Issue: July- Sep 2024

EDPA Quarterly Medical Bulletin

.

East Delhi Physicians' Association

EDPA Quarterly Medical Bulletin

JULY- SEPT 2024
SPECIAL 25TH ANNIVERSARY EDITION

Dear Members of the EDPA,

*As we move ahead towards the last quarter of the **Silver Jubilee year of EDPA**, and reflect on the unity, and growth of our EDPA community, it is my pleasure to present the **3rd quarterly edition of this year's EDPA Medical Bulletin**.*

This edition brings together a variety of content designed to inform EDPA members on health-related topics relevant for EDPA members. You will find original clinical case studies, and other articles of interest offering insights into evidence based diagnostic and therapeutic approaches in various clinical scenarios and academic activities undertaken

by EDPA in this quarter. We hope, this bulletin serves as a valuable resource to support EDPA Members in staying abreast with relevant medical practice areas.

We are also excited to feature articles from our fellow EDPA members, covering everything from medical legal scenarios to latest healthcare trends. These articles foster a culture of shared learning and collaboration, encouraging everyone to actively participate in the exchange of knowledge and experience.

As an association, EDPA has proven its ability to adapt and thrive in challenging times. Now, let's continue pushing boundaries, embracing new opportunities, and shaping the future of healthcare practice in our region.

We again invite members to contribute your own case reports, articles, and personal insights to future editions. Your voices help deepen our collective knowledge, strengthen our community, and create a shared platform for growth and innovation.

As we celebrate 25 years of shared knowledge, collaboration, and professional advancement, let's look forward with renewed enthusiasm and a shared vision for the future. We thank each of you for your continued dedication to both your profession and our EDPA community.

With Kind regards,






EDPA Editorial Team

1. Dr RPS Makkar, Editor
2. Dr. P.N. Chaudhary, President EDPA
3. Dr Vijay Arora, Chairman, Scientific Committee
4. Dr Paras Gangwal, Immediate Past President
5. Dr Anindya Biswas, Joint Editor
6. Dr Swathi Jami, Secretary, EDPA

Table of contents:

1. EDPA Champion of The Month Awards

EDPA Champion for July 2024 – Dr Nirmala Lahoti

We are extremely happy to announce that **Dr. Nirmala Lahoti** has been awarded the prestigious **EDPA Champion of the Month for July 2024.** This recognition comes in light of her exceptional efforts to promote awareness about Parkinson's disease, a cause she has passionately championed.

Dr. Lahoti's dedication to raising awareness about Parkinson's disease in her Neurology Practice in East Delhi has been inspiring for all of us in EDPA. Through her work, she has brought much-needed attention to this neurodegenerative disorder, which affects millions of people worldwide including India.

Her initiatives to providing rehabilitation to PD patient through Parkinson disease movement disorder society (started by very senior and renowned Neurologist Dr BK Singhal from Mumbai) have not only educated the general public in Delhi but also provided support and resources to those affected by the disease.

Dr. Lahoti's commitment to PD patients' rehabilitation extends beyond her professional responsibilities. She has organized numerous workshops, seminars, and community outreach programs on PD aimed at educating both healthcare professionals and the general public about Parkinson's disease. Her efforts have significantly contributed to early diagnosis and better management of the condition, improving the quality

of life for many patients in her practice. One of the hallmarks of Dr. Lahoti's intertest on PD is her innovative approach to PD patient community engagement. She has leveraged various platforms, including social media, to disseminate information and connect with a broader audience. Her ability to simplify complex medical information and make it accessible to patients and their family members has been particularly impactful.

Dr. Lahoti's unwavering dedication and compassionate approach make her a role model for all of us in the EDPA community. Her work exemplifies the true spirit of healthcare—caring for patients and advocating for their well-being beyond the confines of the clinic.

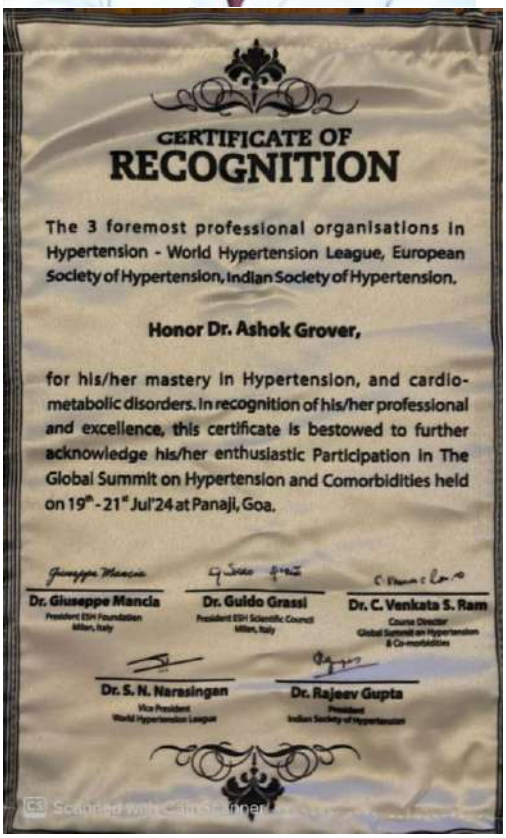
On behalf of the entire EDPA community, we extend our heartfelt congratulations to Dr. Nirmala Lahoti for this well-deserved recognition. Her achievements remind us of the profound impact that one individual can have on society. We are proud to have her as a member of our association and look forward to her continued contributions to the field of medicine and public health.

EDPA Champion for AUGUST 2024 – Dr ASHOK GROVER

The East Delhi Physicians Association (EDPA) is delighted to announce that **Dr. Ashok Grover** has been conferred the **EDPA Champion of the Month Award** for August 2024.

Dr. Ashok Grover is a very senior and highly respected member of our association, and his unwavering commitment to raising awareness about hypertension and his substantial contributions to public health have earned him well-deserved recognition.

His efforts were recently celebrated at the **Global Summit on Hypertension and Comorbidities**, held from **July 19th to 21st, 2024, at the GOA** Convention, where he brought pride not only to himself but also to the EDPA community. At the convention, **The World Hypertension League,** the **European Society of Hypertension,** and the **Indian Society of Hypertension** collectively honoured Dr. Grover for his outstanding work on hypertension and cardiometabolic disorders.



CERTIFICATE OF
RECOGNITION

The 3 foremost professional organisations in Hypertension - World Hypertension League, European Society of Hypertension, Indian Society of Hypertension.

Honor Dr. Ashok Grover,

for his/her mastery in Hypertension, and cardio-metabolic disorders. In recognition of his/her professional and excellence, this certificate is bestowed to further acknowledge his/her enthusiastic Participation in The Global Summit on Hypertension and Comorbidities held on 19th - 21st Jul'24 at Panaji, Goa.

Dr. Giuseppe Mancia — President ESH Foundation, Milan, Italy
Dr. Guido Grassi — President ESH Scientific Council, Milan, Italy
Dr. C. Venkata S. Ram — Course Director, Global Summit on Hypertension & Co-morbidities
Dr. S. N. Narasingan — Vice President, World Hypertension League
Dr. Rajeev Gupta — President, Indian Society of Hypertension

We extend our heartfelt congratulations to **Dr. Ashok Grover** for his well-deserved award and for his unwavering commitment to improving health outcomes in our community. His work continues to inspire us all!

EDPA Champions for September 2024 – Dr Dilip Bhalla, Dr Neeru P. Agarwal, Dr Tushar Gupta

The East Delhi Physicians Association (EDPA) proudly hosted its **MIDCON 2024 Conference** on **Nephrology Updates** on July 28th, 2024, at the Radisson Blu Hotel, Kaushambi. This academic event was a resounding success, thanks to the exceptional efforts of EDPA Members **Dr. Dilip Bhalla**, **Dr. Neeru Agarwal**, and **Dr. Tushar Gupta**, who were central to the planning and execution of this insightful gathering.

With esteemed national faculty, and speakers of great repute, the conference provided valuable updates and fostered clinically meaningful discussions in the field of nephrology. In recognition of their outstanding contributions and flawless organization of MIDCON, **Dr. Dilip Bhalla**, **Dr. Neeru Agarwal**, and **Dr. Tushar** were honoured with the **EDPA Champions of the Sep Month Award**.

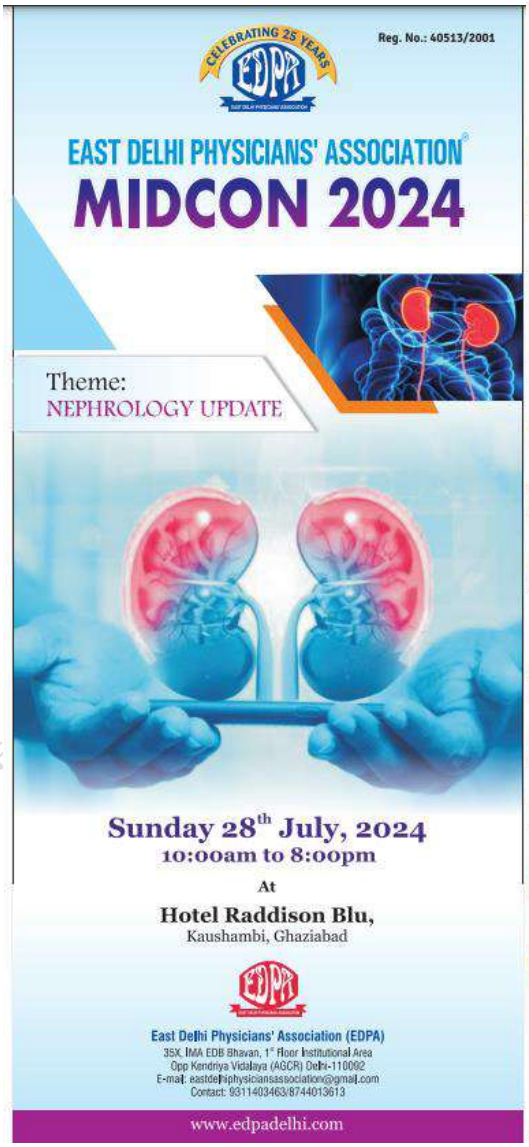
We extend our heartfelt congratulations to the trio for their dedication and achievements. Their efforts continue to elevate the standards of medical education and collaboration within our community.

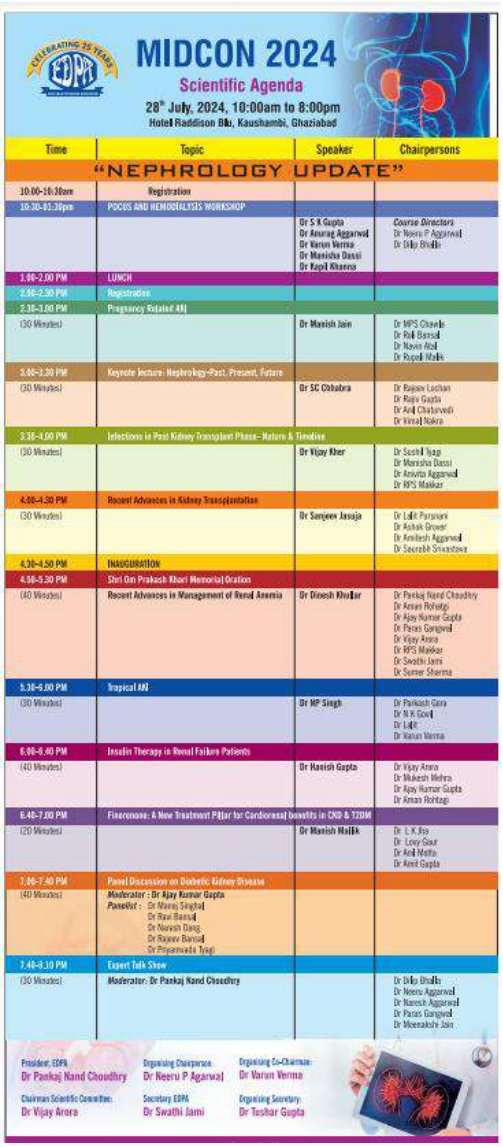
The EDPA is proud to have such committed professionals leading the way!

2. MIDCON, 2024 – an academic feast and a successful EDPA conference yet again!

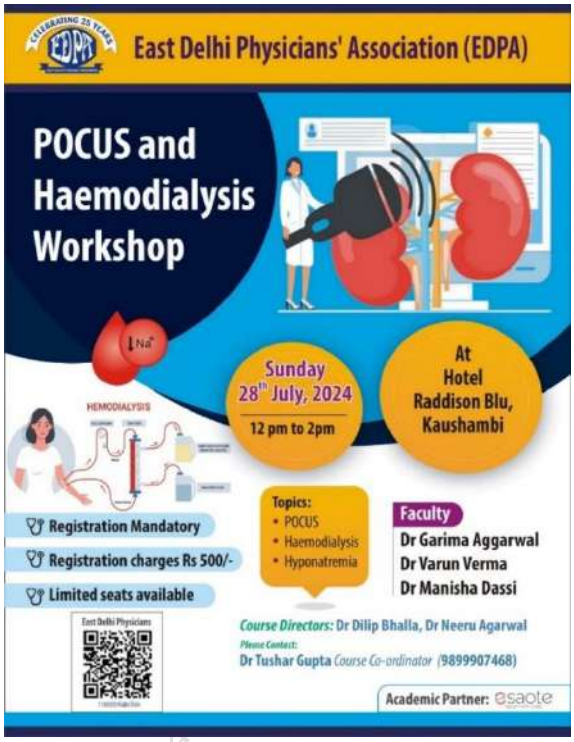
By Dr Swathi Jami

The East Delhi Physician Association held its much awaited MIDCON 2024 conference on July 28, 2024, at the Radisson Blu Hotel, Kaushambi. This day-long academic event featured esteemed national faculty and attracted over 300 delegates from Delhi and NCR. Spearheaded by **Dr. Dilip Bhalla, Dr. Neeru Agarwal, Dr. Tushar, and Dr Vijay Arora** as the chairman Scientific committee, the conference focused on the latest developments in nephrology.



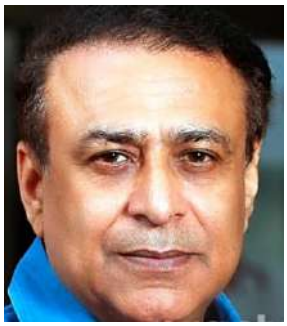


Two workshops—POCUS and Haemodialysis—were conducted for practicing physicians and postgraduate students, coordinated and directed by **Dr. Neeru, Dr. Dilip Bhalla, Dr Garima Agarwal, Dr Manisha Dassi, Dr Tushar, Dr. S.K. Gupta**, and others.



The program was a great success with active participation by interested delegates in both workshops.

In the main MIDCON program, prominent national speakers included eminent nephrologists **Dr. S.C. Chabra, Dr. Vijay Kher, Dr NP Singh (**virtual; joined online from USA**) and Dr. Sanjeev Jasuja**, among others.



Dr. S.C. Chabra delivered the **Keynote lecture**, discussing "**Nephrology: Past, Present, and Future."**

The conference covered various topics such as infections in renal transplant patients, advances in kidney transplantation, tropical AKI, insulin therapy in renal failure, cardiorenal benefits of Finerenone.

The highlight was this year's Omprakash Kahri Oration Lecture, which was delivered by **Dr. Dinesh Khullar (Nephro)**; in his oration, Dr. Dinesh spoke on the recent advances in the

management of renal anaemia, particularly focusing on the new HIPF class of drugs.

Other notable sessions were an engaging panel discussion on Diabetic Kidney Disease, moderated by **Dr. Ajay Kumar Gupta**, with panellists **Dr. Manoj Singhal (Nephro), Dr. Ravi Bansal (Nephro), Dr Naresh Dang, Dr. Rajeev Bansal, and Dr. Priyamvada Tyagi.** They elaborated various aspects of DKD including diagnostic challenges and latest management aspects of DKD.

The day concluded with an Expert Talk Show moderated by **Dr. P.N. Chaudhary** with experts including **Dr. Dilip Bhalla (Nephro), Dr. Neeru Agarwal (Nephro), Dr. Naresh Agarwal (Gastro) Dr. Paras Gangwal, and Dr. Meenakshi Jain.**






EDPA commentary:

MIDCON 2024 was indeed a successful event overall; The delegates attendance could have been better though, and we urge all members to join in large numbers and benefit from the knowledge sharing from such academic events!!

---

3. Acute Treatment of Migraine: Latest Guidelines of International Headache Society (IHS) 2024

Article contributed by Dr RPS Makkar

The **International Headache Society (IHS)** released updated guidelines in August 2024 for the **acute pharmacological treatment of migraines**. These guidelines provide recommendations based on the latest research, targeting various populations, including children, older adults, pregnant women, and those with specific health conditions. Here's a synopsis of the guidelines for quick reference of EDPA members;

1. General Recommendations

- **Initial Treatment**: For individuals whose migraines do not respond to **analgesics** or **non-steroidal anti-inflammatory drugs (NSAIDs)** when taken early in an attack, it is recommended to switch to a **triptan** (5-HT1B/1D receptor agonists) for subsequent attacks.
- **Dose Adjustment**: If a triptan is only partially effective, increasing the dose to the **maximum recommended dose** is suggested for the next migraine episode. If three different triptans fail to provide adequate relief, switching to a different class of acute migraine medications is recommended.
- **Combination Therapy**: For partial responders to triptans, combining **oral sumatriptan (50–100 mg)** with **oral naproxen sodium (550 mg)** is recommended. Alternatively, using a triptan with a fast-acting **NSAID** is also advised.

2. Special Considerations

- **Nausea and Vomiting**: For migraine patients experiencing nausea and/or vomiting that interferes with medication absorption, adding an **antiemetic** to analgesics, NSAIDs, or triptans is recommended.
- **Status Migrainosus**: For migraines lasting more than 72 hours (**status migrainosus**), treatment with **intramuscular NSAIDs**, **subcutaneous sumatriptan (approved in India)**, or **oral/intranasal dihydroergotamine** combined with antiemetics is recommended.
    - **Sub Q Sumatriptan dose**: Available as 6 mg/0.5 ml injection autoinjector. Dose is 1-6 mg given SubQ once. If the headache comes back after being relieved, one more dose may be injected after 1 hour (max 12 mg per day). Do not use more than 2 doses of 6-mg, or 3 doses of 4-mg in any 24-hour period.

3. Specific Populations

- **Children and Adolescents**:
    - **First-Line Treatment**: **Paracetamol (15 mg/kg, up to 60 mg/kg per day)** or **ibuprofen (10 mg/kg, up to 30 mg/kg per day)** is recommended.
    - **Second-Line Treatment**: If these medications are ineffective, **triptans** are considered second-line therapy for adolescents, with **rizatriptan** or **sumatriptan nasal spray** (approved in India) being preferred.
        - **Rizatriptan** dose is 5 or 10 milligrams (mg) as a single dose. If the migraine comes back after being relieved, another dose may be taken 2 hours after the last dose (maximum not more than 30 mg in any 24-hour period).
        - **Sumatriptan nasal spray** available as 5mg and 20mg per actuation. Dose is 5 mg (1 spray into one nostril) or 10 mg (2 sprays in one nostril or 1 spray in each nostril) or 20 mg (1 spray into one nostril). Another spray (5 mg, 10 mg, or 20 mg) may be used as long as it has been at least 2 hours since the last spray. (Maximum 40 mg in a 24-hour period).
- **Older Adults (65+ years)**:
    - **First-Line Treatment**: **Paracetamol** is recommended for older individuals with normal liver function.
    - **Second-Line Options**: **Acetylsalicylic acid** or **NSAIDs** may be used, but monitoring for gastrointestinal and renal or hepatic issues is crucial.
    - **Third-Line Treatment**: **Triptans** can be used in those without uncontrolled hypertension or serious cardiovascular conditions, while **Lasmiditan** (serotonin (5-HT) 1F receptor agonist) or **gepants** are alternatives.
        - Lasmiditan Initial dose: 50 mg, 100 mg, or 200 mg tablet orally once. No more than 1 dose should be taken in 24 hours; a second dose has not been shown to be effective for the same migraine attack.
        - Gepants (Small molecule calcitonin gene-related peptide (CGRP) receptor antagonists): These are not commonly available in India

- **Patients with Cardiovascular Disease**: For those with a history of stroke, cardiovascular disease, or uncontrolled hypertension, **paracetamol** is the recommended first-line treatment. **Lasmiditan** or **gepants** are second-line options.

4. Women's Health Considerations

- **Menstrual Migraines**:
    - **First-Line Treatments**: **NSAIDs** or **triptans** are recommended.
    - **Combination Therapy**: If ineffective, combinations such as **triptans with NSAIDs**, **triptans with antiemetics**, or **NSAIDs with antiemetics** are advised. **Lasmiditan** and **gepants** are also options.
- **Pregnancy**:
    - **First-Line Treatment**: For pregnant women whose migraines are not controlled by non-pharmacological methods, **paracetamol** and **triptans** can be used cautiously during all trimesters.
    - **Nausea and Vomiting**: **Metoclopramide** may be added for nausea, vomiting, or insufficient pain relief.
- **Breastfeeding**: **Paracetamol** is the preferred medication during breastfeeding.

Summary of Treatment Approach

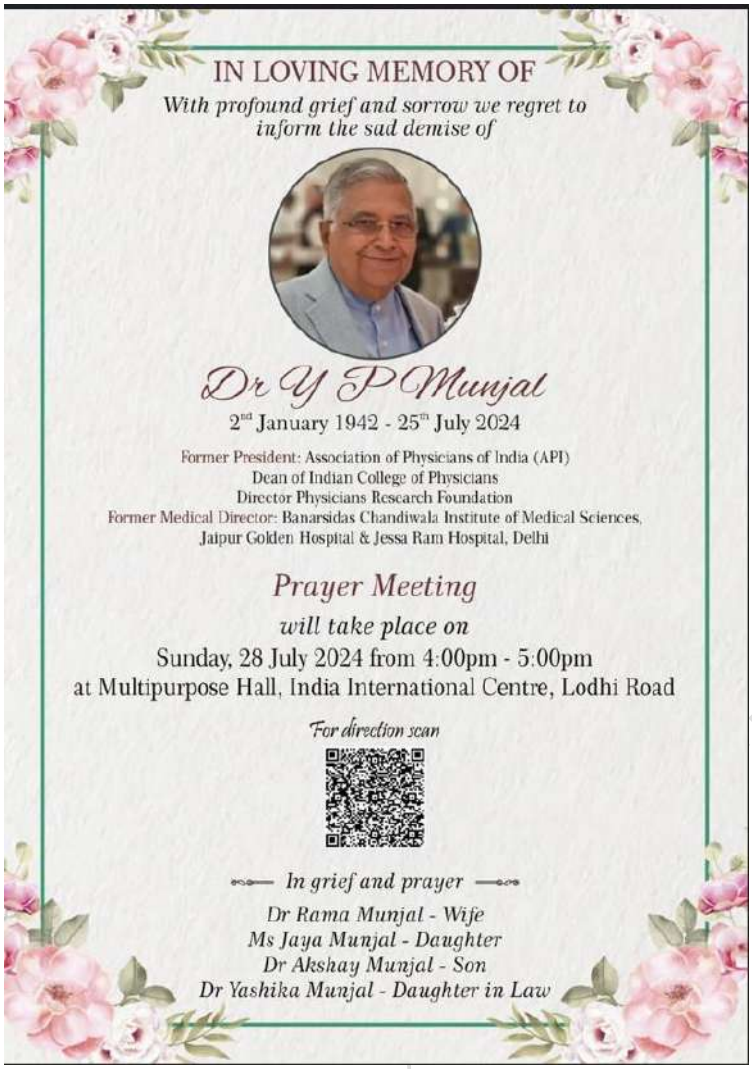
- **Early Treatment**: Start with NSAIDs or analgesics. If ineffective, switch to triptans.
- **Dose Adjustment**: Increase triptan dose if partial relief is obtained. Switch drug classes after failure with multiple triptans.
- **Combination Therapy**: Combine triptans with NSAIDs or antiemetics if single agents are insufficient.
- **Special Populations**: Tailor treatments based on age, pregnancy, cardiovascular risk, and other health conditions.

References: Puledda F, Sacco S, Diener HC, et al. International Headache Society global practice recommendations for the acute pharmacological treatment of migraine. Cephalalgia. 2024 Aug;44(8)

- **These guidelines reflect a structured approach to migraine management, emphasizing individualized care and the importance of early and appropriate treatment for different patient groups.**
- **EDPA urge its members to consider these treatment guidelines while managing migraine patients.**

---

4. Obituary: Dr YP MUNJAL (1942-2024)



It was a feeling of deep sorrow when we came to know of the passing away of **Dr. Y.P. Munjal** on July 25, 2024.

Born on January 2, 1942, Dr. Munjal was an eminent figure in the medical fraternity, a beloved teacher, mentor, and leader. He served as the **President of the Association of Physicians of India (API)** and was the **Dean of the Indian College of Physicians**, where he contributed immensely to the advancement of medical education. Dr. Munjal was also the **Director of the Physicians Research Foundation** and held the position of **Medical Director** at prestigious institutions including **Banarasi Das Chandiwala Institute of Medical Sciences**, **Jaipur Golden Hospital**, and **Jassa Ram Hospital** in Delhi.

A guiding force for generations of physicians in Delhi, India, and abroad, Dr. Munjal's legacy as a teacher and mentor has left an indelible mark on the medical community. His passing is a profound loss, but his contributions to the field will continue to inspire future generations.

In his memory, a prayer meeting was held on **Sunday, July 28, 2024**, at the **India International Centre, Lodhi Road**, which was attended by a large number of physicians from across India, reflecting the widespread respect and admiration for his work and character. Senior EDPA member, Dr Anil Chaturvedi wrote an obituary in his respect.

Dr. Y.P. Munjal will be remembered for his unparalleled dedication to medicine and his compassionate mentorship to countless physicians. May his soul rest in peace. 🙏

5. Ward or ICU? A Practical Guide to Deciding the Right Level of Care for Your Patient

Article contributed by Dr RPS Makkar

"Should I admit this patient in ICU or ward?" We often this situation in our practice where it is sometimes difficult to decide whether to admit a patient in ward or ICU? How does one decide? While it is straightforward in critically ill patients, but it may not be an easy decision to make in stable-looking, less-critical cases. How do we ensure that an appropriate balance is maintained between 'optimal care' and minimising 'cost burden on patient'. Are there any objective guidelines to help make this decision?

In Dec 2023, the Union Ministry of Health and Family Welfare unveiled an **Expert Consensus Statement regarding Intensive Care Unit (ICU) services and standards in India**. These guidelines came out 8 years after the Supreme Court first acknowledged various issues surrounding ICU care for patients in 2016. In response to rising medical negligence cases, the Supreme Court in year 2016 had sought clarifications from the Central Government and the erstwhile Medical Council of India (MCI), now replaced by the National Medical Commission (NMC), regarding guidelines for private hospitals providing care in the ICU and Critical Care Unit (CCU).

The guidelines crafted by 24 healthcare experts and released by the Directorate General of Health Services (DGHS) delved into ICU admission and discharge criteria, and outlined the minimum monitoring needed for critically ill patients while awaiting ICU admission. **These guidelines** aimed at standardizing and enhancing the quality of care in Intensive Care Units as they provide a clear framework for admission, discharge, monitoring, and patient transfer, ensuring a more transparent and patient-centric approach in critical healthcare settings.

The guidelines clarify that the "Criteria for admitting a patient to ICU should be based on organ failure and need for organ support or in anticipation of deterioration in the medical condition. **Conversely, it also states that certain group of critically ill patients should NOT be admitted to the ICU.**

Specific ICU Admission Criteria include:

1. Altered level of consciousness
2. Hemodynamic instability (e.g., shock, arrhythmias)

3. Need for respiratory support (e.g., escalating oxygen requirement, respiratory failure)
4. Severe acute or acute-on-chronic illness requiring intensive monitoring or organ support
5. Anticipation of deterioration
6. Major intraoperative complications
7. Postoperative complications in high-risk surgeries.

Patients who Should NOT be Admitted to the ICU:

1. Patient or next-of-kin refusal for ICU admission
2. Disease with a treatment limitation plan
3. Anyone with a living will or advanced directive against ICU care
4. Terminally ill patients with a medical judgment of futility
5. Low-priority criteria during a pandemic or disaster situation with resource limitations.

Criteria for Discharge from ICU:

1. Return of physiological aberrations to near-normal or baseline status
2. Reasonable resolution and stability of the acute illness that led to ICU admission
3. Patient or family agreement for ICU discharge, especially for treatment-limiting decisions or palliative care
4. Discharge based on the lack of benefit from aggressive care, with the decision primarily being a medical one and not based on economic constraints
5. Discharge for infection control reasons with the assurance of appropriate care in a non-ICU location
6. Rationing in the face of a resource crunch, is guided by an explicit, transparent, fair, consistent, and reasonable written rationing policy.

Minimum Patient Monitoring recommendations while Awaiting an ICU Bed:

The guidelines outline essential parameters to monitor while awaiting an ICU bed:

- Blood pressure (continuous/intermittent)
- Clinical monitoring (pulse rate, respiratory rate, breathing pattern, etc.)
- Heart rate (continuous/intermittent)
- Oxygen saturation (continuous/intermittent)
- Capillary refill time
- Urine output (continuous/intermittent)
- Neurological status (e.g., Glasgow Coma Scale, Alert Verbal Pain Unresponsive scale)
- Intermittent temperature monitoring and Blood sugar monitoring.

Minimum Stabilization recommendations Before Transferring to ICU:

The guidelines emphasize stabilizing a patient before transferring them to the ICU. Key aspects include:

- Ensuring a secure airway (tracheal intubation if GCS ≤8)
- Adequate oxygenation and ventilation
- Stable hemodynamic, with or without vasoactive drug infusion
- Ongoing correction of critical metabolic disturbances and
- Initiation of definitive therapy for life-threatening conditions.

6. Can an MD Medicine without an extra intensive care training treat ICU patients? Learnings from a Medicolegal case

Article contributed by Dr Ajay kr. Gupta

Who can deliver ICU care?

The guidelines issued by Union Health Ministry in 2023 on intensive care unit (ICU) admissions, mark an important advancement in defining the role of an 'Intensivist' or Critical Care Specialist and laying down specific criteria for their recognition. They emphasize the requisite training, certification, and experience needed for a medical professional to be designated as an Intensivist, ensuring a standardized approach to managing critically ill patients in Intensive Care Units (ICUs).

It clarified that to earn the "**Intensivist**" title, a specialist must possess specific training, certification, and hands-on experience in managing critically ill patients within an ICU. The guidelines outlined the educational qualifications deemed acceptable for an Intensivist, including a postgraduate degree in Internal Medicine, Anaesthesia, Pulmonary Medicine, Emergency Medicine, or General Surgery. In addition to this, the Intensivist should have one of the following qualifications:

a) An additional qualification in Intensive Care, such as DM Critical Care/Pulmonary Critical Care, DNB/FNB Critical Care (National Board of Examinations), Certificate Courses in Critical Care from the Indian Society of Critical Care Medicine (ISCCM), or equivalent qualifications from recognized international institutions such as the American Board Certification, Australian or New Zealand Fellowship (FANZCA or FFICANZCA), UK (CCT dual recognition), or its equivalent in Canada.

b) Alternatively, a minimum of one year of training in a reputable ICU abroad.

The guidelines further recognize individuals with ISCCM Certificate Course (CTCCM) certification and a three-year training program in Intensive Care after completing MBBS as eligible Intensivists. However, these qualified individuals must also have a minimum of two years of experience in an ICU, with at least 50% of their time dedicated to ICU services.

For practitioners lacking the specified qualifications, the guidelines stipulate that they should possess extensive experience in Intensive Care in India post-MBBS, totalling at least three years. Again, a significant portion (at least 50%) of their professional time should be spent in the ICU setting. Thus, according to the guidelines, not only specialists with specific training, certification, or ICU experience but also doctors with post-MBBS experience in critical care settings quantifiable as ICU experience of at least three years could work as ICU doctors.

Learnings for EDPA physicians from a Medicolegal case

The above ICU guidelines have a bearing on the case where the National Consumer Disputes Redressal Commission, heard an appeal against Akshaya Hospital (Bhopal) by the complainants whether doctors with an MD in medicine without extra intensive care training are sufficiently qualified to treat ICU patients.

Case details

The case from 2009 revolves around the alleged medical negligence and improper care that led to the death of a patient, a 63-year-old woman. The complainants, patient's husband and their sons, claimed that after experiencing uneasiness following a walk on March 31, 2009, patient was taken to Akshaya Hospital (Bhopal), where she was admitted to the ICU. Despite being admitted for over six hours, the hospital failed to have any senior cardiologists examine her. Instead, she was treated by junior doctors and homeopathic assistants who administered NTG (Nitroglycerin) and other medications for hypertension, despite no evidence of a serious cardiac condition in her ECG reports.

The complainants alleged that throughout her stay, her blood pressure (BP) and condition were not properly monitored, and the NTG infusion was not adjusted appropriately, which could have contributed to her death. The highlighted several inconsistencies in the medical records, including overwritten entries, different handwriting on different pages, and no mention of important discussions with doctors.

The case further details that crucial treatment protocols were not followed, such as frequent BP monitoring, use of proper medical equipment, and obtaining informed consent for high-risk procedures like NTG infusion. Patient's sudden death was attributed to "Acute Coronary Syndrome" and "Cardiac Arrest," but the family questioned these findings as her prior test results, including cholesterol and CKMB, were normal. They believed that the hospital wasted critical time, and the lack of examination by senior cardiologists and proper medical oversight led to her untimely death. A complaint was filed on April 5, 2010.

Hospital Defence

Akshaya Hospital filed a defence against the allegations of medical negligence in the case. In its defence, the Hospital emphasized its reputation as a fully equipped facility in Bhopal with a well-established ICCU and CCU. The hospital claimed to have the necessary instruments and trained staff, with 24-hour services, including at least one postgraduate doctor available at all times. Dr. Deepak Chaturvedi, the hospital's director, provided an affidavit confirming these facts. The hospital argued that upon patient's admission on March 31, 2009, she was immediately attended to by Dr. Amit Singh, a senior MD doctor, without wasting time on paperwork. Her preliminary check-ups, including an ECG, revealed signs of unstable angina, which was communicated to her husband.

The hospital denied claims of neglect, asserting that Dr. Amit Singh and trained staff monitored her condition throughout, administering necessary medications. They contended that there was no need for other senior doctors, such as Dr. Anil Gupta or Dr. Deepak Chaturvedi, to be called.

The hospital explained that patient suffered bradycardia (a slowed heart rate) and cardiac arrest. Despite resuscitation efforts, the patient died; the hospital maintained that sudden cardiac arrest is a common complication in Acute Coronary Syndrome (ACS) cases, and the patient had a history of uncontrolled diabetes, hypertension, and heart issues.

Akshaya Hospital denied any tampering with medical records, acknowledging only a possible clerical error. They also noted that the patient's son had revealed that she had experienced chest discomfort for six months before her admission and had been using medication to manage it without undergoing tests like ECG or angiography. The hospital maintained that there was no deficiency in its service and requested that the complaint be dismissed.

State commission verdict

In this case, the State Commission referred the treatment records to Gandhi Medical College, Bhopal, for expert review. A **Medical Board** (consisting of Dr. T.N. Dubey, Dr. B.S. Yadav, and Dr. Ajay Sharma) submitted a report on July 15, 2009, concluding that the patient was properly monitored and that no negligence occurred on the part of Akshaya Hospital.

The complainants, dissatisfied with this finding, submitted a rejoinder along with affidavits from Dr. D.K. Satpathy, Dr. Ashok Gupta, P.P. Agrawal, and V.C. Rawat, as well as supporting documentary evidence, including an expert opinion from Dr. D.K. Satpathy. The hospital (Opposite Party-1) provided affidavits from Dr. Deepak Chaturvedi, Dr. R.K. Singh, Dr. Ajay Sharma, and Dr. T.N. Dubey, along with their own documentary evidence, including expert testimony from Dr.

R.K. Singh. The complainants also cross-examined Dr. T.N. Dubey, the Chairman of the Medical Board. Dr. Amit Singh, who attended to the patient, submitted an affidavit before the Medical Board. Both parties ultimately filed written submissions summarizing their respective positions.

In this case, the State Commission delivered its judgment on February 15, 2023, dismissing the complaint against Akshaya Hospital. The Commission found that the complainants admitted the patient had a pre-existing condition, Right Bundle Branch Block, since January 2005. The expert opinion provided by Dr. D.K. Satpathy was deemed unreliable because he lacked expertise in cardiology and couldn't interpret crucial medical reports. In contrast, expert opinions from Dr. R.K. Singh, a cardiologist, and the Medical Board report dated July 15, 2009, did not find any negligence in the treatment provided by the hospital.

Despite extensive cross-examination by the complainants, no evidence of deficiency in service or negligence by the hospital was found. As a result, the complaint was dismissed.

The complainants had raised several other allegations (including that the hospital did not arrange for its heart specialists to examine the patient during her six-hour stay in the ICU; that the admission papers showed the patient was under Dr. Anil Gupta's care, but he never visited; the hospital lacked equipment for continuous blood pressure monitoring; a homeopath technician, unqualified to administer modern medicine, handled NTG infusion; Blood pressure was not recorded frequently during the NTG infusion process; no infusion pump or micro drip set was used for NTG drip control, and no informed consent was obtained for this high-risk procedure; the NTG drip should have been reduced when the patient's BP dropped; the attending doctor did not record the patient's medical history or condition during admission, and a junior doctor handled the high-risk NTG infusion procedure) . However, ultimately, the court found these allegations unproven, and the complaint was dismissed, leading to another appeal.

The complainants alleged that they were misled, believing the deceased would be treated by senior doctors, not a junior doctor and homeopaths. They claimed to have inquired about the availability of senior doctors like Dr. Anil Gupta and Dr. Deepak Chaturvedi, but were informed that these doctors would not be available until the next morning. Dr. Amit Singh, who was on duty at the time, confirmed in his affidavit that he managed the patient's care from her admission at 9:30 PM on March 31, 2009, until her death at 3:00 AM on April 1, 2009, overseeing treatments, investigations, and vital sign monitoring with the assistance of technical staff.

The complainants' allegations about the lack of senior doctors' involvement and inadequate care were unproven, as the hospital demonstrated it had the proper equipment and followed medical standards during treatment.

The Medical Board confirmed that all treatment papers were signed by Dr. Amit Singh, MD (Medicine), who attended the patient from the time of her admission. V.C. Rawat, the complainant, was informed that senior doctors Dr. Anil Gupta and Dr. Deepak Chaturvedi would arrive the following morning at 8:00 am. Rawat did not express dissatisfaction with Dr. Amit Singh's care, nor did he inquire about other doctors. If less qualified doctors had attended the patient, Rawat would have likely withdrawn the patient from the hospital.

One of the key issues was whether Dr. Amit Singh was competent for ICU duty. According to Dr. T.N. Dubey, chairman of the Medical Board, MD Medicine doctors are qualified to work in the ICU, and there is no requirement for them to have specialized intensive care training. Although homeopaths were involved, they only supervised the patient's vitals, not the medical treatment. No contrary evidence was provided, proving that Dr. Amit Singh was capable of treating the patient.

National Commission's Observations

The National Commission reviewed the competency of the doctor assigned to the ICU, finding that an MD in Medicine is sufficiently qualified for ICU duties without additional intensive care training. The commission noted that the patient's medical history was accurately recorded upon admission. The hospital's explanations for the treatment administration and informed consent were deemed satisfactory, with no evidence of negligence. The commission found that the patient's vital signs were monitored appropriately and remained within acceptable ranges during treatment. Ultimately, the commission concluded that the hospital provided adequate care and found no deficiency in service.

The court ultimately dismissed the complaint, citing the lack of evidence for medical negligence, and the Medical Board's conclusion that the treatment was appropriate. The family's allegations of improper care and insufficient involvement of senior doctors were unproven.

- **This judgment reinforces that doctors with an MD in Medicine are deemed qualified to manage ICU patients without needing additional intensive care training.**
- **EDPA urges its members to maintain proper documentation and adherence to standard medical procedures in defending against claims of medical negligence.**

7. Sharing images or videos of patients on social media- Think twice!

Article contributed by Dr PN Chaudhary

We often share patient images within our medical colleagues as part of teaching and learning from peers. The sharing of these images is done with the right intent and purely for academic interest, however, this case highlights the critical importance of maintaining patient privacy and dignity. Medical professionals, especially young doctors, must prioritize ethical standards, stay updated on legal frameworks surrounding medical confidentiality, and be vigilant when using technology in clinical practice. It's essential to strike a balance between educational value and the responsibility to safeguard patient rights

Case Summary: Sunil P P v. State of Kerala

In this case, the Kerala High Court dismissed a petition filed by a doctor (an anaesthesiologist) and a hospital staff member, seeking to quash criminal proceedings against them for allegedly recording and sharing videos and images of a woman undergoing a caesarean section through WhatsApp. The case involved serious charges under Indian law, specifically:

- **Section 354(C) of IPC (Voyeurism)**
- **Sections 66(E) (Violation of Privacy) and 67 (Publishing or transmitting obscene material in electronic form) of the Information Technology Act**.

The incident occurred in 2014 at the Government Taluk Hospital, Payyannur, in Kerala's Kannur district, where the woman had delivered triplets via caesarean section. The specific accusation against the petitioners was that they took unauthorized images and videos of the procedure and shared them on WhatsApp.

The petitioners argued that the identity of the woman (defacto complainant) could not be established from the images, and hence, sought to dismiss the case. However, the court found a **prima facie** case against them, based on evidence collected during the investigation, including videos and photographs from their mobile phones.

Court's Observations:

- The Court, presided over by **Justice A. Badharudeen**, found that there were serious allegations against the accused, making out a **prima facie** case.
- The Court emphasized that the **matter must go to trial**, and the quashing of proceedings could not be justified in such a serious case.

- Petitioners' claim of not being able to identify the complainant through images was not sufficient to dismiss the case, as the unauthorized sharing of sensitive material was a clear violation of privacy. The petition was, therefore, **dismissed**, and the case proceeded to trial.

Learnings for EDPA members as well as Young Doctors:

1. **Confidentiality and Patient Privacy:**
    - Doctors have a legal and ethical responsibility to **maintain patient confidentiality**. Unauthorized recording, sharing, or disclosure of sensitive medical procedures without explicit consent can result in criminal prosecution.
    - Always ensure that patient consent is obtained in writing if any kind of recording (photography, videography) is necessary for educational or medical purposes.
2. **Respect for Patients' Dignity:**
    - Recording intimate or sensitive medical procedures, especially during childbirth or surgery, can be seen as an invasion of privacy and **violation of patient dignity**. Such actions may lead to charges under **voyeurism laws**.
    - Maintain professional boundaries; prioritize patient's modesty during all interactions.
3. **Legal Implications of Data Sharing:**
    - Sharing any medical data, images, or videos, even with colleagues, through personal devices or social media platforms like WhatsApp, **without patient consent**, can lead to charges under the **Information Technology Act** and other relevant laws.
    - Hospitals should establish strict **policies for handling sensitive patient data**, including guidelines on how images, videos, and other media can be used and shared.
4. **Be Aware of Cyber Laws:**
    - With the increasing use of digital tools in healthcare, it is crucial to be well-versed in **cyber laws** such as the **Information Technology Act**, which regulates the transmission of electronic data, especially when it concerns personal and sensitive information.
5. **Professional Conduct in the Digital Age:**
    - Young doctors should be aware of how their actions in the digital realm (e.g., sharing patient images or videos) can have **severe professional and legal consequences**. Carelessness in handling digital data can lead to loss of medical licenses, criminal charges, and tarnished reputations.
    - Hospitals should provide **training on digital ethics** and the proper use of technology to ensure that healthcare professionals understand the risks involved.
6. **Avoiding Legal Repercussions:**
    - In the event of a legal issue, doctors should be fully aware of the potential consequences and be prepared to face trial if a **prima facie** case is made. Avoid engaging in any activity that could jeopardize your career, even if it seems harmless at the moment.

8. Can Doctors as ‘professionals’ be exempted from Consumer Law? Making a case from the advocates’ case.

Article contributed by Dr Gaurav Agarwal

In May 2024, the Supreme Court of India ruled that advocates are not liable under the Consumer Protection Act (CPA), 2019, for claims of "deficiency of service." The Court determined that legal services provided by advocates fall under a "contract of personal service," which exempts them from the CPA. The reasoning behind this decision is that the legal profession is unique, and the relationship between advocates and clients does not align with commercial service providers like businesses or tradespeople.

Significantly, the bench suggested that the 1995 *Indian Medical Association (IMA) v. V.P. Shantha* ruling, which brought doctors and healthcare services under the CPA's purview, should be reconsidered. The IMA case previously held that medical services, unless provided for free or under a strict employer-employee contract, are subject to CPA claims. The Court hinted that, medical professionals, like lawyers, might also be excluded from the CPA's scope, given the special nature of their work.

Following this judgment, the Indian Medical Association (IMA) has considered filing a review petition to seek the exemption of doctors from CPA liability. The IMA is planning to engage senior advocates, including Mr. Harish Salve, to represent their case in the Supreme Court, as it could have profound implications on how medical negligence cases are handled under consumer law.

The courts statement reflects a shift change in the legal interpretation of whether professionals like doctors and lawyers should be included under the CPA. While the earlier decision expanded the CP Act’s scope to cover doctors and hospitals, this judgment redefines this, challenging the inclusion of professionals within the consumer framework. The objective remains to balance consumer protection and professional accountability by clarifying the Act's applicability to service-related deficiencies.

Learnings for Young Doctors:

1. **Professional Conduct**: Even as advocacy progresses for exemption from consumer liability, maintaining a professional, ethical practice will continue to be critical.
2. **Professional Accountability**: Despite potential changes in legal liabilities, doctors must maintain high standards of care, as negligence can lead to civil and criminal liabilities outside of CPA, such as through medical councils.

3. **Ethical Boundaries**: The relationship between doctors and patients is based on trust. Any negligence or breach can be damaging to both the patient and the doctor's career, irrespective of CPA involvement.
4. **Legal Awareness**: Staying informed about evolving legal frameworks, especially regarding malpractice, is crucial. Doctors should be aware of their rights and responsibilities under consumer and professional laws.

9. "Costly Cardiac Call!"

Article contributed by Dr Anupam Singh

In a recent judgment, the National Consumer Disputes Redressal Commission (NCDRC) directed Fortis Escorts Heart Institute in Delhi and its head of cardiology, Dr. Ashok Seth, to pay ₹65 lakh in compensation to the family of a 62-year-old man who was left partially paralyzed following what was deemed an "unnecessary elective angioplasty." The commission found that Dr. Seth, a nationally renowned interventional cardiologist had 'disregarded the patient's pre-existing lung condition' and proceeded with a procedure that was "non-essential" at the time, leading to permanent brain damage (haemorrhagic stroke) and leaving the patient in a vegetative state. The compensation took into account the patient's lost income, medical costs, and the family's suffering.

The complaint, filed by the patient's wife in 2012, accused the hospital and doctor of gross negligence during the angioplasty. The hospital argued that both the patient and his daughter, who were doctors, had given informed consent and insisted on the procedure being performed the same day. They denied any negligence.

Despite this defence, the NCDRC ruled in favour of the complainant after reviewing the evidence. It concluded that the hospital and Dr. Seth had ignored the patient's lung condition (TB) and proceeded with

the angioplasty, resulting in severe complications, including pulmonary oedema within 30 minutes of the procedure. The commission held both the hospital and the doctor responsible for the patient's condition and ruled that informed consent did not absolve them of negligence in this case. (https://timesofindia.indiatimes.com/city/delhi/patient-awarded-65l-for-medical-negligence-by-hospital/articleshow/112434773.cms.)

Implications and Learnings for EDPA Doctors:

We as doctors know that the overall risk of complications during any diagnostic procedures remains relatively low, ranging between 1-2%. However, this risk can increase significantly during complex cardiac interventional procedures. Although rare, haemorrhagic or embolic stroke in these settings can lead to significant complications, including high morbidity and mortality rates. The likelihood of these complications is elevated in patients with extensive atherosclerosis in the aorta or aortic arch, complex anatomical features, or in cases where multiple catheter exchanges, excessive manipulation, large-bore catheters, or stiff wires are required.

Despite our knowledge, there are several learnings for us in this case:

1. **Importance of Medical Judgment**: Even when patients provide informed consent, it is essential for doctors to exercise careful judgment regarding the necessity of procedures. Elective surgeries should only be performed when absolutely warranted.
2. **Accountability**: Hospitals and individual practitioners can be held jointly liable for adverse outcomes resulting from negligent medical care. This case highlights the necessity of being meticulous in both medical decisions and procedural execution.
3. **Consumer Protection Awareness**: Medical professionals must understand that they are subject to consumer protection laws. In cases of perceived negligence, patients have the right to seek legal recourse, and substantial compensation may be awarded.
4. **Clear Communication**: Doctors must ensure that patients are fully informed of all risks and alternative treatment options in a transparent manner, without undue influence, even when dealing with fellow medical professionals.

10. Tragedy at R.G. Kar Hospital: A Call for Justice & Safety in Healthcare

Article contributed by Dr Rajeev Bansal

On August 9, 2024, a most tragic and dastardly incident occurred at R.G. Kar Medical College and Hospital in Kolkata, where a 31-year-old female postgraduate trainee doctor on hospital duty was brutally raped and murdered by a man who was also a civic volunteer in the hospital. The victim's semi-nude, seemingly tortured and battered body was discovered in a seminar hall, raising suspicions of institutional negligence and mishandling of the case. Initial reports pointed to possible deliberate delays in investigation, with the family alleging that the hospital tried to label the incident as a suicide.

Large scape protests erupted nationwide and continued across Aug and Sep, disrupting medical services, as junior doctors / medical professionals demanded justice and improved safety for healthcare staff.

Sanjoy Roy, a civic volunteer with prior access to the hospital and a history of violent behaviour, was arrested in connection with the crime. The Central Bureau of Investigation (CBI) took over the investigation after concerns were raised about evidence tampering by local authorities. This case has prompted widespread outrage across India, with the Supreme Court stepping in to ensure a proper inquiry and workplace safety for medical professionals.

Recommendations for Hospital Safety:

1. **Enhanced Security Systems**: Install CCTV cameras in all critical areas, including seminar halls, restrooms, and secluded parts of the hospital. Regular surveillance checks are essential to ensure functionality.
2. **Access Control**: Implement strict ID-based access for all hospital areas, especially for non-medical personnel. This should include biometric or electronic card access to sensitive zones.
3. **Security Personnel**: Hire trained and vetted security officers. Their role should include routine patrols, monitoring of access points, and swift action during suspicious activities.
4. **24/7 Helpline for Staff**: A dedicated helpline for doctors and staff to report safety concerns in real-time.
5. **Awareness Programs**: Organize regular awareness programs for hospital staff on security protocols, self-defence, and managing hostile situations.

Recommendations for young drs to Avoid Aggressive Situations in Hospitals:

1. **Effective Communication**: Clear and compassionate communication with patients and their families about the patient's condition can help mitigate anxiety and prevent escalation.
    1. Always communicate clearly and empathetically with patients and their families. Provide regular updates regarding the patient's condition to prevent misunderstandings.
    2. Ensure the family is informed about treatment progress, risks, and expected outcomes to avoid confusion and unrealistic expectations
2. **Training in Conflict Resolution**: Doctors should undergo training in handling difficult conversations, managing patient expectations, and de-escalating tense situations.

3. **Engage in Shared Decision-Making**:
    1. Involve the patient and their families in the decision-making process regarding treatment plans to make them feel heard and respected.
    2. Be transparent about the limitations and risks of treatment.
4. **Involving Support Systems**: In the event of a patient's worsening condition, involve senior staff, counsellors, or patient relations personnel to address family concerns.
5. **De-escalation Techniques**:
    1. In case of an agitated patient or family member, remain calm and composed. Avoid engaging in arguments or defensive behaviour.
    2. Seek help from hospital security or senior staff if a situation begins to escalate
6. **Proactive Measures**: Set up security teams to respond swiftly in case of threats or aggressive behaviour from patients' families.
7. **Document Everything**:
    1. Keep thorough records of all communications with patients and their families. This can be crucial in case of disputes or legal actions.
8. **Know When to Seek Help**:
    1. In high-tension situations, it is essential to recognize the signs of potential violence and call for assistance, either from colleagues or hospital security.
9. **Emotional Support for Doctors**: Establish peer or professional support systems to help doctors manage the emotional toll of confrontations with agitated families.

The East Delhi Physician Association (EDPA) joined the nationwide protest by the medical community, keeping clinics and hospitals closed for OPD services and elective procedures for 24 hours, from 6:00 AM on August 17 to 6:00 AM on August 18.

Dr PN Chaudhary and Dr Gaurav Agarwal participated and shared their suggestions in a debate on the matter in a national wide telecast on a national TV channel.

- **Implementing the above measures can help safeguard EDPA doctors and healthcare staff, reduce the risk of violence, and ensure that patient care remains the primary focus in a safe working environment.**
- **This incident underscores the urgent need for comprehensive safety measures and institutional reforms to ensure the protection and well-being of healthcare professionals within EDPA.**

11. “Handling Violence Against Doctors”. Time for a Standard Operating Procedure (SOP) within EDPA

Article contributed by Dr RPS Makkar

The rise in violence against doctors in India has become a serious concern. It is crucial that a Standard Operating Procedure (SOP) is established for EDPA members to manage such aggressive situations effectively. The East Delhi Physician Association (EDPA) is committed to ensuring the safety and security of all its members. ON behalf of EDPA Executive team, here’s a suggested SOP that can provide broad guidelines and support to doctors in these circumstances, ensuring their safety and well-being in the unfortunate event of violence or threats against a member by a patient or their family. The following broad SOP is suggested and can be expanded to provide a structured response and safeguard the physician.

1. Immediate Response: SOS Call System

- **Emergency SOS Contact**: An emergency hotline should be established for members to call in case of violence or threats. This hotline should be available 24/7, though this may be not easy.
- **Activation of SOS Alert**: Upon receiving an SOS call, an automated alert should be sent to:
    - EDPA crisis management team
    - Local police station SHO
    - Legal advisor of EDPA
- **Alert EDPA Members**: An internal alert should be sent to members in the vicinity to stay vigilant and offer assistance if possible.

2. Secure the Member’s Safety

- **Evacuation Plan**: If the situation escalates to physical violence, the priority is to secure the member's safety. All EDPA-affiliated clinics and hospitals should have an emergency evacuation plan.
- **Safe Room**: EDPA should coordinate with hospitals and clinics to ensure there is a safe room where the physician can retreat in case of an attack.

3. Report Incident to Authorities

- **File an FIR**:
    - EDPA should establish a protocol to file an FIR (First Information Report) promptly.
    - Designated legal representatives or liaisons should assist the member in drafting and filing the FIR to ensure accurate documentation.
- **Direct Connect with Local SHO**:

- A direct hotline should be established with the local police station SHO, who can be alerted about the incident immediately.
- EDPA should maintain a good relationship with local law enforcement to ensure prompt response in case of member emergencies.

4. Internal EDPA Reporting

- **Incident Reporting Form**: A standard incident reporting form should be created for members to document the violence. This report should include:
  - Time and location of the incident
  - Names and details of individuals involved
  - A brief description of the situation
  - Evidence (if available)
- **Investigation and Legal Support**: EDPA should assign a crisis response team to investigate the reported case. Legal and counselling support will be provided to the victimized member.

5. Emergency Drills and Preparedness

- **Routine Drills**: EDPA should organize regular safety drills at hospitals and clinics to familiarize staff and members with safety protocols in case of violence.
- **Security Training**: EDPA Members and clinic staff should undergo training on de-escalation techniques and handling hostile situations.
- **Mock Drills**: Every 6 months, a mock emergency drill should be conducted in collaboration with local police authorities to ensure all parties are prepared for emergencies.

6. Legal and Counselling Support

- **Legal Assistance**: EDPA should provide access to legal counsel to guide the member in filing police complaints, protecting their rights, and managing legal follow-ups.
- **Counselling Services**: Members who have faced violence should be provided access to professional counselling and psychological support to manage trauma.

7. Coordination with Hospitals and Clinics

- **Hospital Security Collaboration**: EDPA should collaborate with hospitals and clinics to ensure proper security protocols are in place, including CCTV surveillance, security personnel, and restricted access to high-risk areas.
- **Incident Escalation Protocol**: Clinics must have a predefined escalation protocol in the event of violence, involving both internal security teams and law enforcement.

8. Public Awareness and Prevention

- **Zero Tolerance Policy**: EDPA should launch a public campaign outlining a zero-tolerance policy for violence against healthcare workers.
- **Educate Patients and Families**: Clinics should display posters and notices informing patients and their families about respectful conduct and legal consequences of violence against healthcare staff.
- **Grievance Redressal Mechanism**: Establish a patient-physician grievance redressal mechanism to address concerns before they escalate to violence.

9. Post-Incident Follow-Up

- **Ongoing Support**: EDPA should continue to provide support to members even after the incident is resolved, ensuring follow-ups with law enforcement and legal proceedings.
- **Review and Feedback**: A review of the incident should be conducted to assess the response and identify any areas for improvement in the SOP.

10. Communication and Coordination

- **Emergency Contact List**: A directory of local police stations, legal advisors, and crisis management contacts should be shared with all EDPA members.
- **WhatsApp Group for Rapid Coordination**: An exclusive EDPA member WhatsApp group should be created for rapid coordination and alerts during emergencies.

11. Ethical Leadership:

- Hospital administrators and senior medical staff play a crucial role in setting the tone for ethical conduct within healthcare organizations. They should lead by example, promote a culture of integrity, and take swift action against any instances of misconduct.

- **By establishing this SOP, EDPA can ensure that members are prepared to handle any violent incidents, with adequate support from law enforcement, legal teams, and fellow physicians.**
- **The priority remains to secure the safety and well-being of all members and provide a structured, efficient response in case of emergencies.**

12. Provisions Against Violence Towards Doctors under the new Bhartiya Nyaya Sanhita Act, 2023

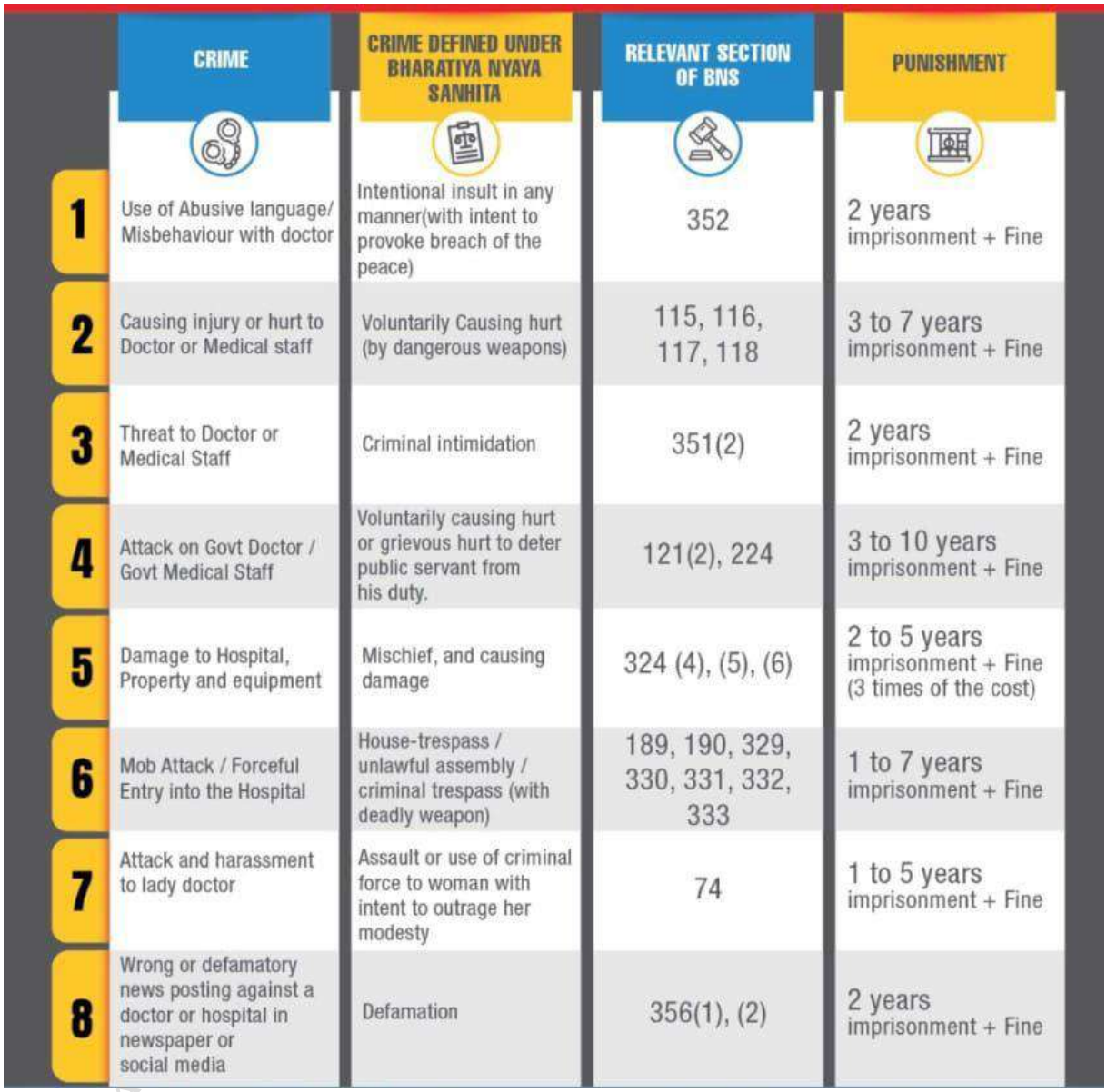
Article contributed by Dr Vijay Arora

The **Bhartiya Nyaya Sanhita (BNS) Act, 2023** includes specific provisions regarding crimes and violence against healthcare professionals, including doctors. Here are the key aspects of the BNS regarding violence against doctors:

1. **Definition of Violence Against Healthcare Workers**:
    - The BNS defines violence against healthcare professionals in clear terms, categorizing it as any act of physical harm, threats, or intimidation directed towards them while they perform their duties.
2. **Increased Penalties**:
    - The law proposes stringent penalties for individuals committing violence against healthcare personnel. This includes:
        - **Imprisonment**: The act stipulates imprisonment for up to 7 years for serious offenses against doctors and healthcare workers.
        - **Fines**: Monetary penalties are also included, enhancing the deterrent effect.
3. **Specific Offenses**:
    - The law outlines specific offenses related to violence against healthcare workers, including:
        - Physical assault,
        - Verbal abuse,
        - Intimidation, and
        - Damage to property in healthcare settings.
4. **Fast-Track Courts**:
    - To ensure speedy justice for healthcare professionals, the BNS proposes the establishment of fast-track courts to handle cases of violence against them. This aims to reduce delays in legal proceedings and provide timely resolution.
5. **Grievance Redressal Mechanism**:
    - Similar to the earlier BNS Law, the new act emphasizes the need for an effective grievance redressal mechanism to address complaints from healthcare workers and ensure their safety.
6. **Awareness and Training**:
    - The BNS emphasizes the importance of creating awareness among the public regarding the rights of healthcare professionals and the consequences of violence against them.
7. **State Responsibilities**:

- The act places the onus on state governments to provide a safe working environment for healthcare workers, ensuring that they can perform their duties without fear of violence or harassment.

For a quick summary, below is a simple graphic that would help EDPA members to know their rights in cases of violence against doctors.



	CRIME	CRIME DEFINED UNDER BHARATIYA NYAYA SANHITA	RELEVANT SECTION OF BNS	PUNISHMENT
1	Use of Abusive language/ Misbehaviour with doctor	Intentional insult in any manner(with intent to provoke breach of the peace)	352	2 years imprisonment + Fine
2	Causing injury or hurt to Doctor or Medical staff	Voluntarily Causing hurt (by dangerous weapons)	115, 116, 117, 118	3 to 7 years imprisonment + Fine
3	Threat to Doctor or Medical Staff	Criminal intimidation	351(2)	2 years imprisonment + Fine
4	Attack on Govt Doctor / Govt Medical Staff	Voluntarily causing hurt or grievous hurt to deter public servant from his duty.	121(2), 224	3 to 10 years imprisonment + Fine
5	Damage to Hospital, Property and equipment	Mischief, and causing damage	324 (4), (5), (6)	2 to 5 years imprisonment + Fine (3 times of the cost)
6	Mob Attack / Forceful Entry into the Hospital	House-trespass / unlawful assembly / criminal trespass (with deadly weapon)	189, 190, 329, 330, 331, 332, 333	1 to 7 years imprisonment + Fine
7	Attack and harassment to lady doctor	Assault or use of criminal force to woman with intent to outrage her modesty	74	1 to 5 years imprisonment + Fine
8	Wrong or defamatory news posting against a doctor or hospital in newspaper or social media	Defamation	356(1), (2)	2 years imprisonment + Fine

Overall, the Bhartiya Nyaya Sanhita Act, 2023, aims to provide a more robust legal framework to protect healthcare professionals from violence and ensure their dignity and safety in the workplace. The provisions reflect a growing recognition of the challenges faced by doctors and healthcare workers in India and the need for protective measures. It is advised for EDPA members to be familiar with the provisions.

13. EDPA monthly CMEs & case presentations: July- Sep 2024

Compiled by EDPA members- Dr Anindya Biswas, Dr Swathi Jami, Dr Anirudh Lochan, Dr Shubha Laxmi

Case 1. (10th July 2024)

Title: A case of Paraparesis

Presented by: Dr Jay Patel, Resident (under Guidance of **Prof (Dr) Ashok Kumar**, Professor and Head Department of Medicine, Santosh Medial college and Hospital, Ghaziabad)

Case Summary:
20-Year-Old Female

Chief Complaints:
- High-grade fever (10 days)
- Vomiting (10 days)
- Loose stools (9 days)
- Sudden onset lower limb weakness and pain (1 day)

Present Illness History:
- **Fever:** Sudden onset, intermittent, peaking at 102°F, associated with chills, relieved by antipyretics.
- **Vomiting:** 4-5 episodes/day, non-bloody, non-foul-smelling, yellowish, watery, with food particles. No aggravating or relieving factors.
- **Loose stools:** 2-3 episodes/day, watery, yellowish, foul-smelling, non-bloody, no specific triggers.
- **Lower Limb Weakness and Pain:** Began after fever subsided, with bilateral weakness starting from the feet and progressing towards the thighs. The patient became unable to bear weight or walk independently.

Symptoms persisted despite initial treatment from a local practitioner. The patient presented to Santosh Hospital on March 12th in a wheelchair, with both lower limbs affected and worsened motor function.

Negative History:

No bladder/bowel incontinence, upper limb involvement, or diurnal variation in symptoms.
No history of hypertension, diabetes, thyroid disorder, or trauma.

Past History:

Abdominal Koch's 1.5 years ago, self-discontinued anti-tuberculosis treatment (ATT) after 6 months.

Differential Diagnosis:

1. **Hypokalemic periodic paralysis**
2. **Guillain-Barré Syndrome (GBS)**
3. **Transverse myelitis**
4. **Compressive myelopathy** (due to possible intramedullary tuberculoma)

General Physical Examination:

- Conscious, oriented, average build
- No pallor, icterus, cyanosis, clubbing, or lymphadenopathy
- Vital signs stable (Pulse: 89 bpm, BP: 118/68 mmHg, Respiratory Rate: 16/min, SpO2: 99% on room air)
- No significant neurocutaneous markers

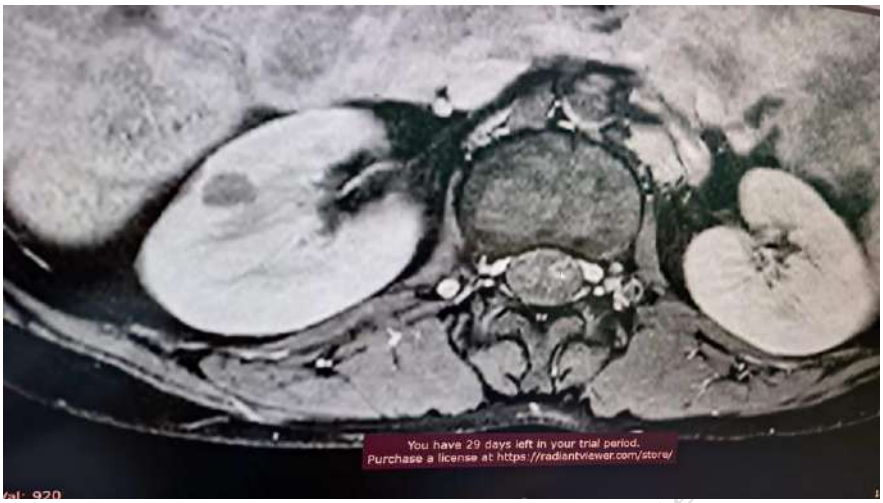
Neurological Examination:

- **Higher Mental Function:** Conscious, oriented, normal memory and speech.
- **Cranial Nerves:** Intact.
- **Motor System:**
  - **Tone:** Upper limbs normal, lower limbs flaccid bilaterally.
  - **Power:** UL: 5/5, LL: 1/5.
  - **Reflexes:** Superficial reflexes present; deep reflexes absent.
- **Sensory System:** Loss of crude touch, pain, and temperature in lower limbs, normal vibration sense.
- **Gait:** Waddling type.
- **Autonomic System:** No bladder/bowel incontinence or autonomic disturbances.

Investigations:

- **CBC, LFT, KFT**: Normal.
- **Ultrasound (Whole Abdomen):** Enlarged mesenteric lymph nodes, mild hepatomegaly, splenomegaly, and minimal ascites.
- **MRI (Spine):** Intramedullary tuberculoma at L1 level confirmed by contrast-enhanced MRI.

- The axial T2-weighted thoracic MRI confirmed an intramedullary hypo intense lesion with peripheral enhancement.



Final Diagnosis:

- Acute onset flaccid paraparesis (LMN type) due to compressive myelopathy, likely caused by intramedullary tuberculoma at the L1 level in a patient with a history of Abdominal Koch's.

Treatment and Outcome:

- Patient was started on steroid therapy (Solumedrol) and anti-tuberculosis treatment (ATT).
- Slight improvement noted after 5 days of treatment, with the patient able to walk with support. Discharged on oral steroids (Omnacortil) in tapering doses.

Follow-Up: Continued monitoring and adjustment of ATT and steroid regimen for long-term management

---

Case 2. 10th July

Title: An unusual case of acute viral hepatitis

Presented by: Dr Divya Darpan

Moderator: Dr Vandana Garg

Chairs: Dr PN Chaudhary, Dr Namita Kaul, Dr Pabitra Sahu

Abstract:

Hepatitis A virus (HAV) infection leads to acute inflammatory liver damage. The virus typically incubates for 28 days (range: 15–50 days) and primarily affects the liver, causing hepatocellular damage. Age influences the severity, though the disease is usually self-limiting and does not lead to chronic liver disease. HAV is a single-stranded RNA virus without an envelope. Clinical symptoms of Hepatitis A often present abruptly, including anorexia, nausea, vomiting, abdominal pain, fever, and jaundice. Hepatomegaly and tenderness are common, with bilirubin levels peaking later and declining slower than aminotransferases. In most cases (≈85%), jaundice resolves within weeks.

Case Summary:

A 26-year-old female from Sector 5, Vaishali, working at an MNC, presented to the emergency department of Max Vaishali Hospital on June 7, 2024, with complaints of high-grade fever, vomiting, and abdominal pain for the past two days.

Past Medical History:

- Pulmonary Koch's disease at age 16, treated empirically.

Current Illness:

- The patient began experiencing yellowish discoloration of the body and yellow-coloured urine the day after initial symptoms appeared.
- Hepatitis A was suspected, and serological tests confirmed HAV IgM positivity.
- She subsequently developed burning micturition on the third day of illness, diagnosed as urinary tract infection (UTI) with Enterococcus faecalis, sensitive to Linezolid.

- By the fourth day, her oral intake decreased, and vomiting increased in intensity, with aminotransferases and bilirubin following typical trends of Hepatitis A.

Complication: Opsoclonus Myoclonus Syndrome (OMS)

- After receiving Perinorm (metoclopramide) for vomiting, the patient developed opsoclonus myoclonus in both eyes along with tremulousness of the limbs. She was transferred to the ICU for further management.
- Despite treatment with Promethazine (25 mg, thrice daily) and Trihexyphenidyl (2 mg, thrice daily), there was no satisfactory response, suggesting the condition was not drug-induced EPS.
- Further workup for Wilson's disease returned negative results.

Diagnostic Workup:

- EEG and MRI brain were normal.
- A lumbar puncture was performed, and the autoimmune encephalitis panel was negative.
- Opsoclonus myoclonus gradually improved over the following days.
- The patient was evaluated for orthostatic hypotension due to persistent giddiness and was noted to have an ataxic gait.
- A repeat MRI brain was performed, which again showed no abnormalities.
- Her bilirubin levels peaked at 9 mg/dL before discharge, and liver function tests (LFTs) showed a cholestatic pattern consistent with hepatitis A.

Final Diagnosis:

- Complicated viral Hepatitis A with Opsoclonus Myoclonus Ataxia Syndrome (OMAS).
- The potential causes of OMAS include:
    - Hepatitis A Virus (HAV).
    - Drug-induced reaction, although this was deemed unlikely after treatment trials.

Treatment and Outcome:

- The patient was treated with corticosteroids and supportive care.
- Opsoclonus persisted but improved with time.
- The patient was discharged on the 14th day with a provisional diagnosis of Opsoclonus Myoclonus Ataxia Syndrome, secondary to viral hepatitis A.

Discussion:

Opsoclonus Myoclonus Syndrome (OMS) is a rare neuroinflammatory disorder characterized by rapid, involuntary eye movements (opsoclonus), myoclonic jerks, and ataxia. OMS is often linked to autoimmune responses, potentially triggered by viral infections, paraneoplastic syndromes, or idiopathic causes. In children, it is most commonly associated with neuroblastoma. In adults, it can be linked to autoimmune diseases or post-infectious syndromes. In this case, the patient's OMS likely resulted from hepatitis A, though drug-induced causes were considered.

Early diagnosis and management are critical to improving outcomes in OMS. Treatment typically involves immunotherapy, corticosteroids, and symptom control. For viral-induced OMS, resolving the underlying infection may lead to gradual improvement in neurological symptoms.

Conclusion:

Opsoclonus Myoclonus Syndrome (OMS) is a rare, potentially debilitating neurological condition characterized by involuntary eye movements, muscle jerks, and ataxia. This case highlights OMS as a rare complication of Hepatitis A virus infection. While OMS can be associated with malignancies or autoimmune disorders, viral infections such as Hepatitis A can also serve as a trigger. Early diagnosis, symptom management, and treatment of the underlying cause are essential for improving the quality of life in affected individuals**.**

References:

1. McIntyre, N. (1990). Clinical presentation of acute viral hepatitis. *British Medical Bulletin*, 46(2), 533-547.
2. Koff, R. S. (1992). Clinical manifestations and diagnosis of hepatitis A virus infection. *Vaccine*, 10, S15-S17.
3. Jeong, S. H., & Lee, H. S. (2010). Hepatitis A: clinical manifestations and management. *Intervirology*, 53(1), 15-19.
4. Pyrsopoulos, N. T., & Reddy, K. R. (2001). Extrahepatic manifestations of chronic viral hepatitis. *Current Gastroenterology Reports*, 3, 71-78.
5. Jacobson, I. M., Gang, D. L., & Schapiro, R. H. (1984). Epstein-Barr viral hepatitis: an unusual case and review of the literature. *American Journal of Gastroenterology*.
6. Gordon, S. C., Reddy, K. R., Schiff, L., & Schiff, E. R. (1984). Prolonged intrahepatic cholestasis secondary to acute hepatitis A. *Annals of Internal Medicine*, 101(5), 635-637.
7. Czaja, A. J. (2013). Acute and acute severe (fulminant) autoimmune hepatitis. *Digestive Diseases and Sciences*, 58, 897-914.
8. Boyer, J. L., & Klatskin, G. (1970). Pattern of necrosis in acute viral hepatitis. New England Journal of Medicine, 283(20), 1063-1071
9. Boyer, J. L., & Klatskin, G. (1970). Pattern of necrosis in acute viral hepatitis: Prognostic value of bridging (subacute hepatic necrosis). NewEnglandJournal of Medicine, 283(20), 1063-1071.
10. Bianchi, L. (1983). Liver biopsy interpretation in hepatitis: Part II: histopathology and classification of acute and chronic viral hepatitis/differential diagnosis. Pathology-Research and Practice, 178(2), 180- 213.
11. Aggarwal, R. (2011). Clinical presentation of hepatitis E. Virus research, 161(1), 15-22.
12. Samanta, T., Das, A. K., & Ganguly, S. (2010). Profile of hepatitis A infection with atypical manifestations in children. Indian Journal of Gastroenterology, 29, 37-39.
13. Hoofnagle, J. H., & Di Bisceglie, A. M. (1991, May). Serologic diagnosis of acute and chronic viral hepatitis. In Seminars in liver disease (Vol. 11, No. 02, pp. 73-83). © 1991 by Thieme Medical Publishers, Inc

Case 3: 10th Aug

Title: A TALE OF TRIADS OF TERRIBLE TUMOR: VHL

Presented by: Dr Setu Gupta

Case contributors:
Dr Karan Pokharel (Clinical Fellow, Department of Endocrinology, Sir GangaRam Hospital)
Dr Setu Gupta (Associate Professor, Department of Endocrinology, Sir GangaRam Hospital)

Chairs: Dr Niti Agarwal, Dr Himanshu Sharma

INTRODUCTION

Von Hippel-Lindau disease is an Autosomal dominant syndrome characterized by formation of tumours in different organs of body including CNS, retina, adrenal glands, kidneys and endolymphatic sac. Pheochromocytoma is a rare NET of adrenal that occurs sporadically or as a part of an inherited syndrome. Incidence is 10-20%, making it second most common tumour associated with VHL.

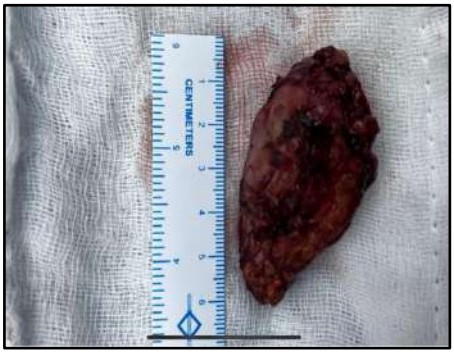
CASE SUMMARY

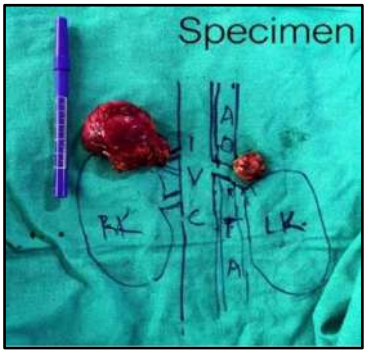
We reported three cases of VHL revealed by pheochromocytoma at different age 19, 16 and 36 years old of the same family.

Index Case 9-year-old boy presented with headache for 1.5 months and found to be hypertensive, 140/100 mm hg on both upper limbs on more than 3 occasions. He was evaluated for young onset HTN. Following the reports his Urine NorMetanephrine was raised and on CT abdomen he was found to have Left sided adrenal mass. Patient was referred to a Urologist and underwent Lap Adrenalectomy and was advised for whole exome sequencing which found to be heterozygous for c>500G>A (p.ARG167Gln) in exon 3 of VHL gene.

Age/Sex	Baseline Bp Pre/post (mmhg)	Urine Nor metanephrine mcg/24hrs (pre/post operation)	CT Abdomen	DOTANOC PET Scan
9yrs/M	140/100 116/80	3960/225	Left adrenal mass (4.4 X 3.2 X2.4)	
14yrs/F	140/85 130/80	589.10/160	B/L adrenal mass RT: 4.5 X 4.4 X 4.2 cm Lt: 9.8 X6.1 mm	Post-surgery: non visualization of previous lesion on B/L adrenal gland on CT abdomen.
36yrs/F	145/90 130/85	1458.4/280	Right adrenal mass (3cm X 1.2 cm)	Bilateral adrenal mass (right:3.7cm X 2.3cm X 1.6 cm and left 1.2cm X 1.1cm X 1.2)

Subsequently his sister and mother were genetically screened and were found to have genetic mutation for VHL.





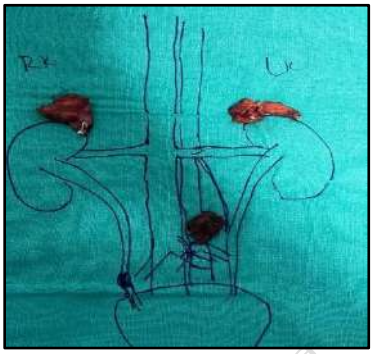


Figure 1: Left adrenal mass of index case.

Figure 2: B/L Adrenal mass of sister(14yr)

Figure 3: B/L adrenal mass/paraaortic lymph nodes of mother.

COURSE OF TREATMENT:

The Index case underwent unilateral adrenalectomy, sister for one and half adrenalectomy and mother underwent bilateral adrenalectomy. Postoperatively the children are having stable BP without antihypertensive whereas mother is requiring a single antihypertensive.

DIAGNOSIS:

Pheochromocytoma in a case of Von Hippel-Lindau disease.

Case 4: 10th Sep

Title: Radiologist in need is a friend indeed: A pulmonologist's view

Presented by: Dr Anirudh Lochan, Dr Tanya Garg

Chairs: Dr Anil Chaturvedi, Dr RPS Makkar

Case Summary:

Patient Presentation:

- **Patient:** Young male.
- **Symptoms:** Presented with **low grade fever** and dry **cough** x 2 months
- **Initial Treatment:** A course of oral **antibiotics** was prescribed, but the patient did not
- respond.

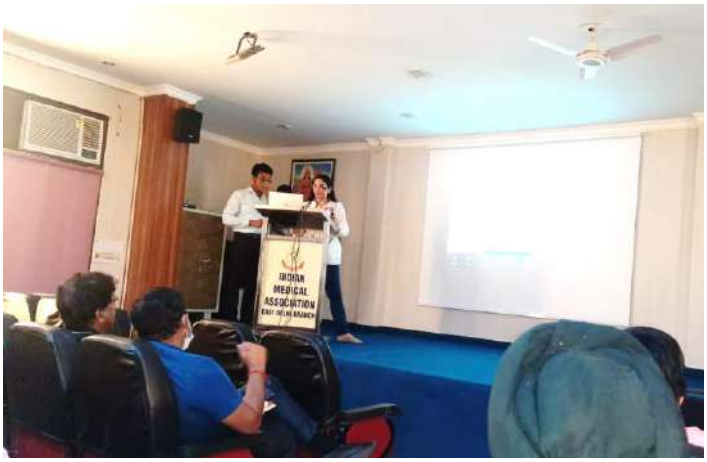
Diagnostic Findings:

- **Chest X-ray:** Showed **left-sided pneumonia** and **pleural effusion**.
- **Pleural Tap:** Performed at least 4 times over next 2-3 weeks duration but was **dry** every time (no fluid aspirated).
- **CT Scan chest:** Demonstrated left sided **consolidation** and **loculated empyema**.

Further Management:

- **Patient Refusal for Further Investigations:** The patient refused further investigations
- such as **fibreoptic bronchoscopy**, **bronchoalveolar lavage (BAL)**, and a repeat **pleural tap**.
- **Second Course of IV Antibiotics:** The patient was given another course of intravenous antibiotics but did not respond.
- **Radiologist's Comment:** Based on imaging, the radiologist suggested the possibility of a **lung abscess** with pleural **empyema**.
- **Empirical Treatment:**
  - **ATT (Antituberculosis Therapy)** was started empirically due to suspicion of **tubercular infection**.
  - **IV Metronidazole** and antibiotics were also administered.

Outcome:



- The patient **responded well** to the combined treatment, with significant improvement on the **chest X-ray** and **clinical improvement** within a week.
- The response to treatment raised the question of whether the improvement was due to **Metronidazole** or **ATT**.

Discussion:

This case presents a clinical dilemma regarding the management of a patient with non-resolving pneumonia and pleural effusion, unresponsive to standard antibiotics. The dry pleural tap and refusal for further investigations, such as bronchoscopy or pleural fluid analysis, limited diagnostic confirmation. However, based on imaging, the combination of **lung abscess** and **loculated empyema** was suspected.

Metronidazole is effective against anaerobic bacteria, which are often implicated in lung abscesses. The patient's rapid improvement after starting IV Metronidazole suggests a possible **anaerobic infection** contributing to the clinical picture.

However, the empirical initiation of **ATT** raises important questions:

- **When to Start ATT:** In regions with a high prevalence of **tuberculosis**, empirical ATT is often initiated when clinical suspicion is high, especially in cases of **non-resolving pneumonia** or **empyema** where TB is a known culprit.
- **Duration of ATT:** Whether to continue ATT in this case depends on the patient's continued response and further investigations to confirm or rule out tuberculosis.

Key Considerations:

- **Differential Diagnosis:**
    - The patient's improvement with Metronidazole suggests the possibility of an **anaerobic lung abscess**.
    - Tubercular empyema remains a concern, and empirical ATT may still be warranted.
- **Empirical ATT:** In cases where tuberculosis is a strong suspicion but not confirmed, it is common to start empirical ATT. However, further diagnostic evaluation (such as a repeat chest imaging, sputum examination for TB, or a follow-up pleural tap) is crucial for guiding whether ATT should be continued.

Recommendations:

- **Monitor Clinical Response:** If the patient continues to improve, it is reasonable to reassess the need for ongoing ATT.
- **Consider Diagnostic Confirmation:** If the patient remains stable, further diagnostic workup (such as sputum for AFB or GeneXpert, or a follow-up pleural tap) should be pursued to confirm or rule out tuberculosis.
- **Reevaluate ATT:** If tuberculosis is not confirmed and the clinical picture points more toward a bacterial abscess or anaerobic infection, **ATT may be discontinued** after careful clinical judgment

14. Doctors and Financial Wisdom: Insights from Talk by a Financial Expert (arranged by EDPA on 10th Sep)

While doctors are experts in healthcare, they often lack the expertise to manage their finances wisely, leading to missed opportunities for wealth growth. Recognizing this, the **East Delhi Physicians Association (EDPA) organized a talk on September 10th** by Nischay Jain from Addwell Health, a firm specializing in personalized wealth management.

Nischay discussed how Indian markets are evolving and emphasized the importance of asset allocation and investment management. His talk focused on helping physicians make informed decisions to grow their wealth.

Key Recommendations for EDPA Physicians to Invest Wisely:

1. **Diversified Asset Allocation**: Spread investments across various asset classes like stocks, bonds, real estate, and mutual funds to minimize risk and optimize returns.
2. **Emergency Fund**: Set aside 6-12 months' worth of living expenses in a liquid fund for financial security in case of emergencies.
3. **Long-Term Investment**: Focus on long-term goals like retirement planning through systematic investment plans (SIPs), public provident funds (PPF), and other reliable financial instruments.
4. **Consult a Financial Advisor**: Seek professional advice for personalized financial strategies aligned with individual risk tolerance and goals.
5. **Tax-Efficient Investing**: Utilize tax-saving instruments under Section 80C, and consider tax-efficient funds to maximize returns while reducing tax liabilities.

By following these recommendations, EDPA member physicians can make smarter financial decisions, ensuring steady wealth growth over time

15. Recent Advances in Lung Cancer Management: CME by EDPA and Dharamshila Hospital

The East Delhi Physicians Association (EDPA), in collaboration with Dharamshila Narayana Hospital, organized a Continuing Medical Education (CME) event on **August 13, 2024, at Park Inn Hotel, East Delhi.** The topic focused on "Recent Advances in the Management of Lung Cancer."

Speakers:

- **Dr. Shubham Garg**: Director, Surgical Oncology
- **Dr. Deni Gupta**: Senior Consultant, Medical Oncology
- **Dr. Nitin Rathi**: Senior Consultant, Pulmonology

Chairpersons:

- **Dr. Ajay Kumar Gupta**: Associate Director and HOD, Max Vaishali
- **Dr. Sameer Khatri**: Medical Oncologist, Max PPG
- **Dr. Sharada V. Kutty**: Consultant Pulmonologist, Karuna Hospital

Key Points Discussed:

1. **Early Detection**: Emphasis on screening for lung cancer in high-risk populations, particularly smokers, using **low-dose CT (LDCT)** scans. Early detection improves survival rates significantly.
2. **Advances in Treatment**: The speakers highlighted newer surgical techniques, chemotherapy protocols, and immunotherapy options available for treating lung cancer.
3. **Multidisciplinary Approach**: The importance of collaboration between pulmonologists, oncologists, and thoracic surgeons to provide personalized treatment plans for patients.

Recommendations for EDPA Members:

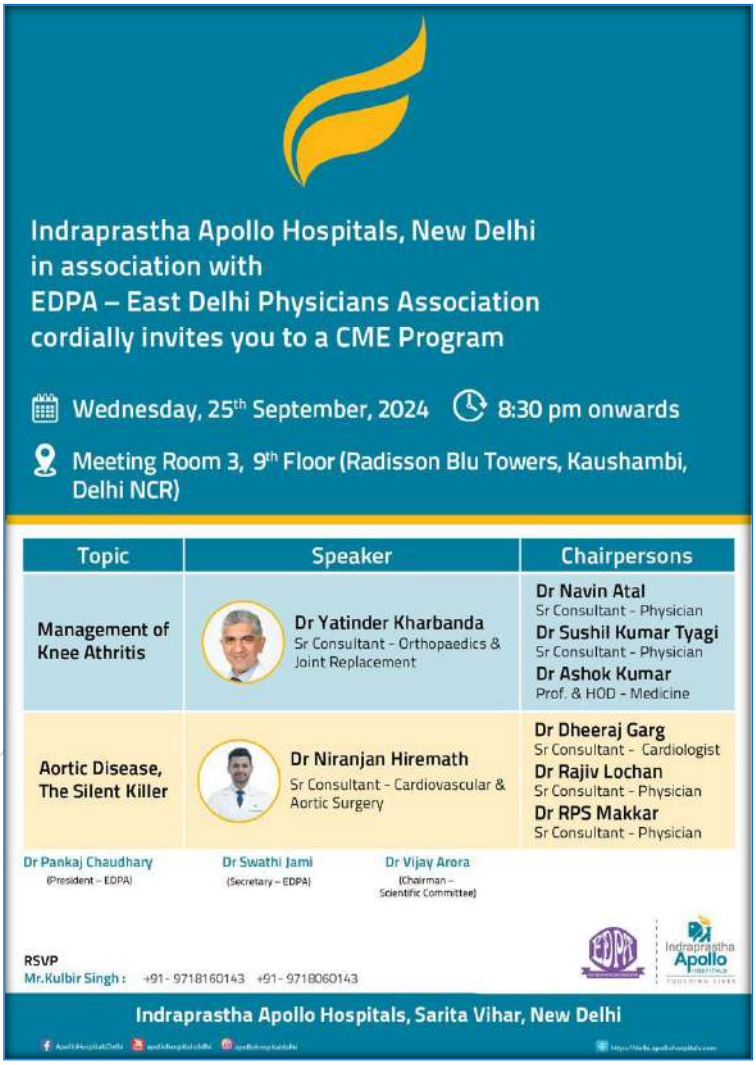
- **Identify High-Risk Patients**: Physicians should actively screen individuals with a history of smoking, exposure to environmental carcinogens, or a family history of lung cancer.
- **Referral Guidelines**: Timely referral to oncologists or pulmonologists should be made when suspicious findings like persistent cough, haemoptysis, or abnormal imaging are present.
- **Promote LDCT Screening**: Encourage the use of LDCT scans for early detection of lung cancer, as it significantly improves survival rates compared to traditional X-rays.

This CME reinforces the critical role of early screening and a coordinated team approach to treatment in improving lung cancer outcomes.

16. CME on Knee Arthritis & Aortic Diseases – organised by EDPA & Apollo Hospital, Delhi- 25th Sep, 2024

EDPA and Indraprastha Apollo Hospital teamed up for a CME on September 25, 2024, at Hotel Radisson Blu, Kaushambi. The session was packed with valuable insights from top experts.

The CME provided valuable insights into cutting-edge orthopaedic and cardiovascular interventions, enhancing clinical knowledge for EDPA members. Here's the lowdown:



1. Managing Knee Arthritis

Speaker:

Dr. Yatinder Kharbanda, Senior Consultant, Orthopaedics & Joint Replacement, Apollo Hospital, Delhi

Chaired by **EDPA members:** Dr. Navin Atal, Dr. Sushil Kumar, Dr. Ashok Kumar

- **Topic Overview**: Dr. Kharbanda focused on the management of knee arthritis, particularly the role of **Total Knee Replacement**
- **Key Points**:
  - **Indications for TKR**: Chronic pain, severe arthritis unresponsive to conservative treatments, and significant functional limitations.
  - **Complications**: Dr. Kharbanda addressed potential complications, such as infection, blood clots, implant loosening, and the importance of post-operative care.
  - **Outcomes**: The speaker highlighted the high success rate and **gratifying outcomes** of TKR in improving mobility and quality of life for patients, with appropriate patient selection and surgical technique.

2. Aortic Diseases – The Silent Killer

Speaker: Dr. Niranjan Hiremath, Senior Consultant, Cardiovascular & Aortic Surgery, Apollo Hospital, Delhi

Chaired by EDPA members: Dr. Dheeraj Garg, Dr. Rajiv Lochan, Dr. RPS Makkar

- **Topic Overview**: Dr. Hiremath presented on surgical management of **aortic diseases**, with an emphasis on aortic aneurysms and aortic valve surgeries.
- **Key Points**:
    - **Complexity of Aortic Aneurysms**: He shared his case experiences from India and abroad, explaining the challenges in diagnosing and managing these life-threatening conditions.
    - **Surgical Interventions**: He discussed advanced techniques in aortic surgeries, particularly in treating **complex aortic aneurysms** and aortic valve diseases.
    - **Life-Saving Impact**: These surgeries, though complex, are often life-saving and have revolutionized cardiovascular treatment.

Key Takeaways:

- **Knee Arthritis**: regular screening and Early detection is the key. Don't wait until your patients can't walk. If the knee pain isn't going away, it's time to refer them to a joint specialist ASAP. Joint replacements are not the end of the world, and patients can walk out of surgeries within a week or two.
- **Aortic Disease**: Sneaky but deadly. If a patient presents with symptoms like chest pain or breathlessness, **don't ignore it**. Aortic issues are hard to catch and require specialized cardiovascular intervention. Immediate referral to an expert could save lives.

Final Takeaway for EDPA Members from the CME Sessions (13th Aug and 25th Sep, 2024)

1. **Teamwork Matters:**
    - Collaborative efforts between GPs / CPs and specialists are crucial for achieving the best outcomes in patient care. Multidisciplinary teamwork, especially in complex cases, ensures that all aspects of a patient's condition are comprehensively addressed. Working together allows for more holistic care and a higher success rate in treatment.
2. **Early Identification of Patients Through Appropriate Screening:**
    - Early detection is key to better patient outcomes, particularly in chronic conditions. Timely diagnosis can make a significant difference in managing these diseases. Physicians should stay vigilant and recommend appropriate screening methods when symptoms suggest early pathology.
3. **Timely Referral to Superspecialists:**
    - One of the most critical steps for successful treatment is referring patients to the right superspecialists at the appropriate time. Delayed referrals can reduce the effectiveness of treatments. Identifying when conservative management is no longer sufficient and making timely referrals ensures that patients receive expert management and achieve optimal results.

17. EDPA CME on "Metabolic Milestones: Evolving Chapters in Diabetes Management"

On September 6, 2024, the East Delhi Physician Association (EDPA) organized a highly informative CME titled **"Metabolic Milestones: Evolving Chapters in Diabetes Management"** at Hotel Leela Ambience, East Delhi. The event, attended by numerous physicians, shed light on the latest advancements in diabetes care.

Moderators and Chairs:

The CME was moderated by **Dr. Vijay Arora**, Consultant Physician at Max Hospital. The event was chaired by prominent physicians:

- **Dr. Rajiv Bansal**
- **Dr. Lalit**
- **Dr. Ashok Sharma**

Expert Speakers and Topics:

1. **Dr. Setu Gupta**, Consultant Endocrinologist, delivered a talk on the **Role of Novel Fixed Combination of Glimepiride, Metformin, and Sitagliptin**. His focus was on optimizing the sulphonylurea class of drugs by utilizing this novel fixed-dose combination to maximize glycaemic outcomes. Dr. Gupta highlighted how this combination helps achieve better glucose control while minimizing adverse effects commonly associated with sulphonylureas.
2. **Dr. Himanshu Sharma**, Consultant Endocrinologist, spoke on **Unmatched Glycaemic Control with Cardio-Renal Protection Using the Novel Fixed Combination of Glimepiride, Metformin, and Dapagliflozin**. His session emphasized the dual benefits of achieving tight glycaemic control while providing protection to both the cardiovascular and renal systems—an increasingly important aspect in the comprehensive management of diabetic patients.

Key Learning Points for EDPA Physicians:

1. **Optimizing Sulphonylureas**: Dr. Setu Gupta's session underscored the importance of using sulphonylureas, specifically glimepiride, in a fixed-dose combination with metformin and sitagliptin to enhance glycemic control. The combination approach allows for effective diabetes management while reducing the risk of hypoglycemia, a known issue with sulphonylureas.

2. **Cardio-Renal Protection**: Dr. Himanshu Sharma's discussion on glimepiride, metformin, and dapagliflozin highlighted the importance of addressing not just blood sugar levels but also the associated complications of diabetes. The novel combination offers strong protection for both heart and kidneys, a critical consideration given the rising incidence of cardio-renal issues in diabetic patients.
3. **Tailored Treatment Plans**: Both speakers emphasized the importance of individualized treatment plans that incorporate novel fixed-dose combinations to meet specific patient needs, particularly those with co-morbid conditions such as cardiovascular disease or chronic kidney disease.
4. **Future of Diabetes Management**: The CME provided a forward-looking perspective, urging physicians to adopt evolving therapeutic approaches that go beyond glycemic control and focus on comprehensive care—addressing metabolic, cardiovascular, and renal health simultaneously.

This CME not only enhanced physicians' understanding of emerging trends in diabetes management but also encouraged them to apply these novel approaches to improve patient outcomes

18. Health Pearls From Our Ancient Past:

Article contributed by Dr Prakash Gera

Haridrā: Ancient Wisdom Meets Modern Medicine

Curcuma longa, commonly known as **Haridrā** in Sanskrit and **turmeric** in English, holds a significant place in Ayurvedic medicine, particularly in **Chikitsa** (natural therapy). Traditionally revered for its potent medicinal properties, Haridrā is extensively mentioned in classical Ayurvedic texts like the *Caraka-saṃhitā* and the *Mādhavacikitsā*, which document its use in treating conditions such as **fevers (Jvaracikitsā)** and other systemic illnesses.

The Ayurvedic text *Mādhavacikitsā* refers to Haridrā under the names **Rajanī** and **Niśā**, emphasizing its role in managing fever and other inflammatory conditions. Its therapeutic benefits extend to improving skin health, treating digestive disorders, and detoxifying the body. The **Yogasārasaṅgraha**, a 15th-century Ayurvedic compendium by Vāsudeva, further documents its application in pharmacy (**bhaiṣajya-kalpanā**), detailing how turmeric's active compounds are used in medicinal recipes for various ailments.

From a pharmacological perspective, Haridrā's primary active compound, **curcumin**, has attracted widespread attention in modern medicine due to its broad range of health benefits. These include **anti-inflammatory, antimicrobial, antioxidant, and anticancer** properties. Its integration into modern medicine as a **complementary treatment** is growing, particularly for conditions such as arthritis, diabetes, and cardiovascular disease, where inflammation is a key factor.

Key Applications of Haridrā in Modern Practice:

- **Anti-inflammatory Agent**: Curcumin's ability to inhibit inflammatory pathways makes it a natural adjunct in managing chronic inflammatory diseases like arthritis.
- **Antioxidant Properties**: By reducing oxidative stress, curcumin supports heart health and metabolic conditions like diabetes.
- **Antimicrobial Uses**: Haridrā has been traditionally used to combat bacterial and viral infections, and modern research corroborates these antimicrobial benefits.
- **Cancer Prevention**: Modern studies show curcumin's potential in preventing the progression of cancer by hindering tumor growth and proliferation.

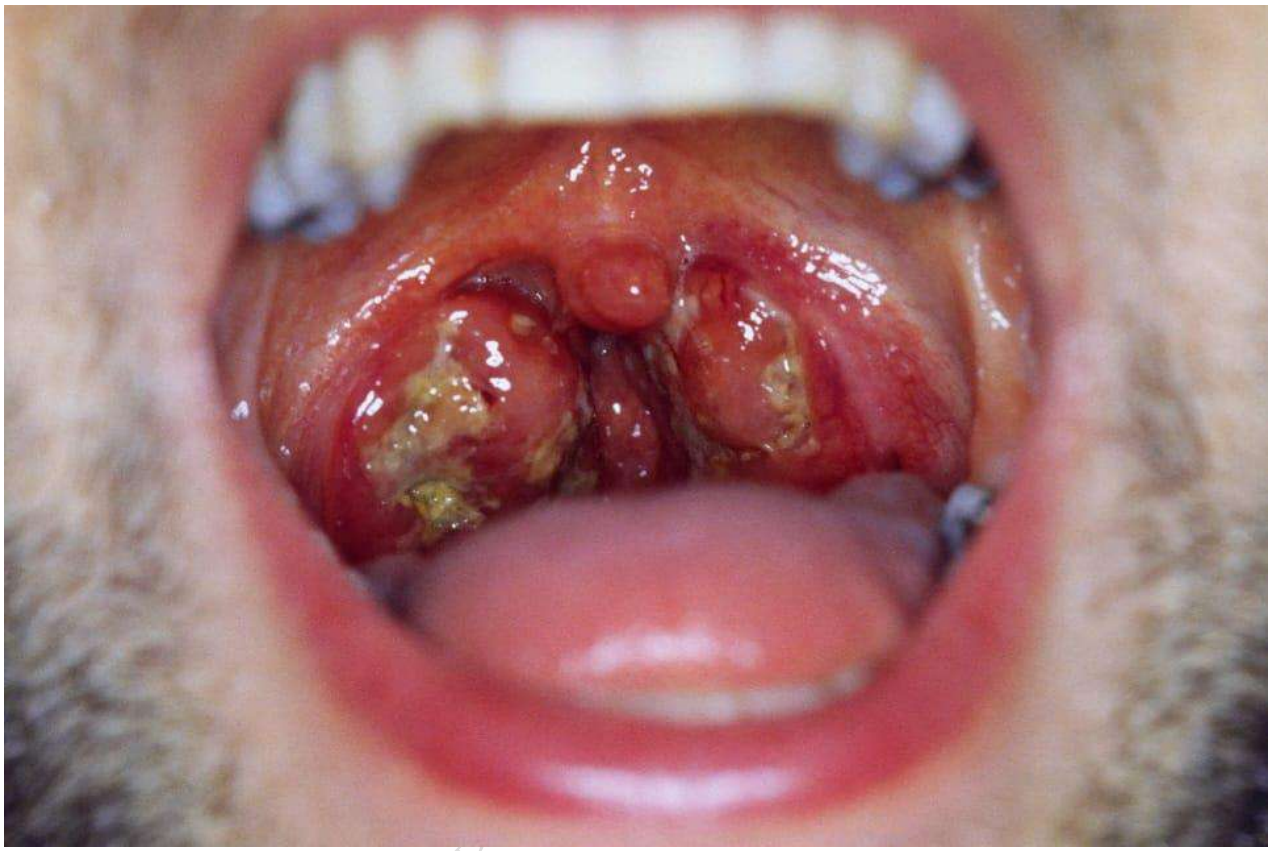
Tips for Physicians:

- **Can Consider use of curcumin as a preventive measure** for patients at risk of chronic diseases.
- **Can Consider the use of turmeric supplements** (with bioavailability enhancers like piperine) in patients with inflammatory conditions.
- **May incorporate turmeric in daily diets**, either through natural food sources or standardized extracts, as part of a balanced approach to wellness.

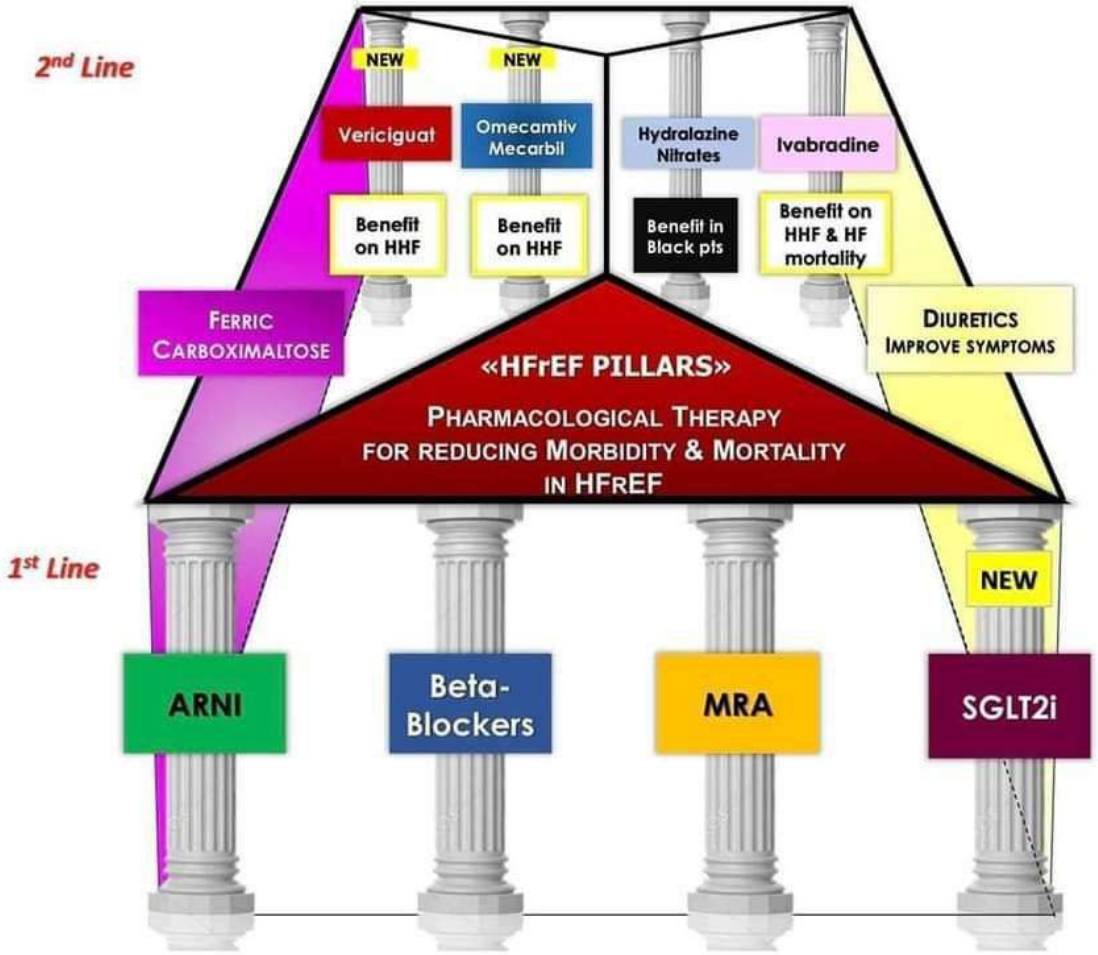
By bridging ancient Ayurvedic wisdom with contemporary research, curcumin (Haridrā) can serve as a powerful natural remedy that continues to enrich modern medical practices. This fusion of traditional and modern understanding can allow Practitioners to harness the healing potential of Haridrā, providing holistic care that respects both ancient insights and cutting-edge science (ref: Royal Society of Chemistry)

19. Medical Images and visuals shared by EDPA members

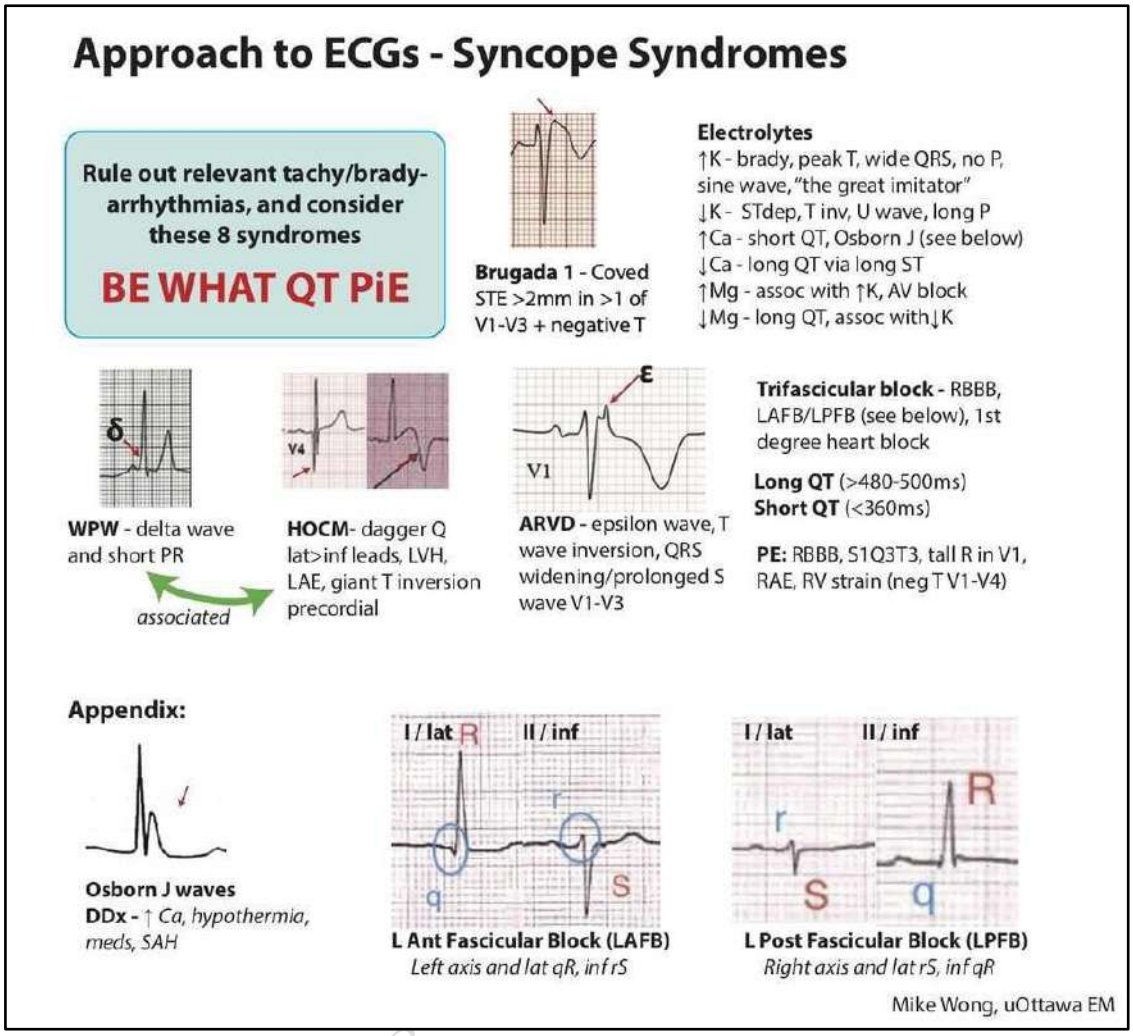
Infectious mononucleosis



Pharmacological Pillars to treat heart failure (HFrEF) – Shared by Dr Vijay Arora



Shared by Dr Dipesh Sood- Cardiac syncope and ECG findings



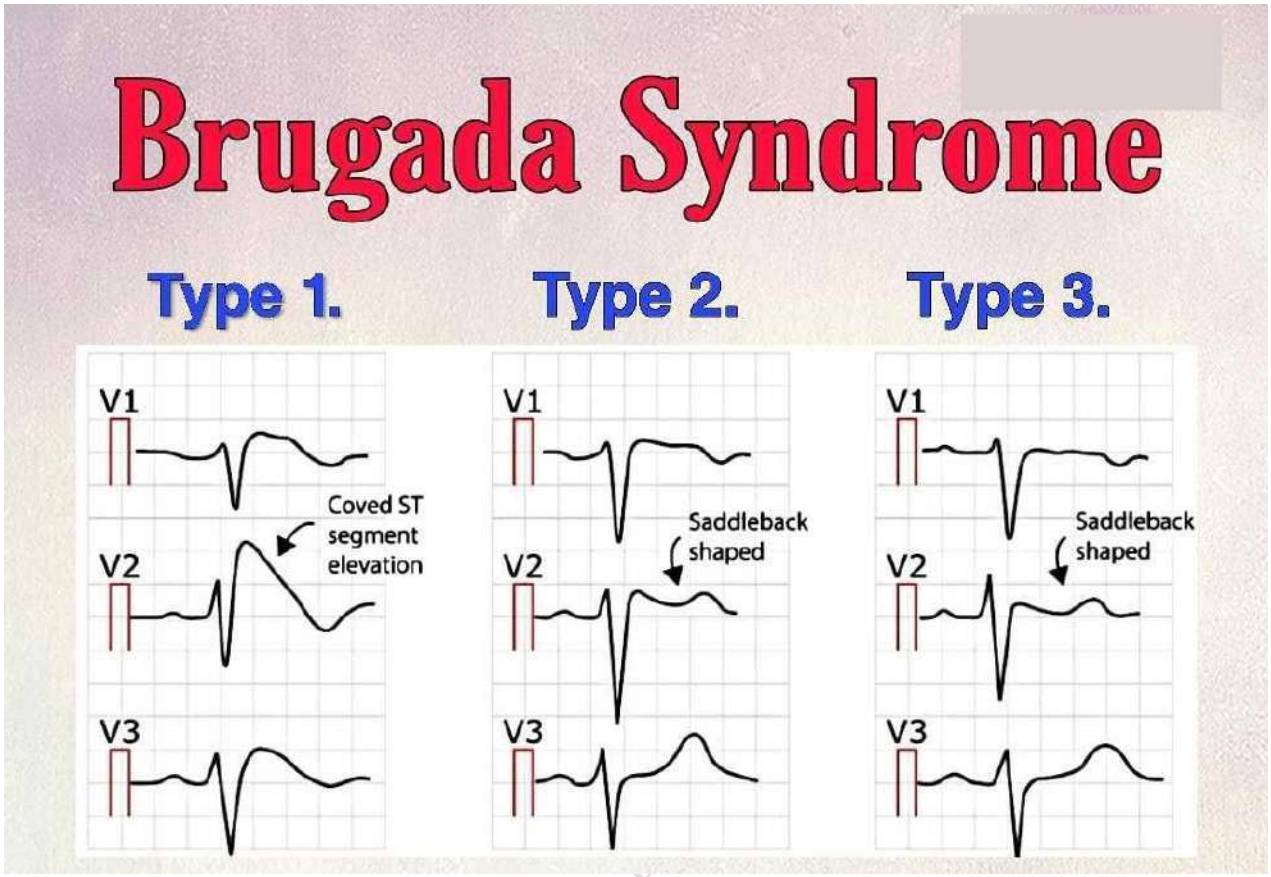
Abnormal Ecg Findings of Cardiac Syncope

Channelopathies	Vascular Abnormalities	Electrolyte Abnormalities	Structural Abnormalities	Conduction Abnormalities
■ Brugada ■ Long QT syndrome ■ Short QT syndrome	■ ACS ■ PE ■ Cardiac tamponade	■ Hyper K+ ■ Hypo K+ ■ Hypo Ca2+	■ HOCM ■ WPW	■ AV Blocks ■ SVT

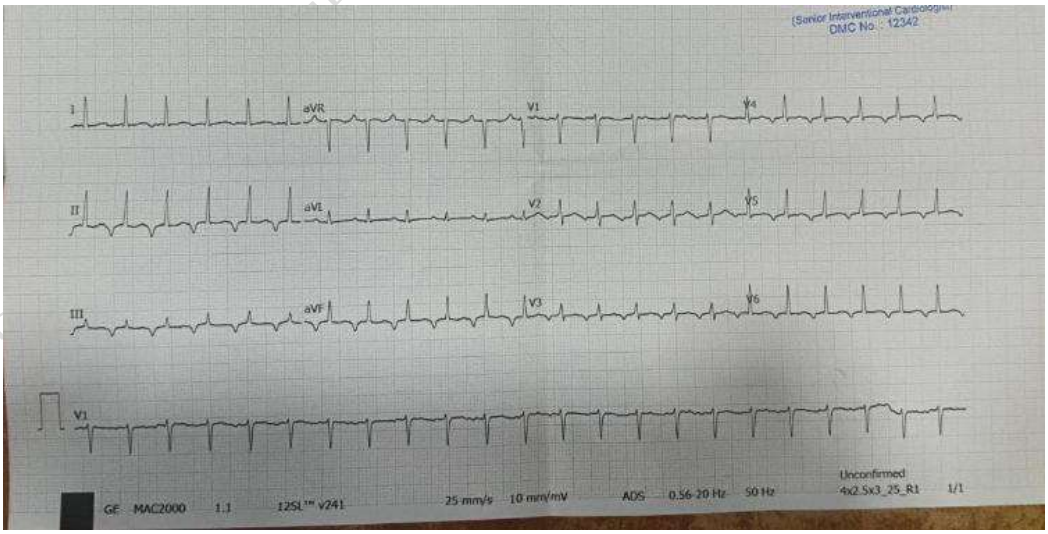
ACS, Acute coronary syndrome; PE, Pulmonary embolism; K+, Potassium; Ca2+, Calcium; HOCM, Hypertrophic cardiomyopathy; WPW, Wolff-Parkinson-White; AV, Atrioventricular; SVT, Supraventricular tachycardia.

Source : Avoiding Common Errors in the Emergency Department

Brugada syndrome – Types- Shared by Dr Dipesh Sood

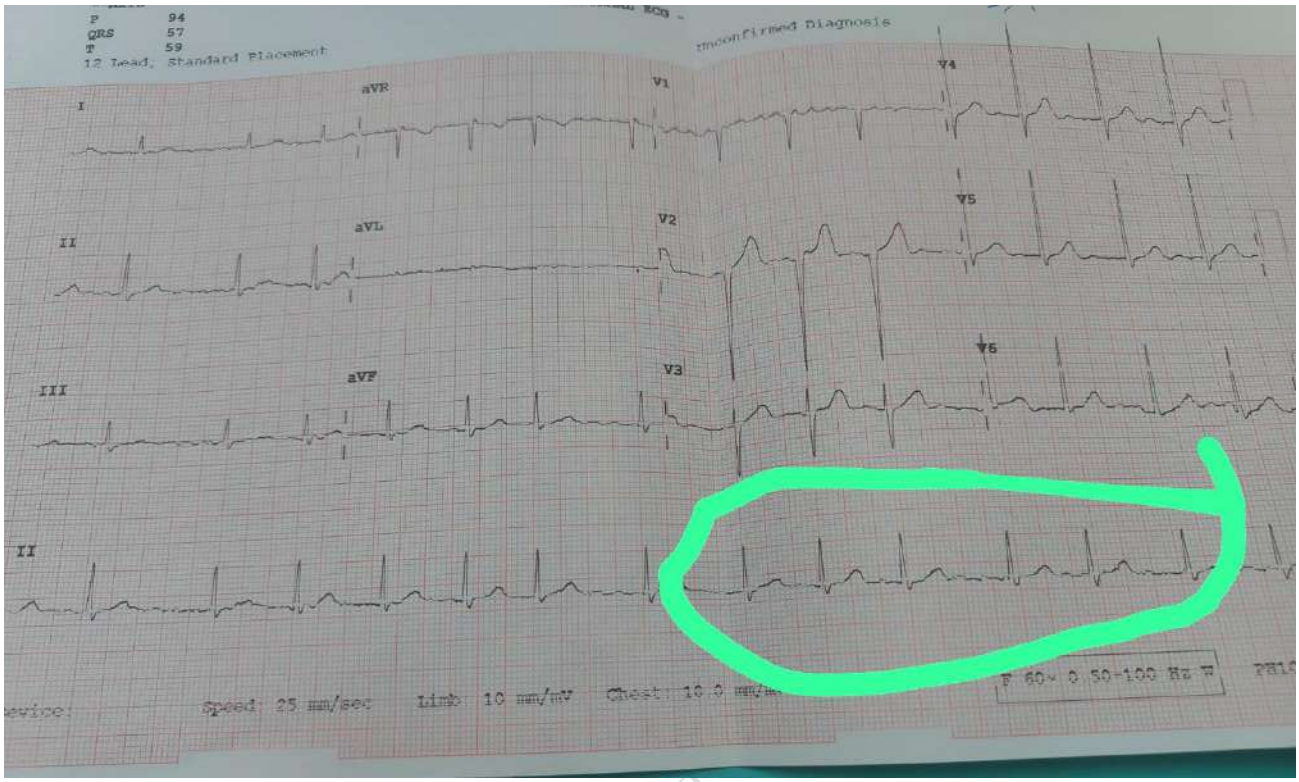


ECG Shared by Dr Ajay Mittal



PSVT with Long RP tachycardia - condition where the heart's rhythm is rapid and regular, but the RP interval is greater than half of the RR interval.

Shared by Dr Ajay Mittal - Atrial Flutter with variable AV conduction



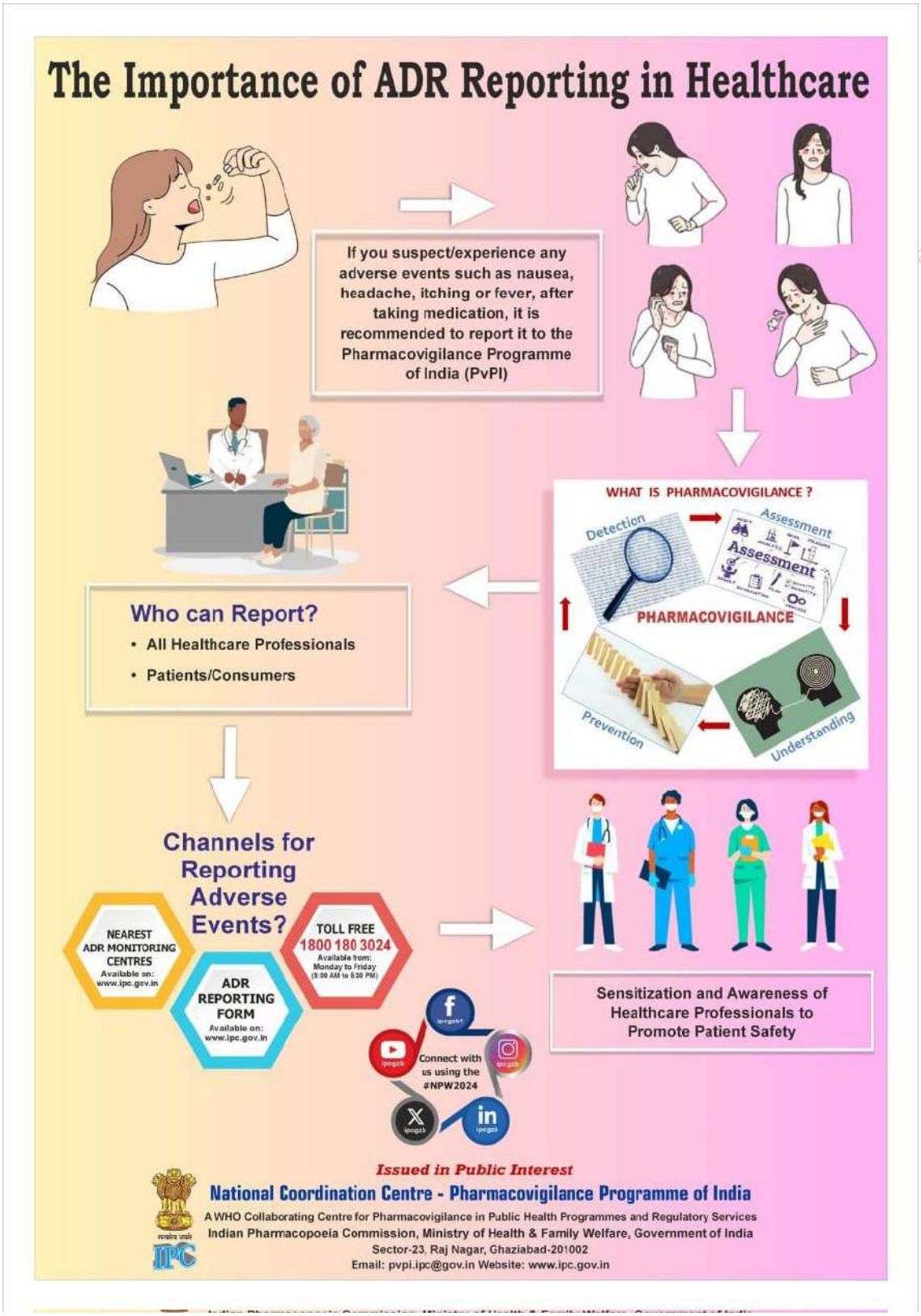
Shared by Dr Dipesh Sood- Insulin in GDM

INSULIN IS THE GOLD STANDARD AND HAS TO BE PREFERRED IN ALL CASES NEEDING PHARMACOTHERAPEUTIC AGENTS !!

Factors which predict need for insulin in GDM

- Higher FBG >110, PPBG >140mg%
- Early detection of GDM <20 weeks
- Past history of GDM
- Older age at diagnosis
- Higher baseline A1C or Fructosamine
- Elevated BMI . Pregnancy weight gain of >20kg
- Need for pharmacotherapy <30 weeks
- Renal /Hepatic dysfunction
- GI intolerance, previous adverse reactions or allergy to metformin
- h/o major congenital anamoly in previous pregnancy
- Hydramnios
- Maternal and fetal distress
- Presence of HT, pre ecclampsia, IUGR

Shared by Dr Dipesh Sood- ADR reporting in clinical practice



Be Vigilant, Be Safe

Report Adverse Drug Reactions for Patient Safety

Patient:
"Doctor, I have nasal congestion"

Doctor:
"OK, I will prescribe anti allergic medication"

Patient:
"I am feeling drowsiness after taking medicine"

Doctor:
"Oh this could be an Adverse event we must report this to Pharmacovigilance Programme of India (PvPI)"

Patient:
"What is PvPI ?"

Doctor:
"PvPI is drug safety monitoring program which collects, collates and analyses drug related adverse events and send recommendations to CDSCO for taking appropriate regulatory actions"

Patient:
"How can I Report to PvPI ?"

Doctor:
"You can report adverse event via Toll free no.: 1800-180-3024
E-mail: pvpi.ipc@gov.in and nearby Adverse Drug Reaction Monitoring Centre (AMC) across the country."

Channels for Reporting Adverse Events?

NEAREST ADR MONITORING CENTRES
List Available on: www.ipc.gov.in

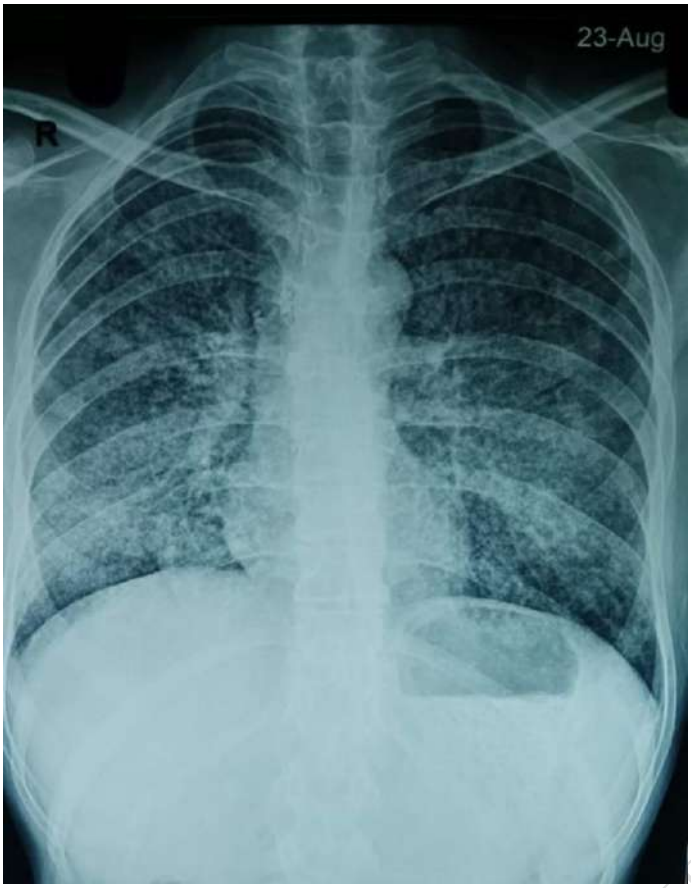
ADR REPORTING FORM
Available on: www.ipc.gov.in

TOLL FREE
1800 180 3024
Available from: Monday to Friday (9:00 AM to 5:30 PM)

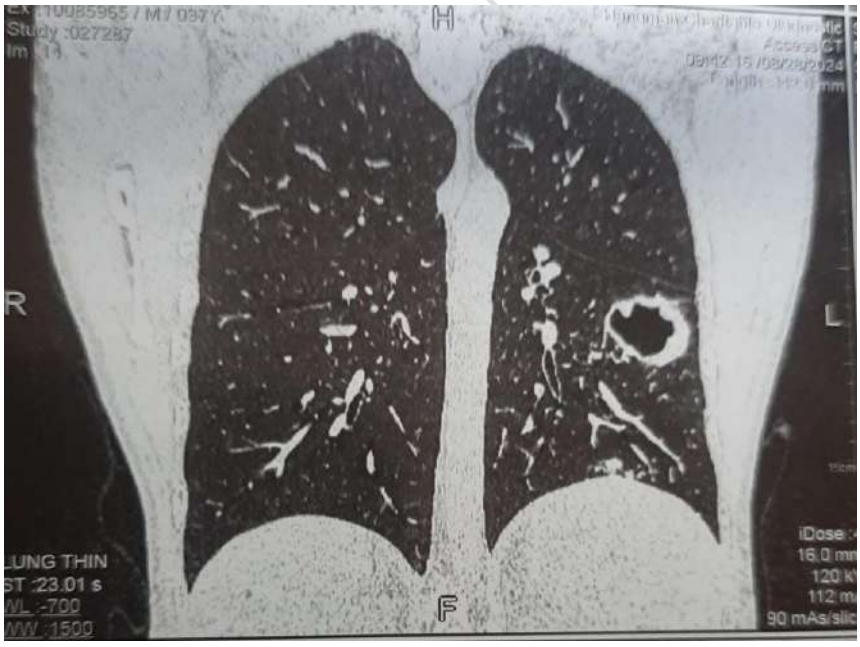
Connect with us using the #NPW2024
ipcgzb1 · ipcgzb · ipcgzb · ipcgzb · ipcgzb

Issued in Public Interest

National Coordination Centre - Pharmacovigilance Programme of India
A WHO Collaborating Centre for Pharmacovigilance in Public Health Programmes and Regulatory Services
Indian Pharmacopoeia Commission, Ministry of Health & Family Welfare, Government of India
Sector-23, Raj Nagar, Ghaziabad-201002
Email: pvpi.ipc@gov.in Website: www.ipc.gov.in



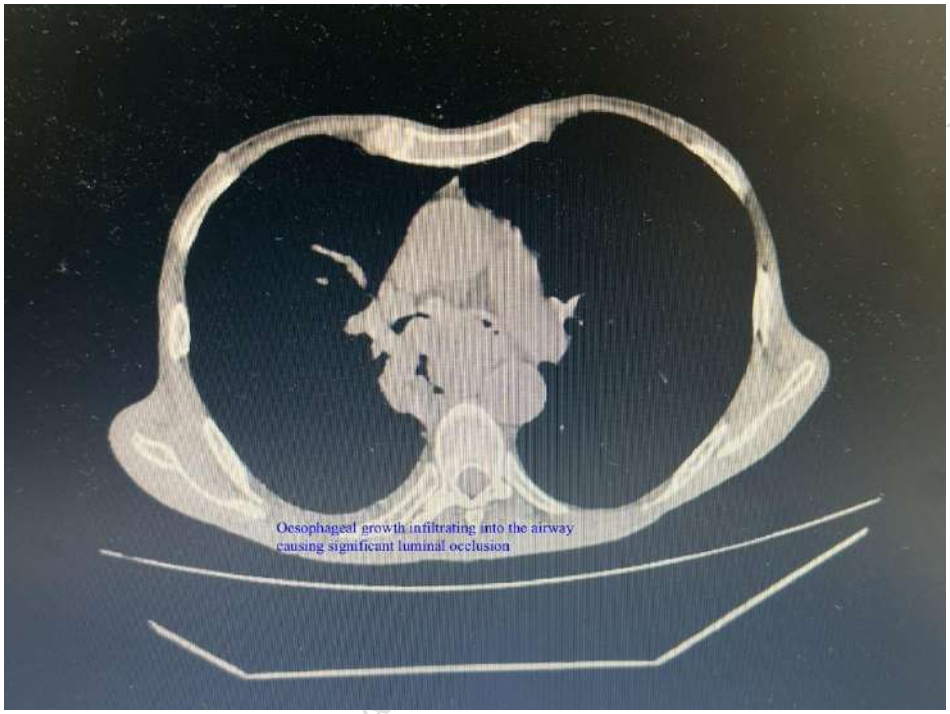
76 yr male with proven H1Ni pneumonia, treated successfully with Tamiflu (shared by Dr RPS Makkar)

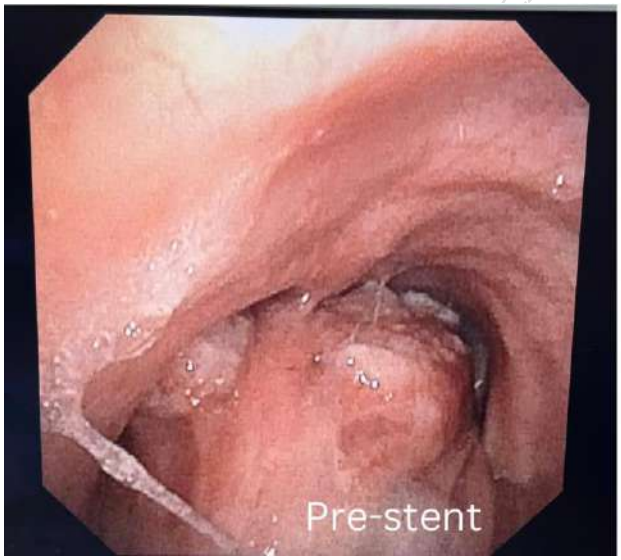


40-year-old male with Broncho-cavitatory Koch's (CECT chest) (shared by Dr RPS Makkar)

Case Shared by Dr Ankit Bhatia; Interventional Pulmonology, Max Super Speciality Hospital

63year male with known advanced Ca oesophagus post-Surgery/chemoradiation; presented with stridor and dyspnea; Patient was intubated in view of worsening stridor and impending Arrest. Imaging showed Oesophageal growth infiltrating into the airway causing significant luminal occlusion; Diagnostic bronchoscopy revealed Tumour infiltrating lower trachea, Carina & both main stem bronchus obstructing more than 80 percent of lumen; Palliative debulking of the tumor with cryo-recanalization technique was done and a Covered SEMS(Hybrid) deployed successfully as the disease had progressed. treated by stenting; Post stenting adequate lumen patency achieved ; Post procedure patient was successfully extubated doing fine without any distress





20. EDPA Medical Crossword Winners for June, August

JUNE WINNER	AUG WINNER:
Dr Aishwarya from MAX PPG won the EDPA Crossword June puzzle.	Dr PN Chaudhary from Max Vaishali won the Crossword AUG Puzzle.
	
Congratulations Dr Aishwarya!!	*Congratulations Dr Chaudhary!!*

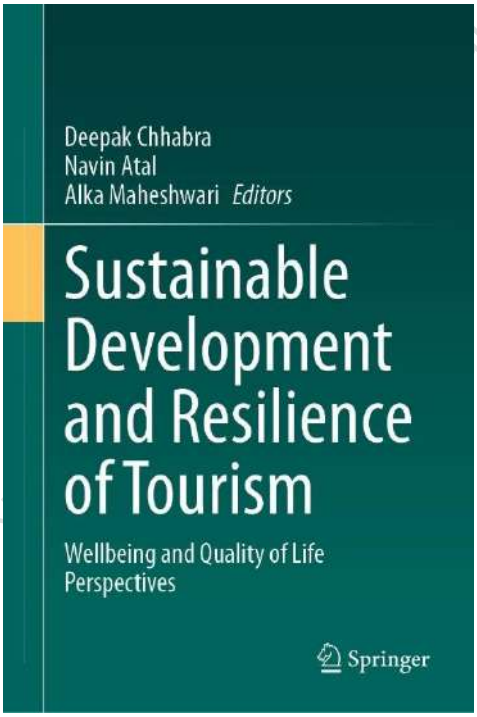
21. Super Talent in EDPA

EDPA is proud to inform that Dr Navin Atal, our senior EDPA member, published his book on **Sustainable development and resilience of Tourism**. He was invited to Amity University to deliver a talk on the subject of based.

The book Examines progress in sustainable and resilient development of tourism , Offers insights on the role of non-pharmaceutical interventions to enhance resilience and wellbeing, and Provides a quality-of-life paradigm to strengthen sustainable development initiatives and tourism resilience

EDPA Congratulates Dr Atal on this achievement!

Editors:
Deepak Chhabra, Navin Atal, Alka Maheshwari

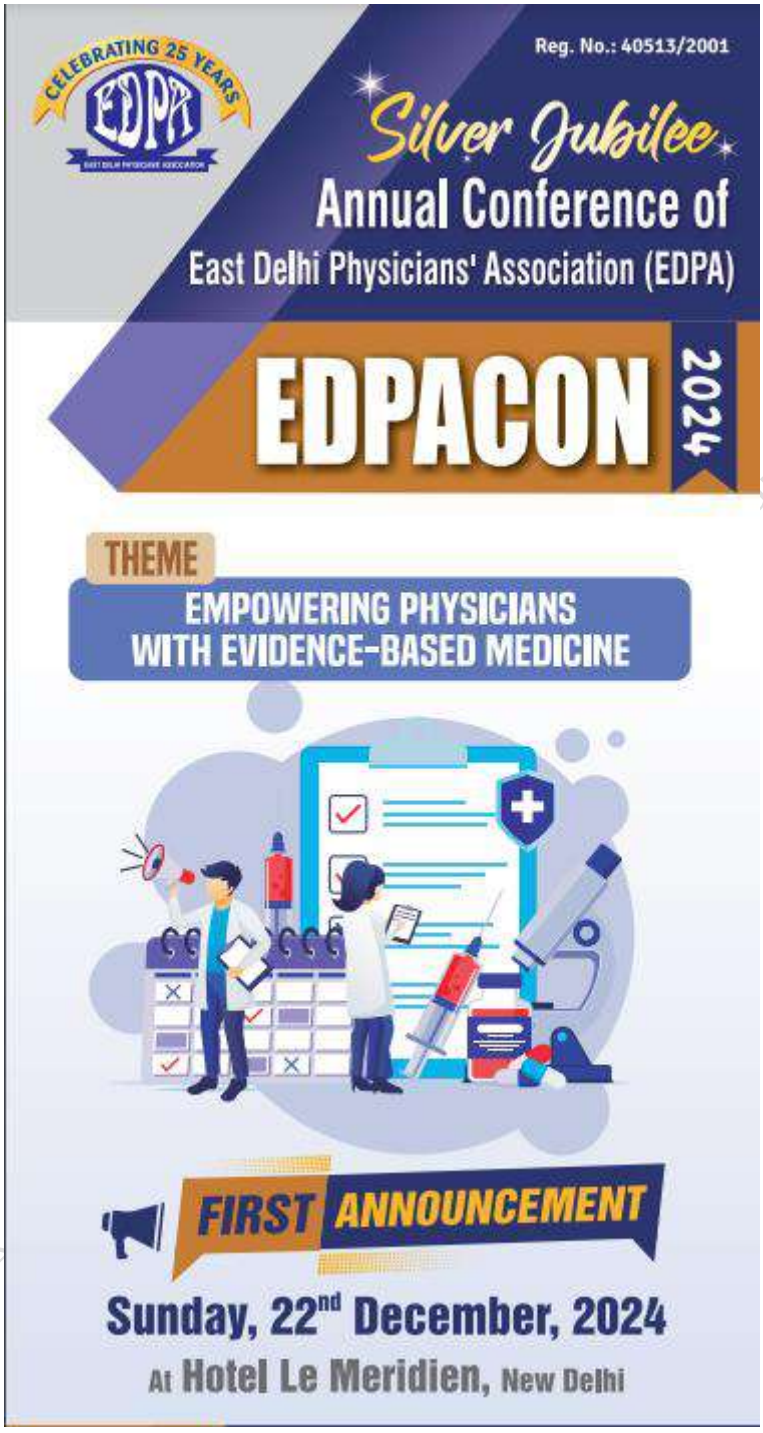


22. FUN-Corner

……After Tab Dolo 650, comes…

EDPA Funniest picture
of the month😊
(Courtesy Dr TM Agarwal)

23. EDPA announcement



STAY TUNED and BLOCK YOUR DAY!!

Silver Jubilee – YEAR 2024

EDPA Quarterly Medical Bulletin

25TH ANNIVERSARY OF EDPA

East Delhi Physicians Association
E-mail: eastdelhiphysiciansassociation@gmail.com
Website: www.edpadelhi.com
Address: 35X, IMA EDB Bhavan, 1st Floor, Institutional area opp. Kendriya Vidalaya (AGCR Enclave) Delhi-92