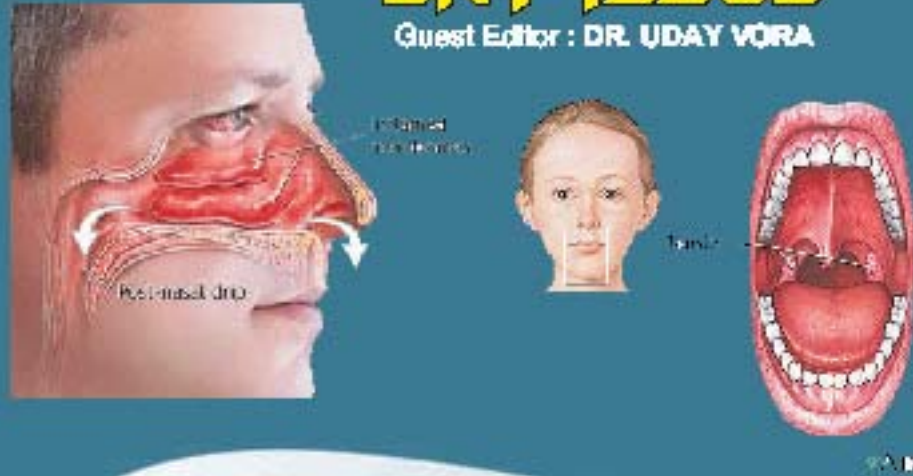




ENT ISSUE

Guest Editor : DR. UDAY VORA



20th JUNE 2010
ONCOLOGY UPDATE

04th JULY 2010
DOCTOR'S DAY CELEBRATIONS

11th July 2010
WORLD POPULATION DAY

16th July 2010
**ELOCUTION COMPETITION OF UNDERGRADUATE
AND POST-GRADUATE MEDICAL STUDENTS**

25th JULY 2010
GYNAECON 2010



JUNE 2010 VOLUME NO 34 ISSUE NO. 3
MEDICAL IMAGE
OF IMA MUMBAI WEST

President : DR. BALKRISHNA M. INAMDAR

Hon. Secretary : DR. ASHOK BALSEKAR

CONTENTS

PRESIDENTSPEAK	3
HON. SECRETARY'S DESK	5
WEEKLY SCIENTIFIC LECTURES - G.P.FORUM	6
REPORTS	9
ORGANIZING SECRETARY MESSAGE	10
"RESPIRATORY DISEASE MANAGEMENT IN 2010"	11
IMPORTANT ANNOUNCEMENT	12
DOCTORS DAY	14
TAKE - HOME MESSAGE	15
THE CLINICAL ESTABLISHMENTS	16
INTERVENTIONAL CARDIOLOGY	19
IMA CONFERENCE TOUR TO KENYA	21
S N O R I N G - DON'T SLEEP OVER IT	23
MANAGEMENT OF TRAUMATIC FACIAL NERVE PALSY	27
ENDOSCOPIC ENDONASAL SURGERY : PAST, PRESENT & FUTURE	29
TRANSCANAL CARTILAGE MYRINGOPLASTY -	31

20TH JUNE 2010 Oncology Update
04TH JULY 2010 Doctor's Day Celebrations
11th July 2010 World Population Day
18th July 2010 Elocution Competition of Undergraduate and Post-graduate medical students
25TH JULY 2010 Gynaecon 2010

<p>DISCLAIMER : Unless otherwise stated, the opinions expressed by any writers are their personal opinions. The appearance of advertisements in "Medical Image" is not guarantee or endorsement of the product or the claims made by the manufacturer / advertiser.</p>	<p style="text-align: center;">EDITORIAL BOARD</p> <div style="border: 1px solid black; text-align: center; padding: 2px;">Editor</div> <p>Dr. Ashok Balsekar</p> <div style="border: 1px solid black; text-align: center; padding: 2px;">Board</div> <p>Dr. Arun Chaudhari Dr. Chhaya Desai Dr. Sanjay Dudhat Dr. Vani Kulhalli</p> <p style="text-align: center;">FOR PRIVATE CIRCULATION ONLY</p>	<p style="text-align: center;">Published by : IMA MUMBAI WEST</p> <p style="text-align: center;"><i>Contact for write-ups, articles, interviews and advertisements :</i></p> <p>IMA Bldg, Behind Chandan Cinema, J.R.Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 400 049. Office : 2625 4368 / 6523 5579 Fax : 2620 6517 E-mail : imamumbaiwest@yahoo.com Website : www.imamumbaiwest.com</p> <p style="text-align: center;">Advertisement Cheques must be drawn in favour of IMA MUMBAI WEST</p>
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Please get your IMA Mumbai West **IDENTITY CARD**. Identity Card shall be mandatory for future events

<p>ANNOUNCEMENT : We have a great pleasure to announce that a long awaited members' directory was released at Annual Day Programme by Chairman, Directory Sub Committee - Dr. Anil Suchak. All the members are requested to collect their copy of Telephone Directory— 2010 from the office from 11.00 am to 05.00 pm, in exchange of the directory coupon.</p>	
<p>TELEPHONE DIRECTORY COUPON</p>	
<p>Name of the Member : _____</p>	
<p>Name of the authorized person : _____</p>	
<p>I hereby authorize Mr. / Ms. _____ to collect Telephone Directory 2010 on my behalf.</p>	
<p>(Signature of Authorized Person)</p>	<p>(Signature of Member)</p>



INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

I.M.A. Bldg., Behind Chandan Cinema, J. R. Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

Office : 2625 4368 / 6523 5579 FAX 2620 6517

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Dr. Gupta K. C.	26121861	26493126	9820333632	Dr. Shah Subhash L.	-	-	9869089971
Dr. Gupta Sanjay	26277448	26704406	9820232606	Dr. Suru J. T.	28062159	28863220	9324362159
Dr. Joshi S. K.	26701418	26712254	9324607663	Dr. Thoravade Pratibha	-	-	9821865203
Dr. Kate Suhas	26833939	28348401	9820147041	Dr. Upadhyaya Jagdip R.	28284271	28482425	9321031220

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Asst. Secretary	: Dr. Shah Ronak	2883 5658	2883 5297	93232 71274

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PRESIDENTSpeak...

THE HEAT IS TRULY ON!

Dear Friends,

The scorching May heat has truly descended on Mumbai. The sweltering heat is making our life miserable. The “water cut” is adding insult to injury. Indeed, these are difficult times!

However, the heat is truly on for our members for more reasons than the above. Two significant developments are destined to make our life more difficult than ever before. Both merit your consideration and thought.

The first one, which is the talk of the nation, is undoubtedly the arrest of Dr. Ketan Desai—“numero uno” of MCI. The surprising - and albeit expected - finding of hundreds of crores of wealth has indeed made everybody sit up and take notice. The law will of course take its own course, but what I fear is the public assumption of medical fraternity being corrupt and criminal. Though MCI is not IMA, whomsoever I have met has commented upon IMA being involved in the scam! This is dangerous and deserves our quick and forceful rejoinder. It is important to take a firm stand in such matters with no loss of time. Unfortunately it is seen that quick and forceful criticism of such events is not the forte of our association. This is leading to misconception that we are somehow involved in this whole sordid affair which is bringing disrepute to our fraternity. We must clarify our stand pronto and denounce corrupt practices apparently prevalent in the highest regulatory body. Our inability to do so is certain to invite wanton criticism and heat! The earlier we take a just stand against such practices the better.

The second one is the apparent passage of “The Clinical Establishments (Registration and

Regulation) Bill, 2010” in Loksabha. The bill was passed without any discussion! Though some of the features are good and long necessary for the patients, I suspect that the fine print may reveal something else. Though the details of the bill are detailed elsewhere in this bulletin, there are some issues which are irksome and need clarification.

For example,

- a) Registration will be done by the state government under the control of national government. What happens then to the various registration formalities by BMC?
- b) Every single clinical establishment including dispensaries, laboratories etc. will be required to register with the authorities. While this is a laudable attempt to document and regulate the medical practice (e.g. “quacks” will have a difficult time under this scheme!), every establishment will be expected to be ready to give emergency treatment to any individual. For life threatening conditions, can these establishments be good enough to impart emergency treatment? How would the non-allopathic & non-clinical establishments be expected to respond in emergency situations ?
- c) Registration and regulation will be carried out by a body which contains “ALL” the “pathies” as it’s constituents! Can non-allopathic members be expected to be good enough to judge allopathic establishments?

I am sure all these and some other questions will be answered once the “fine print” is read and deciphered. However, there is certainly a cause to worry. It should not happen that a new “avenue” is opened for the authorities to harass the medical fraternity! Till the time everything is crystal clear, the “heat” will certainly add to the existing woes of the doctors and other paramedical staff.

However, let me also acknowledge the great way our IMA Mumbai West branch is progressing, thanks to some committed contribution of office bearers, various chairmen and managing committee members. Some of the truly wonderful initiatives are a) medical education CME for postgraduates; b) our proposed “Kenya” conference tour – the first “overseas” tour by our

branch; c) efforts to co-ordinate various Medical Associations; d) the first-ever “movie club”, which will show renowned films based on medical conditions; e) new ideas in cultural programmes; f) our strong initiatives for public health; g) addition of “pantry” and efforts to regularize our building and additions to the facilities; h) newer avenues of sports like “treasure hunt”; i) new ideas in conducting CMEs and seminars etc. Kudos to our managing committee which is indeed committed and enthusiastic in pursuing these initiatives. This has led to a branch which is throbbing with activities, alive with possibilities and advancing rapidly with wind under its sail.

Heat (warmth) is indeed the identification of life and we shall not hesitate to embrace it, absorb it and progress with it !

Warm regards,

DR. BAL INAMDAR

President, 2010-11
9833054054;
bminamdar@gmail.com

Geriatric Cell is announcing an
ESSAY COMPETITION

Topic –
OLD AGE HOME IS A BOON OR A BANE

Entries are invited from IMA Members.

Essays to be mailed on
imamumbaiwest@yahoo.com /
imamumbaiwest@gmail.com or

can be posted to
IMA Building, J. R. Mhatre Marg, JVPD
Scheme, Juhu, Mumbai - 400 049.

Maximum upto 500 words. Last date of receiving entries 31st July 2010. Best entry in the category of one & one against will be given prize.

Dr. Chhaya Desai

Chairperson, Geriatric Cell Sub Committee

❖ **ANNOUNCEMENTS** ❖

GYNAECON 2010

Like last year, this year too **GYNAECON – 2010** will be organized in our branch on **SUNDAY, 25TH JULY 2010** from 09.30 am onwards. Interesting sessions comprising of different subjects, well known speakers and many take-home messages, will be part of this prestigious event.

GYNAECON – 2010 will be organized in collaboration with “**Association of Fellow Gynaecologists**”.

Look forward to this space in forthcoming issues.

DR. SUDHIR NAIK

Convenor
Gynaeccon - 2010

For IMA – AMS Members

**Facility for
Additional Qualification of MMC
for Post Graduate Members**

Registration for Additional Qualification of MMC for Post Graduate. Members of IMA–Academic of Medical Specialist are requested to contact IMA Office for Registration for Additional Qualification Form of MMC.

The branch will make arrangements to collect the Forms and send to MMC for Registration.

Contact :

Ms. Aparna / Ms. Sunita

Tel : 2620 6517 / 2625 4368

Dr. Manoj Patel

Chairman, IMA – AMS Branch Chapter



HON. SECRETARY'S DESK...

Dear Colleagues,

It gives a great pleasure to the editorial committee to bring out a special issue on ENT and this month's guest editor has done a great job of it.

Members are welcome to give their feedback - both brickbats as well as bouquets ! while bouquets will motivate us, brickbats will prod us to improve on our performance.

New people bring new ideas. Dr. Mehul Bhatt, Chairman of Members' Welfare Sub Committee is coming out with a IMA movie club with a movie called COMA based on a book of the same name written by Robert Cook. It will be preceded by a small talk on coma. It will be a nice ending to a mini vacation from CMEs.

As you will see, IMA CGP will be back with a renowned vigour and a variety of CMEs post vacation. Members will be informed from time to time which CMEs are approved by MMC for accreditation.

Unfortunately, Managing Committee has no option but to charge for these programmes because credit hour fees are payable to MMC. Detailed announcement to this effect is made in this issue.

From this Managing Committee Meeting onwards, 2 members of our branch who are not the members of the Managing Committee are going to be presidents' guests. This experience will not only give them a glimpse of the working of the association, but also motivate them to dedicate some time from their busy schedule for the association. Who knows? One of them may be a future president of the largest branch of IMA - i.e. Mumbai West.

Those of you who has surgeon's eyes might have noticed the change of name of our monthly

bulletin. We have managed to do it so subtly that the face of the magazine hasn't changed much. This name has now become our copyright and no other magazine in our country can assume this name. So this is another feather in our cap.

President's dream of conference tour to Kenya and South Africa is taking shape, and when it comes true, it will be another first in the history of our branch.

Only in the last issue, I had mentioned that how a 'captain is as good as his team.' It was sad but not surprising to see how captain India, M. S. Dhoni was blamed and even tipped to be stripped of his captaincy for failure of Indian Cricket Team to win even a single match in 2nd round of T20 world cup. Public memory is too short and it failed to recall that Dhoni's team is at present at no 1 spot in test ranking and no 2 spot in ODI ranking. But the fact remains that ultimately the buck stops at the captain.

British Medical Association (BMA) has asked the British Government to stop funding for national health service for homeopathic treatment (according to a news item), because according to British Medical Journal (BMJ) homeopathy has no scientific basis. In a hue & cry that was made following this, statement of our national past president of IMA - HQ, Dr. Ashok Adhao stands out (DNA, 20th May 2010). He said "we cannot call homeopathy as unscientific. But doctors who prescribe Homeopathic Medicine should not make tall claims".

Yes ! Do not make tall claims and do not malign modern medicine and that is exactly what modern day leading homeopaths of the city resort to in advertising in a economy driven print media.

Finally, it is hightime that IMA HQ makes clear our stand on alleged corruption in MCI at the highest level. Sitting on the fence, undecided can send wrong message to members, unless HQ has decided not to talk about it.

Ultimately, deciding not to take a decision is also a carefully taken decision !

Long Live IMA !

DR. ASHOK BALSEKAR

Hon. Secretary
drag_bal@yahoo.co.in

WEEKLY SCIENTIFIC PROGRAMME

Lectures on Every Thursday
at 02.30 p.m. sharp

Venue : **Lupin CME Auditorium**, IMA Building,
J.R.Mhatre Marg, Behind Chandan Cinema,
J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

DATE	TOPIC	SPEAKER
03-06-2010	Enteric Fever Today	Dr. Shirang Sanglikar
10-06-2010	Clinical and Laboratory diagnosis of Dengue Fever, Leptospirosis and Chikungunya	Dr. Tushar Shah
17-06-2010	Monsoon and the Skin	Dr. Vibha Nigale
24-06-2010	Gastroenteritis in Children	Dr. Vidya Gauri Kulkarni

G. P. FORUM

ADDITIONAL C.M.E. PROGRAMME FOR GENERAL PRACTITIONERS

Every Tuesday
at 02.30 p.m. sharp

Venue : **Lupin CME Auditorium**, IMA Building,
J.R.Mhatre Marg, Behind Chandan Cinema,
J.V.P.D. Scheme, Juhu, Mumbai - 400 049.

DATE	TOPIC	SPEAKER
01-06-2010	Workshop on Tobacco De-Addiction	Dr. Kiran Shandilya
08-06-2010	Glaucoma and General Practitioners	Dr. Rashidaah Kutiyawala
15-06-2010	Blood Components	Dr. Mukesh Desai
22-06-2010	Drug Abuse	Mr. Arun Bhargava
29-06-2010	Acid Base Balance	Dr. Sharad Sheth

- WORKING LUNCH WILL BE SERVED FROM 01.30 PM TO 02.30 PM BEFORE EACH CME.
- CGP & IMA Members who have paid Annual Fees (CGP : Rs. 1000/- & IMA : Rs. 1250/-) FREE
- C.G.P. & IMA MEMBERS : RS. 100/- (NOT PAID ANNUAL FEES) (WEEKLY LECTURES)

Each Lecture Carries A Credit of 1 Hour Each For FCGP Examination.

DR. B. M. INAMDAR DR. ASHOK BALSEKAR
President Hon. Secretary

DR. PRITI BHARGAVA
Asst. Director of Studies
IMA - Mumbai West C.G.P. Sub Faculty

DR. RONAK SHAH
Asst. Secretary



GUEST EDITORIAL...

Dear Friends,

It is with great pride that we bring to you this special issue dedicated to ENT Disorders. Many times, patients presenting with 'common' ENT problems need special attention and evaluation, to determine the underlying cause of their disorder and any related pathology. This becomes very important at times, owing to the anatomically close proximity to critical structures in the head, face and neck region. In this issue, you can read more about some common and not so common ENT conditions. Various aspects of their expert management are presented, while emphasizing the need for reassuring patients at all times. A brief description of the articles has been provided below:

Sometimes, trauma due to various causes can lead to facial nerve paralysis. This debilitating condition can be very emotionally disturbing for patients. Dr. K.P. Morwani and his team have elaborated on the principles of and approaches to facial nerve surgery in their article on 'Management of Traumatic Facial Nerve Palsy'. They have described the technique of grafting

and anastomoses, while emphasizing on the need of an experienced otologist in such cases.

Since long, snoring has always been considered as 'funny' initially, till it becomes a very serious problem in more ways than one. In his article on 'Snoring : Don't Sleep Over It', Dr. Samir Bhargava has given an overview of the reasons snoring is considered serious, the common predisposing factors and pathology which can result in snoring, with some practical self-help tips for the snorer. He has given some details on sleep apnea, which could be an underlying problem and has discussed various treatment modalities.

Dr. Bimal Shah has presented an interesting pilot study conducted in patients with tympanic perforations, using cartilage as the graft via a transcanal approach. The advantages & limitations of this technique have been analyzed in his article: "Transcanal Cartilage Myringoplasty".

In my article on "Endoscopic Endonasal Surgery", I have given an overview of the evolution of the applications of this technique in ENT practice and the advantages it offers over conventional approaches, with a glimpse into what the future of this technique holds for patients suffering from sinonasal disorders and base skull conditions.

I am sure you will find all the articles very informative, interesting and helpful in understanding these conditions better when you see patients presenting with the associated symptoms or signs in your clinical practice. All the authors are available for any further information or details you may require on their respective topics and I would like to thank them for their valuable contribution in releasing this special issue in ENT Disorders.

DR. UDAY K. VORA

85TH IMACON AT JAIPUR 2010			
VENUE : B. M. BIRLA HALL			
REGISTRATION CHARGES			
	Upto 15.06.2010	16.06.2010 to 30.09.2010	01.10.2010 to 25.12.2010
Members	Rs. 1500/-	Rs. 2000/-	Rs. 2500/-
Non members	Rs. 1500/-	Rs. 2500/-	Rs. 3000/-
Spot Registration	Members	-	Rs. 3000/-
	Non Members	-	Rs. 3500/-
MASTACON : Nasik 19th, 20th, 21th November 2010			
Details will follow			

ANTI QUACKERY SUB COMMITTEE

Your complaints about the quacks, who are doing allopathic practice cross practicing, using unethical ways of giving advertisements in the news, TV, media, may be sent to the anti quackery Sub Committee on your letter head with the proof like, paper cuttings along with the date, name of the news paper, photographs, prescriptions copies directly to any of the Sub Committee members – Dr. Suresh Kalambi, Dr. Devesh Desai, Dr. Satish Naik, Dr. Suhas Patwardhan or Hon. Secretary Dr. Ashok Balsekar of IMA - Mumbai west.

Dr. Suresh Kalambi

Chairperson, Anti Quackery Sub Committee

MEDICAL ASSOCIATION CO-ORDINATION SUB COMMITTEE

Kindly get in touch with the members of the committee to co-ordinate the activities of all allopathic organizations to pursue a common agenda to protect the interest of all our brethren.

Dr. Suhas Kate

Chairperson, Medical Association co-ordination Sub Committee

THE SPORTS SUB COMMITTEE

- 1) **TREASURE HUNT** : An fresh innovative programme. To be held on 2nd August Sunday morning from 8.00 am to 11.00 am followed by Beer & Lunch at IMA Hall. Boundaries between Bandra to Oshiwara East & West.
- 2) **BRIDGE TOURNAMENT** : Tentatively to be held in August – September in IMA Hall.
- 3) **TABLE TENNIS, CHESS, SCRABBLE TOURNAMENT**: To be held in October- November.
- 4) **CRICKET DOUBLE WICKET TENNIS BALL TORNAMENT**: To be held under floodlights in December- January.

Dr. Nilesh Shah

Chairperson

Dr. Hiren Ambegaonkar

Co-Chairperson

Sports Sub Committee

ELECTION FOR IMA - MAHARASHTRA STATE BRANCH

Nominations are invited for the Post of President (One Post) & Vice Presidents (Three Posts) of IMA – Maharashtra State Branch for the year 2010 - 2011.

All interested members are requested to apply urgently on their letterhead to the office latest by **20/06/2010** by 5.00 p.m.

DR. B. M. INAMDAR

President

DR. ASHOK BALSEKAR

Hon. Secretary

Report of “WORLD ASTHMA DAY”



Convenor Dr. Prabhudesai

On occasion of WORLD ASTHMA DAY {4th May} a symposium was held on 2nd May 2010 in Lupin Hall. The theme this year is “You Can Control Your Asthma”. Eminent Chest Physician Dr. Pralhad Prabhudesai was the convenor of the programme.

The inaugural address by President, Dr. Bal Inamdar was followed by a very vivid presentation of the pathophysiology of Asthma, by Dr. Salil Bendre. This simplified the understanding of the Management of Asthma. This was followed by a talk by Dr. Mukesh Sanklecha on Paediatric Asthma along with Demonstration of various inhaler devices in the armamentarium. Dr. Prabhudesai emphasized the importance of using Spirometry in the diagnosis of Bronchial Asthma. Dr. Vasant Shetye explained the technicalities of Spirometry and Dr. Prabhudesai followed it up with interpretation of spirometry.

Subsequent MCQs by Dr. Ronak stumped all. A lively panel discussion followed. Dr. S. Gajaria was the highest scorer.

It was well attended by over 120 delegates.

We are thankful to CIPLA
PHARMACEUTICALS and GERMAN
REMEDIES for sponsoring this programme.

Dr. Priti Bhargava
Asst. Director of IMA – CGP

Workshop on “MANAGEMENT OF TUBERCULOSIS”

We intend holding a workshop for imparting training to family physicians on management of tuberculosis, under IMA – GFATM – RNTCP – PPM Project. The workshop will be conducted on **Sunday, 03rd October 2010**, its duration being six hours. It will be conducted by eminent professionals from the field and certificates will be issued on completion of the workshop.

Interested members should register with the IMA – Mumbai West office by 20th June 2010. **No Registration fees.**

Dr. Priti Bhargava
Director of Studies
IMA – Mumbai West CGP Sub Faculty

IMPORTANT IMA – CGP ANNOUNCEMENT

Members who are interested in appearing for FCGP exam to be held in May 2011, may collect the application form from the office and submit the duly filled in form to the office on or before 10th June 2010.

More information regarding this can be obtained on website :
www.imacgpindia.org

The members desiring to appear for this exam are requested to

Contact :
Dr. Priti Bhargava
98338 87603



MESSAGE

It is in need a matter of pride & honor for me to write as the secretary of the conference that is being organized under the auspices of EMA.

As I write to you today after my more than 15 years of association with my teacher Prof. Dr. K. C. Mohanty it reminds me of my first day meeting with him. Sitting in his simple chair in OPD of J. J. Hospital and having his lunch while talking to patients and teaching students, man in his Jodhpuri suit, an obvious center of attraction for his simplicity with dignity.

He told me that day; in future we would see advancement in respiratory medicine where you would be doing endobronchial resection & lasers. You would be doing surgeries through bronchoscope. He told me that you would be able to generate a new lung..... Though I did not realize that time, all that he told me 15 years ago is a reality today. He is visionary & has always given futuristic thoughts. His contribution of quinolones role in TB, immunomodulators for variety of intractable disease are a few of such examples of his innumerable original contribution to medicine.

On his completion of successful & meaningful 70 years we take this opportunity to honor him & felicitate him. And what can be a better way than to offer him something that is close to his heart, a scientific feast.

Teachers all across the country are gathering for this unique event to present their views about the next decade of our speciality i.e. "Management of respiratory disease in 2020".

Post independence it was only tuberculosis but now our speciality has widened its horizon to incorporate sleep medicine, critical care, allergy – asthma, bronchoscopy etc. keeping in pace with the advances, next decade would see a few path breaking modalities like gene therapy / stem cell, making a new lung. The colonies on the surface of moon or may be below the level of water, in ocean are being planned. Corporate have started taking over the individual practices. Insurance, TPA problems & Medico Legal issues are daily phenomena. The present conference is designed to address all these issues.

For the first time we have organized a work shop & hands on training programme on pulmonary rehabilitation & fiber optic bronchoscopy. Please encourage your friends & colleagues to take the advantage as well.

I am sure this conference will have its own mark in the history where we students offer a tribute to our dear teacher who has not only taught us medicine but also have made us good human beings. We request all of you to join us & make this a very successful event as we all are indebted to him directly or indirectly for his guidance, help, support and blessings, which he has showered without any reservation and discrimination.

The added attraction to the conference is going to be the release of three books & launch of "Academy of Respiratory Medicine".

Let's shake hands at the scientific tribute to a living legend.....

DR. AGAM VORA

Organizing Secretary
Environ Medical Association

INVITATION
ENVIRONMENTAL MEDICAL ASSOCIATION
presents
“RESPIRATORY DISEASE MANAGEMENT IN 2010”

Day and Date : SUNDAY, 13TH JUNE 2010.
Time : 09.00 am onwards
**Venue : IMA Hall, IMA Building, Behind Chandan Cinema,
J. R. Mhatre Marg, Juhu, Mumbai - 400 049.**

PROGRAMME

Time	Topic	Speaker	
09.00 am - 09.30 am	Registration & Breakfast		
09.30 am	Welcome		
09.30 am - 10.00 am	Widening Horizon of Respiratory Diseases 2020 ?	Dr. S. K. Khatiyar	Kanpur
10.00 am - 10.30 am	Will the Clinical Examination be Obsolete by 2020 ?	Dr. Rajendra Prasad	Lucknow
10.30 am - 11.00 am	How we would treat our Patient in 2020 ?	Dr. Mohan Kumar	Coimbatore
11.00 am - 11.30 am	Will the individual practitioner survive in 2020 ?	Dr. J. C. Kothari	Mumbai
11.30 am - 12.00 noon	Geriatric Health by 2020—Challenge?	Dr. F. E. Udawadia	Mumbai
12.00 noon - 01.30 pm	Inauguration & Dir. Prof. Dr. K. C. Mohanty Felicitation Programme		
01.30 pm - 02.00 pm	Lunch		
02.00 pm - 02.30 pm	New Lung : a myth or Reality ?	Dr. P. S. Shankar	Gulbarga
02.30 pm - 03.00 pm	New Respiratory Diseases of the Next Decade	Dr. D. Behera	New Delhi
03.00 pm - 03.30 pm	Will 2020 See the end of TB era	Dr. V. K. Arora	New Delhi
03.30 pm - 04.00 pm	Immune Modulators holds the key to Future Therapy	Dr. S. K. Luhadia	Udaipur
04.00 pm - 04.30 pm	Bioterrorism – Weapons of Future	Dr. A. K. Jamneja	Chandigarh
04.30 pm - 05.00 pm	Respiratory issues of Sub Oceanic Townships & Lunar Surface	Dr. V. K. Vijayan	New Delhi
05.00 pm	Vote of Thanks		

- **REGISTRATION FEES : FREE BUT PRIOR REGISTRATION IS A MUST**
- **LIMITED REGISTRATION OF 50 DELEGATES ON “FIRST COME FIRST SERVE” BASIS.**

FOR REGISTRATION CONTACT : MS. APARNA / MS. SEEMA / MS. SUNITA
IMA OFFICE : TEL : 2620 6517 / 2625 4368

DR. B. M. INAMDAR President IMA - Mumbai West	DR. ASHOK BALSEKAR Hon. Secretary	DR. PRITI BHARGAVA Asst. Director of Studies IMA – Mumbai West	DR. RONAK SHAH Hon. Secretary CGP Sub Faculty
Dir. Prof. Dr. K. C. Mohanty Founder President Environmental Medical Association		Dr. Agam Vora Organizing Secretary	

IMPORTANT ANNOUNCEMENT

30 HOURS OF ACCREDITED CME IN 5 YEARS ARE NECESSARY FOR CONTINUATION OF MMC REGISTRATION

The Central Government of India has notified the new Ethics regulations in the Gazette of India on April 16, 2002, provides that “ A Physician should participate in professional meetings as part of Continuing Medical Education Programmes, for at least 30 hours every five years, organized by reputed professional academic bodies or any other authorized organizations”.

Members are informed that as per the above notification, thirty (30) credit hours in five (5) years will be compulsory for our medical registration with MMC to be valid. In view of this, IMA – Mumbai West will be sending request to MMC for accreditation of some of our CMEs. Only those CMEs which are approved by MMC will be accredited.

This is possible because IMA Mumbai West is certified to conduct such CMEs as per recent authorization from MMC dated 13/04/2010.

Members who desire to collect credit hours will have to pay a pre-decided amount for each credit hour. Part of this amount will be paid to MMC as credit hour fees. Also, please be advised that these charges will be over and above the Annual Fees of CGP or registration charges.

Please note that members desiring to get credit hours will be given preference to attend the accredited CME programmes over other members who have paid annual membership for CGP. Such CME programmes will be announced in “Medical Image” from time to time. Members are requested to keep track of such announcements for their benefit.

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

IF THESE MOVIES WERE DUBBED IN MARATHI....

- | | |
|-----------------------------|------------------|
| 1. KUCH KUCH HOTA HAI | कसं तरी होतय् |
| 2. MACHIS | काडे पेटी |
| 3. WOH KAUN THI | कोण होती रे ती ? |
| 4. HOLLOW MAN | पोकळ माणूस |
| 5. DIE ANOTHER DAY | नंतर कधीतरी मर |
| 6. GONE WITH THE WIND | गेला उडत |
| 7. SUPERMAN | लई भारी मानूस |
| 8. SCORPIO KING | विंचू राजा |
| 9. THE MUMMY | आई आई |
| 10. THE MUMMY RETURNS | आई परत येते |

Complied by.... डॉ. अशोक बलसेकर

MEDICAL EDUCATION SUB COMMITTEE
of
INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

Presents

**“EDUCATIONAL PROGRAMME FOR
POST GRADUATE STUDENTS / RESIDENTS”**

Day & Date : **SATURDAY, 03RD JULY 2010**
Time : **06.30 pm onwards**
Venue : **I.M.A. Hall, I.M.A. Building, Behind Chandan Cinema,
J. R. Mhatre Marg, J.V.P.D. Scheme, Juhu, Mumbai - 49.**

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

DR. RASHMIKANT SANGHVI
Chairperson

DR. SANJAY DUDHAT
Co-Chairperson

WATCH FOR DETAILS IN THE NEXT ISSUE

IMA - CGP MAHARASHTRA STATE BRANCH
&
IMA - CGP MUMBAI WEST SUB FACULTY

Invites Members

An Orientation Workshop on

“CONTRACEPTIVE UPDATES AND SAFE ABORTION TECHNIQUES”
on the occasion of **“WORLD POPULATION DAY”**

Day & Date : **SUNDAY, 11TH JULY 2010**
Time : **09.00 am onwards**

DR. B. S. MEHTA **DR. HOZIE KAPADIA**
President Hon. State Secretary
IMA – MAHARASHTRA STATE BRANCH

DR. B. M. INAMDAR **DR. ASHOK BALSEKAR**
President Hon. Secretary
IMA - MUMBAI WEST BRANCH

DR. AKIL CONTRACTOR
Director of Studies
IMA - CGP MS FACULTY

DR. PRITI BHARGAVA **DR. RONAK SHAH**
Asst. Director Asst. Secretary
IMA Mumbai West CGP SUB FACULTY

DR. DILIP DEODHAR **DR. VIVEK BILLAMPELLY**
Hon. Secretary Hon. Joint Secretary
IMA - CGP MS FACULTY

DR. SHUBHANGI DHAGE
Resource Person

DOCTOR'S DAY

Every year our branch celebrates Doctors Day in memory of renowned Dr. B. C. Roy by felicitating great achievers from different walks of society. THIS YEAR WE HAVE DECIDED TO **FELICITATE DOCTORS/ASSOCIATIONS WHICH ARE ICONIC IN THEIR FIELDS OF EXPERTISE**. They have been achievers par excellence, whose contribution to their field has been so immense that their medical field is enriched and known by their very presence.

Day & Date : **SUNDAY, 4ND JULY 2010**

Time : 7.00 p.m. onwards

Venue : IMA Building, J.R. Mhatre Marg, JVPD Scheme,
Juhu, Mumbai - 400049.

PROGRAMME

No.	NAME	MEDICAL FIELD
1.	MEDICINES SANS FRONTIERS (Nobel Peace Prize in 1999) & Dr. Shobha Varthman	Medical Aid to Strife-Torn and Calamity-Torn Communities Around the World
2.	Dr. Dadhich Durga Prasad	Neurology
3.	Dr. Rajan Badwe	Breast Cancer
4.	Dr. Rama Vaidya	Reproductive Endocrinology
5.	Dr. Ashok Johari	Paediatric Orthopaedics
6.	Dr. Shrikant Gokhale	General Practice

GRAND MUSICAL EVENING PERFORMED BY AWARD WINNING ORCHESTRA OF MEDICAL STUDENTS

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

M A T R I M O N I A L

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Contact : 98211 34977 / 98211 37330

Alliance invited from Professionally Qualified Boys for Hindu Nair Girl Doctor, M.B.B.S (Mumbai), MRCP, doing superspecialisation in UK, Registrar – NHS-UK, 29 yrs. Slim, 160 cm, Family Mumbai based professionals.

Email: ankk46@gmail.com

Proposals invited for Gujarati Halai Lohana Doctor Boy, M.S. (General Surgeon) '82 / 5'4" / 56

Contact : 098207 99899

B.Tech. IIT (POWAI) M. Engg. MIT (BOSTAN) M.S..... UIUC (CHICAGO-ILLINOY)
Gujrati 1984-6" Vaishnav Vegetarian boy looking for highly qualified girl.

Contact : 28241651----janaki4prince@yahoo.in

TAKE - HOME MESSAGE

*By Dr. Priti Bhargava, Director
IMA Mumbai west Sub faculty of IMA CGP*

27TH APRIL 2010

HEARING AIDS - DR. BIMAL SHAH

Types of Hearing Aids-

- Pocket type (Body worn)
- BTE (behind the ear)
- ITC (in the canal)
- CIC (complete in the canal)

With a hearing loss of upto 50db improvement in hearing is 70% with one hearing aid and 90% with two hearing aids. With a hearing loss of > 50 db <90db hearing loss improvement in hearing is 50% to 60% with one hearing aid and 70% to 80% with two hearing aids. With a hearing loss of 90db or more expect to improve quality of life with hearing aid but do not expect too much (conversation in the range of 4 feet to 5 feet)

06TH MAY 2010

DECISION MAKING IN CORONARY BYPASS SURGERY- DR. ASHOK HISHIKAR

Indications of CABG-

- Left Main Artery Stenosis
- TVD, especially LVEF< 50%
- Proximal LAD & Proximal Left Circumflex
- DVD with severe proximal LAD
- Disabling angina despite maximal drug therapy

11TH MAY 2010

OVERVIEW AND MANAGEMENT OF HEPATITIS C - DR. SAMIR PARIKH

Indications for treating Hepatitis C-

- HCV +ve acute hepatitis for more than three months.
- HCV +ve chronic hepatitis with raised ALT.
- HCV +ve chronic hepatitis with normal ALT but active histology.

Contraindications to treating Hepatitis C -

- Age <18years >60years
- Decompensated liver cirrhosis (DCLC)
- HIV +ve with CD4<200

Contraindications to IFN-

- Major Depression
- DCLC
- Early post liver transplant
- WBC < 750
- Platelets < 50000
- Autoimmune disorders

13TH MAY 2010

MANAGEMENT AND CHEMOTHERAPY IN LUNG CANCER - DR. TUSHAR PATIL

Symptoms in Lung Cancer-

- U nexplained chronic cough
- Sputum mixed with blood
- Fatigue
- Repeated attacks of lung infection
- Constant chest pain
- Breathlessness, Wheezing
- Loss of appetite or weight loss

Emergencies encountered in lung cancer-

- Hypercalcemia / SIADH
- SVC obstruction
- Spinal cord compression
- CNS metastasis

Treatment modalities-

- Stage I- Surgery
- Stage Ib-Surgery+/- Chemotherapy
- Stage II-Surgery +Adjuvant Chemotherapy
- Stage IIIA-Surgery for min. bulky disease / Concurrent chemoradiation / Sequential chemoradiation
- Stage IIIB-Concurrent chemoradiation / Sequential chemoradiation
- Stage IV-Chemotherapy

The Clinical Establishments (REGISTRATION AND REGULATION ACT) BILL, 2010

The Clinical Establishments (Registration and Regulation Act) Bill, 2010 - approved by the Union Cabinet last month - makes it mandatory for all clinical establishments to provide medical care and treatment to stabilize any person in an emergency condition.

If the Bill is passed in Parliament, this will be the first time emergency medical care is made obligatory under law in the country.

While there is no provision for imprisonment for non-compliance, the registering authority can impose a heavy fine — up to Rs. 5 lakh — on the erring establishment. If it fails to pay, the fine will be recovered as arrears of land revenue.

In 1989, the Supreme Court gave directions that emergency care be not denied to victims under any circumstances. The Law Commission also recommended legislation to make it mandatory.

Accident victims are often referred to government hospitals from private facilities to avoid legal hassles. Also, women are turned away from private hospitals and nursing homes if they fail to deposit money in advance.

As per the Bill, all clinical establishments will be required to register themselves with the State Council for Clinical Establishments. **These include hospitals, maternity homes, nursing homes, dispensaries, clinics and similar facilities with beds that offer diagnosis, treatment or care for illness or injury or pregnancy under any recognized system (allopathy, Yoga, naturopathy, Ayurveda, Homoeopathy, Siddha and Unani). Clinical establishments also include any laboratory (an independent entity or part of an establishment) which offers pathological, bacteriological, genetic, radiological, chemical, biological and other diagnostic or investigative services.**

Whether the establishment is owned by the government or a department of the government, a trust (public or private), a corporation (including a cooperative society), a local authority or an individual, registration will be compulsory. The clinical establishments of the armed forces have been excluded from the purview of the proposed legislation.

The legislation will help in addressing unregulated growth of the private sector, often accused of inadequate treatment, excessive use of higher technology, medical malpractices and negligence. It would also empower the State governments or the Registering Authority to direct any clinical establishment to furnish details, statistics or any other information. This would be extremely useful for monitoring outbreaks of diseases.

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WANTING TO SETUP THEIR OPD

WE INVITE ALL DOCTORS
INTERESTED TO HAVE A LOOK
AT THE SPACE &
BOOK THE TIME SLOTS

FOR MORE INFORMATION CONTACT:
NIMESH DEDHIA : 98214 83114
MUKUND SHINDE : 9930 889810
EMAIL: bobby4u2@hotmail.com

THE CLINICAL ESTABLISHMENTS (REGISTRATION AND REGULATION) BILL, 2010

STATEMENT OF OBJECTS AND REASONS

1. At present, the supervision and regulation of the quality of services provided by the health care delivery system to the people by both public and private sectors has largely remained a contentious and therefore, unresolved issue. The current structure of the health care delivery system does not provide enough incentives for improvement in efficiency. The private sector health care delivery system in India has remained largely unregulated and uncontrolled. Problems range from inadequate and inappropriate treatment, excessive use of higher technologies, and wasting of scarce resources to serious problems of medical malpractice and negligence.
2. Despite many State Legislatures having enacted laws for regulating health care providers, the general perception is that current regulatory process for health care providers in India is inadequate or not responsive to ensure health care services of acceptable quality and prevent negligence. Concerns about how to improve health care quality have continued to be frequently raised by the general public and a wide variety of stakeholders, including Government, professional associations, private providers, agencies financing health care, National Human Rights Commission and also by judiciary.
3. Accordingly, a need has long been felt for a central legislation for ensuring uniform standards of facilities and services by the clinical establishments throughout the State where the Legislative Assemblies have passed resolutions under article 252 of the Constitution and the Union territories and the States which may adopt the legislation by such resolutions.
4. In view of the above, the Clinical Establishment (Registration and Regulation) Bill, 2007 was introduced in Lok Sabha on the 30th August, 2007 and the same was referred to the Department-related Parliamentary Standing Committee on Health and Family Welfare which made certain recommendations on the provisions of the said Bill. However, the said Bill was lapsed due to dissolution of the Fourteenth Lok Sabha.
5. It is now proposed to introduced the Clinical Establishments (Registration and Regulation) Bill, 2010 on the lines of above Bill incorporating therein certain recommendations made by the Department-related Parliamentary Standing Committee on Health and Family Welfare.
6. **The salient features of the proposed legislation, *inter alia*, are as follows:—**
 - (i) the proposed legislation provides for the constitution of a National Council consisting of representatives of Medical Council of India, Dental Council of India, Nursing Council of India, the Pharmacy Council of India, the Indian Systems of Medicines representing Ayurveda, Siddha, Unani and Homoeopathy systems, the Indian Medical Association, the Bureau of Indian Standards, the Zonal Councils setup under the States Reorganisation Act, 1956, the North-Eastern Council, etc.;
 - (ii) the function of the National Council shall be to determine the standards for the clinical establishment, classify the clinical establishment into different categories, develop the minimum standards and their periodic review, compile, maintain and update a National Register of clinical establishments, perform any other function determined by the Central Government, from time to time;
 - (iii) the function of the State Council shall be to compile, maintain and update the State Registers of clinical establishments and to send monthly returns for updating the National Registers. The State Councils shall also publish reports on the implementation of standards within their respective States, annually;

- (iv) the concerned State Governments shall, by notification, set-up an authority to be called the district registering authority under the chairmanship of District Collector for registration of clinical establishments;
- (v) no person shall carry on a clinical establishment unless it has been registered in accordance with the provisions of the proposed Bill. The legislation would not apply to the clinical establishments of the Armed Forces;
- (vi) it is proposed that clinical establishments already in existence may be allowed for provisional registration to carry out their business. There shall be no prior enquiry for provisional registration. But the authority shall have power to make enquiry in accordance with such rules as may be prescribed.
- (vii) the clinical establishment having provisional registration shall fulfil the standards which may be notified for the purpose. The provisional certificate shall not be granted or renewed beyond a period of two years from the date of notification of standards;
- (viii) any clinical establishment may apply for permanent registration in such form and shall pay such fee as may be prescribed by the State Government. A detailed procedure for permanent registration is being provided in the proposed legislation;
- (ix) the authority shall have power to cancel the registration of the clinical establishment which fails to comply with the conditions prescribed by the Central Government. The authority shall have power to inspect a registered clinical establishment. Any person aggrieved by an order of the registering authority shall prefer an appeal to the State Council;
- (x) the clinical establishments shall undertake to provide within the staff and facilities available, such medical examination and treatment as may be required to stabilise the emergency medical condition of any individual who comes or is brought to such clinical establishment;
- (xi) the certificate of permanent registration issued by the authority is valid for a period of five years from the date of issue;
- (xii) there shall be register of clinical establishment at the district level, State level and the National level;
- (xiii) if any person contravenes any provisions of the proposed legislation or any rules made thereunder, he shall be punished with fine. The maximum penalty being provided is rupees five lakh;
- (xiv) conferring power upon an authority, to levy monetary penalty for violation of the provisions of sections 41 and 42 of the proposed Bill;
- (xv) any person aggrieved by the decision of authority may prefer an appeal to the State Council.

WELCOME NEW MEMBERS

KANDIVLI : Dr. Madachimpara Mohan Krishnan
ANDHERI : Dr. Mistry Kamlesh Chhabildas
 Dr. Mistry Bhawna (Mrs.) Kamlesh
KHAR : Dr. Mhatre Purnima Dinkar
SANTACRUZ : Dr. Mohanty Ragini N.
VILE PARLE : Dr. Dutta Nalini (Mrs.) Surinder
 Dr. Shah Nikhilesh A.

DR. B. M. INAMDAR
 President

DR. ASHOK BALSEKAR
 Hon. Secretary

Interventional Cardiology : Evolution, Challenges faced and New technologies

In the management of chronic stable angina, there are two invasive techniques available for myocardial revascularisation: coronary artery bypass surgery and catheter attached devices. Although coronary artery bypass surgery was introduced in 1968, the first percutaneous transluminal coronary angioplasty was not performed until September 1977 by Andreas Gruentzig, a Swiss radiologist, in Zurich. The patient, 38 year old Adolph Bachman, underwent successful angioplasty to a left coronary artery lesion. After the success of the operation, six patients were successfully treated with percutaneous transluminal coronary angioplasty in that year.

By today's standards, the early procedures used cumbersome equipment: guide catheters were large and could easily traumatise the vessel, there were no guidewires, and balloon catheters were large with low burst pressures. As a result, the procedure was limited to patients with refractory angina, good left ventricular function, and a discrete, proximal, concentric, and non-calcific lesion in a single major coronary artery with no involvement of major side branches or angulations. Consequently, it was considered feasible in only 10% of all patients needing revascularisation.

During 1977-86 guide catheters, guidewires, and balloon catheter technology were improved, with slimmer profiles and increased tolerance to high inflation pressures. As equipment improved and experience increased, so more complex lesions were treated and in more acute situations.

Although percutaneous transluminal coronary angioplasty causes plaque compression, the major change in lumen geometry is caused by fracturing and fissuring of the atheroma, extending into the vessel wall at variable depths and lengths. This injury accounts for the two major limitations of percutaneous transluminal coronary angioplasty-acute vessel closure and restenosis.

In the 1980s, two main developments aimed at limiting these problems emerged. The first were devices to remove plaque material, such as by rotational atherectomy, directional coronary atherectomy, transluminal extraction catheter, and excimer laser. The second development was the introduction of intracoronary stents deployed at the site of an atheromatous lesion. These were introduced in 1986 with the objective of tacking down dissection flaps and providing mechanical support.

The first large randomised studies conclusively showed the superiority of stenting over coronary angioplasty alone, both in clinical and angiographic outcomes, including a significant 30% reduction in restenosis rates. Bare Metal Stents did reduce rates of restenosis compared with balloon angioplasty; however, they were unable to eliminate it. Vascular brachytherapy was initially tried to prevent and/or treat in-stent restenosis, and although highly effective, it quickly fell out of favor following its association with high rates of late ST. The continuing search for an effective treatment for restenosis ultimately paved the way for the arrival of Drug Eluting Stents in 2002. Drug Eluting Stents can be categorized into first and second generation Drug Eluting Stents.

The arrival of Drug Eluting Stents was seen as the third revolution in interventional cardiology, after balloon angioplasty and Bare Metal Stents. The first generation Drug Eluting Stents consisted of the same metal framework as the previous stents; however, they were coated with antiproliferative agents such as sirolimus or paclitaxel like Cypher from Johnson and Johnson, Taxus from Boston Scientific and Endeavor from Medtronic.

First generation Drug Eluting Stents consist of a metallic stent platform, a cytostatic or antimetabolic pharmacological agent resulting in local suppression of neointimal hyperplasia, and a carrier vehicle, most frequently a polymer, serving for controlled drug delivery. After initial

enthusiasm, however, there has been controversial debate on the long-term safety of Drug Eluting Stents, with a focus on the potential for an increased risk of late stent thrombosis (ST). Polymers have been hailed by some as essential to controlled drug elution and maligned by others as a ticking time bomb: the potential cause of increased late thrombosis and other adverse tissue responses. The polymer has also been blamed for stent-delivery glitches; in particular, the increased friction, or “stickiness,” between the delivery balloon and the stent itself

The mechanisms behind late Stent Thrombosis appear to be multifactorial, varying from factors such as inappropriate stent deployment techniques to delayed or inadequate endothelialization of the stent surface. Since the presence of permanent polymer coatings may have pro-inflammatory and thrombogenic potential, present Drug Eluting Stents research has been focusing either on utilization of biodegradable polymer coating or on a completely polymer-free Drug Eluting Stent platform.

Challenges faced with the first generation Drug Eluting Stents and increased prevalence of complex lesions with rise in coronary heart disease has led to evolution of second Generation Drug Eluting Stents like BioMatrix from Biosensors International, Xience Prime from Abbott, Endeavor Resolute from Medtronic.

Xience Prime Everolimus Eluting Coronary Stent System (from Abbott Vascular) offers design and delivery system for easy deliverability and excellent crossability.

Endeavor Resolute Zotarolimus Eluting Coronary Stent System (from Medtronic) releases the drug more gradually producing a more tightly constrained drug level in the tissue, but sustaining it for a longer duration.

Biosensors International’s Drug Eluting Stent BioMatrix has a proprietary drug Biolimus a9. It uses a Biodegradable [poly lactic acid] polymer which completely biodegrades into naturally occurring CO₂ and H₂O by six to nine months time. Timely drug elution and complete biodegradation of the polymer helps the stent achieve bare metal profile in six to nine months.

The performance of BioMatrix Drug Eluting Stent has been supported by LEADERS study where BioMatrix with biodegradable polymer was compared with first generation Drug Eluting Stent with durable polymer. The two years data have shown promising and encouraging results for the BioMatrix Drug Eluting Stent in all real world cases that included stemi, bifurcation, CTO, SVG, Multivessel, Left main, long length etc. The primary endpoint of non inferiority was maintained till two years. Incidence of very late stent thrombosis in BioMatrix Drug Eluting Stent was very low and there were no cases of stent thrombosis in patients who stopped clopidogrel due to non-compliance.

The next few years are expected to see active research and development in the drug eluting stents field. Newer technologies like biodegradable stents, dual drug stents are in the pipeline and presently been studied.

Dr A V Ganesh Kumar
HOD Cardiology
L H Hiranandani Hospital, Powai.

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IMA CONFERENCE TOUR TO KENYA

Tour Operators : Cox Kings (I) Ltd.

16th August - 23rd August - 29th August 2010

Day 01 Arrive Nairobi & Take connecting flight to Mombasa

0930 Arrive **Mombasa**, Check in the hotel at Standard Time – Early Check in subject to availability
1300 Packed Snacks.
1900 Dinner at Indian restaurant - **MAHARAJA**
Overnight at **Whitesands / Travelers Beach Hotel**.

Day 02 Breakfast.

0900 Mombasa City tour.
1300 Packed Snacks, Time free at Leisure.
1900 Dinner at Indian restaurant - **MAHARAJA**, Overnight at **Whitesands / Travelers Beach Hotel**.

Day 03 Breakfast at the Hotel.

0600 Transfer to Mombasa Airport.
0820 Take flight to Nairobi.
0920 Arrival Nairobi & Transfer to Aberdare National Park
1000 After briefing by your safari driver guide, depart and drive through the lush foothills of the Aberdares Mountain Range.
1330 Lunch Aberdare Country Club.
1500 The Ark comprises three decks from which numerous balconies and lounges provide superb vantage points for game viewing.
After lunch transfer to The Ark (children under 7yrs not permitted, light overnights bags only).
Overlooking a waterhole and salt lick where the 'Big Five' occasionally gather for an exhilarating night of wild encounters.
2000 Dinner and overnight at **The Fairmont Ark (L/D/B/)**.

Day 04 Aberdare - Lake Nakuru National Park

0800 After breakfast and check out, depart and drive via Thomson Falls to Lake Nakuru National park at the heart of the Great Rift.
1300 Arrive for check in and lunch followed by some time to rest.
Proceed for an afternoon game drive. This park is well known for its abundance of greater and lesser flamingoes.
Return at sunset for dinner and overnight at **Flamingo Hill Lodge (L/D/B/)**.

Day 05 Lake Nakuru - Masai Mara National Game Reserve

0800 After breakfast depart and drive through the floor of the Rift Valley past the Narok Township to Masai Mara game reserve.
1300 Arrive for check in and lunch followed by some time to rest. Proceed for afternoon game drive. Return at sunset for dinner and overnight **Mara Simba Lodge (L/D/B/)**

Day 06 Masai Mara National Game Reserve

You will have a full day in the Mara with early morning and afternoon game drive. You will have the opportunity to see the breath taking experiences of millions of wildebeests crossing the Mara River. This will be on their journey back to the Serengeti. All meals and overnight at **Mara Simba Lodge (L/D/B/)**

Day 07 Masai Mara – Nairobi

0800 After breakfast check out and drive back to Nairobi, arriving at mid day.
Check in at your hotel followed by the rest of the day at leisure. Packed Snacks
Dinner at an Restaurant with overnight at **Safari Park Hotel / Intercontinental (B, D)**.

Day 08 Nairobi – Depart.

After breakfast check out and proceed for days sightseeing within Nairobi.
1300 Check Out & Lunch at Indian Restaurant. Later transferred to Jomo Kenyatta airport for your homeward departure flight.

Group size	Approx. 40 Adult Passenger Traveling Together		
Date of Travel	August 2010		
Destination	Kenya		
Duration	07 Nights/08 Days		
Hotel	Mombasa	- 02 Nights	- White Sands Beach Resort
	Aberdares	- 01 Night	- Fairmont Ark Lodge
	Lake Nakuru	- 01 Night	- Flamingo Hill Lodge
	Masai Mara	- 02 Nights	- Mara Simba Lodge
	Nairobi	- 01 Night	- Safari Park Club

Highlights of Kenya (with Mombasa) Tour

- 1) "First ever" overseas conference tour by IMA Mumbai West;
- 2) all inclusive unbelievably low cost of such a tour (actual saving could be Rs. 20,000/- due to group concession);
- 3) tour in "migratory season (high season)", when you will see hundreds of wild beasts (including "big 5") - considered as nature's wonder!;
- 4) Stay at Mombasa - a beautiful beach resort;
- 5) South Africa extension at competitive rates for those who wish to experience that country too;
- 6) Renowned and reliable Tour operator - "Cox & Kings (I) Ltd."

Package Price : (per person)

- IMA for Members + family : Rs. 90,000/-
- Annual CGP Members : Rs. 89,500/-
- IMA Members from other Branches : Rs. 92,000/-
- Non Members (Non family Members) : Rs. 95,000/-

LAST DATE FOR REGISTRATION :
15th JUNE 2010

Important Disclaimer : Indian Medical Association Mumbai West will have a role of only recommending names and telephone numbers of interested members/their guests to Cox & Kings. IMA Mumbai West will have no liability of any kind towards any mismanagement, cancellations, add-on tours, refunds of any kinds and any other mater related to this tour. IMA Mumbai West will not entertain any queries/correspondence towards any grievances / cancellations / mismanagements/ refunds queries / add-on tours or any mater related to the tour. The concerned member should directly contact Cox and Kings for the same to settle their issue.

Cost Includes the following services :-

- Economy Class Return Airfare with Airport Taxes
- Kenya Visa on arrival
- Overseas Travel Insurance
- 01 hr conference facility
- One dinner with 01 hrs free flow of soft drink & beer

- Accommodation As per Itinerary.
- Parking Fees.
- Meals As per Itinerary.
- All Airport Hotel Transfers
- Transportation in small vehicle – 06 Passengers per vehicle, except in Nairobi where 20 seater coached will be used.
- Visa on Arrival.
- Sightseeing as mentioned in Above itinerary

Cost Excludes the following services :-

- Any Free of Costs.
- Early Check in / Late Check Out charges.
- Any other services which are not mentioned above.
- Any increase in Airfare, Visa, and Passport Charges.

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1340 1440
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IMPORTANT NOTE

- Passport should be valid at least 6 months beyond period of stay.
- Check-in at the hotels are 1400 hours & check-out 1000hours.
- Missed or delayed flights can lead to changes in itinerary and at clients expense should the case arise.
- Non a/c vehicles are used for transfers in Nairobi and on safari in Kenya
- Luggage limit of one soft bag per person during travel in Kenya. Hard cases should be avoided as they cannot fit in safari vehicles
- Luggage limit of 20 KGS pp on domestic flight to Mombasa.

CANCELLATION CHARGES for Hotels

- After Confirmation to 45 days before the departure 50% of the tour cost.
- 44 Days to 00 days before the departure 100% of the tour cost

SNORING

Don't Sleep Over it

Snoring is a fairly common disorder. 60% of males and 40% of females after the age of 60 snore occasionally and 25% are habitual snorers. Snoring is seen more frequently in males and it usually progresses with age.

IS SNORING SERIOUS ?

Socially – Yes. Snoring disrupts family life. Other household members spend sleepless nights and this causes resentment. Snorers become an object of ridicule and are unwelcome on vacations or business trips.

Medically – Yes. Snorers have a high probability of developing sleep apnea leading to high blood pressure, cardiac arrhythmias and even death at a young age. It disturbs the sleeping patterns of the snorer himself so that he is unable to sleep restfully. Furthermore, heavy snorers tend to develop high blood pressure, cardiac arrhythmias and even death at a young age.

Sleep disordered breathing has a wide spectrum with primary snoring only at one end and obstructive sleep apnoea at the other end. The most exaggerated form of snoring is known as obstructive sleep apnea, when loud snoring is interrupted by frequent episodes of totally obstructive breathing. This is serious if the episodes last over 10 seconds each and occur more than 5 times per hour. Sleep apnea syndrome is defined as at least 30 episodes of cessation of breathing at the nose or mouth for at least 10 seconds or more during a bout of sleep lasting for seven hours. Obstructive sleep apnoea (OSA) is mild if AHI (apnoea-hypopnoea index – number of events in one hour of sleep) is 5 to 15, moderate between 16 and 30, and severe if greater than 30.

Apnea patients may experience 30 to 300 obstructed events per night and many spend as much as half their sleep time with blood oxygen levels below normal. During their obstructive episodes, the heart must pump harder to circulate the blood faster. This can cause irregular heartbeats, and after many years it leads to elevated blood pressure and heart enlargement. The immediate effect of this oxygen starvation is that the person must sleep in a higher stage and tense his muscles enough to open his airway to get air into his lungs.

Persons with obstructive sleep apnea may spend little of their night time hours in the deep sleep stages that are essential for a good rest. Therefore, they awaken unrefreshed and are sleepy much of the day (excessive daytime sleepiness-EDS). They may fall asleep while driving to work or while on the job.

WHAT CAUSES SNORING ?

The noisy sounds of snoring occur when there is an obstruction to the free flow of air through the passages at the back of the mouth and nose. This is the collapsible part of the airway where the tongue and upper throat meets the soft palate and uvula. When these structures strike against each other and vibrate during breathing, that is snoring. Persons who snore have at least one of the following problems.

- **Obstructed nasal airways** – When a person has a stuffy or blocked up nose, he must pull hard to draw air through it. This creates an exaggerated vacuum in his throat and it pulls together the floppy tissues of the throat. So snoring occurs even in persons who would not snore if they could breathe through the nose properly. This explains why some people snore only when they have a cold or sinus infection. Also deformities of the nose or nasal septum

frequently cause such obstruction. If by using decongestant nose drops, the patients snoring improves, he may benefit with nasal surgery alone.

- Excessive length of the soft palate and uvula may narrow the opening from the nose into the throat and acting as a flutter valve during relaxed breathing. It contributes to the noise of snoring. A long uvula makes matters even worse.
- Excessive bulkiness of tissues of the throat, large tonsils and adenoids, for example, commonly cause snoring in children. Overweight persons also have bulky neck tissues.
- Poor muscle tone in the muscle of the tongue and throat. Flabby muscle allow the tongue to fall backwards into the airway or allow the throat muscles to be drawn in from the sides into the airway. This occurs when the person's muscular control is too relaxed from alcohol or from drugs that causes sleepiness.

HOW TO DIAGNOSE SLEEP DISORDER ?

A snorer should undergo thorough examination of the nose, mouth, nasopharynx, palate, hypopharynx, larynx, thyroid and neck. Physical examination will reveal any anatomical abnormality that have been enumerated earlier like large adenoids, tonsils, bulky uvula, deviated nasal septum, large tongue etc. A patient with collar size of more than 17.5 is likely to have sleep apnoea.

A sleep study in a sleep laboratory (Polysomnogram) will be valuable in determining the severity of the snoring and the presence of sleep apnea and its effect on the patient's health. This test is the 'gold standard' in diagnosing sleep apnea syndrome. Cephalometry (X-Rays) will give information about the anatomical layout of the upper airway and will help in determining the treatment options. A flexible pharyngoscopy with Muller's manoeuvre will determine the exact site and area of obstruction. Sleep MRI is a useful investigation to diagnose the site of obstruction.

CAN WE CURE SNORING ?

A large majority of snorers can be helped. Adult occasional or mild snorers can be recommended certain self – help remedies :-

- ❖ They should exercise daily not only to lose weight but also to develop good muscle tone.
- ❖ They should avoid alcohol and heavy meals a couple of hours before going to sleep.
- ❖ They should avoid sleeping pills and tranquilizers at bedtime.
- ❖ They should sleep on their sides rather than on the back. To avoid sleeping on the back, you can consider sewing a pocket on the pajama back to hold a tennis ball.
- ❖ Tilt the bed with the head end upwards by 4 inches.
- ❖ Allow the non-snorer to sleep first.

The heavy or "obnoxious" snorers and those who snore in any position they sleep in, need more treatment. If obstructive sleep apnea problem is suspected and if the snoring is disrupting the life of the snorer and his family, medical intervention should be availed.

Treatment for snoring or obstructive sleep apnea will depend on the diagnosis (whether it is snoring alone or degree of sleep apnoea). It may be as simple as treating a nasal allergy or infection, or correcting a deviated nasal septum (septoplasty), or polyps, or removing tonsils and adenoids. Surgery can also remove and tighten up excessive pharyngeal tissue and shorten a long floppy uvula and soft palate and expand the air passages – *Uvulo-palato pharyngoplasty* operation. This can also be done using the laser assisted Uvulo palatoplasty or radiofrequency. *Radiofrequency* (RF) is the latest technique of minimally invasive surgery which can be used for volumetric reduction of turbinates, soft palate and base of tongue. RF requires a multi-staged procedure but can be done on an OPD basis. Injection snoreplasty is a new procedure in which a sclerosing agent is injected

into the soft palate to reduce palatal flutter. Palatal pillar implants to stiffen the soft palate is a recent technique tried to treat snoring. Patients with receding chins may require surgical advancement of the mandible and maxilla but mild cases can be helped with the use of oral inserts that thrusts the mandible or tongue forward. There are more than 300 patented products in the US market.

Moderate or severe sleep apnoea patients require more major procedures like hyoid suspension / advancement operation, tongue base resection, geniotubercle advancement or maxillo-mandibular advancement operation. Advanced procedures carry greater morbidity.

If surgery is risky, unwanted or unsuccessful, night use of continuous positive airway pressure (CPAP) which delivers air pressure through a nasal mask, can help to prevent collapse of airway. It is a very effective treatment for apnea provided the nasal airways are clear. It is considered the gold standard in treatment of sleep apnoea but the compliance rate is less than 40% since it will need to be used every night all throughout life to prevent the medical problems of sleep apnoea.

For moderate to severe sleep apnoea patients CPAP is first recommended. For those who refuse CPAP, surgical procedures are advised. Various types of CPAP machines including auto CPAP are now available in the market which are easy and comfortable to use.

Thus snoring which is an extremely common disorder leading to serious medical problems is no longer considered a funny and frivolous disorder. With better medical understanding of this breathing disorder and several treatment options available, this condition is certainly not hopeless.

Dr. Samir Bhargava

Ear, Nose, Throat Surgeon,
DLO (London), MS, DNB



Congratulations !

- **DR. SACHIN VIJAY PAHADE** - son of our active life member & eminent general practitioner **DR. VIJAY N. PAHADE** passed his **DNB UROLOGY** in April 2010 from H. N. Hospital, Mumbai.



- Our life member **DR. HEMA JERAJANI** is elected as a President of Indian Association of Dermatologists, Venereologists and Leprologists (IADVL), the apex body for Dermatologists. She is a first Lady President in the history of IADVL after its inception in 1973.

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MANAGEMENT OF TRAUMATIC FACIAL NERVE PALSY

In this article we will be restricting our discussion on management of traumatic facial nerve palsy. Traumatic facial nerve palsy can be:

1. Iatrogenic – injury could be in cerebello-pontine angle (CPA), temporal bone, infra-temporal fossa (ITF) or in parotid
2. Post head injury – if patient is critically ill, unconscious or on ventilator, etc, diagnosis of facial nerve palsy may be delayed

In cases where there is definite grade V or grade VI palsy of immediate onset, then an HRCT of temporal bone needs to be done (1mm slice with overlap). CT brain if performed for head injury should not be considered adequate as it does not give required information. A fracture line bisecting the fallopian canal (anywhere from stylomastoid foramen to internal auditory meatus) on CT scan, is an indication for surgical intervention (Fig 1). Approach depends upon location of fracture line, hearing status (i.e. normal, conductive hearing loss, mixed or profound hearing loss) and prevalence of concurrent conditions like CSF otorrhea or ossicular discontinuity.

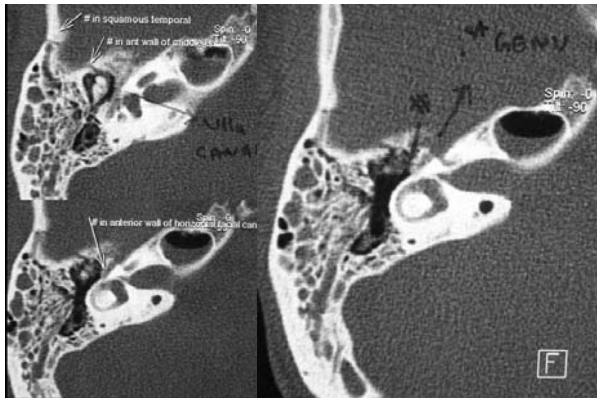


Fig 1: Fracture temporal bone involving the tympanic segment of facial nerve close to geniculate ganglion

APPROACHES:

1. Middle cranial fossa approach – used for internal auditory meatus (IAM) and labyrinthine portion with or without CSF otorrhea, with serviceable hearing
2. Trans-mastoid, trans-labyrinthine approach – used in cases of total or profound hearing loss with fracture line going through IAM. In these cases, most often, there will be complete laceration of the nerve with retraction of two ends of the nerve. Depending upon timing of surgery these cases may require grafting (greater auricular nerve or sural nerve). Whenever possible suture the graft to the nerve. But in CPA, it is not possible to suture and hence you have to use fibrin glue with Fascia lata or rectus sheath to stabilize the nerve ends.
3. Trans-mastoid, trans-attic approach – in cases where injury is in 1st genu or horizontal segment with or without ossicular discontinuity. Depending upon the site of injury, anterior attic or posterior attic approach can be used.
4. Trans-mastoid approach – in cases where the injury is in horizontal or vertical course. Concurrent CSF otorrhea and ossicular discontinuity can be dealt with in the same sitting.

Principles of facial nerve surgery:

1. In case of laceration of sheath or minimal damage to the fibres – surgery is decompression of FN with incision of FN sheath
2. In case of almost complete laceration or loss of nerve tissue – use grafting.
3. In case if patient presents after few months to upto one year – still FN surgery gives excellent results, depending upon site and extent of injury. In these cases, either post-traumatic neuromas or fibrosis develop at one or both ends of FN. This has to be excised till you get healthy nerve. Graft has to be sutured at freshly incised healthy nerve ends.



4. For iatrogenic trauma during mastoid surgery, skull base or parotid surgery– ideal time of repair / management of facial nerve injury is at the time of injury, which could be in the form of decompression, suturing, rerouting and suturing or grafting. These procedures can be applied anywhere between CPA to peripheral branches. In parotid or neck surgery/ injury, facial nerve main trunk as also the peripheral branches are traced and any trauma, either to the main trunk or peripheral branches are repaired by end to end suturing or using nerve graft.(Fig 2)

Fig 2: Graft in parotid between main trunk and lower division of facial nerve.

5. In cases FN palsy of more than 2 yr – most important aspect is to protect the eye. This was done previously by tarsorrhaphy. For last 15 yrs we have been performing gold eyelid implant instead, as it gives better cosmetic and functional result, field of vision is not restricted and is a reversible procedure, when indicated. (Fig 3)

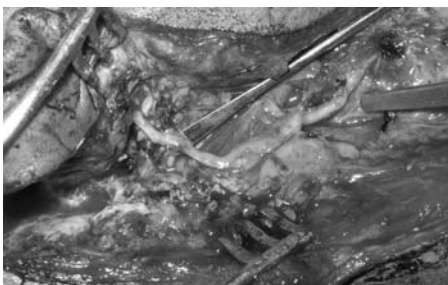


Fig 3: Preop left eye exposed; postop of left gold upper eyelid implant insertion showing complete closure of eye

6. All procedures gives better results if performed earlier

7. It is not advisable to wait for more than 6 months for grade V or VI FN palsy

Quite often at the time of primary surgery, the surgeon is either not aware or is ignorant of FN trauma caused by him. In these cases outer limit for waiting is two months. If after 2 months patient has a grade V or VI FN palsy, management is on the same line as described earlier. The difference is in case of trauma at CPA, it is at times difficult to find the medial end due to atrophy, fibrosis or retraction. In these specific cases it is best to perform facio-hypoglossal anastomosis at the earliest.



Technique of facio-hypoglossal anastomosis

Create a 1/3rd thickness wedge in hypoglossal nerve in the neck and reroute the facial nerve main trunk to hypoglossal nerve. In case of inadequate length it is best to perform a jump graft (interposition graft between facial and hypoglossal nerves) using greater auricular nerve or sural nerve (Fig 4)

Fig 4: Facial – hypoglossal anastomosis using jump graft

In last 30 yrs, more than 400 cases have been managed by our group.

Dr. Morwani K. P., Dr Jayashankar N., Dr Agrawal R
ENT & Skull Base Consultants

ENDOSCOPIC ENDONASAL SURGERY : Past, Present & Future

INTRODUCTION :

In clinical practice, nasal disorders are routinely diagnosed through a careful history and physical examination. Over the years, it has been seen that most infections of the paranasal sinus are rhinogenic, spreading from the nose into the sinuses. Objective information through a detailed physical examination is therefore very critical since the information required to make a thorough diagnosis is not generally obtained by the mere knowledge of sinonasal symptoms. There are various methods available to directly evaluate the nasal passages. Amongst these, the methods commonly employed for most patients with long standing sinus or nasal complaints are: anterior rhinoscopy (looking into the nose with a headlight and nasal speculum to open nostrils), nasal endoscopy (looking into the nasal passages with an endoscope or telescope) and CT scanning. These three techniques reveal valuable information which is necessary for the right diagnosis, treatment and monitoring of patients suffering from sinonasal complaints. It is important to note that at times, abnormalities detected on endoscopy or imaging can be present without symptoms. And at times, there could be diseases of the base of skull, which commonly cause symptoms referable to the realm of an otolaryngologist.

Over the last two decades, the surgical technique of endonasal endoscopic surgery has rapidly evolved.

INDICATIONS :

Since the introduction of the endoscopic technique, the spectrum of indications has considerably widened. From cases of chronic and polypoidal rhinosinusitis which can be well diagnosed and managed today with this approach, it is now possible to control imminent complications of acute sinusitis.

Other conditions considered appropriate for an endoscopic endonasal approach (EEA) are:

1. Mucocoeles of all sinuses- even with considerable intracranial extension; lesions of the anterior skull bone (including cerebrospinal fluid fistulae) and meningoencephaloceles.
2. Decompression of the orbit as well as of the optic nerve, dacryocystorhinostomies or choanal atresia can be treated endoscopically.
3. Benign tumors such as inverted papillomas, mycoses, juvenile nasopharyngeal angiofibroma and localized malignancies can be suitably resected endoscopically.
4. Pituitary and other skull base tumors are being resected through the EEA today.

TECHNIQUE :

Critical success factors for achieving a high success rate for this technique include making an accurate preoperative diagnosis and conducting an atraumatic procedure - damage to the mucosa should be avoided.

Endoscopic surgery can be performed under local or general anaesthesia. The telescopes are of 2.7 and 4 mm in diameter. Routine endoscopy is done with a telescope of 4 mm and 0°. The 30° and 70° telescopes are reserved for working along the lateral nasal wall and skull bone. The nasal mucosa is infiltrated with 2% xylocaine and adrenaline (to reduce bleeding).

The surgical techniques of endonasal endoscopy aim at achieving the two most important prerequisites for the functional and morphological regeneration of the paranasal epithelium of the maxillary, frontal and sphenoid sinuses:

- improved ventilation and
- drainage of secretions

The technique varies according to the etiology of the disease:

In sinusitis : the surgery is directed at the diseased areas in key positions of the lateral nasal wall. After relatively localized intervention in these areas, massive changes in the mucosa of the adjoining large sinuses are also known to regress, even without being touched. Thus, using less traumatic interventions which preserve the mucosa, a cure is possible in majority of all cases of chronic sinusitis, without having to resort to the older and more external radical surgical approaches that were implemented.

For chronic sinusitis today, we can say that interventions which earlier used to be directed at the large sinuses (eg Antral Puncture, Caldwell-luc, ethmoidectomies), are now targeted at their prechambers in the lateral nasal wall: the ostiomeatal unit with the narrow infundibulum of the ethmoid and the frontal recess.

In nasal polyposis : the miniature shaver or microdebrider is an ideal instrument. It cuts off the mucosa or polyp masses with an oscillating movement. The masses are then sucked into the channel, thereby minimizing unintentional injury to vital structures is easily avoided.

In orbital pathologies, endoscopic decompression of the orbit may be indicated for various diseases such as endocrine orbitopathy, hemorrhage, trauma or abscesses. Decompression of the optic nerve is indicated in cases of traumatic and/or inflammatory compression or damage to the optic nerve in the area of the apex of the orbit or the optic canal.

In CSF rhinorrhoea :

In recent years, EEA for the repair of cerebrospinal fluid rhinorrhea has proven to be an excellent method. It is done by closing defects in the area of the anterior skull base or the sphenoidal sinus. The nasal mucosa, cartilage or fat is used as a suitable graft material.

LIMITATIONS & COMPLICATIONS

In the hands of a skilled surgeon, EEA has demonstrated a low rate of complications and morbidity.

Limitations become evident in cases of malignant or invasive mycotic lesions and for pathologies which appear far laterally in the frontal sinus. Endoscopic techniques are subject to risks and possible complications such as trauma to orbit\optic nerve, dura at anterior skull base or blood vessels. Therefore, this technique should only be used after suitable training and careful learning of anatomy.

For revision and skull base surgeries, image guided navigation system is increasingly being used. This facilitates the identification of vital structures and thus minimizes the risk of complications.

FUTURE OF ENDONASAL ENDOSCOPIC APPROACH

With many technological advances in tomography, instrumentation and navigation techniques, the future will see major improvements in the treatment of base skull pathologies – from crista galli to C2. For all extended applications, the endoscopic procedure uses the possibility of a far less traumatizing procedure. Thus, the expanded endonasal approach will become the procedure of choice in the future, replacing conventional external approaches to many critical areas in base skull, offering advantages of lower incidence of complications and lower morbidity / mortality rates.

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E.N.T. Surgeon



Transcanal Cartilage Myringoplasty - New Technique - A Pilot Study

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M.S. (ENT), D.O.R.L. (MUM)

Abstract : A pilot study of transcanal cartilage myringoplasty in a selected group of patients with chronic suppurative otitis media has been carried out. The study includes tragal cartilage for the closure of tympanic membrane perforation via transcanal approach. The results of the present study can be summarized as follows:

1. **Closure of tympanic membrane perforation was seen in 90% cases.**
2. **Hearing improvement was seen in 80% cases.**
3. **Technique is easy, rapid to perform with minimal blood loss & well accepted cosmetically.**

Introduction : The success of Tympanoplasty depends upon **eradication of middle ear disease, graft material used, technique employed and the control of infection.** In the past, many different methods have been used for closure of tympanic membrane perforation like post-aural approach, end-aural approach, endomeatal approach etc. Also, different materials have been used for closure of tympanic membrane perforation like temporalis fascia, perichondrium, skin etc.

The use of tragal cartilage in micro-ear surgery is an important development. It has extensively been used for reconstruction of ossicular chain or for creating middle ear space in patients with Adhesive otitis media. However, its use as a tympanic membrane graft material has not yet highlighted.

A pilot study of 10 cases was done in clinical practice over a span of one year, using tragal cartilage as a tympanic membrane graft material via transcanal approach in a selected group of middle – aged patients of either sex.

Materials and methods : A total of 10 patients of either sex of middle age group suffering from chronic suppurative otitis media were selected based on **following criteria for case selection.**

1. Perforation of less than 4 mm. in diameter in pars tensa.
2. Mild or Mild to moderate conductive hearing loss.
3. Perforation should not be overlying on any ossicle.
4. Perforation should be surrounded by adequate rim of tympanic membrane from all sides.
5. Patch test over the perforation showing improvement of hearing.
6. Pneumatic or minimally sclerotic mastoids on X-ray examination.

A routine blood examination was carried out in all patients pre-operatively. All the patients were given adequate coverage of peri-operative antibiotics to prevent any type of infection. Surgery was carried out in local anesthesia with intra-venous sedation.

Technique :

1. After surgical cleaning, ear microscopy was performed using aural speculum.
2. Edges and undersurface of the perforation were freshened with sickle knife and circular knife respectively.
3. A small horizontal incision of 1 cm was made on the tragus and tragal cartilage with perichondrium attached on both sides, was harvested. The wound was closed with 3-0 mersilk.
4. Tragal cartilage was refashioned to adjust the size of perforation.
5. Middle ear cavity was filled with dry, small pieces of gel foam till the level of perforation.
6. Tragal cartilage with perichondrium was kept on gel form so as to adjust to the size of perforation edge to edge.
7. External auditory canal was filled with gel foam soaked in antibiotic solution. A small gauze piece was kept outside as a closure.

Patients followed up at weekly intervals after surgery and results of the surgery were assessed. Postoperative audiogram was done in all patients after 3 months.

Observations : Closure of tympanic membrane perforation was seen in 9 out of 10 patients. One patient showed presence of a residual perforation, probably due to shift of tragal cartilage graft. Improvement in hearing was significant i.e. within normal range, in 7 patients. 1 patient showed some hearing improvement probably due to delayed resorption of cartilage graft, which increased impedance of the tympanic membrane with slight hearing gain. One patient developed tympano-sclerotic plaque at the site of the graft and accordingly, hearing did not improve. Also, patient with residual perforation did not show any hearing improvement.

Age / Sex	Air conduction levels (dB)		Complications
	Pre operative	Post operative	
18 / M	30	20	-
23 / M	35	20	-
28 / M	35	30	-
33 / M	40	-	Residual Perforation
38 / M	30	20	-
17 / F	40	25	-
22 / F	45	25	-
27 / F	35	-	Tympano-Sclerotic Plaque
32 / F	30	20	-
37 / F	35	25	-

Discussion :

Transcanal cartilage myringoplasty has following **advantages:**

1. Unlike standard techniques, tympano–meatal flap is not elevated. Hence blood supply to the remaining part of the tympanic membrane and the graft is maintained.
2. Cartilage with perichondrium remains more viable as compared to temporal is fascia used alone.
3. Relatively blood less procedure.
4. Rapid to perform.
5. Scar on the tragus is very small. Hence it is well accepted cosmetically.
6. Site of surgery is away from site of harvesting graft. Hence infection at incision site does not infect surgery site.
7. If revision surgery is required, temporalis fascia graft is readily available.

However, technique also has some **drawbacks.**

1. Gel foam support for cartilage graft is not very reliable. It can occasionally cause shift of graft material.
2. Tympanic membrane becomes thickened due to cartilage graft. Hence impedance of the tympanic membrane increases till the cartilage gets resorbed.
3. Cartilage gets resorbed to a variable period of time.
4. Tympano – sclerotic plaques at the site of surgery is occasionally seen.
5. Failure rate increases, if case selection is not done properly.

In **conclusion**, transcanal cartilage myringoplasty using tragal cartilage for the closure of tympanic membrane perforation is a good technique in a selected group of patients with more than 80% of patients showing hearing improvement. The technique is easy, rapid to perform with minimal blood loss and is well accepted cosmetically.

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PROGRAMME

Time	Topic	Speaker
09.00 am - 09.30 am	Registration & Breakfast	
09.30 am - 09.45 am	Welcome Address Inaugural Address	Dr. Ashok Balsekar Dr. B. M. Inamdar
09.45 am - 10.30 am	Controversies in Diagnosis and Treatment of Breast Cancer	Dr. Arun Kurkure Consultant Onco Surgeon Breach Gandy Hospital
10.30 am - 11.30 am	Controversies in Management of Urological Cancers	Dr. Rishikesh Pandya Consultant Uro Oncologist B.S.E.S. & Nanavati Hospitals
11.30 am - 12.30 pm	Oncological Emergencies	Dr. Sanjay Dudhat Consultant Surgical Oncologist Nanavati & Rajheja Hospitals
12.30 pm - 01.00 pm	MCCs and Prize Distribution	Dr. Priti Bhargava
01.00 pm - 01.45 pm	Panel Discussion	Dr. Arun Kurkure Dr. Rishikesh Pandya Dr. Sanjay Dudhat
01.45 pm - 02.00 pm	Feedback	
02.00 pm	Vote of Thanks & Lucky Draw	Dr. Ashok Balsekar
02.00 pm onwards	Lunch	

CONVENOR : DR. SANJAY DUDHAT

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