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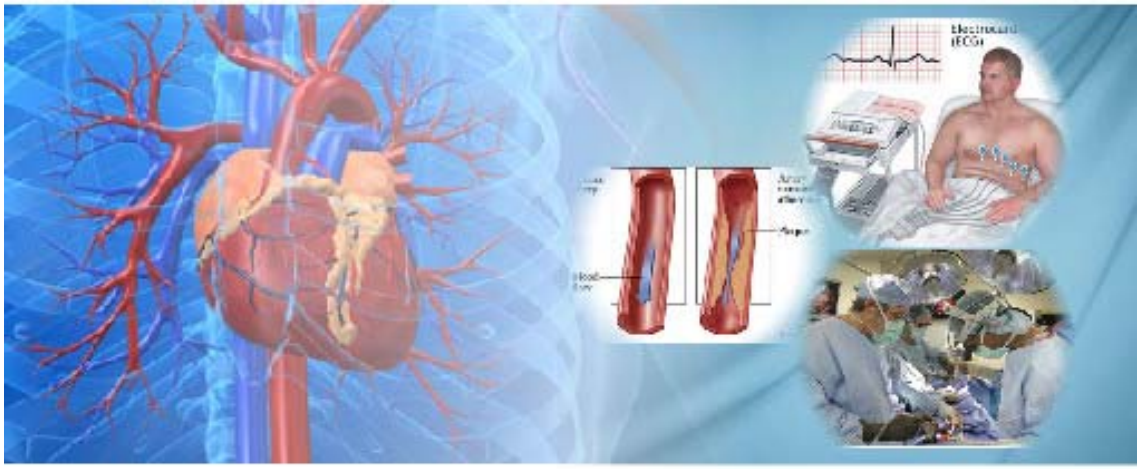
MEDICAL IMAGE

OF IMA MUMBAI WEST



CARDIOLOGY

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ANTI QUACKERY DAY

03RD OCTOBER 2010
A SINGING COMPETITION

10TH OCTOBER 2010
A VISIT TO PAGODA

Published by : **IMA MUMBAI WEST**

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IMPORTANT ANNOUNCEMENT

The CMEs scheduled on Tuesdays of September 2010 are accredited by MMC for 1 hour. Accreditation for other CMES has been applied for.

For accredited CME delegates desirous of credit hour have to pay Rs. 50/- additional, per CME.

Dr. Balkrishna M. Inamdar	**Dr. Ashok Balsekar**	**Dr. Priti Bhargava**
President	Hon. Secretary	Director - IMA CGP

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

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PresidentSpeak...

STRADDLING THE PYRAMID

"Yesterday is not ours to recover, but tomorrow is ours to win or to lose."

- Lyndon B. Johnson

Friends,

It was indeed heartwarming to see a full-house for the Gynecon 2010 held in our premises. The attendance implied that we are now positive about updating ourselves with knowledge and also about getting ourselves duly accredited for MMC. Indeed a sign of good things to come! This will certainly lead to a tomorrow for ours to win! Convenor Dr. Sudhir Naik did a great job of putting together a remarkable conference. Our associate organization AFG did well to have a faculty which was outstanding. Kudos to Dr. Bipin Pandit (President, AFG) and Dr. Sudhir along with the team of Gynecon 2010.

"Teacher's Day" is unfolding on Sunday, 5th September 2010 at the prestigious "The Club"– the "Five Star" facility at D.N. Nagar under the leadership of Dr. Suhas Kate and Dr. Priti Bhargava. The venue is idyllic, felicitees outstanding (Dr. B. S. Singhal, Dr. V.R. Joshi, Dr. G.B.Parulkar and Dr. V.N. Acharya) and CME is futuristic. Register in advance to prevent disappointment.

Our Annual Conference is spread over a week from 24th October 2010 to 31st October 2010. Await details of this great feast of knowledge and fellowship.Look forward to further announcements on this IMACON 2010.

The IMA Mumbai West juggernaut rolls on with its breathtaking array of activities. The enthusiasm of the chairmen is infectious and is something that we are fortunate to have. New ideas abound with many new flavours! Many of them are sure to translate into programmes as the year rolls on! Dr. Priti/Dr. Ronak, Dr. Sanjay Dudhat/Dr. Rashmikant, Dr. Bhavna / Dr. Ushma, Dr.Nilesh/Dr.Hiren, Dr.Pratibha, Dr.Kalambi, Dr.Mehul Bhatt, Dr. Kedia, Dr. "SK", Dr.Rohini, Dr.Chhaya, Dr.Baldwa, Dr.Kate, Dr.Dattaben Shah, Dr. Suhas Patwardhan, Dr. Subhash and others have been wonderful in their commitments and IMA Mumbai West is proud to have them in it's files and ranks of the leaders. Well done folks!

Any organization has a **pyramidal structure of three levels** of existence –

- **The base, which is about facts and figures, is the widest part**. Typically the base results from past efforts undertaken and signifies number of members, financial strength of the organization, number of years of existence and everything else that goes into making the foundation strong. However, by very nature of its place, it has a view related to what it "sees" around it and hence is essentially myopic.
- **The mid-level, which is about laws, rules and culture of the organization**, evolves from the base as a first foray into the abstract "thinking" for and about the organization. It is much more involved in "maintenance" of the organization and has a restrictive viewpoint about the future as it can "see" only the rules and the foundation. But it has a great advantage in that it gives rise to …..
- **The top, which is about principles pertaining to the individual constituents** of the organization, evolves with an advanced form of abstract thinking for and about the organization. By the very nature of it's position at the top, it has a 360 degree view and can see the "Big Picture". It has the capacity to draw ideas from the lower two levels, think and predict the future, see a long way, and develop the capacity to chart the best way forward for the organization.

Obviously it is difficult for any one level to take the organization on the forward path of progress. All the three levels of the pyramid cannot exist without each other and any misdirected efforts for the progress of any one level is bound to be catastrophic for the well being of the organization.

All the levels of this pyramid take enormous efforts and long time to construct and evolve. Unfortunately, in many organizations, we see a disjointed effort in different levels leading to the inevitable stalling of progress. Prudency lies in having a harmonious progress involving all the levels and then undoubtedly a glorious future will be reached with leaps and bounds.

Hence, **it important to "Straddle the Pyramid" in toto** for the organization to race ahead at all levels, well entrenched in future. All our chairmen and leaders are undertaking such well directed efforts and I have no hesitation in saying that IMA Mumbai West is straddling the pyramid and certainly is evolving into an organization with a bright future!

"Each is given a bag of tools,
A shapeless mass and a set of rules,
And each must build, ere the time will fly,
A stumbling block or a stepping stone"

..... Robert Sharp

With warm regards,

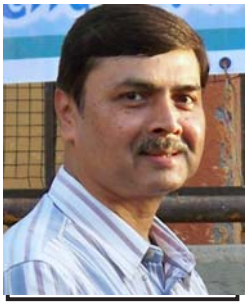
DR. BAL INAMDAR
President, 2010-11
9833054054
bminamdar@gmail.com

CONGRATULATIONS !

Dr. Suraj Suchak, Our life member & son of our Trustee & Past President **Dr. Anil Suchak** has secured 1st rank in the ALL INDIA M Ch (Urology) Entrance Exam. He secured a SEAT at Karnataka University in Urology**.**

Dr. Balkrishna M. Inamdar
President

Dr. Ashok Balsekar
Hon. Secretary



Hon. Secretary's Desk...

Dear Colleagues,

Truth is effective only when combined with tact. We can not make people realize their mistakes, unless we select the right opportunity to explain to them. Also we need to tell them in a way they can understand. So, timing & the method both are important when we put forth our point of view. And in a democratic setup consensus is always preferred than confrontation. This is one of the many lessons one gets to learn while working in a democratic setup.

One of the advantages of working for the association like IMA is a growth in the personality. What's more! One gets the personality development training for free, apart from the satisfaction of working for the association.

Better sense prevailed and elections for the President & Vice President's of IMA – Maharashtra State were avoided. So Additional General Body Meeting on Sunday, 08th August 2010 was a short affair.

Flag hoisting ceremony on Sunday, 15th August 2010 was attended by quite a few managing committee members who then proceeded to Khandala for a managing committee meeting.

Asst. Director of IMA – CGP is doing excellent work on CME front. Now that our weekly CMEs are also accredited for 1 (one) hour each, we hope to see the membership of IMA, swelling in the days to come. Dr. Priti Bhargava, Asst. Director IMA – CGP, is an excellent example of how, by delegation of work to proper person and by giving them an authority to work within ambits of constitution, can bring about excellent results. It gives people right kind of motivation to work.

Teacher's Day is being planned on Sunday, 05th September 2010. It will be held in "The Club". It is going to be another feast for knowledge seekers as well as Gastronomics. Well-known medical teachers of our times will be felicitated on that day.

Preparations for Neurocon, on Sunday, 29th August, are in full suing. We have roped in another rookie, Dr. Amit Shah, a Neurologist from Western Suburbs who is given the responsibility of convenership for Neurocon.

Diabetes minicon, unfortunately has to be deferred due to State Executive Meeting on the same day.

Paul the octopus and now the "superbug"! Seems like animal kingdom is taking precedence over human world for headlines in the media.

Hon. Minster Mr. Gulab Nabi Azad (TOI) (14.08.2010) has stated that there may be a conspiracy by parties with conflicting interests in spreading a news that NDM – I bacteria originated in India. It may be a ploy by a western medical world who are having sleepless nights about India emerging as a hub of medical tourism.

Last year when panic spread like wild fire due to swine flu epidemic, there was one school of thought that it was a conspiracy by pharma companies with vested interest to push down the throat of developing countries, osteltamivir & vaccine for H1 N1. Their contention was that more people die of malaria & dengue in our country then H1 N1 infection. Same was true for HIV. Such a hype was created by the media about HIV & AIDS. (and medical field fell prey to it). And then the bubble burst ! WHO had to make a statement last year that the number of HIV +ve cases in Mumbai have actually come down !

One of our past president rightly put it in a correct perspective ___ "More people are living off AIDS then dying of it".

Long live I.M.A. !!

DR. ASHOK BALSEKAR
Hon. Secretary
drag_bal@yahoo.co.in

G. P. FORUM

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
07-09-2010	UTI in Children	Dr. Atul Deokar
14-09-2010	Management of Colorectal Cancer	Dr. Deepak Chhabra
21-09-2010	Giddiness	Dr. Nitin Sampat
28-09-2010	Vascular Intervention in Neurology	Dr. Anil Karapurkar
05-10-2010	Hyperbaric Oxygen Therapy	Dr. Jayesh Shah
12-10-2010	GERD	Dr. Ajay Chokshi
19-10-2010	Osteoporosis	Dr. Pradumna Mamtora

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
02.09.2010	**HOLIDAY - GOPALKALA**	
09.09.2010	Management of Aggressive Patient	Dr. Karthik Rao
16.09.2010	**HOLIDAY - GAURI VISARJAN**	
23.09.2010	Anxiety Disorders	Dr. Kiran Shandilya
30.09.2010	Geriatric Psychiatry	Dr. Alka Subramanium
07.10.2010	The Dilemma of Ca Breast Management	Dr. Sanjay Dudhat
14.10.2010	Hepatitis B - LFT & Clinical Significant	Dr. Jayant Barve
21.10.2010	Role of G.P. in Acute Stork	Dr. Anil Karapurkar

- **WORKING LUNCH WILL BE SERVED FROM 01.30 PM TO 02.30 PM BEFORE EACH CME.**
- **CGP & IMA Members who have paid Annual Fees : 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 President
DR. ASHOK BALSEKAR Hon. Secretary
DR. PRITI BHARGAVA Asst. Director of Studies
DR. RONAK SHAH Asst. Secretary
IMA - Mumbai West C.G.P. Sub Faculty

Guest Editorial...

Dear Colleagues,

It gives us great pleasure to bring to you this special issue in cardiology and cardiac surgery.Think of adult cardiology and cardiac surgery and the first thing that comes to mind are angioplasty and CABG surgery. I am going to try to alter that perception by introducing to you other related topics which are increasingly becoming more important as the population of India starts ageing. Angioplasty and bypass surgery are not the end of the road so as so speak.

I have tried to give a simple introduction to the varied topics being broached in this issue by stalwarts in their particular field of specialization.

Heart failure is the third most prevalent cardiovascular disease of twenty first century that results from structural and functional cardiac impairment causing significant mortality and morbidity. The increasing incidence of heart failure has posed an enormous economic and public health burden in India. The aging of the population and improved survival after myocardial infarction by our modern health care system is leading to increased prevalence of heart failure in the future. It must be remembered that Heart failure is both a medical and surgical disease and is best managed by multidisciplinary approach.

Padmashree Dr **K M Cherian**, Emeritus professor of cardiac surgery, MGR University, Chennai and my senior colleague, has graciously contributed the article on Heart failure and the surgical management of ESHF along with Dr **JS Ganesh**. Dr Cherian has a number of firsts (in India), to his credit – 1st CABG in 1975,1st use of bilateral IMA for CABG, 1st paediatric heart transplant in 1997, 1st b / l lung transplant in 1997 ,1st heart lung transplant in 2001…the list goes on and on. He is currently at the helm of India's most prolific heart transplant center at present – the frontier lifeline Hospital at Chennai where complex paediatric cardiac repairs, homograft harvesting and cutting edge research in stem cell therapy is conducted.

Dr **Yash Iokhandwalla** is one of the foremost cardiac electrophysiologists in our country. I have had the opportunity to have been associated with him right through from my UG, PG and cardiac surgical residency days at KEM Hospital. His contribution on cardiac pacemakers and AICDs is as lucid as it is simple to understand.

Dr **Prasanna Nyayadhish** is head of Unit, dept of cardiology at the KEM hospital. A rising star, I have seen his professional growth from his days as resident in cardiology to his current status. He has special interest in structural diseases of the heart although he is equally at home performing the most complex of coronary angioplasties.

I would like to thank all authors and their team members for their valuable time to contribute the articles in this special issue.

DR. HEMANT P. PATHARE
MB MS MCh FIVS FAHE FIACS
Consultant Cardiovascular &
Thoracic Surgeon.
Hospital affiliations :
Nanavati (Vile Parle), Kohinoor (Kurla),
Criticare (Juhu), BSES (Andheri)

AN INTRODUCTION TO HEART VALVE REPLACEMENT

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INTRODUCTION

Even in this day and age, most doctors have a working knowledge about coronary artery disease, coronary angioplasty and to a lesser degree on coronary artery bypass surgery, but less is known about options for valve replacement. Heart valve repair is an extensive topic on its own and should be carried out whenever feasible, currently I am going to limit myself to valve replacement surgery. Recent advances have allowed our interventional colleagues to implant aortic valves via the axillary or femoral artery route or across the left ventricle in certain very selected and moribund patients who were at perhaps too high a risk to undergo conventional valve replacement surgery.

The human heart has 2 atrio-ventricular valves : tricuspid and mitral (surface area 4 - 5 cm^2) and 2 semi-lunar valves – aortic and pulmonary valve (surface area 3 - 4 cm^2) which function to maintain unidirectional flow of blood within the heart. The Commonest disease in India causing valve damage requiring replacement is RHD - the Mitral and aortic are most commonly involved. Mitral valve repair has superior long-term outcomes w.r.t mitral valve replacement in the west because it is predominantly performed for myxomatous diseases, MV repair does not have the same long term results in rheumatic MR. In elderly patients – degenerative calcific aortic stennosis is becoming more common as Indians start to live longer. IV Drug abusers suffer Tricuspid Valve Endocarditis and may require isolated Tricuspid replacement

Tissue or mechanical – that is the question!

The choice between tissue or mechanical valves is dependant upon the benefits and risks of each valve, the lifestyle, age and medical condition of each patient.

The ideal heart valve attributes – the holy grail of cardiac surgery ?

Attributes of an ideal replacement valve. It should be Durable – i.e. no need to re–replace the valve several years later, have Low Thrombogenicity i.e.-no need for anticoagulation, be Easily implantable, be Readily available (off the shelf / long shelf life), be Affordable and Available in all sizes

Mechanical prosthetic valves

The currently available mechanical prosthetic valves come as a mixed package of boon and bane because Mechanical valves require the use of anticoagulants, which are expensive, need changes in the patient's lifestyle and are replete with fears of hemolytic, thrombotic, embolic or hemorrhagic complications or worse a catastrophic device dysfunction. The constant valve clicks of certain mechanical valves also may disturb the patient. The advantages being that they are Easier to implant ,Usually low profile – especially useful in cases of a small LV. These valves do not degenerate over time, so a repeat surgery is not required. Most of these designs are rotatable, so that after implantation, the best orientation can be sought so as to not interfere with subvalvar apparatus or LVOT .The choice of implanting a mechanical valve is often based on the age off the patient. However there is no clear agreement on the exact age cut off where a tissue valve may be preferable to a mechanical valve.

THERE ARE 3 BASIC TYPES OF MECHANICAL VALVES

1. A bileaflet valve has 2 semicircular discs (referred to as leaflets) that are mounted on hinges within a housing and open and close simultaneously. These low profile prostheses have the lowest peak pressures due in large part to the wide opening angle – which results in minimal disturbance to flow when the valve is open. Eg st jude.
2. A tilting disc design UHD polyurethane or similar material (with or without tungsten) disc which opens and closes over a central pivot. Most have a peak pressure values of 6-7 mm Hg. Approximately 70% blood flows through the major orifice. If this major orifice is directed towards the lesser curvature of the aorta the flow is not uniform and stasis may occur along the greater curvature. Eg Chitra.
3. The ball and cage design has a silicone ball that moves within a metallic cage. This high profile valve no longer used since it can occlude the IVOT in the mitral position or result in frequent ectopics d/t the cage contacting the LV wall during contraction. E.g. Starr Edward.

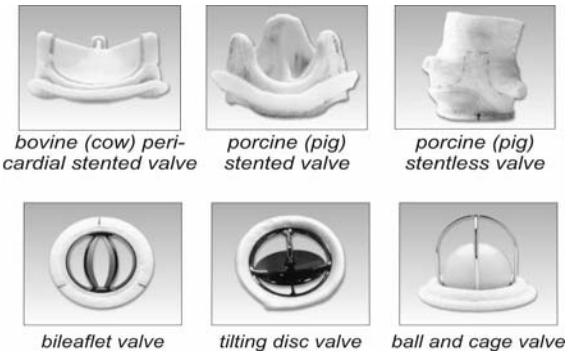
The most dreaded complications of mechanical prosthetic heart valves are

1. Valve Thrombosis and embolism– because of lower than required INR levels. Obstructive thrombosis can cause catastrophic hemodynamic or embolic consequences including all peripheral emboli, non hemorrhagic strokes, TIAs, RIND or major cerebrovascular accident. The highest incidence occurs in the 1st 15 months after replacement.
2. Infection i.e. prosthetic valve Endocarditis-eradication is difficult, long drawn and carries an extremely high mortality(50%) even in the best of centers. Only an extremely small number of cases of IE might be prevented by antibiotic prophylaxis even if it were 100% effective. The vast majority of cases of IE caused by oral micro-flora most likely result from random bacteremias caused by routine daily activities, such as chewing food, tooth brushing, flossing etc
3. Stroke – Thrombotic / embolic / hemorrhagic. Each of these can result in death or severe lifelong morbidity

Tissue or biological valves

These are Prostheses made from biological tissue which may be valvular or non-valvular Homografts - autografts (pulmonary or pericardial) or cadaveric, and Xenografts glutaraldehyde preserved porcine aortic valves & bovine or equine pericardial prostheses. Classical example of autograft is the Ross procedure wherein the human pulmonary valve is transferred to the aortic position .Autologous tissues (pericardium) has been used to fashion a neo-aortic valve. Xenografts usually have bovine or equine pericardium or porcine leaflets sown onto a flexible or semi-flexible frame to make a stented valve or the natural pig aortic root is left intact to function as the frame to make a stentless valve. The 1st generation tissue valves did not require systemic anticoagulation but were prone to calcification and early degeneration. The Currently available generation of tissue valves have increased durability because of zero pressure fixation in glutaraldehyde, calcification retardant treatment and antibiotic impregnation. The Commonly available biprosthetic valves in India are the Carpentier Edwards porcine, Medtronic Hancock porcine, St Jude Medical Biocor porcine, Medtronic Mosiac tissue valve and Edwards bovine pericardial PERIMOUNT and MAGNA.

Figure depicting commonly available mechanical and bio-prosthetic valves



Tissue valves are ideally suited for

- Population above age 55 yrs
- Patients who live far from centers where regular PT / INR testing can be done
- Patients at risk for hemorrhage e.g. peptic ulcer disease, CNS AV malformations
- Women who plan future pregnancy
- Middle aged adults who do not want to sacrifice their lifestyle for problems related to anticoagulation
- I personally prefer tissue valves for anyone above 45 yrs since the risks of a redo surgery are far lesser than complications associated with anticoagulation When not to use
- Whenever accelerated deterioration due to calcific degeneration is expected viz children, adolescents and young adults.
- Hyperparathyroidism.
- Individuals in CRF who require haemodialysis.

  Thromboembolism rate of tissue valves are Low i.e 0.7 to 1.2% per pt yr in aortic position and 1.5 to 1.8% per pt yr in mitral position. They require to be anti-coagulated for 3 months only unless the patient is in Atrial Fibrillation.
- By avoiding anticoagulation (nicoumalone or warfarin) we avoid bleeding complications including the dreaded intracranial bleeds
- Valve infection is "relatively" easier to treat

  The future is here ! – Tissue engineered heart valves.

researchers are attempting to fabricate a viable and functional heart valve from autologous stem cells by transferring cells onto a biocompatible and biodegradable matrix. Prosthetic valves constructed from polymeric leaflets which are hemocomapatible and so does not require anticoagulation are in animal tests.

Percutaneous MVR:
Strategies for transcatheter mitral valve repair currently being investigated include remodeling of the annulus of the mitral valve by suture-based techniques e.g. Mitralign and remodeling of the mitral valvular complex by transventricular or transatrial remodeling of the annulus of the mitral valve by devices implanted in the coronary sinus.

Percutaneous AVR

The concept of transcatheter aortic valve replacement was developed for offering a therapeutic solution to patients with severe symptomatic aortic stenosis who are not considered good candidates for surgical valve replacement. Currently, 2 valve models, the Edwards SAPIEN valve (balloon expandable) and the CoreValve ReValving system (nitinol self expanding) have been used in over 2,000 cases worldwide for the treatment of symptomatic aortic stenosis. Trans femoral , trans axillary (via cutdown) and trans apical delivery routes can be selected depending on the quality of vascular access and the type of prosthesis used. currently associated with this procedure. Permanent pacemaker implantation was required in 9.3% .

INR testing

since Blood has a property to coagulate when it touches any foreign surface, including stents or artificial valves, patients require long term anticoagulation. Each patient reacts differently to oral anticoagulant treatment. Drugs such as pain killers, antibiotics and even foods rich in vitamin K may interfere with Vitamin K antagonists.

How long you take this anticoagulant therapy?

Patients with artificial (non biological) valves have to take this therapy lifelong whilst those with porcine, bovine or human cadaveric valves have to take it for at least 3 months.

Parameters to judge the effectiveness of the therapy

For patients with mechanical mitral or double aortic / mitral heart valve replacement I maintain the INR between 3-4, For patients with isolated mechanical aortic valve replacement I maintain the INR between 2.5 – 3.0, patients with bioprosthetic valves are maintained on an INR of 2- 2.5 in the first 3 months after which anticoagulants are stopped.

PACEMAKERS AND ICDS - AN OVERVIEW

DR. YASH LOKHANDWALA
Consultant Cardiologist &
arrhythmias Specialist

INTRODUCTION

Over the last 5 decades, the indications for implantation of cardiac pacing devices i.e. pacemakers, implantable cardioverter defibrillators (ICDs) and cardiac resynchronization therapy devices (CRTs) have broadened for the treatment, diagnosis and monitoring of bradycardia, tachycardia and heart failure. The goal of pacing therapy presently is to improve the survival and functional status of patient with indicated arrhythmias, by preservation of a heart rate response to exercise, maintenance of atrioventricular (AV) synchrony, the preservation of atrial electrical stability, and the optimization of haemodynamics using programmable and automated features.

Pacemakers

A cardiac pacemaker is a device which uses electrical impulses to regulate the beating of the heart by means of electrodes implanted near the heart muscles. The primary purpose of a pacemaker is to maintain an adequate heart rate, either because the heart's native pacemaker is not fast enough, or there is a block in the heart's electrical conduction system. Broadly, the selection of pacemaker systems is dependent on the chamber paced: single-chamber (atria or ventricle) or dual-chamber (both).

Single chamber pacemakers

There are essentially only two forms of single-chamber pacing: AAI and VVI, with optional rate modulation (AAIR and VVIR); the VVI/VVIR form of single-chamber pacing being more common.

AAI/AAIR pacing is indicated for patients who have isolated sinus node dysfunction and have no known or anticipated AV block. As compared to dual-chambered pacemakers, AAI/AAIR pacing is a cost-effective alternative in patients with isolated sinus node dysfunction.

VVI/VVIR pacing is indicated for patients with chronic atrial arrhythmias that are not expected to return to sinus rhythm. While VVI/VVIR protects patients from lethal brady-arrhythmias, it does not maintain AV synchrony, which sometimes leads to 'Pacemaker syndrome'. Nevertheless, VVI/VVIR pacemakers are still very commonly used in developing countries mainly because of the cost consideration and simplicity of implantation.

Dual chamber pacemakers

The VDD and the DDD/DDDR pacing system are the two forms of dual-chamber pacing systems used in patients indicated for pacemaker therapy.

VDD pacing is indicated in patients with intact sinus node function and AV block (acquired, congenital, or post-operative) with normal structure of the heart.

DDD/DDDR pacing is the preferred option in patients with sinus node dysfunction and AV block. The goal in permanent pacemaker therapy is to have physiological' pacing (rate modulation and AV synchrony). Consequently, the dual-chamber system has become the preferred choice in pacemaker systems because of its ability in maintaining AV synchrony.

Indications for pacing

Sinus node dysfunction (SND) and atrioventricular (AV) block are the indications for pacing for bradycardia. In India, the major indication for pacemakers has been AV block (60%), while SND has been the most frequent indication for pacing in the Western countries. Pacing therapy plays a life-saving role when indicated for bradyarrhythmias due to AV block.

Implantable cardioverter defibrillator (ICD)

The ICD was conceived to circumvent the delay in providing definitive therapy to patients with life-threatening ventricular arrhythmias. An ICD typically delivers an electrical shock to the heart within 15 seconds of an arrhythmia onset,

converting the abnormal rhythm back to normal, effectively preventing sudden cardiac death. Over the past twenty years, ICDs have become miniaturized and pectorally implanted with transvenous leads; are multi-programmable, allowing for antitachycardia pacing, low energy shocks, and high-energy defibrillation shocks, have dual-chamber pacing capability; and, have incorporated biventricular pacing in patients to improve heart failure and to defibrillate the heart. The ICD device consists of a pulse generator with lithium batteries and a defibrillator capacitor that can send a powerful shock to the heart ,an electronic logic circuit to tell the ICD when to discharge. Lead electrodes, which incorporates defibrillation coils, are placed in the heart to sense the cardiac rhythm and deliver the shock to the heart muscle. An ICD also delivers pacing (antibradycardia, antitachycardia) in addition to internal defibrillation and synchronised cardioversion. The anti-tachycardia pacing (ATP) is very useful in patients with VT, since many of these episodes can be terminated without the need for a painful shock ATP is a series of rapid pacing pulses faster than the VT. ATP is capable of terminating slower, stable VTs. Also, ATP prevents any significant battery drainage, allowing the ICD to last for up to 10 years. DFT (defibrillation threshold) testing is mandatory in ICD implantation. wherein, VF is induced during the procedure and it is confirmed that the ICD terminates the VF successfully .An external defibrillator with remote defibrillator pads is a mandatory back-up requirement during ICD implantation. ICD therapy is indicated to prevent SCD in patients who have not yet experienced life-threatening ventricular tachyarrhythmias but have a high risk for SCD (Primary prevention) and in patients who have already experienced a life-threatening ventricular tachyarrhythmia (Secondary prevention).

Role in ICD implantation in specific clinical conditions

1. History of cardiac arrest (excluding acute myocardial infarction)

When someone has been resuscitated from a cardiac arrest, not due to a reversible cause, that patient is at high risk for SCD. It is obvious that an ICD is strongly recommended in this setting.

2. Sustained monomorphic ventricular tachycardia in patients with ventricular dysfunction

This occurs in patients with old myocardial infarction who develop scar VT. Patients with dilated cardiomyopathy and arrhythmogenic RV carduiomyopathy can also develop such VT.[5]

3. Hypertrophic cardiomyopathy

Well established risk factors for SCD in HCM patients include a family history of SCD in more than two primary relatives, a clear history of recurrent syncope, a flat blood pressure response (less than 20 mmHg rise) during exercise, evidence of NSVT on ECG monitoring, and left ventricular wall thickness greater than 30 mm. If two or more risk factors are identified ICD therapy is recommended.

Cardiac Resynchronization Therapy (CRT) or Bi-ventricular pacing

The term “cardiac resynchronization” was used by Cazeau et al used epicardial leads on all four cardiac chambers to modify the ventricular activation sequence and improve haemodynamic performance in heart failure due to dilated cardiomyopathy accompanied by LBBB.[6,7]

Presently, CRT or bi-ventricular pacing therapy is indicated for Class 3 or 4 patients with dilated cardiomyopathy and left ventricular dyssynchrony caused by left bundle branch block. [6,7]

In conclusion The precise indication is not the only factor which is associated with the selection of pacemaker type; age and economic resources play a significant role. The current pacemaker guidelines for mode-selection are to preserve AV synchrony with atrial or AV sequential pacing in the absence of permanent atrial fibrillation. In developing countries, with limited health-care resources, ventricular pacing devices may be used as a cost-effective alternative.

There is an underutilization of the excellent AAIR pacing mode for symptomatic SND. Evidence-based practice now supports the fact that atrial based pacing reduces the incidence of atrial fibrillation and that continuous right ventricular pacing increases the risk of heart failure progression. [8] Therefore, all attempts to avoid unnecessary right ventricular pacing by implementing strategies to preserve normal ventricular activation are recommended.

REVIEW OF STRUCTURAL HEART DISEASES & INTERVENTIONS

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INTRODUCTION
Structural heart diseases is a large problem in the Indian subcontinent. We still have a large number of rheumatic valvular heart disease (RHD) and congenital heart disease (CHD) patients. (CHD) are relatively common with a prevalence ranging from 3.7 to 17.5 per 1000 live births. The Prevalence of RF/RHD in the most vulnerable group i.e. school children between 5 to 15 years of age is still high. We herein discuss the trans-catheter management of some of the common structural cardiac diseases ie in CHD and RHD.

Valvular heart diseases:

RHD

Rheumatic heart disease more commonly affects the mitral and the aortic valves.

MITRAL STENOSIS (MS)

MS is the commonest valvular disease in India - a cardiac cause for progressive dyspnoea in young age group. India has a large population of juvenile MS patients with severe MS at age < 20 yrs. Catheter based PBMV is now a well established treatment of choice in symptomatic patients with severe MS and a morphologically suitable valve .The Inoue method of trans-septal puncture is the most widely used technique. The mechanism of increase in mitral valve area with BMV is splitting along the lines of least resistance ie. Along one or both the commissures. currently PBMV is carried out in Symptomatic patients with moderate to severe MS with favorable valve morphology decided echo cardiographically by Wilkins score (< 8 / 16) OR Asymptomatic patients with moderate or severe MS causing PASP > 50 mm Hg at rest or 60 mm Hg with exercise. It can also be done in symptomatic patients at high risk for surgery (elderly, pregnant females, multiple organ failure, short life span). Contraindications to PBMV include > Gr II MR, LA thrombus ,Severe subvalvar crowding, Calcific non pliable valve leaflets.

PBMV in pregnant patients is carried out electively in those who do not respond to medical treatment or those who live away from tertiary medical centers where expert cardiac monitoring may not be available during labour and delivery. Preferably it is done in the second trimester to minimize radiation induced damage to the fetus and overload of the heart.

The best results of PBMV are observed in young patients who have MS with favorable anatomic characteristics (i.e. pliable noncalcified valves and moderate impairment of the subvalvular apparatus)Though this procedure has a success rate > 90 % it is not free from complications which can result in emergency MVR or death: acute severe MR (< 5%), cardiac tamponade (< 1%), embolisation (< 1%)) death (1-3%).

SEVERE PULMONARY STENOSIS (PS)

PS occurs mainly at the valvular level (80–90%), in isolation or in combination in 25–30% of congenital heart disease.Because of the risks of right ventricular myocardial fibrosis due to hypertrophy becoming permanent even after correction; not only in severe cases but also moderate PS, early correction of PS is advisable. With success rates > 90% and freedom form re intervention of > 83% at 10 years transcatheter balloon pulmonary valvotomy is now treatment of choice even with dysplastic valve, thus

avoiding surgical morbidity and risk of significant pulmonary regurgitation post surgery. As the pulmonary regurgitation is progressive and may require pulmonary valve replacement later, surgical treatment is reserved only for patients who have, multiple cardiac defects or if percutaneous BPV fails.

Currently Balloon Pulmonary Valvotomy is recommended in moderate to severe PS if the gradient > 50 mm Hg or Right Ventricular Systolic Pressure > 50 % systemic pressure.

AORTIC STENOSIS

Congenital Aortic stenosis accounts 3-6% of patients with CHD. Bicuspid aortic valve accounts for 80-90% of these cases. The rest of the cases are due to unicuspid or tricuspid dysplastic valves. The bicuspid aortic valve patients become symptomatic later due to progressive damage to valve due to unequal pressure distribution whereas the patients with unicuspid aortic valve have severe stenosis at birth and may present with neonatal LV dysfunction and failure. Percutaneous balloon aortic valvuloplasty has now become the first line of treatment for congenital AS. Percutaneous BAV ia advised in All patients with gradients > 75 mm Hg or in presence of LV strain with peak gradient > 60 mm Hg or LV dysfunction and syncope regardless of symptoms. Success rates of around 70 % have been achieved after BAV with restenosis rates < 15 % at 7 yrs. Percutaneous BAV has also been used in elderly patients as a bail out procedure with severe degenerative AS who are not suitable for aortic valve replacement due to other comorbidities AVR remains the treatment of 1st choice whenever feasible in the elderly d/t the high complication rates of performing a BAV in a calcified aortic valve

CONGENITAL HEART DISEASE:

Patent Ductus Arteriosus

A common congenital anomaly especially in pre term infants and found incidentally due to continuous murmur in school going children. PDAs can be closed by transcatheter coil or occluder devices in most of the cases. Surgical ligation is now limited to large PDA>12 mm, neonate with large PDA with LV failure.

PDA coil closure: single or multiple gianturco coils of different loop diameter and number of loops are placed depending on the ampula size .If immediate closure is not seen on check angiogram, then additional coils can be placed from the aortic end. Coil closures are today reserved mainly for smaller PDA of size < 3mm in India because of cheaper coil cost but with higher risk of coil embolization.

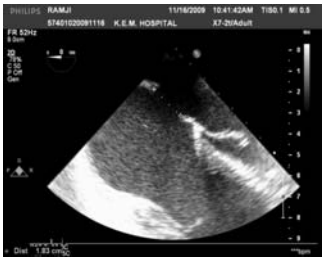
PDA device closure-the nitinol duct occluder has simplified the percutaneous therapy for PDA especially because of possibility of easy retrievability and redeployment and lesser chances of embolisation as compared to coils.

Currently Coil closure is preferred if PDA size < 3.5 mm or in a neonate (wt < 5 kg) with LV failure with large PDA as large duct occluders may obstruct flow in DTA.However Transcatheter duct occluder devicesare preferred if PDA size > 3.5 mm with suitable anatomy.In case of larger ducts or unsuitable anatomy other devices with better stability like the VSD or ASD devices have been tried with success.

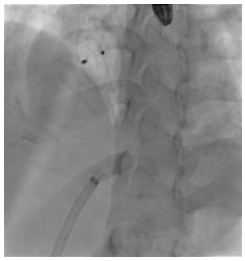
ATRIAL SEPTAL DEFECT

Ostium secundum atrial septal defect accounts for 7% of all congenital heart lesions. Patent Foramen Ovale is still more common (appearing in 10 - 20% of adults) but asymptomatic and therefore undiagnosed. This pretricuspid shunt causes increased pulmonary flow with right heart enlargement and accordingly we have the ostium secundum, ostium primum, sinsus venosus and the coronary sinus type of the defect in decreasing order of frequency .

The defect that is restricted to the fossa ovalis also called as ostium secundum ASD can be closed today with percutaneously placed flexible nitinol special device with success rate of 98 % at one year. Currently Ostium secundum defects only (size < 40 mm) with significant L-R flow (Qp>1.5) causing right sided volume enlargement with PVR < 8 WU with Good rims (> 7mm) except the aortic rim.The transcatheter closure is usually done after the age of 3 –4 yrs as it requires TEE guidance.



Ostium Secundum ASD – good rims



ASD device closure

VENTRICULAR SEPTAL DEFECT

VSD, accounting for almost 20-30% of the CHD, is one of the most common congenital anomalies. About 70% are the perimembranous VSD, the remaining 30 % are the muscular VSDs .The muscular VSDs reduce in size and may close in first 2 yrs of life. About 80% of the perimembranous VSDs close by the end of second year mainly due to tricuspid valve prolapse. Multiple muscular VSDs. (Swiss cheese) never close spontaneously. significant L-R shunt leads to early pulmonary hypertension and Eisenmengerisation. There will be a Lifelong Risk of IE and Increased risk of progressive AR due to aortic cuspal prolapsed in case of outlet or perimembranous VSD. Thus VSD closure is indicated in any patient with significant shunt Qp/Qs > 2:1, PVR< 8 WU or in case of AR due to cuspal prolapse.

Percutaneous muscular VSD closure:

Today we have a dedicated special muscular nitinol VSD device which is deployed from the RV aspect after forming an AV loop provided patient Wt > 5 kg due to delivery system restriction and there are Adequate rims or distance form AV, TV, MV, and PV> 4 mm.

Registry studies have shown a success rate of > 85% with major complication rate 7-10% including embolisation, stroke and cardiac perforation

Perimembranous VSD device closure

Recently a special device has come out designed for perimembranous VSD .The unique design with smaller aortic rim avoiding impingement of that rim and delivery cable are special features of the device. All hemodynamically significant perimembranous VSD with at least 2 mm aortic rim can be closed by Transcatheter technique with successful deployment in 90% patients with successful closure at 6 months in 96% patients. The Presence of AR, other pathologies, inlet or outlet VSD excludes the possibility of device closure.The complication of CHB occurs in < 2 % patients.

Coarctation of aorta

Accounts for 6-8 % of CHD patients. It is usually a discrete narrowing at the point of insertion of the ductus arteriosus (juxtaductal).Bicuspid AV is seen in around 85% patients with coarctation. Patients with severe coarctation can present in early neonatal period with severe LV dysfunction once PDA closes or may present with hypertension and lower limb claudication in later life. Trans catheter balloon coarctoplasty is optimal for Neonate with severe coarctation with LV failure. Surgical repair has been advised as first line treatment due to excellent results. However Early surgical repair (in 1st year of life) is associated with restenosis rates of 15 % at 5 yrs and 30 % at 10 yrs after surgery. Too late repair after 5 yrs is associated with residual hypertension in 30- 50% patients as against 6% in those undergoing repair < 5 yrs of age. Balloon coarctoplasty is optimal treatment in case of restenosis after surgical repair . Balloon coarctoplasty with stenting is done only in children > 10 yrs of age due to large delivery sheath sizes in order to decrease the incidence of late aneurysms or prevent dissections from progressing.

Misc disorders

Certain other disorders like ruptured sinus of valsalva ,coronary cameral fistula and Hypertrophic Cardiomyoapthy which till now had to be corrected surgically can now be closed percutaneously with VSD or duct occluders with good success rates and low complication rates nearly comparable to surgical techniques.

SURGICAL MANAGEMENT OF END-STAGE HEART FAILURE

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INTRODUCTION:

Heart failure is the 3rd most prevalent cardiovascular disease of 21st century and causes significant mortality and morbidity that is increasingly affecting young Indians. Dilated and ischaemic cardiomyopathy are the main causes of ESHF, though it may be caused by valvular and congenital heart disease. Other rarer causes include non ischemic cardiomyopathies(CMP), restrictictive and terminal case of hypertrophic CMP and complex congenital heart diseases.

Heart failure is rarely a curable disease, although many precipitating factors that contribute to acute decompensation can be reversed. Therefore , patients with new onset of heart failure should undergo extensive diagnostic testing (coronary angiogram, myocardial viability tests etc.) and revascularization procedures for suitable patients. Common reversible causes of heart failure such as thyroid disease , uncontrolled tachycardia, vitamin deficiencies etc should be treated. Diuretics along with dietary sodium restriction, ACE inhibitors or ARBs, beta-blockers and optional use of digoxin has transformed the paradigm of heart failure management. The results of biventricular pacing ie cardiac resynchronization therapy or CRT in patients with electro-mechanical dysynchrony (LBBB) are encouraging.

Despite all this, the quality of life is poor and the prognosis is grim for those patients with advanced CHF. Although mechanical assist devices (LVAD/BVAD/ Heart mate) offer an alternative and bridging therapy for heart failure patients, its prohibitive cost precludes it use routinely. Cardiac transplantation believed to be the most effective therapy for end stage heart failure (ESHF). Overall the prognosis of ESHF remains dismal. The 5-year mortality is 60% in men and 45% in women, despite optimised medical management. The 1-year mortality can be as high as 10% and survivors will be rare after 10 years. Here we describe the surgical options available for managing chronic end-stage heart failure.

Surgical techniques

Surgical ventricular restoration (+/- CABG or MV repair)

A common complication of ischemic and non ischemic dilated cardiomyopathy is severe MR. surgical correction for MR in symptomatic patient with severe LV dysfunction remains a clinical dilemma. Dor and colleagues introduced surgical ventricular restoration (SVR), whereby the dilated and distorted left ventricular cavity is remodelled to improve its function. Patients with akinetic or dyskinetic scar may benefit from SVR. LV reconstruction for dilated cardiomyopathy (the Batista procedure) is not performed anymore due to the high mortality and morbidity in this group of patients. The concept behind the operation was the improvement of ventricular stress by reduction of ventricular cavity radius through the removal of variable lateral wall between the papillary muscles. Systolic function was significantly improved in most patients but at the expense of diastolic function. Ideal candidates for SVR include those who have had myocardial infarction leading to a dyskinetic or akinetic area of >35% of the ventricular perimeter. These patients present with heart failure, angina or intractable ventricular arrhythmias. The technique of Dor et al i.e. endoventricular circular patch plasty includes operative methods to reduce LV volume and restore the elliptical shape of the ventricle. The decision to

perform MV repair is by measurements of the ventricular volume, annular size and the degree of mitral regurgitation. Successful repair of MR involves establishing leaflet co-aptation by reducing annular size restoring ventricular geometry. SVR results in significant acute improvement of systolic function and reduction in wall stress. These improvements are maintained in the long-term. It is reported that SVR induces significant reverse remodelling and associated clinical improvement and survival.

Regenerative Cell based therapy

Stem cell therapy(autologous unfractionated bone marrow cell or skeletal myoblasts) for heart failure patients is still in the infant stage. In 1994, an article was published in the journal Science (Soonpaa et el), which triggered an interest in mimicking natural development processes in the heart by formation of new blood vessels and new myocardial contractile units. The new cells are expected to replace damaged heart cells and effectively perform the function of the heart. An ideal cell type should be capable of myogenesis and neovascularisation and should be readily available. Various cell populations like the skeletal myoblasts, embryonic stem cells, bone marrow derived stem cells, haematopoietic stem cells, endothelial stem cells, cardiac stem cells and inducible pluripotent cells. Bone marrow derived stem cells are fairly easy to aspirate, isolate and administer into the heart. At present bone marrow is the most frequent source of stem cells for cardiac regeneration. The progenitor cells in the bone marrow include haematopoietic stem cells, endothelial progenitor cells and mesenchymal stem cells.

Cellular therapy involves injecting the stem cells into the target area intravenously, into the coronary arteries or directly into the ventricular wall. Each approach has its own advantages and disadvantages. Clinical applications include intra-coronary injection in acute myocardial infarction (TOPCARE-AMI study, which showed improvement in ventricular function and regional wall motion in AMI), chronic myocardial ischaemia and congestive heart failure. Achieving true cardiac regeneration may require more than simple injection of the right kind of cells into the right place. Further research and advances in this field are exciting and may undo all current modalities of treatment for ESHF.

Ventricular assist devices

Ventricular assist devices (VADs) have been proven to be the standard of care for refractory ESHF patients. VADs are proven to improve survival and quality of life in these group of patients. REMATCH trial prove the significant advantage of VAD implantation over medically treated ESHF(Rose, Gelijns et al. 2001). The design of VAD have also undergone drastic improvements in the recent decade. There are a variety of these devices, and they can be classified as assist versus total artificial heart, full versus partial support, pulsatile versus continuous flow devices and those that can be used for short or long-term support.

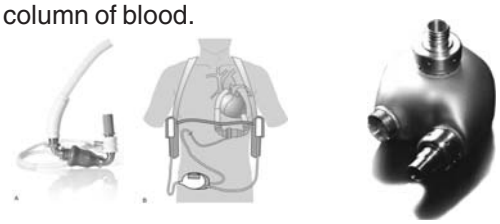
Indications for VAD include cardiogenic shock following acute myocardial infarction, postcardiotomy, myocarditits and refractory ventricular arrhythmias, as a bridge to heart transplantation or as a permanent solution for ESHF (destination therapy). Contra-indications to VAD include irreversible end-organ failure of the kidneys, liver and lungs. When the end-organs are involved, the outcomes are very poor with VAD implantation. Thorough neurological evaluation and ruling out sepsis is important before VAD implantation due to the attendant risks associated with these conditions, especially device endocarditis and systemic sepsis. Predictors of adverse outcome following VAD implantation include mechanical ventilation, prior cardiotomy, prior LVAD implantation, CVP >16mmHg and Prothrombin time (PT) >16 seconds (Rao, Oz et al. 2003).

Types of VAD devices

Short term devices include intra-aortic balloon pump (IABP), extra-corporeal membrane oxygenation (ECMO), extra-corporeal centrifugal pumps (Centrimag by Levitronix, Abiomed BVS500 etc.), percutaneously inserted centrifugal pumps (Abiomed Impella, TandemHeart etc.). These devices provide

temporary and more often partial support of the heart for 5 to 10 days.

Long term mechanical support devices can be either pulsatile (Thoratec Heartmate, Thoratec PVAD, Thoratec IVAD etc.) or continuous flow devices (Thoratec Heartmate II, Jarvik 2000, MicroMed DeBakey, Incor Berlin heart etc.). Several newer generation assist devices like the VentraCor VentrAssist are designed to address the shortcomings of the previous generation devices, including device durability and thromboembolic complications. These devices are designed on the magnetic levitation technology where by a propeller rotates magnetically, being suspended in a column of blood.



A brief mention should be made on total artificial hearts (TAH). Currently available models include the AbioCor implantable replacement heart and CardioWest TAH-t. These are originally huge devices to be used with the patient in a medical facility. Several newer improvements are being made to make them more portable. Postoperative management of VAD patients include antibiotics, treatment of right heart failure, vasoconstriction to counteract the vasodilatory effects of VADs and antiarrhythmics. Anticoagulation is required for the newer generation VADs including the HeartMate II and VentraCor VentriAssist. Complications following VAD implantation include bleeding, infection, thromboembolism, right heart failure, device malfunction and multi-organ failure.

Heart transplantation

Heart tx continues to offer patients with end stage heart failure a chance for a better quality and length of life. Heart transplantation (HTx) is an established mode of treatment for ESHF. It is estimated that >5000 HTx are being performed every year worldwide. Around 3300 HTx annually are being reported to the International Society for Heart and Lung Transplantation (ISHLT) from USA, Europe and Canada. A further 2000 HTx are estimated to be performed worldwide from centres not reporting to the ISHLT (Taylor, Stehlik et al. 2009). Outcomes following HTx have improved due to improved immunosuppression, better antibiotic prophylaxis and multi-disciplinary team approach with physicians, surgeons, co-ordinators and other paramedical staff playing a vital role in the management of the patient.

Common indications for HTx include NYHA III/IV symptoms from ESHF refractory to maximal medical treatment, ESHF in ischaemic heart disease not amenable to percutaneous intervention or surgery, symptomatic ventricular dysrrhythmias not amenable to medical, device or surgical treatment. Most importantly, patients with severe LV dysfunction but free of symptoms and managed with medical therapy should not be considered for HTx, as HTx itself has its attendant risks and complications.

Evaluation of patients for wait listing for HTx includes thorough history, physical examination and a battery of tests to assess the suitability. Cardiac function is evaluated by echocardiography, cardiac catheterisation and peak exercise oxygen consumption (Peak VO2) testing. Screening tests are performed to rule out undetected malignancy (especially of the breast and cervix in women and prostate in men). Screening is also performed hepatits B, hepatitis C, Epstein Barr Virus (EBV), cytomegalo virus (CMV), HIV and HTLV serology. Immunological screening for panel reactive antibodies (PRA) are done to assess the immunological reaction with potential HTx. PRA levels >20% portend a higher risk of rejection and may need pre-transplant treatment with plasmapharesis etc. HLA-DR typing is also done, though not HLA matching is possible pre-transplant, due to the short duration available from donor heart retrieval to HTx. Peak VO2 correlates well with predicting mortality on the waiting list and suitability of HTx (Mancini, Eisen et al. 1991). Peak VO2 >14ml/kg/min will not

benefit from HTx and below this value have moderate to high risk of dying on the waiting list and may benefit from HTx. Heart Failure Survival Score index (HFSS) was developed by Aaronson and colleagues at Columbia University to risk stratify ambulatory waiting list patient mortality (Aaronson, Schwartz et al. 1997).

The immediate postoperative management of HTx patients is similar to other heart surgical patients with attention directed to managing arrhythmias and ventricular support. Immunosuppression is started intraoperatively with high dose steroids. Some centres use induction immunosuppression using anti-thymocyte globulin (ATG), anti-CD3 monoclinical antibody (OKT3) and IL-2 receptor antagonists. Maintanence immunosuppression includes cyclosporine, mycophenolate mofetil (MMF) and prednisolone (on a reducing dose from 1mg/kg to 0.15mg/kg, in divided doses, by 3 months). Cyclosporine can be replaced with tacrolimus, depending upon institutional policies. Early complications after HTx include bleeding (3% to 5%), depressed global ventricular dysfunction and right sided heart failure. Antibody mediated rejection is monitored by regular endomyocardial biopsies. The ISHLT has provided with a suitable grading system for HTx rejection and well established treatments are available. Infection is associated with 18% early and 40% long-term deaths after HTx, associated with immunosuppression. CMV infection is frequent after HTx especially if the recipient/ donor are infected preoperatively. Chronic allograft vasculopathy is accelerated and diffuse narrowing of large and small sized coronary vessels. Chronic immunosuppression also leads to a higher incidence of neoplasia in HTx patients. ISHLT published survival rates in HTx recipients are 86%, 70%, 51% and 30% in 1-, 5-, 10- and 15-years, respectively. Patient half-life (ie time to 50% survival) is 10 years. Thus it can be said that in carefully selected ESHF patients, HTx offers markedly improved survival and quality of life.

Cardiac Seminar – A Report

INDIA AT HEART

Cardiac Seminar -

'INDIA AT HEART' was organised on Sunday, 1st of August, with an aim to understand differences, if any, in the INDIAN population, in various clinical and biochemical parameters with regard to the cardiovascular system. Following inaugural address by Dr. Bal Inamdar the ball was set rolling with an informative and engrossing talk by Interventional Cardiologist Dr. Akshay Mehta. He spoke on "Intensive Statin Therapy for Indian Benefit and Risks". The beneficial role of high doses of Statins in the initial stage of acute MI was emphasized. Interventional cardiologist Dr. Mahesh Shah followed suit with two consecutive presentations separated by the MCQs. His talks were titled' Prevention of CAD' and 'Get on with Indian Guidelines and avert an MI'. The talks were informative and interesting, presented in an excellent manner . The ultimate session of this overall excellent seminar was delivered by Dr. Jayesh Desai. He spoke on 'Guidelines for Diabetics and Kidney Disease'.

Over 110 delegates attended the seminar. The engrossing MCQs (conducted by Dr. Ronak Shah) saw three winners(score 14/15).

Vote of thanks was proposed by Hon. Secretary, Dr. Ashok Balsekar. It ended on a happy note with 'LUCKY DRAW' by Dr. Akil Contractor.

This seminar was granted one hour credit by MMC.

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

GERIATRIC CELL SUB COMMITTEE - A Report

The essay competition -**"Old Age Home is a Boon or a Bane"** received excellent response from our members as well as the senior citizens. 35 entries were received. The essays are written in 4 languages English, Marathi, Hindi & Gujrati.

We had announced that the prize would be given to the best essay – one for "boon" side and one for "bane" side. But some of the essays expressed mixed reaction. So we will be giving prize to the first two best entries.

The judges are Dr. Chhaya Desai, Dr. Sanjay Dudhat, Dr. Sabira Karmalii and Dr. Rohini Badwe.

Judges are pleased to announce the results of the essay competition as follows

1st prize : Mrs.Uma Akolkar (Senior Citizen - **जेष्ठ नागरीक संघ**)
2nd prize : Dr. (Mrs.) Poornima Sarda (Member IMA – Mumbai West Branch)

Dr. Chhaya Desai
Chairperson, Geriatric Cell Sub Committee

INFORMATION, EDUCATION & COMMUNICATION SUB-COMMITTEE - A Report

We had organised a lecture on the topic of **"AWARENESS OF HIV AND AIDS"** for IXth std. students at Satya Sai School, Dharmakshetra, Mahakali, Andheri (E), on **THURSDAY, 29TH JULY 2010** from 11.00 am to 12.30 pm.

Lecture was given by Dr. Pratibha Thoravade. It was followed by question & answer session for ½ hour. It was attended by 150 students. Tea & biscuits were distributed to all.

It was attended by Dr. Kamlesh Gandhi, Dr. Suresh Kalambi, Dr. Dharnikumar Chalmela & Mr. Krishna Kokate. We thank Principal of the School, Mrs. Neesha Patil and Mr. Samant for helping in organizing this programme.

Dr. Pratibha Thoravade
Chairperson, Information Education & Communication

"OUTBREAK" A Movie – A FEEDBACK

Very happy to see IMA taking bold step to show movies as we hardly go to theatres.

First one "coma" was a medical suspense thriller with a theme "greed against ethics".

Second one on 1st August 2010, a friendship day, was "outbreak" a movie with a theme "power & politics against human values with a medical science at its best.

The film was engrossing and thought provoking. Dustin Hoffman and Morgan Freeman performed excellently. Donald Sutherland was at his villainous best. The scenes of CDC (Communicable Disease Control) looked very real.

The theme of movie was quiet catchy and editing was slick.

Long live IMA. Keep it up!

We all love you !!

From, **Dr. Devesh M. Desai**

MEDICAL EDUCATION SUB COMMITTEE - A Report

Dr. Sanghvi felicitating Dr. Nilesh Doctor

Dr. Rajashree Agaskar addresses the audience

Our Second Educational Programme for Residence was held on **SATURDAY, 24TH JULY 2010,** in Auditorium of Nanavati Hospital. The theme of this programme was **"LIVER RESECTION AND TRANSPLANTATION"**. Introduction of the programme was done by Dr. Rashmikant Sanghvi, Chairperson of Medical Education Sub Committee. Dr. Sanjay Dudhat was convenor for this programme.

First lecture was given by Dr.Samir Parekh, DM (Gastroenterologist, Nanavati Hospital) on Preoperative Assessment of Liver for Surgery. Dr. Nilesh Doctor, M.S. (Consultant Surgical Gastroenterologist, Jaslok Hospital) made an excellent presentation Steps of liver resection & transplantation. Dr. Rajashree Agaskar, MD. (Consultant Anaethetist, Jaslok Hospital) delivered nice lecture on "Anaesthesia for liver resection and transplantation".

Thirty Two Residents attended the CME and were very happy with the content of seminar.

Dr. Sanjay Dudhat
Co-Chairperson,
Medical Education Sub Committee

WOMEN'S WING SUB COMMITTEE - A Report

Our programme by **"SAFE KIDS FOUNDATION"** - NGO on **SATURDAY, 07TH AUGUST 2010** was greatly successful children's programme. It was a sight to see !! The hall was decorated with blue and pink balloons. At the registration counter the children were welcome with chocolates.The programme was conducted by very sweet, loving parsi lady Ms. Jasmin Wadia from **'Safe Kids'**. She explained all the rules, regulation of traffic on road by projection, sign boards, pictures, puzzles and making it one to one interactive. She also made them perform on the spot skit and made it very interesting. She also explained certain rules to the adults in the audience. At the end, children danced to a music.

Ms Jasmin Wadia &
children enjoying solving the puzzles

Dr. Bhavna Patel
Chairperson, Women's Wing Sub Committee

GYNAECON 2010 – A Report

The annual conference of Gynaecology and Obstetrics - GYNAECON 2010, was held on Sunday, 25th July 2010. It was organised jointly by CGP Sub faculty of IMA Mumbai West & Association of Fellow Gynaecologists. As always, it was a sell out with over 150 delegates-both consultants and family physicians.

Asst. Secretary, Dr.Ronak Shah invited Dr.Saurabh Dani to conduct the day's proceedings.

The first session was 'New Ideas In Old Problems'. Dr. Parikshit Tank, Dr. Mukesh Gupta and Dr. Amita Maheshwari set pace for the day by their informative and educative talks on 'Vaginal Infections', 'Prevention of Cervical Cancers' and 'Fertility Preservation in Gynaecological Malignancies' respectively.

This was followed by the INAUGURAL SESSION. President, Dr. Bal Inamdar led this session which saw a number of dignitaries on the stage.Senior Gynaecologist, Dr. Mahendra Parikh, was felicitated and awarded 'Life Time Achievement Award'. He subsequently delivered his Key Note Address on 'PCOD' as a true Master.

The second pre lunch session was 'New Ideas in Infertility'. In this the topic of 'Male Infertility' was addressed efficiently by Dr. Kapil Kochchar. A lively Panel Discussion on 'Infertility' followed. The panelists were Dr. Nandita Palshetkar, Dr. Rajendra Jain, Dr. Kapil Kochchar and Dr. Mohan Gadam.The moderators for the session were Dr. Unnati Shah and Dr. Sudhir Naik. The lively session had to be cut short for want of time.

Post lunch Dr. Bipin Pandit dealt with 'Abnormal Uterine Bleeding' very efficiently and Dr. Sarita Bhalerao was efficient in dealing with 'Recurrent Pregnancy Loss'.

The ultimate session 'Debate' lived up to its name. It tested the debating skills of the participants-Dr. Nitul Parikh and Dr. Vipin Cheker debated on VBAC v/s LSCS & Dr. Raju Sahetya and Dr. Urmila Surekha debated on Forceps v/s Vaccum Delivery.

MCQs by Dr. Ronak Shah and Dr. Pinky Shah teased both, the Gynaecologists and the non - Gynaecologists. Winners of the Quiz were Dr Rutvij Dalal & Dr Neepa Desai scoring 38 out of 43.

The whole event was a grand success. Vote of thanks was proposed by Dr. Unnati Shah.

The seminar was granted credit of two hours by MMC.

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

PUBLIC HEALTH & WELFARE SUB COMMITTEE – A Report

1. A camp for diabetes patients was conducted at Dr. Kedia's Clinic on 24th July 2010 in Bandra (East). A battery of tests were done to detect control of diabetes and complications. Tests done : CBC, BSF/ PP, Hb A1c, SGPT, Serum Creatinine, Lipid Profile, Neuropathy Detection, Micral Test, ECG, BP, Ankle – Brachial Index, Ophthal Check-up, Waist Hip Ratio, BMR & Diet Advice. The above camp was attended by 25 patients. We thank M/s. USV Pharma for sponsoring this camp.
2. An osteoporosis detection camp was organised at Dr. Kedia's Clinic on 31st July 2010 for a group of patients
   a) Age above 40 years
   b) H/o backache
   c) H/o fractures
   d) Backache

   105 patients attended this camp. We thank M/s. Elder Pharmaceuticals for their co-operation in this camp.

Dr. Subodh Kedia
Chairperson, Public Health &
Welfare Sub Committee

WOMEN'S WING SUB COMMITTEE - A Report

TREE PLANTATION DRAW

We had a dual programme on SATURDAY, 21ST AUGUST 2010. We began with Tree Plantation, an essential and very important project for our environment and health. President-Dr.Bal Inamdar, Hon. Secretary-Dr. Ashok Balsekar, Chairperson–Women's Wing - Dr. Bhavna Patel, Co-Chairperson- Dr.Ushma Mashru, Programme Co-ordinator-Dr. Nandini Kulkarni, Dr. S.K.Joshi and the guests of honour from Mumbai Police Dept., President – Giant Club of Juhu, Teachers from Bhavan's and Vidhyanidhi College planted the trees. The NSS Students and our members, all proceeded from IMA, shouting the slogan,

पेड बचाव, पेड लगाव

"Save Trees, Save Earth"

A crowd of 50 created a great impact on the road from our project. The three workers from Municipal K ward helped us planting trees, watering them and applying tree - guards around. We are very much thankful to the Asst.Municipal Commissioner from Garden Dept.-Mr.Ramesh Pawar whom we had approached at K (W) ward, who supported us to make this project a grand success at a short notice. Dr. Nandini Kulkarni was a programme co-ordinator for this programme.

MARSHAL ART TRAINING

2nd programme on Marshal Art Training. Our President Dr. Bal Inamdar gave a opening speech for this workshop. It was conducted by two trainers Mr. Rajan Nair and Mr. John M. from J.R.D. Tata Trust - appointed by Mumbai Police Dept. it was an excellent project to train girls and women of all age groups. We learnt self defence technique from them in an amazing way. They made it interactive with the participants. It was a lecture, practical demonstration and on the spot live play to make us understand how to fight against any untoward incidence. One and all appreciated this training workshop.

At the end we distributed "Tulsi-plant" to all those who attended.

Dr. Bhavna Patel
Chairperson,
Women's Wing Sub Committee

DEEPAVALI SWARPRABHAT

Encouraged by the response of last year, Cultural Sub Committee announces a Similar Dhamaka this Diwali on **SUNDAY, 07TH NOVEMBER 2010** keep an eye on "Medical Image" for further details. Your suggestions are welcome.

Dr. Rohini Badwe,
Chairperson, Cultural Sub Committee

CULTURAL SUB COMMITTEE &
GERIATRIC CELL SUB COMMITTEE

OF

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

jointly organise

A SINGING COMPETITION

FOR MEMBERS AND SPOUSES

for **YOUNG AT HEART** (above 40 yrs of age)

on

SUNDAY, 03RD OCTOBER 2010

from 02.00 p.m. onwards

at

I.M.A. Hall, IMA Building, Behind Chandan Cinema,
J. R. Mhatre Marg, Juhu, Mumbai - 400 049.

- ▶ All Bathroom Singers, shed your inhibiti[illegible]n in large numbers.
- ▶ Entry **FREE,** but registration must befo[illegible]mber 2010.
- ▶ Come with friends and family to cheer [illegible]
- ▶ Accompaniment on key board & tabla wi[illegible]d.

TIME LIMIT : 3 MIN.

Group I - 40 yrs. to 50 yrs.
Group II - 51 yrs. to 60 yrs.
Group II - 60 yrs. Onwards.

FOR REGISTRATION CONTACT :

MS. APARNA / MS. SEEMA / MS. SUNITA
IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

DR. ROHINI BADWE
Cultural Sub Committee
(9321024708)

DR. CHHAYA DESAI
Geriatric Cell
(9820429360)

(Entry form printed Elsewhere in this issue)

ANTI QUACKERY SUB COMMITTEE

of

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

Presents

"ANTI QUACKERY DAY"

Day & Date : **SUNDAY, 03RD OCTOBER 2010**

Time : 09.30 a.m. onwards

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

PROGRAMME

Time	Topic	Speakers
09.30 am - 10.00 am	Registration & Breakfast	
10.00 am - 10.15 am	Welcome	Dr. B. M. Inamdar
10.15 am - 11.00 am	Are We Responsible to Promote Quackery	Dr. Jayant Navrange
11.00 am - 11.45 am	Does Cross Pathy Practice Amount to Quackery	Dr. Ghanashyam Umre
11.45 am - 12.30 pm	Panel Discussion **"WHAT ARE THE MEANS TO CONTROL QUACKERY"**	Moderator : Dr. Ashok Balsekar • **Mr. S. S. Mohite** Asst. Commissioner of FDA • **Shri. Prasanna** Deputy Commissioner of Police • **Shri. Shailesh Kamdar** Ex. High Court Judge
12.30 pm - 12.35 pm	**Vote of Thanks**	Dr. Suhas Patwardhan
12.30 pm onwards	**Lunch**	

REGISTRATION **FREE** : BUT compulsory before 30th Sep. 2010

FOR REGISTRATION CONTACT

MS. APARNA / MS. SEEMA / MS. SUNITA

IMA OFFICE, TEL. NOS.: 2620 6517 / 2625 4368

Dr. Balkrishna M. Inamdar
President

Dr. Ashok Balsekar
Hon. Secretary

Dr. Suresh Kalambi
Chairman
Anti Quackery Sub Committee

CULTURAL SUB COMMITTEE

OF

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

announces

A visit to PAGODA (at gorai) An excellent opportunity to escape from busy routine life to a serene Spiritual atmosphere.

on SUNDAY, 10TH OCTOBER 2010

PROGRAMME :

- 07.30 a.m. : Breakfast, at IMA Mumbai West, Juhu
- 08.00 a.m. Departure
- 09.00 a.m. to 12.00 noon : Guided Tour of Pagoda
- 12.00 noon : Packed Lunch will be given.

PLEASE NOTE :

Victuals : 100/- per person. (Includes transport, breakfast & lunch)

Registration on first come first served basis. (Last date 5 oct. 2010)

Max. Number of Registration : 27

FOR REGISTRATION CONTACT :

MS. APARNA / MS. SEEMA / MS. SUNITA

IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. BALKRISHNA M. INAMDAR	**DR. ASHOK BALSEKAR**	**DR. ROHINI BADWE**
President	Hon. Secretary	Chairperson Cultural Sub Committee (93210 24708)

MISCONCEPTS :- GOUT & HYPERURICEMIA

- Hyperuricemia means Gout.
- All patients with Gout have Hyperuricemia.
- Articular symptoms with high UA means Gout.
- All hyperuricemic individuals need therapy to prevent Gout.
- Gout does not occur in tea tottler.
- Gout occurs only in non – vegetarians.
- Hypouricemic agents need to be given during acute episode.
- Normalization of S. UA will abort Gouty attacks.
- Hypouricemic agent to be discontinued on the normalization of S.UA.

DR. NIMISH J. NANAVATI
RHEUMATOLOGIST
NANAVATI HOSPITAL

IMA MUMBAI WEST ANNOUNCES

FOR THE FIRST TIME

"EMERGING STARS OF MEDICINE" CONFERENCE

APPLICATIONS ARE INVITED FROM ELIGIBLE CANDIDATES

FOR

IMA MUMBAI WEST CITATION OF "EMERGING STARS OF MEDICINE"

ELIGIBILITY FOR APPLICANTS :

1. Age less than 45 years;
2. Residing/practicing between Bandra to Dahisar;
3. Member of IMA Mumbai West will be given preference;
4. Must be successful in private practice or institutional practice;
5. Must be known as an expert in his/her chosen field of medicine;
6. May have done pioneering work in medicine;
7. Should submit two (2) recommendations from peers/teachers about the veracity of his/her application;
8. Should submit his/her **"JUSTIFICATION FOR APPLICATION"** in a one page format (not more than 300 words);
9. Should submit application in hard copy and soft copy to IMA Mumbai West along with proof of all the educational qualifications (Xerox copies);

All the applications will be scrutinized by the selection committee of IMA Mumbai West and final results announced in December / January "medical image". **Final number of awards will be decided by the selection committee but will not be less than three (3).**

Successful applicants will be given **a prestigious IMA Mumbai West citation of "EMERGING STARS OF MEDICINE"** and will be invited to speak in the above conference on their chosen topic.

KINDLY APPLY IN TRIPLICATE TO ...

IMA - MUMBAI WEST, IMA BUILDING, J. R. MHATRE MARG,
BEHIND CHANDAN CINEMA, J.V.P.D. SCHEME, JUHU, MUMBAI – 400049
Tel. : 2620 6517, 6523 5579
EMAIL**: imamumbaiwest@gmail.com, imamumbaiwest@yahoo.com**

LAST DATE FOR APPLICATION: 15TH OCTOBER 2010

DR. BALKRISHNA INAMDAR
PRESIDENT

DR. ASHOK BALSEKAR
HON. SECRETARY

MEDICAL EDUCATION SUB COMMITTEE
of
INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

Presents

"EDUCATIONAL PROGRAMME FOR POST GRADUATE STUDENTS / RESIDENTS"

Day & Date : SATURDAY, 18TH SEPTEMBER 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.

PROGRAMME

Time	Topic	Speakers
06.30 pm - 07.00 pm	Registration	
07.00 pm - 07.15 pm	Welcome Address & Inauguration	Dr. Balkrishna M. Inamdar
07.15 pm - 08.30 pm	Pulmonary Function Tests & Oxygen Delivery	Dr. Salil Bendre
08.30 pm - 09.15 pm	Ventilator Management	Dr. Rajratna Sadavarte
09.15 pm - 09.30 pm	Discussion	
09.30 pm	Vote of Thanks	Dr. Rashmikant Sanghvi Dr. Sanjay Dudhat
09.30 pm onwards	Dinner	

CONVENOR: DR. SANJAY DUDHAT

REGISTRATION FEES: FREE BUT PRIOR REGISTRATION IS A MUST.

FOR REGISTRATION CONTACT :

MS. APARNA / MS. SEEMA / MS. SUNITA

IMA OFFICE, TEL. NOS : 2620 6517 / 2625 4368

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

DR. RASHMIKANT SANGHVI
Chairperson

DR. SANJAY DUDHAT
Co-Chairperson

ANNOUNCEMENTS

To educate your patients, about the quacks, a poster is printed in 4 languages, which is enclosed with this issue. You are requested to display it in your clinic at a prominent place, before 2nd October **Anti Quackery Day.**

Dr. Suresh Kalambi
Chairperson, Anti Quackery Day

MEMBER'S WELFARE SUB COMMITTEE

of

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

Invites our members to join

MASTACON CONFERENCE 2010

NASHIK-SHIRDI-TRIMBAKESHWAR TOUR

19TH, 20TH & 21ST NOVEMBER 2010 (Tentative Programme)

19TH NOVEMBER 2010

06.00 am	:	Tea - Coffee
06.30 am	:	Departure from IMA - Mumbai West, Juhu
12.00 noon	:	Checking in Hotel at Nasik Lunch at - Dr. Pawar Hospital / College
01.00 to 7.00 pm	:	State Council Meeting at Dr. Pawar Hospital
08.00 pm	:	Dinner / Banquet

20TH NOVEMBER 2010

Breakfast at Conference Venue, Conference / Visit to Shirdi

Lunch at Shirdi, Sight seeing

06.00 pm : Installation Ceremony, Prize Distribution / Banquet

21ST NOVEMBER 2010

Breakfast at Conference Venue, Visit to Trimbakeshwar

11.00 am	:	Lunch at Conference Venue.
12.00 noon	:	Check out. Proceed to Mumbai.
07.00 pm	:	back to IMA – Mumbai West

CHARGES :

- Total Rs. 4000/- (inclusive of Mastacon Registration / Transport / Accommodation & all meals.) for conference delegate
- MASTACON Conference Registration Mandatory before 30.09.2010.
- Hotel Accommodation on twin sharing basis.
- Accompanying person / Non Medical Spouse Rs.5,000/-.

DR. B. M. INAMDAR	**DR. ASHOK BALSEKAR**	**DR. JAYESH LELE**	**DR. MEHUL BHATT**
President	Hon. Secretary	Co-ordinator	Chairperson- MWC

CULTURAL SUB COMMITTEE, MEMBER'S WELFARE SUB COMMITTEE

OF

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

&

BOMBAY NATURAL HISTORY SOCIETY

Invites

"*JUNGLE TRAIL*"

for doctors and their family members

Guides :

Dr. M. Almeida, Mr Sanjoy Monga, Mr Isaac Kehimkar, Dr Shubhalaxmi, Dr. Swapna Prabhu, Ms. Priti Chougale, Ms. Kavita Kumar, Mr. Vandan Jhaveri Mr. Sachin Chorge

Dr. Almeida, Mr. Sanjoy Monga and Mr. Isaac Kehimkar have written popular books on plants, nature and wild flowers and butterflies.

On **SUNDAY, 19TH SEPTEMBER 2010**

from **08.00 am and 11.00 am**

Venue : **Conservation Education Centre** (CEC, BNHS),
Next to Film City, Goregaon - East

HIGHLIGHTS : Observe Monsoon Plants, Butterflies and Birds with experts in the field Ample parking space

Victuals : Rs. 100/- for adults
Rs. 50/- for children

RSVP : 10th September 2010

ALL ARE WELCOME.

Instructions : Please carry water bottle, light food and put on headgear, canvas shoes and eco friendly clothes. Please avoid carrying plastic bags.

Chief Co-ordinator : DR ASHOK KOTHARI, life member IMA and
Hon. Secretary, Bombay Natural History Society.

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

FOR FREE TRANSPORTATION FROM BRANCH OFFICE (AND RETURN) CONTACT OFFICE (FIRST COME FIRST SERVED BASIS)

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

DR. ASHOK KOTHARI
Hon.Gen.Secretary (BNHS)

DR. MEHUL BHATT
Member's Welfare Sub Committee

DR. ROHINI BADWE
Cultural Sub Committee

Is this Balloon Angioiplasty (or Bypass Surgery) appropriate ?

Appropriateness Criteria for Coronary Revascularization

- Dr Akshay Mehta

Patients come in all sizes and shapes. So does coronary heart disease. What is an appropriate procedure for one may not be appropriate for another. How to decide whether a procedure is appropriate in a given patient? To answer this question, the below mentioned bodies* considered 180 clinical scenarios in coronary heart disease and rated them on a scale of 1 to 9 where revascularization would be considered appropriate (scores of 7 to 9), inappropriate (scores of 1 to 3), and of uncertain benefit (scores of 4 to 6). Coronary revascularization is considered appropriate when the expected benefits, in terms of survival or health outcomes (symptoms, functional status, and/or quality of life), exceed the expected risk.

They based their judgment for each situation on the following parameters :

a. The clinical presentation (e.g. acute coronary syndrome, stable angina, and so on);
b. Severity of angina (asymptomatic, Canadian Cardiovascular Society [CCS] Class I, II, III, or IV);
c. Extent of ischemia on noninvasive testing and the presence or absence of other prognostic factors, such as congestive heart failure (CHF), depressed left ventricular function, or diabetes;
d. Extent of medical therapy ; and
e. Extent of anatomic disease (1-, 2-, 3-vessel disease, with or without proximal left anterior descending artery [LAD] or left main coronary disease).

The primary objective of this report was to provide guidance regarding the suitability of coronary revascularization for diverse clinical scenarios It should be understood that the appropriateness criteria are intended to assist patients and clinicians, but are not intended to diminish the acknowledged difficulty or uncertainty of clinical decision making and cannot act as substitutes for sound clinical judgment and practice experience.. *(In other words, with proper justification, an operator may deviate from the criteria in a given situation due to factors present at that time and place)*.

The following are the summary points to remember about these appropriateness criteria for coronary revascularization (for more details, please look up the reference given below):

1. In patients with ST-elevation myocardial infarction (STEMI), revascularization of the culprit vessel in patients presenting within 12 hours is considered appropriate.
2. In patients with STEMI who present between 12-24 hours of symptom onset, revascularization is appropriate in patients who have persistent symptoms, severe heart failure, or hemodynamic or electrical instability, whereas percutaneous coronary intervention (PCI) is considered inappropriate in the absence of these features. (*The guidelines from European Society of Cardiology differ here).*
3. In patients with STEMI who have undergone primary PCI or fibrinolytic therapy and have no symptoms, electrical or hemodynamic instability, or provokable ischemia, revascularization of a nonculprit vessel in the same hospitalization is considered inappropriate. In patients with STEMI who have no symptoms after primary PCI or fibrinolysis, but have a depressed left ventricular ejection fraction (LVEF) and three-vessel coronary artery disease (CAD), elective or semi-elective revascularization is appropriate.
4. In patients who have undergone PCI of the culprit vessel for STEMI or non-STEMI and have symptoms of recurrent ischemia or high-risk findings on noninvasive testing performed after index hospitalization, revascularization of one or more vessels is considered appropriate.

5. Revascularization of more than one vessel is appropriate in patients with cardiogenic shock or in patients with non-STEMI when the culprit artery cannot be clearly identified.
6. In asymptomatic patients, revascularization is considered inappropriate in patients with low-risk findings on noninvasive testing and one- or two-vessel disease.
7. In asymptomatic patients with three-vessel disease, revascularization is considered appropriate in patients with high- or intermediate-risk features on noninvasive testing or in the presence of abnormal LV function, or in patients with left main artery disease.
8. In asymptomatic patients with proximal left anterior descending artery disease (and one- or two-vessel CAD), and presence of high-risk features on stress testing, revascularization is considered appropriate, while it is of uncertain value if the noninvasive findings are of intermediate or low risk.
9. Revascularization is considered inappropriate in patients with class III or IV angina in the presence of borderline stenosis (50-60%) in the absence of high-risk noninvasive features or in the absence of further invasive evaluation (fractional flow reserve or intravascular ultrasound).
10. In asymptomatic patients with chronic total occlusions (CTOs), revascularization is either inappropriate (low-risk features on noninvasive testing) or of uncertain value. Revascularization is considered appropriate in patients with a CTO who have high-risk features and have class III or IV angina on maximal therapy.
11. Stable Ischemic Heart Disease (Stable angina) In general, the presence of high-risk findings on noninvasive testing, higher severity of symptoms, or an increasing burden of CAD tended to elevate the rating to appropriate. Inappropriate ratings tended to cluster among groups receiving no or minimal anti-ischemic treatment with low risk findings on noninvasive testing.

Adapted from : *ACCF/SCAI/STS/AATS/ AHA/ASNC 2009 Appropriateness

Criteria for Coronary Revascularization :

A Report of the American College of Cardiology Foundation Appropriateness Criteria Task Force, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, American Association for Thoracic Surgery, American Heart Association, and the American Society of Nuclear Cardiology Endorsed by the American Society of Echocardiography, the Heart Failure Society of America, and the Society of Cardiovascular Computed Tomography . *J. Am. Coll. Cardiol. published online Jan 5, 2009*

MEDICOLEGAL ALERT !!!

DO YOU KNOW ABOUT MEDICAL MISCONDUCT ?

The Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 vide chapter 7 describes misconduct as:

1. If he/she does not maintain the medical records patients for a period of three years.
2. If he/she as refuses to provide medical records within 72 hours when the patient or his/her authorised representative makes a request for it.
3. If he/she does not display the registration number in his clinic, prescriptions and certificates etc.
4. On no account sex determination test shall be undertaken with the intent to terminate the life of a female foetus developing in her mother's womb.
5. Any registered practitioner who is shown to have signed report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.
6. Adultery or Improper Conduct.
7. Conviction by a Court of Law for offences involving moral turpitude / Criminal acts.
8. A registered medical practitioner shall not contravene the provisions of the Drugs and Cosmetics Act and regulations made thereunder.
9. Performing or enabling unqualified person to perform an abortion.
10. A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person.
11. A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices.
12. An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation centre or any type of training institution etc. may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees.
13. It is improper for a physician to use an unusually large sign board and write on it anything other than his name, qualifications, specialty, registration number.
14. It is improper to affix a sign-board on a chemist's shop or in places where he does not reside or work.
15. The registered medical practitioner shall not disclose the secrets of a patient except in a court of law.
16. The registered medical practitioner shall not refuse on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision and medical termination of Pregnancy. Except when the registered medical practitioner is incompetent to do so.
17. Before performing even minor operation the physician should obtain in writing the consent.
18. In an operation which may result in sterility the consent of both husband and wife is needed.
19. A registered medical practitioner shall not publish photographs or case reports of his / her patients without their permission, in any medical or other journal. If the identity is not to be disclosed, the consent is not needed.
20. In the case of running of a dispensary by a physician and employing assistants to help him / her, the ultimate responsibility rests on the physician.
21. A Physician shall not use touts or agents for procuring patients.
22. A Physician shall not claim to be specialist unless he has a special qualification in that branch.
23. Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR. Violation of existing ICMR guidelines in this regard shall constitute misconduct.

Summary and points to remember:

1. Some unethical acts
   a. advertising
   b. Running chemist shop
   c. Taking cuts
   d. Using Secret Remedies
2. Some Misconducts of medical professional
   a. not maintaining medical records
   b. medical records be maintained for three years
   c. not displaying the registration number
   d. issuing false certificates
   e. giving interviews in lay press
   f. A Physician shall not claim to be specialist unless he has a special qualification in that branch.

…….by Dr. Mahesh Baldwa
Chairperson, Medicolegal Sub Committee

WELCOME NEW MEMBERS

Borivali

Dr. Priyam (Mrs.) Mohinish Bhatjiwale

Vile Parle

Dr. Borkar Navin V.
Dr. Hegde - Borkar (Mrs). Savita N.
Dr. Nomita Vijay Barde
Dr. Ameya Datttatraya Puranik

XX- Sub

Dr. Dinesh Umakant Mohandas

Dr. B.M. Inamdar President — **Dr. Ashok Balsekar** Hon. Secretary

ENTRY FORM

of

SINGING COMPETITION

on SUNDAY, 03RD OCTOBER 2010

Name : _____

Name of IMA Branch : _____

Age : _____ Sex : _____ Date of Birth : _____

Address : _____

_____

Contact No.: (Resi.) _____ Clinic _____ Mobile _____

Song Name : _____

No. of Accompanying Persons : _____

Please submit your form on or before **20th September 2010** at following address

IMA Hall, IMA Building, J. R. Mhatre Marg, JVPD Scheme,
Behind Chandan Cinema, Juhu, Mumbai – 400 049.

QUACKERY, BOON OR BANE? YOU DECIDE !!!

Dr. Suresh Kalambi - Dr. Mahesh Baldwa

Introduction :

It is a well known fact that qualified physicians & surgeons cure most of the patients by carefully treating them. But this is expected of qualified physicians & surgeons and therefore never publicized. But some patient is affected by complications of drugs/surgery causing death or disability. This is not expected from qualified physicians & surgeons and therefore over publicized causing harm to everyone. Quacks take advantage of this over publicized complications of drugs/surgery causing death or disability. Quacks offer "no side effect-non surgical treatment" with "money back guarantee" for every possible disease one can think of. Medical quackery has been around as long as medicine has existed. It was not until early in the twentieth century that there much difference between the practices of mainstream medicine and quacks. Snake oil salesmen used to sell "cures" from the back of a horse-drawn wagon; today they use the Internet and sophisticated marketing ploys. However, the psychology and operating method of using people's fears and unrealistic expectations to make a buck selling worthless medical treatments or devices has not changed. Medical quackery can threaten both health of people at large and practice of qualified medical people.

What is Medical Quackery?

Medical quackery exists in various forms and typically involves a medical scheme or remedy that is known to be false or unproven and sold for a profit. It may involve drugs, devices or lifestyle changes.

Some promoters of quackery are sincere and believe in what they are doing; however, they really don't have a clue. Others are manipulators out for a fast profit or personal notioriety. Quacks may hold respected credentials, such as MD or PhD, or they may have bogus degrees from mail-order "diploma mills" widely available in small advertisements in classified columns of famous newspapers.

The World Wide Web is making it easier to promote worthless products to an even larger audience. Some reputable medical Web sites have "alternative" medicine categories containing links to questionable health products and services.

A quack's vocabulary or way of engaging gullible patients

Buzz words: watch out for words used to describe medical treatments such as

- "secret or secret formula"
- "proven remedy "
- "miracle remedy "
- "foreign remedy "
- "breakthrough remedy "
- "works overnight cure remedy "
- "guaranteed that remedy will work"

"Conspiracy Theory": Many quacks claim they are fighting against a conspiracy of physicians who are unwilling to acknowledge new treatments. They may claim their products provide a complete cure for a wide variety of problems without any side effects.

Conditions often targeted include obesity, depression, cancer, AIDS, diabetes, and arthritis. Quacks may also claim to have products that increase lifespan.

Class of quack therapies: quack claim that their remedy is well researched and based scientific data and medical facts

Stephen Barrett, M.D., an expert on medical quackery and author of several books and operator of a website on the subject, observes that the current surge of interest in "alternative medicine" by the media and the public has "legitimatized" some quack treatments.

Persons unsure about a treatment should ask a registered physician, registered pharmacist, or registered dietitian for advice and seek independent opinions from responsible health organizations or consumer groups. If your doctor or pharmacist is not familiar with health claims made by a new product ask again or have them research it. Be cautious of groups calling

themselves "consumer groups" crusading for a cause instead of providing objective health information- they may be nothing more than a "front or cover" for a quack promoter.

Problems caused by quackery: Quackery poses genuine threats to health and well being !

Lost time

Some cancers respond well to treatment, especially with early detection. This is true of other health problems as well. But if one relies on useless remedies, the time lost and it could seriously harm chance of recovery and sometimes resultant death.

Lost money

bogus treatments market growing leaps and bounds. It is multi Crores rupee lucrative business. And often those who purchase quack products are least able to afford them. These are the very people who could spend same money on modern scientific treatment

Dangerous treatments

Not only does quackery fail to help, it also may cause harm. Quack drugs are not produced under the quality control standards required for prescription medications. They may contain substances that are not safely if taken with one another(unsafe drug interactions)

Lost hope

People who realize they have been manipulated by quackery have reason to be bitter. Many become angry toward the medical profession as a whole. This could lead them to shun proper treatment.

Other persons with incurable diseases, such as certain cancers, may turn to quackery after conventional treatment has failed them. Although this may seem harmless and at least worth trying there are several reasons not to including the false hope it may give others who have not yet tried conventional therapies and that it reinforces the predatory practices of the quack. Money spent on quack cures for terminal conditions might be better donated to a worthy cause.

False fear

Some victims of quackery are not even ill (they are harbouring anxiety about prospective "wish" disease). Unscrupulous promoters try to heighten their anxiety and cash upon it.

Guilt

Many quack theories promote an idea that "natural harmony" within your body can fully protect you from disease or provide a cure if you become ill. When disease strikes, patients can feel "shame" at being "responsible" for their illness or failure to recover. Guilt also can affect a patient's loved ones. Examples are :- parents who take their diabetic child off insulin injection due to guilt of producing a diabetic child and dabble in quack oral diabetic therapy. For a juvenile diabetic it is a worthless therapy/quack therapy only to put the child in the jaws of DKA (diabetic ketoacidosis)

Persons Susceptible to Quackery

No one is immune to quackery, regardless of education level. People who purchase fraudulent products often have similar characteristics:

- They tend to be isolated, lacking the emotional support of families and friends.
- An illness may lead to a sense of "losing control" over their lives.
- Persons with chronic or incurable diseases.
- They may have problems that also can cause emotional distress, such as impotence, baldness, excess weight.
- May suffer from chronic depression or anxiety or have problems with interpersonal relationships and are unable or unwilling to seek conventional psychological treatment.
- They may have a fear of established medical and government health agencies.

There can be a number of reasons not seeking appropriate professional help including lack of financial resources, fear of being labelled with "an emotional problem", not being aware of treatment options or not being willing to acknowledge an emotional problem exists. Finally, some persons may not be willing to put the time, money and energy into proper treatment and be looking for a quick or "magic" solution. Unfortunately, as any honest magician will tell you, "Magic is just an illusion."

Why does quackery 'work' for some people?

Quackery thrives on vulnerability. We are all vulnerable at certain times in our lives. Anxiety and fear can be so strong that reason gives way

to false hope or an unsuspecting person may simply be enticed by catchy advertising and convincing personal testimonials.

The two main reasons why a quack product might seem to "work" are:

A placebo effect - Placebos have no active ingredients. They may work on the power of suggestion. Scientists speculate that a person's confidence in a certain treatment may activate chemical impulses in the brain that diminish symptoms. It is estimated that 10% to 20% of persons are very responsive to placebo treatments.

A self-limiting illness - Diseases vary in their duration and intensity. Arthritis, for instance, can be a life-long problem whose symptoms may improve for periods of time. If you happen to be using a quack treatment when pain subsides, it's natural to think that the "wonder cure" really helps. Colds are another example of a self limiting illness that gets better whether or not a person seeks treatment.

IMPORTANT ANNOUNCEMENT

XXI ANNUAL SCIENTIFIC CONFERENCE

A) <u>DR. C. T. THAKKAR ORATION AWARD</u>

Entries are invited from members of our branch for **DR. C.T. THAKKAR ORATION AWARD**. The winner of this oration award shall be felicitated at our forthcoming **21ST ANNUAL SCIENTIFIC CONFERENCE** on **SUNDAY, 31ST OCTOBER 2010** and shall present the award winning paper at the conference.

Subject :

1. Urban Planning of Mumbai is essential to prevent epidemics.
2. Evidence Based Medicine.
3. Euthanasia.

Eligibility : The contestant must be a life member of IMA-Mumbai West for a continuous period of three years.

Submission : The composition must be neatly typed in double spacing, not exceeding 2000 words. Four copies the paper should be submitted at the office of IMA - Mumbai West Branch on or before **MONDAY, 11TH OCTOBER 2010** latest by **5.00 pm** in a sealed envelope.

Selection : The best paper, selected by the panel of judges, will be treated as an oration award paper and it will be presented at the **21ST ANNUAL SCIENTIFIC CONFERENCE**.

Duration : 15 (Fifteen) minutes.

Terms : The paper should be original paper of the contestant and should not have been presented at any other conference.

The paper read once will not be entitled for future awards.

The paper selected will be treated as the property of IMA - Mumbai West Branch.

B) <u>FREE PAPERS</u>

Clinical or non-clinical free papers are invited from members of our branch for presenting at our **21ST ANNUAL SCIENTIFIC CONFERENCE**.

Duration : 10 (Ten) minutes each.

Selection of the papers will be done by a panel of judges. The decision of the judges will be final and binding on all.

The paper must be neatly typed in double spacing, not exceeding 2000 words. Please submit three copies of the paper on or before **MONDAY, 11TH OCTOBER 2010** latest by 5.00 pm sharp to the office of our branch in sealed envelope.

DEADLINE FOR BOTH THE PAPERS:
MONDAY, 11TH OCTOBER 2010
LATEST BY 5.00 PM

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary

Acute Myocardial Infarction – Management

DR. JAMSHED J. DALAL
Director, Cardiac Sciences, Kokilaben Dhirubhai Ambani Hospital

Initial therapy for acute myocardial infarction is directed toward restoration of perfusion as soon as possible to salvage as much of the jeopardized myocardium as possible. This may be accomplished through medical or mechanical means, such as percutaneous coronary intervention (PCI).

A study published in 2010 determined that treatment strategies for myocardial infarction are more effective if done as the guidelines recommend (<90 min for PCI and <30 min for lytics). Reperfusion delivered outside these recommendations was associated with significantly increased 30-day mortality, a statistically nonsignificant increase in 1-year mortality, and significantly increased risk of the composite of mortality or readmission for acute myocardial infarction or heart failure at 1 year.[6]

Treatment is based on (1) restoration of coronary blood flow to prevent further ischemia, (2) pain relief, and (3) prevention and treatment of any complications that may arise.

- Thrombolytic therapy has been shown to improve survival rates in patients with acute myocardial infarction if administered in a timely fashion in the appropriate group of patients. If PCI capability is not available or will cause a delay greater than 90 minutes, then the optimal approach is to administer thrombolytics at onset of symptoms in patients with ST-segment elevation greater than 0.1 mV in 2 or more contiguous ECG leads, new left bundle-branch block (LBBB), or anterior ST depression consistent with posterior infarction. Tissue plasminogen activator (t-PA) is superior to streptokinase in achieving a higher rate of coronary artery patency; however, the key to efficacy lies in the speed of the delivery of therapy. Tenecteplase is also often used nowadays.
- Aspirin and/or antiplatelet therapy
  - Aspirin has been shown to decrease mortality and re-infarction rates after myocardial infarction. Administer soluble aspirin immediately, which the patient should chew if possible upon presentation. Recent data from the CLARITY trial (CLopidogrel as Adjunctive Reperfusion Therapy Thrombolysis in Myocardial Infarction [TIMI]) suggest that adding clopidogrel to this regimen is safe and effective.The clopidogrel dose used was 300 mg. Further studies suggest that a higher dose of clopidogrel may have added benefit.
  - Administer a platelet glycoprotein (GP) IIb/IIIa-receptor antagonist, in addition to acetylsalicylic acid and unfractionated heparin (UFH), to patients with continuing ischemia or with other high-risk features and to patients in whom a percutaneous coronary intervention (PCI) is planned. Eptifibatide and tirofiban are approved for this use. Abciximab[9,10] also can be used for 12-24 hours in patients with unstable angina or NSTEMI in whom a PCI is planned within the next 24 hours.
- Heparin (and LMWH) have an established role as an adjunctive agent in patients receiving t-PA. Heparin is also indicated in patients undergoing primary angioplasty. Few data exist with regard to efficacy in patients not receiving thrombolytic therapy in the setting of acute myocardial infarction. Low molecular-weight heparins (LMWHs) have been shown to be superior to UFHs in patients with unstable angina or NSTEMI. Bivalirudin (a direct thrombin inhibitor) has shown some promise in the setting of STEMI if combined with high-dose clopidogrel load and may be an appropriate strategy when patient is taken for PCI.
- Nitrates have no apparent impact on mortality rate in patients with ischemic syndromes. Their utility is in symptomatic relief and preload reduction. Administer to all patients with acute myocardial infarction within the first 48 hours of presentation, unless contraindicated (ie, in RV infarction).

- ACE inhibitors reduce mortality rates after myocardial infarction. Administer ACE inhibitors as soon as possible as long as the patient has no contraindications and remains in stable condition. ACE inhibitors have the greatest benefit in patients with ventricular dysfunction. Continue ACE inhibitors indefinitely after myocardial infarction. Angiotensin-receptor blockers may be used as an alternative in patients who develop adverse effects, such as a persistent cough, although initial trials need to be confirmed.
- Beta-blockers reduce the rates of reinfarction, recurrent ischemia and mortality. Administer to patients with myocardial infarction unless a contraindication is present.

Interventional Care

- Percutaneous coronary intervention
  - PCI is the treatment of choice in most patients with STEMI, assuming a door to balloon time of less than 90 minutes in at least 75% of the patients presenting with STEMI. PCI provides greater coronary patency (>96% thrombolysis in myocardial infarction [TIMI] 3 flow), lower risk of bleeding, and instant knowledge about the extent of the underlying disease. Studies have shown that primary PCI has a mortality benefit over thrombolytic therapy. Door to balloon times correlate closely with mortality rates, making this the key measurement for any successful interventional program.
  - The choice of primary PCI should be individualized to each institution and to the patient's presentation and timing. PCI in patients with occluded arteries for more than 24 hours appears to offer no added benefit over medical treatment.
  - The widespread use of stenting and adjunctive IIb/IIIa therapy are improving the results of primary PCI. One trial showed that, in patients with acute myocardial infarction, coronary stenting and abciximab lead to a greater degree of myocardial salvage and a better clinical outcome than fibrinolysis with thrombolytic therapy. Improvement of long- and short-term outcomes, however, depends highly on the speed with which reperfusion is achieved.
  - Primary PCI is also the treatment of choice in patients with cardiogenic shock, patients in whom thrombolysis failed, and those with high risk of bleeding or contraindications to thrombolytic therapy.
  - Only an experienced operator should perform primary PTCA, and PTCA should be performed only where the appropriate facilities are available. Operators should have at least 75 cases per year, while the center should perform at least 200 cases per year as per the recommendations of the ACC.
  - Cantor et al studied high-risk patients with ST-segment elevated myocardial infarction (STEMI) who received fibrinolytic therapy in hospitals that do not have percutaneous coronary intervention (PCI) capabilities.
    - This study randomized 1059 patients to either standard treatment (ie, if needed, included rescue PCI, or delayed angiography) or immediate transfer to another hospital and PCI within 6 hours following fibrinolysis.
    - All patients received aspirin, tenecteplase, and anticoagulation (heparin or enoxaparin), and clopidogrel was recommended.
    - The study's primary endpoint was a composite of death, reinfarction, recurrent ischemia, new or worsening congestive heart failure, or cardiogenic shock within 30 days. The primary end point occurred in 11% of patients in the group that was immediately transferred compared with 17.2% of patients randomized to the standard treatment (P=0.004).
    - A significant decrease in ischemic complications was observed in high-risk patients with STEMI who were treated with fibrinolysis and transferred for PCI within 6 hours following fibrinolysis.
  - Emergent or urgent coronary artery graft bypass surgery is indicated in patients who develop mechanical complications such as a VSD, LV, or papillary muscle rupture.

TAKE - HOME MESSAGE

By Dr. Priti Bhargava, Director CGP

29.07.2010 :
APPROACH TO MONOARTHRITIS
DR. JAWAHAR PANJWANI

i) MANAGEMENT OF ACUTE MONOARTHRITIS

- Rest the joint
- Establish a working diagnosis
- Pharmacotherapy • Pain relief
- If infective – antibiotics (intravenous)

ii) SURGERY IN ACUTE PHASE

- Aspiration
- Arthroscopic Joint Wash
- Arthroscopic Synovectomy
- Tackling Traumatic Conditions

iii) SURGERY IN CHRONIC MONOARTHRITIS GOALS

- Reduce Pain • Improve Joint Mobility
- Correct Deformity
- Improve Quality of Daily Activities

<u>05.08.2010 : NUTRITION IN YOUNG CHILD</u>
DR. PRASHANT GANGAL

EARLY FEEDING CUES –

- Baby Opens Eyes
- Tries to Take Hand Out (IF WRAPPED UP)
- Movements in Mouth • Smacking of lips
- Hand /thumb Sucking • Cooing

ADEQUACY OF BREAST FEEDING

- Baby should pass urine 6-7 times in 24 hours
- Weight gain should be adequate (Follow growth curves).

10.08.2010 : BARIATRIC SURGERY – GP'S PERSPECTIVE
- DR. DIVYESH RAVESHIA

PATIENT SELECTION

- Mainly for BMI over 40kg/m2
- 35-40 BMI several other co factors must to justify the procedures

CONTRA INDICATIONS

- Substance abuse • Not fit for anesthesia
- Severe psychological disorder
- Cirrhosis • Malignancy
- End stage lung disease

17.08.2010:MIGRAINE-DR. ROOP GURSAHANI

<u>Acute treatment :</u>

- Mild-to-moderate attacks:
- Paracetamol with or without domperidone
- Paracetamol-ibuprofen, diclofenac or naproxen
- Not to exceed 2 tablets/day or 5 per week

Moderate-to-severe attacks:

- Oral: Sumatriptan 50 mg: can be repeated at 30 minutes and at 6 hours. Not to exceed 3 doses in 24 hours
- Oral: Rizatriptan 5 or 10 mg. Not to exceed 20-30 mg in 24 hours
- Inj: Sumatriptan SC
- Nasal: Sumatriptan, Elmetriptan

Management of migraine in the Casualty

- Analgesics:
- Oral: APC, Ibuprofen+Paracetamol, Triptans
- IV/IM: Ketorolac, Diclofenac
- Anti-emetics:
- Metoclopramide vs Ondansetron
- Migraine abortive therapy:
- IM/SC: Dihydroergotamine (1 mg)
- Intranasal: Sumatriptan
- **Others:**
- IV fluids • IV Dexamethasone

<u>19.08.2010 FEBRILE CONVULSIONS</u> –
DR. PREETHA JOSHI

- Febrile seizures are seizures that occur in febrile children between the ages of 6 and 60 months who do not have an intracranial infection, metabolic disturbance, or history of a febrile seizures.

When To Admit?
< 18 Months

Febrile status
Parental anxiety with first episode of Simple FC Sick child

- DO not panic and do not let parents panic
- Simple febrile seizures do not need any major investigations in a well looking child.
- Parental counselling important esp with complex partial FS
- Intermittent anticonvulsant prophylaxis with fever.
- Fever therapy + Tab. Clobazam + Midazolam nasal spray (1 puff for 2 kg)
- Plenty of reassurance

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

"Teacher's Day 2010

Day & Date : **SUNDAY, 5TH SEPTEMBER 2010**
Time : 08.30 a.m. onwards
Venue : **The Club,** D.N.Nagar, Andheri (West), Mumbai - 400 056.

PROGRAMME

Time	Topic	Speakers
08.30 am - 09.00 am	**REGISTRATION & BREAKFAST**	
	Welcome	
09.00 am - 09.30 am	Thyroid Disorders in Family Practice	Dr. Shashank Joshi
09.30 am - 10.00 am	Rheumatology- Ruling the Lab.	Dr. Nimish Nanavati
10.00 am - 10.30 am	Diabetic Nephropathy – How to Diagnose Early	Dr. Ramesh Rao
10.30 am - 11.00 am	Inflammatory Back Pain & Spondyloarthopathies	Dr. Yojana Gokhale
	Welcome Speech	
	Guruvandana & National Anthem	
	President's Speech	Dr. B. M.Inamdar
	FELICITATIONS :	
11.00 am - 12.00 noon	**DR. VINAY R. JOSHI** Consultant Physician & Rheumatologist P. D.Hinduja National Hospital & Medical Research Centre	
	DR. G. B. PARULKAR Ex. Dean, KEM Hospital & Director - Wokhardt Ltd.	
	DR. B. S. SINGHAL Consultant Neurologist, Bombay Hospital.	
	DR. VIDYA N. ACHARYA Senior Consultant Nephrology & Member of MCFOT.	
	Introduction of Chief Guest and his Address : **HON. SHRI SUBHASH DESAI, MLA**	
12.00 noon - 12.30 pm	Clinical Approach to Hepatitis B	Dr. Saumil Shah
12.30 pm - 01.00 pm	Practical Aspects of Rabies Vaccination	
	in Animal Bite Cases	Mr. Roy Cherian
01.00 pm - 01.30 pm	Recent Advances in Endoscopy	Dr. Vipulroy Rathod
1.30 - 2.15	**LUNCH**	
02.15 pm - 02.45 pm	Diabetes – Management – Paradigm Shift	Dr. Manoj Chawla
02.45 pm - 03.15 pm	Revision Joint Replacements	Dr. Girish Dewnany
03.15 pm	**Vote of Thanks & Lucky Draw**	

CONVENER: DR. SUHAS KATE

REGISTRATION CHARGES : Maximum 150 delegates

- CGP and IMA Members who have paid ANNUAL Fees = Free. (Only if Registered in Advance)
- CGP & IMA Members : Rs. 300/-
- Spot Registration & Eligible Non Members : Rs. 800/- (Actuals)

- **Early Bird Prizes for those who register by 09.00 a.m.**
- **Lucky draw at the end of the programme.** • **No Telephonic Registration.**
- **Collect your delegate coupon from office on or before Wednesday, 1st September 2010.**

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

DR. BALKRISHNA M. INAMDAR
President

DR. ASHOK BALSEKAR
Hon. Secretary