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SUNDAY 28TH NOV.
MEDICINE UPDATE

TREASURE HUNT

SATURDAY, 11TH DEC.
EDUCATIONAL PROGRAMME

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- **DR. J. S. SIKCHI AWARD** for
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PresidentSpeak...

TOGETHER WE CAN!!

Dear Friends,

A very happy Diwali and the upcoming New Year!

As the festivities of Diwali are about to begin, IMA Mumbai West has been given a pleasant surprise! We are recipients of the most coveted awards from IMA Maharashtra State! What a news when we are on the threshold of our Annual Scientific Conference – IMACON – 2010! This pat on the back of our branch is indeed heartwarming and motivating!

We have received THREE BIG AWARDS! Yes, not one or two but THREE awards. They are "The BEST BIG BRANCH" Award, THE BEST SUB FACULTY OF IMA – CGP" AWARD (for the fourth consecutive time) and "THE BEST BULLETIN AWARD" (shared). It is probably for the FIRST TIME that our branch has receiver THREE BIG AWARDS IN ONE SINGLE YEAR! Indeed a proud and historic moment for all of us. Such all round appreciation with awards speaks volumes for the commitment, dedication and sincerity with which all the subcommittee chairs, office bearers and the managing committee members have worked. Kudos to all of you, guys! You are indeed priceless for our Association! Our office staff – Seema, Sunita, Aparna, Sandeep, Rupesh, Alam, Hirjee and many others who are part of our support system also deserve this accolade which has been bestowed upon us by IMA Maharashtra State. Our caterers also deserve praise for this honour as many of our programmes are successful due to their back ground support in F & B department. A great and proud moment for all of us indeed!

The individual awardees also deserve kudos and accolades. Our Past President Dr. Kanti Dave has been bestowed the prestigious "Lifetime Achievement Award". Congratulations for this unique honour, Dr. Kanti! We are proud of you! Dr. Akil Contractor, Dr.Jayesh Lele, Dr.Deepak Jumani, Dr.Niranjan Vaidya and Dr.Shailendra Mehtalia received various awards in the individual category. This signifies their sincerity and commitment for IMA Maharashtra State Branch. Great work by you and great moment for all of us, friends! You are indeed the feathers in our cap!

October saw some wonderful programmes. On 3rd October, Dr. Rohini Badwe and Dr. Chhaya Desai, alongwith their team, organized the "Singing Competition" for various age groups above 40. This was on occasion of "World Senior Citizen's Day". The programme was houseful, judges eminent and participation and performance really excellent. Congratulations to all the winners and special kudos to Dr. Rohini and Dr. Chhaya for their wonderful efforts. Prizes were also given to various winners of essay competition organized so innovatively and successfully (more than 35 entries!!) by Dr. Chhaya Desai. Well done Dr. Chhaya, Dr. Rohini and the team!

All the other subcommittees are moving like a well-oiled machine – smoothly and strongly. This has been a feature of our team this year - total and all round dedication and sincerity! Well done Team! It is a pleasure to work with you all!

The conference week is just round the corner. 24th October will be in "Grand Hyatt" – thanks to Dr. Lekha Pathak. Dr. Lekha has been a veritable source of energy and motivation to take our IMACON to this "grand" venue. It has been solely due to her efforts that we will be enjoying the grandeur and opulence of such an idyllic venue. Thank you Dr. Lekha. You are indeed a "Friend of IMA"!

IMACON – 2010 has outstanding speakers, interesting subjects and 7 hours of MMC

Accreditation! At one go, you will be fulfilling your re-registration requirements! What else you need to be happy? Convenor Dr. Jayesh, Co-convenor Dr. Subodh Kedia, Organizing Co-Chairs Dr. Priti and Dr. Manoj, Co-ordinator Dr.Suhas Patwardhan, Co-Secretaries Dr. Ronak and Dr. Heena along with other conference team members have worked tirelessly to give you a great event! Go for it and enjoy the conference!

MASTACON is being held on 19th to 21st November 2010 at Nasik. We have organized conveyance and a picnic for our members in and around Nasik. We will be receiving all the above awards. Register in large numbers with our office and be there to witness the glory of our branch.

Finally, do not miss "Dipawali Swaraprabhat" organized by our Cultural Chair Dr. Rohini Badwe on Sunday, 7th November at 7.00 am! Dr. Anita Bapat-Patel is a renowned singer and along with her co-performers, we will be floating in the ethereal world of music of 60s to 80s! A very attractive proposal indeed! You will miss it only at your peril!

All this is coming to you with a throbbing intensity and sincere wishes of the managing committee for your benefit. Your contribution in terms of your presence will go a long way in making us more enthused and inspired to give you better and better programmes in future.

Indeed, the greatest word in the dictionary is "WE"! Together we can and together we will!!

"We are what we think. All that we are arises with our thoughts. With our thoughts, we make our world."——**The Buddha.**

Warm Regards,

Dr. B. M. Inamdar
President, 2010-11
9833054054
bminamdar@gmail.com

ACHIEVEMENTS

It gives us great pleasure in informing you that our branch will be receiving following awards at the **forth comming** IMA – Maharashtra State Conference "MASTACON" at Nashik.

- **President's Special Felicitation Award - 2009-10 - Awarded to**
  - i) Dr. Balkrishna M. Inamdar
  - ii) Dr. Akil Contractor
- **Appreciation Awards for Selfless Service – Awarded to**
  - i) Dr. Jayesh M. Lele
  - ii) Dr. Deepak Jumani
  - iii) Dr. Niranjan R. Vaidya
  - iv) Dr. Shailendra C. Mehtalia
- Ex. President & Senior Veteran Leader of our branch **DR. KANTILAL M. DAVE** of Goregaon (W) will be honoured with prestigious **"LIFE TIME ACHIEVEMENT AWARD"** from **IMA Maharashtra State** in recognition his selfless and invaluable contribution at branch State & HQ level in various capacities.

We are proud of you ! keep it up !

Dr. Balkrishna M. Inamdar	**Dr. Ashok Balsekar**
President	Hon. Secretary

HON. SECRETARY'S DESK...

Dear Colleagues,

Season's Greetings ! Happy Diwali & Prosperous New Year to all our members, their near & dear ones, and all our well wishers.

By the time members get this diwali issue in their hands, Annual Scientific Conference will be in its last stage. Conference committee has worked as a single homogenous unit, all the sub committees working in close co-ordination with each other, under the able & experienced guidance of convenor and IPP. Dr. Jayesh Lele. When you have a strong aim and a clear goal, you automatically receive cooperation from others. But without an able leader all the efforts of grass root workers can be directed in different directions and can work at cross purposes. So we do need a strong leader with a clear vision to see that every ounce of energy spent, is spent in the right direction.

Thank you, Dr. Jayesh Lele!

On behalf of the conference committee, I offer an apology to those who were denied registration for the 24th October, pre conference CME. But we were rendered helpless because of the restrictions put by the hotel authorities. So, there is a clear advantage of holding a conference in our own premises where we have space & time to maneuver and cater to maximum number of members.

After last year's successful experiment of Diwali Swarprabhat, Cultural Sub Committee – chairperson Dr. Rohini Badwe is presenting DSP II on Sunday, 07th November 2010 with an innovative programme of music, masti, rangolis, diyas, diwali faral followship and gifts - all on the house !

Membership of the association has not grown phenomenally, but attendance at the CME lectures has more than doubled. Managing Committee may have to do a rethink on holding the CMEs in a bigger hall if this trend continues. And in all like hood it seems to be the case.

Sports Sub Committee Co-chairperson – Dr. Hiren Ambegaonkar has arranged an innovative sports activity – "A Treasure Hunt" – in the month of November. Details are given in this issue. He is also planning a "limited overs – tennis ball" – cricket tournament for members. So it is not that the association is indulging only in cerebral activity, but also some physical training.

Members of our branch will be "running" in Mumbai Marathon under IMA banner. We are planning a "training" for Marathon participants once our annual conference is over.

Dr. Avinash Thakurdesai, who runs every mumbai more than will be personally taking up & responsibility of training our members.

So good news for those who are likely to go into "Post - Partum - Depression - Like - Syndrome" after the conference is over.

After all, there is a life after conference, Right?

Long Live IMA !

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

IMA CGP REQUESTS THE MEMBERS TO FOLLOW CERTAIN RULES TO HELP US TO HELP YOU

- Prior registration for CME – must (upto 12 noon).
- Registration for accreditation at CME venue will close 10 mins. after talk begins.
- Accreditation desiring delegates should be seated in the hall by 10 mins. after CME begins.
- Feedback forms will be made available after felicitation of speaker.
- Feedback form has to be submitted subsequent to the CME on the same day.

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
02-11-2010	**Post Conference Holiday**	
09-11-2010	**Post Conference Holiday**	
16-11-2010	Tuberculosis – RNTCP	Dr. Manisha Bidaye
23-11-2010	Gastric Cancer - Prevention, Screening and Diagnosis	Dr. Prachi Patel
30-11-2010	Clinical Examination of Shoulder - Approach to Shoulder Pain	Dr. Hetal Chiniwala

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
04-11-2010	**Diwali Holiday**	
11-11-2010	**Diwali Holiday**	
18-11-2010	Management of Epilepsy	Dr. Ashok Sirsat
25-11-2010	Workshop – Insulin Therapy	Dr. Sanjeev Shah
02-12-2010	HIV in Paediatrics	

- **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 : ₹ 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 and friends,

I feel priviledged on being asked to write the editorial for this month's edition of medical image which is a special issue on Diabetes.

World Diabetes day was created by the International Diabetes Federation (IDF) in 1991 inorder to bring the world's attention on this growing global problem.

Diabetes is a global pandemic

Though it now affects more than 250 million people worldwide and is expected to affect over 380 million by 2025, diabetes still lurks in the shadows. Diabetes is a growing epidemic that threatens to overwhelm healthcare services and undermine economies worldwide - especially in developing countries.

India I believe is not economically, socially, medically equipped enough to deal with the devastating complications of Diabetes

United Nations Resolution on diabetes

On 20 December 2006, the United Nations General Assembly passed Resolution 61/225. This landmark Resolution recognizes diabetes as a chronic, debilitating and costly disease associated with major complications that pose severe risks for families, countries and the entire world. It designates 14 November, the current World Diabetes Day, as a United Nations Day to be observed every year.

Governments have acknowledged that diabetes is increasing at epidemic rates and is affecting all countries. For the first time, a non-infectious disease has been seen as posing as serious a global health threat as infectious epidemics such as HIV/AIDS.

The full impact of the World Diabetes Day Resolution will take many years to unfold. There are two main challenges that need to be addressed: the prevention of diabetes itself, and the prevention of complications in those affected by diabetes.

Diabetes is one of the world's most important causes of expenditure, mortality, disability and lost economic growth. There are simple, cheap treatments that can help prevent these losses, many of which will actually save money in countries, rich and poor.

World Diabetes Day (WDD) is celebrated every year on November 14.

Where is it celebrated?

World Diabetes Day is celebrated worldwide by the over 200 member associations of the International Diabetes Federation in more than 160 countries and territories, all Member States of the United Nations, as well as by other associations and organizations, companies, healthcare professionals and people living with diabetes and their families.

How is it marked?

The global diabetes community including International Diabetes Federation member associations, diabetes organizations, NGOs, health departments, civil society, individuals and companies develop an extensive range of activities, tailored to a variety of groups. Activities organized each year include:

- Radio and television programmes
- Sports events
- Free screenings for diabetes and its complications
- Public information meetings
- Poster and leaflet campaigns
- Diabetes workshops and exhibitions
- Press conferences
- Newspaper and magazine articles
- Events for children and adolescents
- Monument lightings
- Human blue circles
- Walks
- Runs
- Cycle Race
- Political Events

Is there a theme?

Each year World Diabetes Day is centred on a theme related to diabetes. Topics covered in the past have included diabetes and human rights,

diabetes and lifestyle, and the costs of diabetes. Recent themes include:

2005 : Diabetes and Foot Care
2006 : Diabetes in the Disadvantaged and the Vulnerable
2007-2008 : Diabetes in Children & Adolescents
2009-2013 : Diabetes Education and Prevention

The World Diabetes Day logo

The World Diabetes Day logo is the blue circle - the global symbol for diabetes which was developed as part of the Unite for Diabetes awareness campaign. The logo was adopted in 2007 to mark the passage of the United Nations World Diabetes Day Resolution. The significance of the blue circle symbol is overwhelmingly positive. Across cultures, the circle symbolizes life and health. The colour blue reflects the sky that unites all nations and is the colour of the United Nations flag. The blue circle signifies the unity of the global diabetes community in response to the diabetes pandemic.

India being the world capital for diabetes needs to take a giant step towards prevention which should be included in our national health policies & should have interventions & goals set up in a framework to prevent the next generation from this disorder.

The time has come for all of us to stand up, raise our hands & in a single voice pledge our commitment in our fight against diabetes. It's time to forget our differences and come together across the country for a unified campaign.

I would just like to end by thanking my colleagues who have contributed their articles for this edition & friends who are all engaged in our fight against diabetes.

Dr RAJIV R. KOVIL
MBBS, D DIABETOLOGY
Consultant Diabetologist
Dr Kovils Diabetes Care Centres, Mumbai
Honorary :
BSES, Holy Spirit, Arogya Nidhi Hospitals

DEEPAWALI SWARAPRABHAT

Melodious Musical Morning

By **'SWASHAND'**

Come One, Come All !!!!!!

Cultural Sub Committee Invites you

Following the great success of **Deepawali Swarprabhat** last year, we are coming again for you with popular demand from all the members, with a **Doctor's Orchestra** to entertain you on the auspicious day of **Diwali** on **SUNDAY, 07TH NOVEMBER 2010.** Please attend in large numbers.

PROGRAMME :

Time	:	07.00 am to 09.30 am
Venue	:	IMA Hall, Juhu.
Dress Code	:	Traditional Festival Mood

Come & Enjoy – Decorative Rangolis & Delicious Breakfast on this festival of Diyas
Registration : FREE but compulsory IMA members / family & friends

DR. BALKRISHNA M. INMADAR — President
DR. ASHOK BALSEKAR — Hon. Secretary
DR. ROHINI BADWE — Chairperson, Cultural Sub Committee

CULTURAL SUB COMMITTEE - A Report

A very special music competition was organised jointly by Cultural Subcommittee & Geriatric cell on the occasion of World Senior Citizens Day (1st October) This was held on **SUNDAY, 3RD OCTOBER** at I. M. A. Hall, Juhu. Total 51 doctors & spouses from all over Mumbai participated in this competition. They were divided into 3 groups.

Group 1 .... 60 years and above
Group 2 .... 50 to 60 years
Group 3 .... 40 to 50 years

They presented popular & hit Hindi Songs. A melodious accompaniment was provided by Mr. Ajay Ghogane and his musicians. We are thankful to our eminent judges **Mr. Kedar Pawangadkar** -Renowned vocalist & classical singer and **Mrs. Anupama Deshpande** -reputed playback singer for sparing their precious time.

Well known author **Dr. Subhash Bhende** was the Chief Guest. The lucky winners of music and essay competition were honoured with prizes at the auspicious hands of Dr. Subhash Bhende.

The lucky winners are:

GROUP 1	GROUP 2	GROUP 3
1 Dr Mohan Iyre (Chembur)	1 Dr Sanjay Nabar (BWSB)	1 Mr Shailesh Ambegaonkar (BWSB)
2 Dr Sharad Oza (BWSB)	2 Dr Sunil Paranjpe (BWSB)	2 Dr Shantanu Malik (Chembur)
3 Dr Ranjan Shah (BWSB)	3 Dr Neel Tandan (Chembur)	3 Dr Sandhya Saharan (Mulund)

All the participants were awarded Certificate of Participation. Dr Shantanu Malik gifted his own songs CD album to all the participants & managing committee members. We are thankful to the over whelming response given by all our enthusiastic members. We hope to receive your Love & Encouragement in all our future activities.

Please do attend in large number "**DEEPAWALI SWARPRABHAT**" on **7TH NOVEMBER 2010** at 07.00 am.

Dr. Rohini Badwe
Chairperson
Cultural Sub Committee

AIR CONDITIONED, POSH LOCATION AND BRAND NEW CONSULTING ROOMS WITH ALL FACILITIES

AT

MOTILAL NAGAR NO. 3, OPP. AZAD MAIDAN, GOREGAON (WEST).

CONTACT - 98922 70707

Geriatric Cell Subcommittee - - A Report

Prize distribution of the essay competition "Old age home is a boon or a bane" was held on **3rd October 2010,** along with the singing competition for senior members of I.M.A. and their spouses.
Chief Guest was **Mr. Subhash Bhende,** an eminent Marathi writer, who distributed the prizes and the certificates.

FIRST PRIZE .... MRS. UMA AKOLKAR
SECOND PRIZE .... DR. (MRS) PURNIMA SARDA

All the participants were awarded certificates for participation.
Function was well attended.

Dr. (Mrs) Chhaya Desai
Chairperson
Geriatric Sub Committee

WORLD MENTAL HEALTH DAY – A Report

World Mental Health Week (4th Oct. to 10th Oct) culminated in World Mental Health Day on Sunday, 10th October 2010. It was observed at IMA Mumbai West by organising a CME.

Talk on Suicide and Self Harm by Dr. Syeda Rukseda saw active and prolonged participation from the audience. Mental Health in Chronic illness was dealt by Dr. Jay Shastri in a very straightforward and precise manner.

Considering that a large proportion of chronic physical illnesses affect the mental health of an individual, a talk on Peripheral vascular disease was delivered by Dr. Rahul Sheth.

The CME and the guest speakers received great appreciation from the audience .

This CME was accredited for one hour by MMC.

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

INFORMATION, EDUCATION & COMMUNICATION SUB COMMITTEE - A Report

We had organised a lecture on the topic of **"Malaria, Dengue, Gastroenteritis, ORS (Oral Rehydration Solution), Tuberculosis for students of hostel** on Saturday, 16th October 2010 from 01.30 pm – 04.30 pm at Mahajan's Bunglow, Dattatakadi, Borili (E).

Lecture were given by myself Dr. Pratibha Thoravade, and Dr. Kamlesh Gandhi. It was followed by question & answer session for ½ hour. It was attended by 100 students. Dr. Dharnikumar Chalmela, Dr. Devesh Desai, Dr. Jayant Sampat were present for the programme.

Brahmakumari Miss. Anita from Chembur and Miss Nidhi from Borivli conducted programme for meditation & delivered a lecture to all students. Biscuits packets were distributed to all.

We thank Dr. Sunil Mahajan, trustee of the hostel and Mr. Krishna Kokate, for helping in organizing this programme.

Dr. Pratibha Thoravade
Chairperson, Information Education & Communication

INDIAN MEDICAL ASSOCIATION - MUMBAI WEST

IMA - CGP MUMBAI WEST SUB FACULTY

Presents

"MEDICINE UPDATE 2010"

Day & Date : **SUNDAY, 28TH NOVEMBER 2010**

Time : **04.00 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 - 400 049.

PROGRAMME

Time	Topic	Speaker
03.30 pm - 04.30 pm	Registration	
	MORPHEUS "A.R.T. IN INFERTILITY" SESSION	
04.30 pm - 05.30 pm	Endoscopy in Infertility	Dr. Shyam Desai
	Ovulation Induction	Dr. V. G. Pisat
	CARDIOLOGY SESSION	
05.30 pm - 06.00 pm	Mending Little Hearts	Dr. K.S. Moorthy (Bangolre)
	DIABETIC₹SESSION	
06.00 pm - 06.30 pm	Multitarget Approach to Achieve Comprehensive Glycemic Control	Dr. Tejas shah
06.30 pm - 07.00 pm	Diabetic Retinopathy	Dr. Ajay Dudani
07.00 pm	Vote of Thanks	
07.00 pm onwards	Dinner	

REGISTRATION CHARGES :

- ✤ CGP and IMA Members who have paid ANNUAL Fees = Free. (Only if Registered in Advance)
- ✤ CGP & IMA Members : ₹ 100/-
- ✤ Eligible Non Members : 150/-

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IMA - Mumbai West C.G.P Sub Faculty

ANNOUNCEMENT - Sports Subcommittee

All ye land lubbers shed your lethargy & come with us for some Bounty Hunting. We promise you a rollicking time.......

Come one, come all for this novel programme brought exclusively for you to let down your hair & to engage your grey cells lulled into hibernation by our daily routine by solving some mischievously simple yet TEDHE MEDHE clues & completing some outrageously funny tasks on the way to win a TREASURE.

TREASURE HUNT

DAY & DATE : SUNDAY 28TH NOVEMBER 2010

TIME : 9:00 AM TO 12:00 NOON

LIMITS : BANDRA to OSHIWARA (East & West)

This Treasure Hunt is open to IMA Members & their Family Only.

Maximum 4 persons in a car. Minimum 2 persons in a car.

One IMA member compulsory in every car.

PRIZES TO BE WON	1)	FIRST PRIZE	2000/- per team
	2)	SECOND PRIZE	1000/- per team
	3)	4 Consolation PRIZES	500/- per team

DRESS CODE : Bollywood Villains & Vamps

Prizes for The Best Dressed Couple
The Best Dressed Villain
The Best Dressed Vamp.

- The Programme will be Followed by LUNCH free for all participants.
- RSVP must before 22nd November 2010.

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

ANNOUNCEMENT

IMA - MAHARASHTRA STATE CGP CONFERENCE

on SUNDAY, 14TH NOVEMBER 2010

This Conference is being held in the memory of late Prof Dr. K. Ramamoorthi.
The Conference has many renowned faculty Speakers.
This conference is 1st of it's kind in IMA - Maharashtra State

All the delegates will get attractive gift & many lucky draws. **DELEGATES FEES : 100/-**

FOR REGISTRATIONS, PLEASE CONTACT:
MR. ASHISH, MS.VIJAYA, MS. PRACHI
IMA - MAHARASHTRA STATE OFFICE, Tel. No.: 26232965/ 23233890,

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, 11TH DECEMBER 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 - 400 049.

PROGRAMME

Time	Topic	Speaker
06.30 pm - 07.00 pm	Registration	
07.00 pm	Welcome Address & Inauguration	Dr. Balkrishna M. Inamdar
07.00 pm - 08.00 pm	Sleep Apnoea	Dr. Salil Bendre Consultant Chest Physician
08.00 pm - 09.00 pm	Current Trends in Diabetes Management	Dr. Rahul Tambe Consultant Physician
09.00 pm - 09.15 pm	Discussion	
09.15 pm	Vote of Thanks	Dr. Rashmikant Sanghvi / Dr. Sanjay Dudhat
09.15 pm onwards	Dinner	

▶ **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

Congratulations !

Heartiest congratulations to our life member from Borivali – Dr. Mahendra Sawant for passing following examinations with flying colours this year

i) Master in Marketing Management (MMM) of May 2010 (76% & first in the college)
ii) Master in Business Administration (MBA) in Health Care Services of July 2010 (81%)
iii) NET in management of June 2010.

We wish him bright career ahead we are really proud of him

Dr. Balkrishna M. Inamdar
President

Dr. Ashok Balsekar
Hon. Secretary

INDIAN MEDICAL ASSOCIATION - 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 (26206517, 65235579)
EMAIL: imamumbaiwest@gmail.com, imamumbaiwest@yahoo.com

LAST DATE FOR APPLICATION :

WEDNESDAY, 15TH DECEMBER 2010

DR. BALKRISHNA M. INAMDAR
PRESIDENT

DR. ASHOK BALSEKAR
HON. SECRETARY

वृद्धाश्रम - शाप की वरदान

परवाच पेपरमध्ये 'जेष्ठ नागरिकांना दिलासा' या मथळ्याखाली आलेले एक स्फुट वाचले आणि मन सुन्न झाले. ते वृत्त असे होते, 'मुलांनी टाकलेल्या किंवा त्यांच्याकडून त्रास होण्याऱ्या वृद्धांना त्यांच्या सुरक्षा आणि देखभालीचा खर्च रक्ताच्या नात्यातील माणसाकडून मागण्याचा हक्क कायद्याने प्राप्त होणार आहे आणि सरकारने त्यासाठी विशेष न्यायालय स्थापण्याचे आदेश दिले आहेत'. मला कळेना खरंच हा ज्येष्ठांना दिलासा आहे का? असा कायद्याचा बडगा दाखवून भितीपोटी आपल्या मातापित्यांना सांभाळण्याची वेळ यावी ह्यात कोणाला समाधान मिळणार आहे ? ना त्या मातापित्यांना ना त्या मुलांना. आईवडिलांच्या सेवेत खंड पडू नये म्हणून पांडुरंगालाही विटेवर उभा करणाऱ्या पुंडलिकाचे आणि अंध मातापित्यांना काशीयात्रेचे पुण्य घडावे म्हणून त्यांना कावडीत बसवून घेवून जाणाऱ्या श्रावणबाळाचे संस्कार झालेल्या आम्हाला हे कधीच पटणार नाही आणि मानवणार तर नाहीच नाही.

पण.... त्या बातमीच्या निमित्ताने विचारांना एक नवी दिशा मिळाली एवढे मात्र खरे. आजच्या प्रगत आणि त्यातल्यात्यात वेद्यकीय विज्ञानातील नवनवीन उपचार पद्धतींमुळे आयुष्यमान निश्चित वाढले आहे आणि त्यामुळे भारतात आज सर्वाधिक संख्या वृद्धांची आहे असे फेस्कॉमच्या मिशन स्टेटमेंटद्वारे सिद्ध झाले आहे. बदलत्या युगात वस्तू जुनी झाली की टाकून द्यायची, "Use And Throw" ही पद्धत आता वस्तुपुरती मर्यादित न राहता माणसांच्या बाबतीतही लागू होत आहे. म्हणूनच घरातील वृद्ध, आजाराने परावलंबित्व आलेली, कौटुंबिक जबाबदाऱ्या पेलण्यास असमर्थ असलेली माणसे आजच्या 'बिझी' मुलांसाठी एक प्रचंड डोकेदुःखी झाली आहे. मग त्यावर उपाय म्हणून अनेक पर्याय पुढे येऊ लागले. घरात २४ तासासाठी मोलकरीण ठेवायची. २/३ भावंड असली तर आईवडिलांनी हप्त्याहप्त्याने प्रत्येकाकडे रहायचे किंवा दोनच भावंड असली तर आईवडिलांची वाटणी. आईने एकाकडे, वडिलांनी दुसऱ्याकडे. त्यातही स्वार्थ आलाच. आईवडिलांना सांभाळण्याची जबाबदारीही पार पाडली जाते व घरातील छोट्यांचीही सोय होते. पाळणाघराचा खर्चही वाचतो. यातील काहीच जमण्यासारखे नसेल तर वृद्धाश्रमाचा पर्याय आहेच. असेच हळुहळु वृद्धाश्रम भरत चालले. मातापित्यांना सांभाळण्याचाच असमर्थ असलेल्या मुलांना वृद्धाश्रम हे वरदान वाटले. ठराविक रक्कम भरल्यावर एखादी संस्था जर परस्पर आपली जबाबदारी स्वीकारत असेल तर काय हरकत आहे ? हा मुलांचा दृष्टीकोन. आणि आजच्या वेगवान जगात कुटुंबाची व्याख्या इतकी संकुचित झाली आहे की कुटुंब म्हणजे फक्त स्वतःपुरते बघणे हा आजच्या तरूण पिढीचा परवलीचा शब्द झाला आहे व त्यामुळे स्वतःचे आईवडिलही त्यांना परके च वाटु लागले तर काय नवल ? अशा मुलांकडे अपमान झेलत लाचार जीवन जगण्यापेक्षा वृद्धाश्रमात राहून शांत जीवन जगू इच्छिणाऱ्या वृद्धाश्रमाचा पर्याय वरदानच वाटणार.

आदिमानवाच्या काळात टोळी करून राहणाऱ्या मानवाला नैसर्गिक आपत्तीच्या वेळी वृद्ध आणि अपंग व्यक्तिंना मागे सोडून स्थलांतर करणे अपरिहार्य होते. मग पुढे कुटुंबव्यवस्था आली. - एकत्र कुटुंबपद्धती. ह्यात घरातील अनेक माणसांत वृद्धांची सोय-सेवा आपोआप होत असे. कोणालाच कोणाची अडचण नव्हती. नंतर नव्याने रूढ होत असलेली जीवन पद्धती, बदलते शहरीकरण. आर्थिक स्वातंत्र्याबाबत आलेली जाग, जागतीकरण, त्याचे दुष्परिणाम या सर्वांचा एकत्रित परिणाम म्हणजे विभक्त कुटुंबपद्धती व त्यात वृद्धांच्या वाट्यास आलेली उपेक्षा व एकाकीपणा; व यावर उत्तम तोडगा म्हणून वृद्धाश्रमाची संकल्पना पुढे आली व त्याचा फायदा प्रत्येकजण आपापल्या सोयीनुसार घेऊ लागला. कोणी अनिच्छेने कोणी स्वखुशीने. जो ज्या चष्म्यातून त्याकडे पाहील तसे त्याला ते दिसेल. सरसकट सर्व वृद्धांना जरी वृद्धाश्रमाची गरज नसली तरी आज फेस्कॉमच्या निष्कर्षावरून १० कोटी जेष्ठांच्या लोकसंख्येत ६६% जेष्ठांना दोन वेळचे जेवण मिळत नाही, ५५% विधवा निराधार आहेत, ३७% वृद्ध एकाकी आहेत. अशांना वृद्धाश्रमाचाच आधार आहे. म्हणून मला वाटतं, वृद्धाश्रम हा शापही नाही आणि वरदानही नाही तर ती बदलत्या काळाची निनांत गरज आहे. आणि अशा निराधार वृद्धाना त्याठिकाणी सुखाने व मानाने जगत यावे म्हणून जे जे शक्य असेल ते ते सरकारने व समाजसेवी संस्थानी एकत्र येऊन अवश्य करावे.

फक्त जाता जाता एकच सुचवावेसे वाटते अशा संस्थाना 'वृद्धाश्रम' न म्हणता 'वृद्धनिवास' किंवा 'वृद्धनिवारा' म्हटलं तर ? तर तो आश्रम न वाटता मानव मंदिर वाटेल. तिथे आपुलकीच्या भिंती असतील, जिव्हाळ्याच्या गोष्टी बोलायला जवळचे 'मित्र' असतील, निवांत पांघरायला ऊब असेल, तृप्तीची शाल असेल.... आणि मग आपल्याला हा प्रश्नच राहणार नाही, वृद्धाश्रम - शाप की वरदान ? काय ? बरोबर ना ?

द्वारा - श्रीमती उमा अकोलकर

OLD AGE HOME IS A BOON OR A BANE ?

Old age homes are boon for the society. There are lots of old people living alone in this world due to following reasons.

1) In some cases only child or all the children of the family go to other country and, unfortunately could not take their parents there.
2) As the old age is advancing day-by-day, in some houses two generation of retired people are there in one house.
3) Due to some unavoidable circumstances, they cannot live with their children.
4) Some people have no issues, lots of people do not get married or are divarced & stay alone.
5) Due to conflict in families, two generations cannot stay together in house.

Staying alone in house may give rise to following problems :-

1) Security problems,
2) Proper timely medical advice,
3) Nursing problems,
4) Lonliness giving rise to depression,
5) Nobody to interact,
6) Lack of socialization.

In ancient India, there were Asharams for old people and old age homes are modern version of them. People of same age group stay together there, having lots of fun and spend time with each other. They can share their feelings, previous experiences and present with each other.

The old age home having following facilities with good standards can be a boon to the society:-

1) Proper kitchen facilities,
2) Regular medical check-ups with extra care for sick persons,
3) Proper sanitary facilities,
4) Comman room having a library, T.V., Radio, some indoor games, instruments for singing, yoga and laughter classes and mild exercise facilities,
5) Peaceful atmosphere,
6) Affection atc staff expert,
7) Facilities to arrange small cultural and social programmes and get-togethers in the premises by themselves,
8) Garden.

The people in the old age homes should not be completely forgotten by youngsters. There is a moral responsibility of young relatives to be in touch with them. They should be invited in family functions and other occassions by family or institutes where they were working. Old people having no relatives can be invited by some families having no old person and can be helped by them. The amount required for maintaining oldage homes should come from the pensions of old person, their relatives and charities. If this type of oldage homes are opened and maintained, they can be boon to the old people. These oldage homes can help to secure the life of the people.

From **Dr. (Mrs.) Purnima Sarda**

HbA1C-THE NEW DIAGNOSTIC TOOL

DR. MANOJ S CHAWLA

Consulting Diabetologist

LINA DIABETES CARE CENTRE/ASIAN
AN HEART INSTITUTE

Introduction:
HbA1c, also called A1C, is a measure of the amount of glucose attached to hemoglobin (Hb) in red blood cells. The higher the glucose levels over the previous 2-3 months, the higher the A1C. The A1C test is used to monitor the glucose levels of patients who have been diagnosed with diabetes.

HbA1c Recommended for Diagnosis
An international expert committee that includes representatives from the American Diabetes Association (ADA), International Diabetes Federation (IDF), and European Association for the Study of Diabetes (EASD) has officially endorsed the use of HbA1c to diagnose diabetes. The recommended cut off is HbA1c e” 6.5%. The recommendation has been officially endorsed by the American Diabetes Association and endorsed with qualifications by the American Association of Clinical Endocrinologists/American College of Endocrinologists and the Endocrine Society.

ADA –American Diabetes Association Recommendations
HbA1c Recommended for Diagnosis
The ADA Clinical Practice Recommendations now recommend using HbA1c to diagnose diabetes using a NGSP-certified method and a cutoff of HbA1c e”6.5%. POC assay methods are not recommended for diagnosis.

A1C or “the A1C test”
The National Diabetes Education Program and major clinical diabetes organizations including the American Association of Clinical Endocrinologists, the American Society of Clinical Endocrinologists and the American Diabetes Association recommend use of the term A1C or “the A1C test” to describe HbA1c in clinical practice.

A1C

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control).
- Perform the A1C test quarterly in patients whose therapy has changed or who are not meting glycemic goals.
- Use of point-of-care testing for A1C allow for timely decisions on therapy changes, when needed.

Glycemic Gloals in Adults

- Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for non-pregnant adults in general is <7%.

Reference: American Diabetes Association Clinical Practice Recommendations: Executive Summary: Standards of Medical Care in Diabetes - 2010 Diabetes Care 2010;33, suppl.1: S4-5.

HbA1c & Estimated Average Glucose (eAG)

Why is relating HbA1c to glucose important?
We are frequently asked about the relationship between HbA1c and plasma glucose levels. Many patients with diabetes mellitus now perform self-monitoring of blood glucose (SMBG) in the home setting, and understanding the relationship between HbA1c and glucose can be useful in setting goals for day-to-day testing.

HbA1c: A "Weighted" Average

Many studies have shown that HbA1c is an index of average glucose (AG) over the preceding weeks-to-months. Erythrocyte (red blood cell) life-span averages about 120 days. The level of HbA1c at any point in time is contributed to by all circulating erythrocytes, from the oldest (120 days old) to the youngest. However, HbA1c is a "weighted" average of blood glucose levels during the preceding 120 days, meaning that glucose levels in the preceding 30 days contribute substantially more to the level of HbA1c than do glucose levels 90-120 days earlier. This explains why the level of HbA1c can increase or decrease relatively quickly with large changes in glucose; it does not take 120 days to detect a clinically meaningful change in HbA1c following a clinically significant change in AG.

How does HbA1c relate to average glucose (AG)?

In the Diabetes Control and Complications Trial or DCCT (New Engl J Med 1993;329:977-986) study of patients with Type 1 diabetes, quarterly HbA1c determinations were the principal measure of glycemic control; study subjects also performed quarterly 24-hour, 7-point capillary-blood glucose profiles. Blood specimens were obtained by subjects in the home setting, pre-meal, 90 minutes post-meal, and at bed-time. In an analysis of the DCCT glucose profile data (Diabetes Care 25:275-278, 2002), mean HbA1c and AG were calculated for each study subject (n= 1439). Results showed a linear relationship between HbA1c and AG (*AG(mg/dL) = (35.6 x HbA1c) - 77.3)*, with a Pearson correlation coefficient (r) of 0.82.

Table 1

HbA1c (%)	eAG (mg/dL)	eAG (mmol/l)
5	97	5.4
6	126	7.0
7	154	8.6
8	183	10.2
9	212	11.8
10	240	13.4
11	269	14.9
12	298	16.5

Data from the A1c-Derived Average Glucose (ADAG) Study:

A more recent study (2006-2008) sponsored by the ADA, EASD and IDF was designed to better define the mathematical relationship between HbA1c and AG. The study included 507 subjects with Type 1 and Type 2 diabetes and without diabetes from 10 international centers. Estimated AG (eAG) was calculated by combining weighted results from at least 2 days of continuous glucose monitoring performed four times, with seven-point daily self-monitoring of capillary glucose performed at least 3 days per week. The relationship between eAG and HbA1c based on linear regression analysis was: ***eAG(mg/dl)= (28.7*HbA1c)-46.7,*** *r2=0.84* (Diabetes Care 2008;31:1-6). Table 1 depicts this relationship.

The regression equation from the ADAG study provides lower eAG values compared with the widely used equation derived from the DCCT, and the scatter around the regression is less wide. The proposed explanation for the difference is in the frequency of glucose measurements used to calculate AG, with the ADAG estimate providing a more complete and representative measure of average glucose.

How does Fasting Glucose Relate to HbA1c?

Further analyses of the DCCT data showed that among single time-point measurements, post-lunch and bedtime glucose showed relationships to HbA1c that were the most similar to full 7-point profile glucose. Fasting glucose correlated less well and results showed that with increasing HbA1c, fasting glucose progressively underestimated the level of HbA1c and/or AG calculated from the 7-point profile.

What Does All of This Mean?

First, there is a very predictable relationship between HbA1c and AG. Understanding this relationship can help patients with diabetes and their health-care providers set day-to-day targets for AG based on HbA1c goals (e.g. American Diabetes Association recommendations). Second, fasting glucose should be used with caution as a surrogate measure of AG. Finally, it is important to remember that HbA1c is a weighted average of glucose levels during the

preceding 4 months. Unless the patient's glucose levels are very stable month after month, quarterly measurement is needed to insure that a patient's glycemic control remains within the target range.

HbA1c Assay Interferences
HbA1c methods and Hemoglobin Variants (HbS, HbC, HbE and HbD traits)

In people who have hemoglobin variants such as HbS (sickle cell trait), some A1C tests give falsely high or low readings that can lead to the over-treatment or under-treatment of diabetes. Laboratories use many different methods for measuring A1C, but some of these methods can give inaccurate results when the patient has a hemoglobin variant such as sickle cell trait. Doctors or patients interested in getting information about the accuracy of a particular A1C method for patients with hemoglobin variants should first find out which method your laboratory is using.

The following table lists the 20 methods most often used to measure A1C and whether the method is affected by either HbS or HbC or HbE or HbD trait. Methods are listed in alphabetical order by manufacturer. If your diabetes patient has a hemoglobin variant, your lab should use one of the methods that does not show interference from the variant, thus producing an accurate A1C result.

	Interference from			
Method	HbAS	HbAC	HbAE	HbAD
Abbott Architect/Aeroset	Yes	Yes	-	-
Axis-Shield Afinion	No	No	No	No
Bayer (Metrika) A1cNOW	Yes	Yes	No	No
Beckman Synchron System	No	No	No	No
Bio-Rad D-10	No	No	No	No
Bio-Rad Variant A1c	No	No	No	Yes
Bio-Rad Variant II A1c	No	No	No	No
Bio-Rad Variant II Turbo A1c	No	No	Yes	Yes
Dade Dimension	No	No	No	No
Olympus AU system	Yes	Yes	No	No
Ortho-Clinical Vitros	No	No	No	No
Primus HPLC (affinity)	No	No	No	No
Roche Cobas Integra Gen.2	No	No	No	No
Roche/Hitachi (Tina Quant II)	No	No	No	No
Siemens (Bayer) Advia HbA1c # (original version)	Yes	Yes	-	-
Siemens (Bayer) Advia A1c (new version)	No	No	-	-
Siemens (Bayer) DCA 2000	No	No	-	-
Tosoh A1c 2.2 Plus	No	No	Yes	No
Tosoh G7	No	No	Yes	No
Tosoh G8	No	No	Yes	No

 # This method is being replaced by the newer A1c version

**** Excerpts taken from ADA clinical practice recommendations and NGSP*.**

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DIABETIC RETINOPATHY

DR. ANUPAM MALPANI
VITREO-RETINAL SURGEON

DIABETIC RETINOPATHY, a complication of diabetes, is caused by changes in the small blood vessels of the retina. These damaged blood vessels may leak fluid & blood, or show growth of fragile new vessels and scar tissue thereby affecting vision.

Diabetic retinopathy is one of the most common causes of blindness in those over 45 years of age.

Diabetes is a rapidly emerging problem in developing world. India is estimated to have 33million diabetics and this is likely to increase to 57 million by 2025.

It is estimated that 80% of diabetics will have some form of diabetic retinopathy and 25% will have advanced form of diabetic involvement of retina (proliferative diabetic retinopathy) at 15years. Compared to non diabetic, a diabetic with retinopathy has 25 times greater risk of blindness. Hence, diabetic involvement of the eye has a major affect not only on the individual but also places a great burden on the family. This is particularly tragic because timely treatment can prevent up to 60-70% of vision loss due to D.R provided the condition is detected early and treated adequately.

TYPES OF DIABETIC RETINOPATHY:

Background disease (BDR) is an early stage in which sight is not seriously affected.

In some cases vision is affected when the leaking fluid collects at the macula, the part of retina responsible for detailed vision. This is called ‘diabetic maculopathy’.

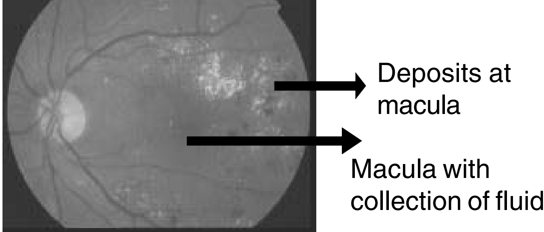
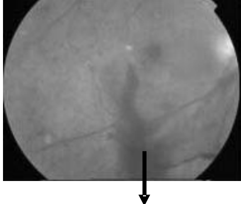


Figure1:Diabetic maculopathy

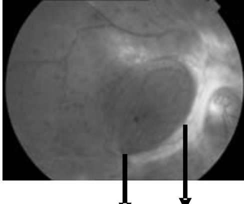
Proliferative diabetic retinopathy (PDR) is the more serious type of retinopathy in which there is growth of abnormal, fragile new blood vessels and scar tissue on the surface of retina and optic nerve. These new vessels have weak walls and may rupture and bleed producing vitreous haemorrhage which blocks the light from reaching the retina while the scar tissue contracts and exerts pull on the retina lifting it up from its normal position. This is called tractional retinal detachment.

Figure2 : Vitreous haemorrhage



Vitreous haemorrhage

Figure 3:Tractional retinal detachment



Traction at macula

SYMPTOMS :

Patients with significant changes of diabetic retinopathy *can have good vision* and be totally asymptomatic. Sight is usually unaffected in background diabetic retinopathy unless there is macular edema.

Black spots (floaters) of sudden onset often indicate a minor bleed in the eye, while sudden visual loss may occur due to extensive bleeding into the vitreous.

Vision is also affected when there is traction at macula or traction induced detachment of retina involving macula.

DETECTION AND DIAGNOSIS:

Functional vision can be preserved or restored in many patients with even severe disease. However, accurate & timely detection of retinopathy remains a major problem as serious retinopathy can be present without symptoms. Therefore, a diabetic should be aware of the risks & have their eyes (& retina) examined regularly as suggested below –

Age of onset of Diabetes Mellitus	Recommended time of First Examination	Routine minimum follow-up(more frequent in case of abnormal findings)
0 – 30 years	5 years after onset	Yearly
31 years and above	At the time of diagnosis	Yearly

Some studies have shown that **pregnancy may aggravate** existing retinopathy. To minimise potential visual loss, a retinal examination is recommended in diabetic patient during the first trimester & every 3 months thereafter.

Besides the routine examination, to detect diabetic retinopathy, the inner part of the eye has to be examined using an instrument called **Indirect Ophthalmoscope**. If diabetic retinopathy is noted, depending on the need, special tests may have to be performed. These include **Fundus Fluorescein Angiography (FFA)**, **Optical Coherence Tomography (OCT)** and **Ultrasonography (USG)**.

During **FFA**, a fluorescent dye is injected into a vein in the arm. Photographs of the retina are taken in rapid succession as the dye passes through the retinal blood vessels. This test is used to detect the sites of leakage in the retina or the presence of new blood vessels thereby helping to determine if treatment is necessary.

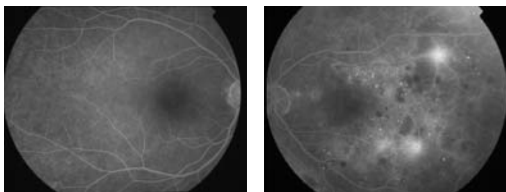
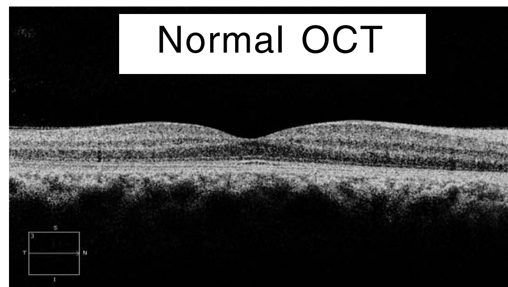
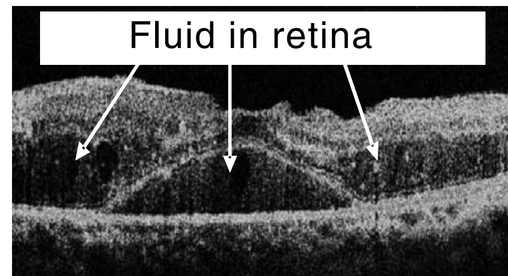


Figure 4: Normal FFA picture

Figure 5 : FFA- Diabetic changes

OCT is a new and very useful diagnostic tool in which a beam of light is used to scan the central area of retina (Macula). This gives a cut sectional view of retina and a detailed picture of retinal structure can be seen. This helps in detection of extent of fluid in the retina as well as any traction and also to judge the response of treatment.





Ultrasonography is a non-invasive diagnostic test utilizing ultrasonic waves. This test is used to rule out presence of tractional retinal detachment in eyes with vitreous haemorrhage or cataract.

TREATMENT : Not all cases of diabetic retinopathy require treatment. Several factors such as patient's age, history and degree of damage to the retina have to be considered before deciding for the treatment.

Many studies have shown that **good control** over glucose levels delays the onset & decreases the severity of retinopathy. Numerous drugs have been tried in an effort to alter the course of retinopathy, but none of these have shown to be effective in arresting or reversing the retinopathy. Diabetic retinopathy is frequently found in conjunction with **hypertension**. Controlling hypertension may also help the retinopathy from becoming worse.

LASER PHOTOCOAGULATION is the most important mode of treatment of diabetic retinopathy. Laser beam is used to seal the leaking vessels and destroy the new vessels. It must be remembered that laser treatment is **performed to maintain vision and NOT** to improve it. Hence, to be most helpful, the laser treatment must be delivered **before** patient complains of visual loss.

Laser treatment does not require hospitalisation and is performed on an out-patient basis. It may be performed in one sitting or may have to be repeated depending upon the severity of the retinopathy. After photocoagulation, patient is asked not to bend down, not to strain or lift heavy objects at least for 3-4 weeks, to sleep with head raised using 2-3 pillows and to control coughing & sneezing with appropriate medicines.

Laser photocoagulation is very safe and essential with negligible side effects if any.

Figure7: Laser application

INTRAVITREAL INJECTIONS:

In certain conditions, where laser is not possible or is not effective, certain medicines (Anti-VEGF/Steroids) are now used in form of injections in the eye. This is a painless procedure and done in operation theatre to ensure sterility. This form of treatment does give benefit in selected cases but is usually combined with either laser or surgery. Recent studies have shown very good results in previously untreatable conditions.

VITRCTOMY :

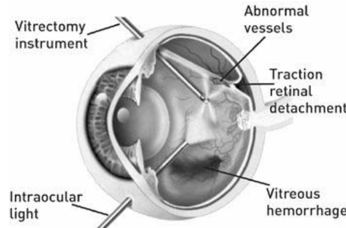
In most cases disease is controlled by laser but more than one sitting may be required. In some patients with advanced proliferative diabetic retinopathy, extensive haemorrhage may occur clouding the vitreous for long time or a retinal detachment may be present. In presence of fresh vitreous haemorrhage without retinal detachment, at first strict rest with head-up is advised. No oral medicine or drops has been found to be of use in helping the absorption of vitreous haemorrhage. If the haemorrhage does not show signs of absorption after 2-3 months or if retinal detachment is suspected, in such cases vitrectomy operation may be needed.

Vitrectomy is a sophisticated microsurgical operation in which cloudy vitreous and scar tissue over retina are removed from the eye. Along with this, laser treatment can also be given at the same sitting by means of an instrument called 'endolaser'. Being a complex surgical procedure with many potential complications, vitrectomy is reserved only for selected patients in whom all other treatment modalities have failed.

Common indications for Vitreous surgery includes:

1. Non resolving vitreous haemorrhage
2. Tractional retinal detachment involving or threatening macula
3. Combined (Tractional & Rhegmatogenous) retinal detachment
4. Vitreous haemorrhage in seeing eye of one eyed patient

Figure 1: Vitrectomy being performed



CONCLUSION :

With progress in the medical management of diabetes and the increasing life span of diabetics, it is inevitable that unless treated, most diabetics will suffer some degree of visual loss in decades after onset of the disease. Early detection of the retinopathy is the best protection against loss of vision. **It should be remembered that laser treatment only helps in preventing further loss of vision**, hence, it is most useful when used before the patient complains of decreased vision. Thus **regular retinal check-up** in diabetic patient is very important for early diagnosis and treatment to prevent blindness.

Recommended Schedule for Retinal Check-Up:

Age of onset of Diabetes Mellitus	Recommended time of First Examination	Routine minimum follow-up (more frequent in case of abnormal findings)
0 – 30 years	5 years after onset	Yearly
31 years and above	At the time of diagnosis	Yearly
Pregnancy with pre-existing diabetic retinopathy	During first trimester	Every 3 months

(Recommended by American Academy of Ophthalmology)

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DIABETES AND LIVER

DR. TEJAS SHAH

It is estimated that 40 million people have Type 2 diabetes in India with core defects of insulin resistance and insulin deficiency.

Liver disease is an important cause of mortality in type 2 diabetes. In population based Verona diabetes study cirrhosis was fourth leading cause of death with diabetes. The entire spectrum of liver disease is seen in patients with type 2 diabetes, mainly:

I – abnormal liver enzymes
II – non-alcoholic fatty liver disease (NAFLD)
III – Cirrhosis
IV – hepatocellular carcinoma
V – Acute liver cell failure

I – Abnormal liver enzymes:
Elevation of SGOT and SGPT is common in patients with type II diabetes. 98% of individuals with elevated enzymes have fatty liver disease and chronic hepatitis.

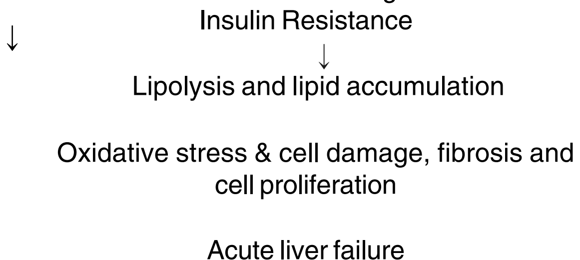
II – Non-alcoholic fatty liver disease (NAFLD):
It is defined as fatty liver disease in absence of < 20gm alcohol per day. The prevalence of NAFLD in diabetes is estimated at 34 – 74% and with obesity at 100%. Dyslipidemia in type 2 diabetes, insulin resistance resulting in lipolysis, with increased free fatty acid and accumulation in liver are the proposed mechanisms for increased incidence.

Increased levels of TNF-á and decreased levels of adiponectin is prosteotic & pro-inflammatory and also responsible.

The natural history of NAFLD is progression from steatosis to hepatitis ’! cirrhosis ’! hepatocellular Ca in some.

III – Cirrhosis:
Cirrhosis itself is associated with insulin resistance. IGT is seen in 60% and overt diabetes in 20% of people with cirrhosis. Insulin mediated glucose disposal is reduced by 50% in cirrhosis.

IV – Hepatocellular Carcinoma:
Numerous studies have shown four fold increased prevalence of hepatocellular CA in patients with diabetes. The pathogenic sequel of events seems to be following



V – Acute liver Failure:
Incidence of acute liver cell failure is increased in type 2 diabetes. The mechanism for increased risk remains unclear.

<u>Hepatitis C in diabetes</u>:
The prevalence of hepatitis C virus (HCV) is higher in DM than in general population (4.2% v/s 1.6%). Patients with HCV are more likely to develop diabetes (21% v/s 10%), suggesting HCV may have a role in pathogenesis. Certain studies suggest that core protein of HCV impairs insulin signaling, modifying metabolic effects of insulin.

Patients with HCV and fatty liver also have higher TNF-á and reduced adiponectin.

Given the higher association it is advisable to screen type 2 diabetes patients with increased liver enzymes for HCV.

MANAGEMENT OF DIABETES WITH LIVER DISEASE:

Lifestyle modification:

Low glycemic, low calorie diet with weight loss is found to be beneficial. Exercise Improves insulin sensitivity and alcohol should be specially avoided.

Pharmacologic Therapy:

There are concerns about altered drug metabolism and hepatotoxicity,only patients with evidence of liver failure such as ascites,coagulopathy have altered drug metabolism.

Biguanides : First line therapy with metformin is appropriate except in patients with advanced liver disease. Some benefit has been seen in patients with fatty liver disease with metformin.

Insulin secretagogues : Sulphonylureas are generally safe but not very effective due to high insulin resistance in such patients. Short acting ones like glipizides are better and patients with advanced disease should be monitored closely for hypoglycemia.

Alpha glucosidase inhibitors : Acarbose and miglitol are both found to be useful in reducing post prandial hyperglycemia though rarely acarbose has found to have mild elevation in liver enzymes.

TZDs : TZDsmay be beneficial due to its role in improving insulin insensitivity. NO difference in incidence of abnormal liver function has been noted in patients on pioglitazone and rosiglitazones as compared to other drugs however due to past experience with troglitazone initial monitoring of liver enzymes is advised before starting therapy and periodically thereafter.

Insulin : Insulin requirement may vary in patients with liver disease, it may decrease due to reduced capacity for gluconeogenesis and reduced breakdown of insulin or requirement may increase due to increased insulin resistance.Short acting analogs like aspart or lispro may particularly be useful.

MANAGEMENT OF LIVER DISEASE IN PATIENTS WITH DIABETES:

All patients with diabetes should have SGOT/ SGPT done at initial evaluation.The initial workup for patients with minor elevations should include testing for hepatitis C,hepatitis B, hemochromatosis - iron and iron saturation and an ultrasound abdomen.

FATTY LIVER AND NAFLD:

The diagnosis should be suspected in any diabetic with elevated liver enzymes.Mild elevation of alkaline phosphatase and serum ferritin levels may be seen. Ultrasound usually reveals a “bright” liver.

Most patients do not require treatment unless biopsy proved NASH.Exercise and weight reduction improves insulin sensitivity and reduces steatosis. The ideal weight loss recommended is 1.5 kg/week and a very rapid weight loss is to be avoided.

Pharmacologic therapy for NAFLD is evolving and various drugs like metformin, pioglitazone, vitamin E,atorvastatin, pentoxyifylline have been studied but FDA has yet not approved any therapy for NAFLD due to mixed results with most and side effects of some.

HEPATITIS C : Most effective treatment for HCV is alpha interferon and ribavirin however reports of abnormal glucose tolerance have been seen in nondiabetic patients after six months of treatment and hence have to be used with caution in patients with diabetes.

SUMMARY: 1 Type 2 diabetes is largely associated with liver diseases mainly fatty liver and cirrhosis with increased association with HCV.

2: Presence of liver disease has little implication for treatment of diabetes unless decompensated liver disease. Patients with advanced liver disease are more susceptible for hypoglycemia and hence carefull monitoring and appropriate selection of therapy is required.

More trials are required for treatment of NAFLD and type 2 diabetes.

TAKE - HOME MESSAGE

*By **Dr. Priti Bhargava,** Director CGP*

05.10.10 : HYPERBARIC OXYGEN THERAPY
DR. JAYESH SHAH

UHMS Approved Indications for HBO

1 Air and Gas Embolism
2 Carbon Monoxide Poisoning
3 Clostridal Myositis , Myonecrosis
4 Crush injury, Compartment Syndrome, other Acute Traumatic Ischemias
5 Decompression Sickness
6 Arterial Insufficiencies: Central retinal artery occlusion Enhancement of healing in selected Problem Wounds
7 Exceptional Blood Loss (Anemia)
8 Intracranial Abscess
9 Necrotizing Soft Tissue Infections
10 Refractory Osteomyelitis
11 Delayed Radiation Injury/Soft tissue and bony necrosis
12 Compromised skin grafts/flaps
13 Thermal Burns

07.10.10 : CA BREAST MANAGEMENT
DR. SANJAY DUDHAT

ADJUVANT HORMONAL THERAPY-ER+ PR+

- Premenopausal
  Tamoxifen
- Postmenopausal
  Tamoxifen Aromataze Inhibitors :
  Anastrazole (Arimidex 1 mg.)
  Letrazole (2.5 mg.)

FOLLOW UP AFTER TREATMENT-

- Bi-annual physical examination for 5 years followed by yearly checkup.
- Mammography once in 18 months.
- X-Ray chest, USG abdomen + pelvis, LFT

12.10.10 : GERD
DR. AJAY CHOKSHI

- **Alarm Signs/Symptoms in GERD**
  - Dysphagia
  - Early satiety
  - GI bleeding
  - Odynophagia
  - Vomiting
  - Weight loss
  - Iron deficiency anemia

14.10.10 : LFT IN CHB
DR. SAMIR PARIKH

WHICH HBV DISEASE NEEDS NO Rx?

- Acute Hepatitis - < 6 months HBsAg +ve, acute hepatitis, IgM anti HBc +ve, no clinical e/o CLD.
- Inactive HBV carrier - > 6 months HBsAg +ve, e Ag –ve, anti HBeAg +ve, DNA < 20000, normal ALT, LBx score < 4.
- Resolved HBV – HBV infection in past, HBsAg –ve, total anti HBc +ve, normal ALT, HBV DNA –ve.

19.10.10 : Osteporosis
DR. PRADUMNA MAMTORA

Drugs causing Osteoporosis

- Excess thyroid hormone
- Anticoagulants (esp. heparin)
- GnRH Agonists
- Anticonvulsants
- High dose tetracycline
- Aluminum-containing antacids
- Cyclosporin
- Rifampin
- Exchange resins
- Loop diuretics
- Alcohol
- Glucocorticoids

Recommended Dietary Calcium Intake

- 1300 mg/d for adolescents
- 1000 mg/d for young & middle aged adults
- 1200 mg/d for adults over 50

Vit D Intake

- No osteoporosis: 800-1000 IU/d
- With Osteoporosis: 800-2000 IU/d

Exercise

- Must be *weight bearing* (not cycling or swimming)
- Walking 3 to 5 miles per week prevents bone turnover and increases spine
- BMD in postmenopausal women with osteoporosis or osteopenia
- Adults: 30 mins/d, Children: 60 mins/d

Other agents

- Bisphosphonates
- Calcitonin
- Strontium Ranelate
- Vitamin K2
- PTH (Teraparatide)

A Happy and Healthy Diwali

And

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