem. It most commonly follows fractures, foot surgery, or other injuries to the limbs.

Who is most at risk? Research shows that CRPS is more common in women, particularly those in their mid-forties. People with a history of anxiety or depression are also at higher risk, as are those who have had multiple procedures or prolonged periods in plaster. Fractures are the most common trigger overall, followed by elective foot and ankle surgery.

About 1 in 25 patients undergoing elective foot or ankle surgery may develop CRPS. Identifying those at higher risk before surgery allows for better preparation and early support.

The reason CRPS happens is not fully understood, but researchers believe it involves several things going wrong at once. Nerves in the injured area become overactive and keep firing pain signals even when there is no longer any damage. The brain and spinal cord, bombarded by these signals, become hypersensitive so that even gentle touch triggers pain. The body's automatic control system, which normally regulates blood flow, temperature, and sweating without you noticing, starts misfiring. This is why the affected foot can switch from hot and red to cold and mottled, and why it may sweat more than the other foot. Psychological stress does not cause CRPS, but it does make it worse and harder to recover from.

Processes That Drive CRPS

PATHOPHYSIOLOGY: FOUR KEY MECHANISMS

Neurogenic Inflammation

Neuropeptide release
Mast cell activation
Pro-inflammatory cytokines
Peripheral sensitisation

Central Sensitisation

NMDA receptor upregulation
Wind-up phenomenon
Reduced descending inhibition
Cortical reorganisation

Autonomic Dysfunction

Sympatho-afferent coupling
Vasomotor instability
Sudomotor abnormalities
Trophic changes

Cortical Changes

Somatosensory remapping
Maladaptive body schema
Motor control disruption
Psychological amplification

CRPS shows up in four main ways. There is intense, burning pain usually much worse than expected and often triggered by the slightest stimulus. The skin changes colour, may look mottled or blotchy, and the temperature of the affected foot is noticeably different from the other. The foot swells, and sweating may be uneven. Finally, movement becomes limited, the muscles may feel weak or shaky, and over time the skin can become shiny with changes to the nails and hair. Not everyone gets all of these but the more that are present, the more likely CRPS is the explanation.

Sensory

Burning constant pain
Hyperalgesia
Allodynia
Hyperaesthesia

Vasomotor

Skin colour changes
Temperature asymmetry
Mottled / livedo pattern

Sudomotor / Oedema

Swelling/oedema
Sweating asymmetry
Hyperhidrosis

Motor / Trophic

Reduced range of motion
Weakness / tremor
Dystonia
Skin and nail changes

FOUR CLINICAL DOMAINS

There is no single blood test or scan that diagnoses CRPS. Doctors use a set of internationally agreed clinical criteria checking which symptoms a patient reports and which signs can be found on examination. Scans and blood tests are still useful, but their job is to rule out other problems that might look similar: infection, a blood clot in the leg, a broken piece of hardware, or a nerve trapped by scar tissue.

BUDAPEST DIAGNOSTIC CRITERIA

SYMPTOMS (Patient-Reported)

3 or more of 4 categories required

Sensory: Hyperaesthesia and/or allodynia
Vasomotor: Temperature or colour changes
Sudomotor: Oedema or sweating changes
Motor/Trophic: Weakness, tremor, stiffness

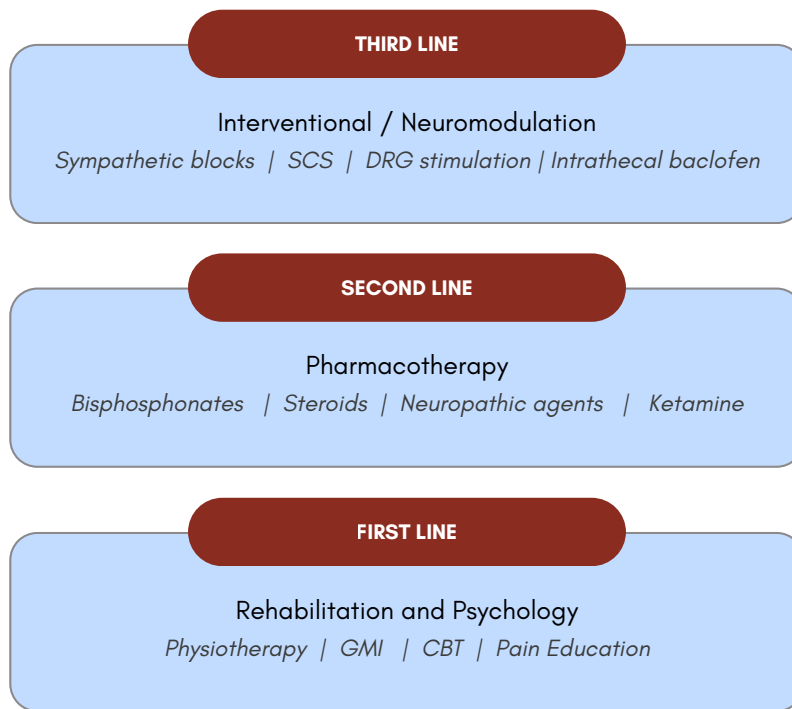
SIGNS (Examination Findings)

2 or more of 4 categories required

Sensory: Hyperalgesia and/or allodynia
Vasomotor: Temp asymmetry more than 1 deg C
Sudomotor: Objective oedema or sweating
Motor/Trophic: Weakness, tremor, dystonia

CRPS Treatment & Management

The good news is that with the right treatment, many people with CRPS do recover. The earlier it is caught and treated, the better the outcome. Around half of patients see significant improvement within two years. Treatment works best when it tackles both the physical and the psychological side of the condition at the same time.



STEPWISE MULTIDISCIPLINARY MANAGEMENT

Physiotherapy is the most important treatment. It is not optional, and it is not just something to do while waiting for medication to work, it is the treatment. The goal is to gradually retrain the nervous system to stop overreacting. Early movement, weight-bearing, and hands-on therapy help break the cycle of pain and stiffness. Even when movement is very painful at first, gentle and progressive physiotherapy with a specialist who understands CRPS is the single most effective intervention. The longer movement is avoided, the harder recovery becomes. A physiotherapist will guide you through this safely, at a pace you can manage.

Medication can help. A group of drugs called bisphosphonates usually used for bone thinning have the best evidence in CRPS and can reduce pain meaningfully. A short course of steroids helps when the condition is in its early, very inflamed stage. Nerve pain medicines such as amitriptyline or pregabalin may take the edge off the pain enough to allow physiotherapy to progress. None of these replace physiotherapy, they create a window in which it becomes more possible.

For more stubborn cases. If CRPS does not respond to physiotherapy and medication, specialist pain clinics can offer procedures such as nerve blocks or spinal cord stimulation. The most advanced option stimulation of the nerve root itself now has strong evidence for lower limb CRPS. These are not cures, but they can reduce pain enough for rehabilitation to continue.

The mental health piece matters. CRPS is a genuine physical condition – but anxiety, low mood, and the tendency to catastrophise pain all make it harder to recover. This is not the patient's fault. It is a biological reality: stress hormones keep the nervous system switched on. Psychological support – whether counselling, cognitive therapy, or simply good communication and reassurance from the clinical team – is part of the treatment, not a suggestion that the pain is in your head.

The message is simple.

Keep moving, even when it hurts.

Avoiding movement makes CRPS worse, not better. Your physiotherapist is your most important ally.

Important: further surgery on a CRPS-affected limb usually makes things worse. This should only ever be considered once the condition has fully settled, by a specialist team, with a very clear reason.

Quick Reference

PAIN OUT OF PROPORTION

The defining feature pain that is far worse than the injury should cause.

CLINICAL DIAGNOSIS

Symptoms in 3+ domains AND signs in 2+ domains on examination.

RULE OUT ALTERNATIVES

Infection, DVT, nonunion, and nerve problems must be excluded first.

PHYSIO IS THE FOUNDATION

Early, active physiotherapy at every stage not optional, not an add-on.

BEST MEDICATIONS

Bisphosphonates and short steroid courses work best in early disease.

ADVANCED OPTIONS

DRG stimulation has the strongest evidence for stubborn lower limb cases.

AVOID MORE SURGERY

Further operations can make CRPS significantly worse.

MIND MATTERS TOO

Anxiety and catastrophising independently drive the condition, address both.



CLINICAL ADVISORY & INDEPENDENT MEDICAL OPINION SERVICES

At HCASB we work with over 100 medical specialist with focus on over 23 core specialities. All assessments are grounded in clinical evidence, imaging correlation and longitudinal outcome analysis.

Our team provides:

- **Independent medical opinions and reporting**
 - **Functional capacity evaluation**
 - **Medico-legal reporting**
- **Second opinions for complex medical cases**
 - **Claims clarification support**

OBJECTIVE ANALYSIS. CLINICAL CLARITY. RESPONSIBLE REPORTING.

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WhatsApp or Call to speak to our Medico-Affairs Team

 [018-208 9070](tel:018-208 9070)

Events & Conferences

MEDICAL CONFERENCES & EVENTS

International Conference on Advances in Medical Science & Healthcare (ICAMSH)

1 July | Kuala Lumpur / Putrajaya

International Conference on Medical & Biosciences (ICMBS)

2 July | Putrajaya

MYLIVE 2026 (National Heart Association of Malaysia)

16 – 18 July | Kuala Lumpur Convention Centre, Kuala Lumpur

APHM International Healthcare Conference & Exhibition 2026

28 – 30 July | Kuala Lumpur Convention Centre, Kuala Lumpur

APHM Healthcare Exhibition (co-located with THIS ASEAN)

28 – 30 July | Kuala Lumpur Convention Centre, Kuala Lumpur

LAW CONFERENCES & EVENTS

International Conference on Human Rights (ICHR)

1 July | Kuala Lumpur / Putrajaya

INSURANCE CONFERENCES & EVENTS

MARIM International Conference 2026

28 – 29 July | Le Méridien Putrajaya

HEALTHCARE CONSULTANTS ASIA

2026

Stay Connected With HCASB

Unit 28-12 Level 28, Q Sentral, Jalan Stesen Sentral 2,
Brickfields, 50470 Kuala Lumpur, Federal Territory of
Kuala Lumpur

03-2276 6681 | +6018-208 9070 | admin@hcasb.com

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