DIALOGUE

INDIAN MEDICAL ASSOCIATION
DOMBIVLI BRANCH
VOLUME 32, ISSUE 4

Editors :
Dr. Suchitra Kamath Dr. Meena Pruthi Dr. Sheetal Khismatrao

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यथा चतुर्भि: कनकं परीक्ष्यते निघर्षणच्छेदनतापताडनौः ।
तथा चतुर्भि: पुरुष परीक्ष्यते त्यागेन शिलेन गुणेन कर्मणा ॥

Translation-

The way gold's purity is tested by rubbing, cutting, heating and pounding, similarly, a person's qualities are tested by gentleness, manners, habits and deeds.

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EDITORIAL

Editorial

Many centuries ago, the hare and the tortoise decided to have a race. The hare used to boast about his speed to other animals. Only the tortoise had the courage to accept his challenge. The Day and the time was decided. The race started off. The hare ran and seeing the tortoise nowhere at sight, decided to take a nap. The tortoise slowly moved ahead. When the hare woke up, the tortoise had already reached the end post.

Moral: Slow and steady wins the race.

After a few centuries, the Grand children of the Hare and the Tortoise decided to have a race. Having learnt lessons from the past, the hare decided that he wouldn't rest till he reaches the end post .And he won by miles.

Moral: Avoid procrastination and success is yours.

A few generations later, the hare and the tortoise decide to have one more race. This time both learnt lessons from their ancestors. Both took it as challenge. Day and time was decided. The D day arrived. Much to the disappointment of all, it was overcast. The weather bureau predictions were wrong as usual. Still they decided to ahead with the race.

In short time, it started pouring and the visibility was decreased also 26/7.

The tortoise had an idea. He suggested that hare should carry him on his shoulders. His she'll would act as an umbrella and the hare wouldn't get wet. The hare liked the idea and did as told. The hare ran and the Tortoise she'll protected him.

They reached the river that they had to cross. Here the hare suggested that the hare would climb over the tortoise s back and it would swim across.

Thus both crossed the river and reached the end post together.

Moral: In modern times, Cooperation, Coordination and Teamwork are sure Mantra for success.

The Dialogue magazine is also effort of team work. I sincerely thank all those who have helped me.

A Bouquet looks beautiful because it consists of various flowers held together by a thread Friends, I am just the thread holding the articles together.

Dr. Suchitra Kamath

FROM THE PRESIDENT'S DESK

The year has passed by swiftly and how! It seems only yesterday that the team of 2018 – 19 took over! So much has happened in last 1 year…so many activities, so many events, so much of bonding, so much of friendship, so many happy memories!! When the year started, there was some uncertainty as to how will it be possible to do so much in such a short period of time…but as time progressed, with the help and support of the entire team, we were able to carry out some good work!

This was the **YEAR OF FIRSTS**…so many new things were done for the first time in IMA Dombivli. 1st time, IMA Dombivli celebrated **'WHO DAY'** by itself as decided in the AGM of February 2018. After 48 years of its establishment, IMA Dombivli got its **1ST APPROVED CONSTITUTION**! 1st time **ONLINE PAYMENT FACILITY** was integrated into IMA Dombivli website and for the 1st time system of **ONLINE CERTIFICATES** was introduced. 1st time IMA Dombivli undertook **AHA CERTIFIED BLS COURSES**. 1st time IMA Dombivli has started branding its annual conference under the name **IMAFEST**. IMA Dombivli undertook the very first IMA Maharashtra State conference of Hospital Board of India – **MAHAHOSPICON 2018**. IMA Dombivli for the first time conducted **PRE CONFERENCE WORKSHOP** prior to our annual conference IMAFEST. 1st time IMA Dombivli organised an awareness run called **'LIFE SAVER'S RUN 2019'** to create awareness about the importance of learning Life Support! 1st time a comprehensive directory of IMA Dombivli members '**GREEN BOOK'** which also contains all information about IMA in general, was released. 1st time Organ Donation Awareness was taken up on a large scale at IMA Dombivli through a unique program '**DAAN KI ADALAT'.**

53 total programs were carried out in the entire year. Each program was unique and outstanding in its own right! Lots of efforts were put in by team members to execute each and every program! There were many problems encountered during execution of few programs, but they were all taken care in due time in such a way that the final product was flawless! Each program made us a little more capable of handling problems…we learnt to make contingency plans and tackle problems as they came, without taking lot of stress! I can't thank my team members enough! **Dr. Vandana Dhaktode** and **Dr Sunit Upasani** were wonderful and consistent in their support throughout the year and they along with **Dr Rashmi Phansalkar** efficiently carried out many training programs under HBI.The Scientific committee was ably looked after by **Dr. Ashwini Acharya**! **Dr. Meena Pruthi, Dr. Makarand Ganpule and their cultural team** dished out superb cultural programs one after another! **Dr. Nayana Chaudhari, Dr Manasi Karandikar, Dr Bhakti Lote and their team** perfectly navigated women's wing through multiple projects under able guidance of **Dr. Niti Upasani**. **Dr Sandhya Bhat, Dr. Deepa Shukla and Team Sanjeevan** did great work of giving Life support training! Team BBBP did appreciable work under **Dr. Vijayalaxmi Shinde and Dr. Hemant Patil**. All editions of Dialogue was nicely delivered in time by **Dr Suchitra Kamath and her team of co-editors**! Aao School Chalein under **Dr Dushyant Bhadlikar, Dr Vijay Chinchole and team** undertook the much appreciated school health program! My gratitude to all the team leaders and all the team members!

The Annual Maintenance Charges(AMC) that was collected from members at the beginning of the year was put to good use. We were able to carry out 22 community service programs, thereby enhancing the public image of Doctors of IMA Dombivli in front of community; IMA Dombivli could come out with its own directory; and all the expenses related to Staff payment, stationaries, AGM, installation, Doctor's day could be managed smoothly. My sincere thanks to all members for their support and I hope similar support is extended to all presidents for smooth functioning of the branch year after year.

I sincerely thank **Dr. J.L.Daga and Dr. S.K. Juvale** , senior members of IMA Dombivli family, who were office bearers of an old association – Hospital Owner's Association. This association had approximately Rs.65000/- in DNSB in a dead account. They trusted IMA Dombivli enough to transfer this money to IMA Dombivli account. Thank you for your trust sir... I assure you that this money will surely be used for good cause.

IMA Dombivli's trust formation is presently put on back burner in view of certain unexpected developments, the details of which were given during the AGM on 24th Feb 2019. A 3 member committee comprising of Dr. Mangesh Pate, Dr. Niti Upasani and Dr. Meena Pruthi will be looking into this matter.

The only sad episode that happened during the year was the unfortunate accident met by Hrishikesh kelkar, son of Dr. Swati and Dr. Prashant kelkar – through IMA Dombivli Help Fund we were able to raise Rs. 2,80,000/- and after paying GST, cheques worth Rs. 2,37,286/- were handed over to Dr. Kelkar as a small token of support from IMA Dombivli family. I am glad Hrishikesh is back home and doing well and on behalf of all of us at IMA Dombivli, I pray to God for his complete recovery!

On a personal level, the year was a pretty difficult one! We had many major illnesses in the family – 2 major hospitalisations of my mother in law, 2 major hospitalisations of my brother, knee replacement surgeries of both my parents…not to count the multiple small problems! The Presidency taught me endurance and perseverance, to deal with personal, professional and organisational issues at different levels and made me a much better organiser in general. I could not have done it without the rock solid support of my husband **Dr Mangesh Pate**, who has always stood with me, stood for me in any adverse situation and supported me in all my endeavours. My children **Vihaan and Nihaal** have been my greatest strengths – my presidential year, MMC work, health issues in family, IMA work has practically kept me away from my children for the entire year and they have always supported my commitments happily! I thank my mother in Law for being there for my children when I was not around!

The entire focus and all attempts this year had been towards uniting the IMA Dombivli family but somewhere I feel I have failed in my attempts. The only grievance I have in my heart while stepping down is about the poor participation in programs from our own members and the lack of enthusiasm from members regarding activities of branch and of IMA in general. I do hope the incoming team gets more support from branch members!

Before I sign off, let me thank all members and colleagues of IMA Dombivli family for their love and trust...May our esteemed branch of IMA Dombivli continue to shine brightest and do wonders for fraternity and society! I apologise if I hurt anyone knowingly or unknowingly through my deeds or words during the year. If there was any lapse or any flaw in working during the year, I sincerely seek forgiveness for the same. My best wishes to the incoming president Dr. Meena Pruthi and her team for a wonderful and successful tenure! May she achieve super success in all her ventures!! Amen...

Dr. Archana Pate
President, IMA Dombivli (2018 -19)

SECRETARIAL REPORT

It is a Privilege to write as Hon. Secretary of IMA and a matter of great Pride for me to be the Secretary of such a Prestigious Association.

Indian Medical Association is the only representative voluntary organization of Doctors of Modern Scientific System of Medicine, which looks after the interest of doctors as well as the well-being of the community at large.

The objects of the Association are:

1) To promote and advance medical and allied sciences in all their different branches and to promote the improvement of public health and medical education in India.

2) To maintain the honour and dignity and to uphold the interest of the medical profession and to promote co-operation amongst the members thereof;

3) To work for the abolition of compartmentalism in medical education, medical services and registration in the country and thus to achieve equality among all members of the profession.

The Association was started in 1928 on the occasion of the 5th all India Medical Conference at Calcutta .TODAY, I.M.A is a well-established organization with is Headquarters at Delhi and State/Terr. Branches in 23 States and 9 union Territories. It has more than 3lac doctors as its members through over 2000 local branches spread all over the country.

Over the period of 72 years, IMA while maintaining its glorious traditions has secured a place of pride in the community. It has been rendering yeoman's service in the field of health care delivery, disease control and eradication. Its services to the community during natural calamities like earthquakes, droughts and floods, famines and epidemics in the pre and post-Independence periods have been highly lauded. Its role and involvement in the formulation and implementation of National Health Programmes e.g. Family Welfare, Maternal and Child Health, Universal Immunization Programme, Oral Rehydration Therapy, AIDS Prevention, Control and Management etc., has been highly significant and has received recognition by the Central and state Governments and the UNICEF. The IMA and its branches have been running many community service Projects and a number of branches have established Family Welfare Clinics, Immunization Centres, Ambulance Services, Blood Banks, Polio Eradications and RCH programmes, etc.

Indian Medical Association publishes a Scientific Journal called 'Journal of the Indian Medical Association' a copy of which is mailed to each and every member of the Association. "Your Health" in English and "Aap Ka Swasthya" in Hindi are published regularly and cater to health education needs of the lay public. Some of the State Branches are also publishing their bulletins in English and/or Regional languages. IMA News is published monthly by the IMA Headquarters. Besides this, IMA College of General Practitioners has a publication named "Continuing Medical Education" Bulletin.

With IMA Post comes ALL THE ABOVE RESPONSIBILITIES! What a Daunting task!

We conducted CME's, IMAFEST, MPH, AAO SCHOOL CHALEIN, PROJECT AADHAR, BBBP, ORGAN DONATION, SANJEEVAN-LIFESAVER, NAVRANG, DANDIYA, ANANDMELA, CELEBRATION OF VARIOUS DAYS, DIALOGUE, GREEN BOOK, IMAFEST SOUVENIER and the list goes on .

It was a memorable year, thanks to the love and support given by all the members. All the meetings, brainstorming, preparations for the events with adrenalin running in our blood are unforgettable. I made many new Friends. With our President DR ARCHANA PATE,54 Programs were conducted.Our Local Branch created waves at State and National IMA level.

It was a great Journey and I am happy that I could give a tiny bit back to the society.

It is time to hand over the bastion to the next team. The future team will uphold all the objectives of the IMA like the present and past teams.

*True joy of nature is when every **drop of water** shines like a pearl. ... Thoughts are like **drops of water**: with our thoughts we can drown in a **sea** of negativity, or we can float on the **ocean** of life.*

*The older I get, the greater power I seem to have to help the world; I am like a **snowball** - the further I am rolled the more I gain. ...*

I hope to inspire all those who read this…

Dr. Vandana Dhaktode
Hon. Sec. IMA Dombivli (2018 -19)

1) 8th April 2018 - WHO Day Celebration (Community Service)

WHO Day Program was celebrated for the first time by IMA Dombivli at Sarvesh Hall..Keeping in mind the theme of WHO day "Health for All" wonderful informative sessions on Health Insurance by Dr. Sultan Badami, Healthy mind by DrAdwaitPadhye,Diet& Nutrition by nutritionist Rochita Date and on Spiritual wellbeingby AOL trainer Mr Ravi Kadamwere arranged which were well appreciated by the attendees. The program was a grand success.DrMakarandGanpule was the moderator for the program.

100 non-medical and medical people attended the program



2) 18th April 2018 – Multispeciallity CME

A **Multi-specialty CME** with topics on TB notification and Approach to summer Illnesses was arranged on 18th April... Since world Asthma Awareness day was just round the corner on 1st May 2018, a special lecture on COPD and Asthma was organized.1 CME credit point was granted by MMC. Dr. Medha Oak was the moderator for the program.

The CME was attended by 95 members.



3) 24th April 2018 – Project Aadhar (Community Service for senior citizens)

IMA Dombivli Women's Wing conducted **"Project Aadhar - Care for Senior Citizens".** A medical health checkup camp was organized for residents of SandhyaChhayaVriddhashram at Dombivliwest.Residents of old age home weregivencomprehensive medical examination (Opthal, Dental,psychiatric, Blood, Vascular age, etc). Necessary treatments were also recommended. The project head was DrNayanaChoudhari and project co coordinator was DrVijayalaxmiShinde under the guidance ofIPPDrNiti Upasani and WW Chairperson Dr. LeenaLokras. The consultants who participated in Health checkup camp were – Dr. VandanaDhaktode, DrRashmiPhansalkar, Dr. Vijay Chinchole, Dr. ReenaChoudhari, Dr. Bharti Choudhari and members of IDA.

13 residents of the old age home were benefited.



4) 29th April 2018 – AHA certified BLS workshop

The first **AHA Certified BLS Workshop** in association with Symbiosis Institute of Health Sciences (SIHS) was held on 29th April at Heritage Hall, Dombivli East under Project Sanjeevan. Delegates from Dombivli, Kalyan, Ambernath, Navi Mumbai and Thane attended the workshop. 2 MMC credit points were granted to RMPs. All delegates appeared for a test at the end of workshop and passed with flying colours. They have been awarded with AHA certification with BLS provider card (Internationally valid for 2 years).

34 healthcare professionals were trained in BLS(AHA certified) under Project Sanjeevan.



5) 12th May 2018 - Mother's Day

Mother's day was celebrated at IMA Dombivli in a unique way. Women's Wing IMA Dombivli organized a health checkup for Mothers on 12th May at Dombivli Gymkhana. Mothers were given comprehensive Health Check Up –Pathology (by Dr Makrand Ganapule), Bone Density, ECG, Neurological Assesment, Fundoscopy, Cosmetic consultation (by Dr Gayatri Bhardwaj), X RAY and Mammography (by Dr Utkarsh Bhingare).

45 mothers took benefit of the health check-up camp.



6) 30th May 2018 – Hypertension Symposium

On 30th May, a **Hypertension Symposium** was organized. The topics were -JNC 8 Classification -Guidelines for Hypertension,BP Management in Acute Stroke and Treatment of Resistant Hypertension.1 CME credit point approved from MMC. Dr. Ashwini Acharya was the moderator for the CME.

The CME was attended by 97 Doctors.



7) 31st May 2018 – BLS training for Lay Rescuers (Project Sanjeevan)

A **BLS Workshop for Lay Rescuers** was organized by IMA Dombivli under 'Project Sanjeevan'. It was organized atEktaNagarwhere enthusiastic lay people were given hands on CPR training and were also trained on the use of AED by DrSandhyaBhat, DrDeepa Shukla, Dr. NayanaChoudhari and Dr. MeenaPruthi. The event was highly appreciated by all participants and they were issued certificates after successful training.

38 lay rescuers were trained for BLS under Project Sanjeevan.



8) 17th June 2018 - Father's Day Celebration

IMA Dombivli celebrated **Father's Day** in a grand way on 17th June 2018 for the first time ever. 3 generations of families were invited. The event was executed by Cultural committee. The evening 'Ek Suhaani Shaam' was made alive and memorable by the mellifluous voice of Dr. Shashikant Kamat and his group. There were lots of sentimental moments when the children expressed their love and gratitude for their father. The fathers were felicitated and lots of prizes were given.



9) 21st June 2018 – Nurses Training Program on Communication skills

A **nurses training program** was organized by IMA Dombivli under HBI activity of IMA Dombivli. The event was a Patient Management Program on Communication and Interpersonal skill.Dr. Sunit Upasani was the coordinator for the workshop.

Program was attended by 90 nurses and para clinical staff from 26 different hospitals.



10) 24th June 2018 - World Elder Abuse awareness Program as per IMA HQ/IMAMS directive with BLS training for Lay Rescuers

24th June 2018, Sunday – a community program was held in Pathare Hall, Dombivli Gymkhana

On the occasion of **'World Elder Abuse Awareness Day'**. The program started with a training on Basic Life support by members of Team Sanjeevan – Dr. Dee Shukla and Dr. Nayana Chaudhari, followed by a skit presentation on Elder Abuse by 'Kalakar Amhi Kalyankar' group. This was followed by a lecture on Elder abuse and its prevention by Mr. Ramesh Parkhe and another lecture on Ageing Gracefully Dr. Dushyant Bhadlikar.The program was coordinated by Dr. Vijay Chinchole.

About 60 senior citizens and their caretakers attended the program and were also trained for BLS under Project Sanjeevan.



11) 27th June 2018 – Multispeciality CME

Multi-specialty CME (with 1 credit point from MMC) was organized on 27th June. The topics were presented by renowned speakers from Dombivli. The topics for the same were Fever in Pregnancy By Dr. Krishnakumar, Gall Bladder Diseases – Diagnosis and Treatment by Dr Rahul Mahadar and a lecture on Monsoon Preparedness was taken. Dr. Niti Upasani was the moderator for the program.

The program was attended by 97 delegates.



12) 1st July 2018 - Doctor's Day Celebration

DOCTOR'S DAY was celebrated by IMA Dombivli on 1st July 2018. A special GBM was convened in which IMA HQ theme of Healthcare Violence was discussed. Member of Parliament Dr. Shrikant Shinde was the Chief Guest for the Doctors Day Program after GBM. MP Dr Shrikant Shinde was explained the issue of healthcare violence in depth by IMA National Jt Sec and National Convener for Committee on Zero Tolerance of Violence on Doctors Dr. Mangesh Pate. He also appealed the MP to raise the issue and all IMA demands in Parliament in coming Loksabha session. Dr. Pate also appealed Dr. Shinde to push for a strong Central act for safety of healthcare professionals.

As per IMA Dombivli tradition, awards were distributed to Doctors with professional or personal achievements and also to children of IMA members with academic and extracurricular excellence. An appeal was made to the people *to donate blood on the occasion of Blood Donation drive organized by IMA Dombivli on 8th July 2018

A Press Meet was organized and a press release regarding violence issue & IMA demands was given.

This was followed by fellowship program.The meet was attended by over 165 people.

13) 3rd July 2018 - Mission Pink Health

Mission Pink Health by IMA Dombivli - IMA Dombivli Women's Wing &Aao School Chalein committees jointly conducted a camp at DKVC School, Dombivli East on 03.07.18 as a part of MISSION PINK HEALTH program, with guidance from state co- coordinator MPH Dr. MeenaPruthi.

Anemia detection & treatment with general health checkup was conducted for girls between the age group 12 to 16 yrs.Atalk on Anemia awareness, menstrual health & hygiene was given by Dr. ManasiKarandikar. General checkup, Anemia detection & treatment of boys of age the group 12 - 15 yrs was conducted. A lecture for boys on general health &adolescent issues was taken by Dr.DushyantBhadlikar,chairman, Aao School Chalein Committee. The consultants who participated in the program were –

Dr. Anjana Parashar, Dr. Charusheela Deodhar, Dr. Shalaka Sonawane, Dr. Vijayalaxmi Shinde, Dr. Nayana Chaudhari, Dr. Shyamkant Ghotikar, Dr. Dilip Joshi, Dr.Vandana Dhaktode, Dr. Sunit Upasani, Dr. Rahul Karandikar and Dr. VinayByadgi.

Nearly 250 children benefited.



14) 4th July 2018 - Aao School Chalein

Health Education at Gurukul Day School under Aao School Chalein was conducted on 4th July 2018 from 9.30 am till 11.00 am. Dr.Dushyant Bhadlikar, Chairman of ASC Committee took session on Reproductive health and Changes during adolescence for boys. Dr.Manasi Karandikar, project Coordinator for ASC took session on Reproductive health, nutrition and hygiene for girls.

About 150 students were benefited.



15) 8th July 2018 - Blood Donation Drive

On the occasion of Doctor's day, **Blood Donation camp** was organized as per the directives of IMA MS/IMA HQ in association with Plasma Blood Bank on 8th July 2018 at Dombivli Gymkhana. Dr. Utkarsh Bhingare was the project chairman.

74 units of blood was collected.



16) 18th JULY 2018 - MISSION PINK HEALTH

IMA Dombivli Women's Wing & Aao School Chalein committees jointly conducted a camp at Kumkum School, Dombivli East as a part of MISSION PINK HEALTH programme with guidance from state co coordinator for MPH Dr. MeenaPruthi. Anemia detection & treatment, deworming and health education for boys and girls between age groups 11 – 14 years was conducted for 168 boys and girls.

A lecture on Anemia awareness, hand hygiene, good touch/ bad touch, adolescent health and hygiene was given by Dr.Vijayalaxmi Shinde for girls and on adolescent education for boys by Dr. Dushyant Bhadlikar.

General health checkup was conducted by

Dr. Leena Lokras	Dr. Niti Upasani
Dr. Vandana Dhaktode	Dr. Dilip Joshi
Dr. Anusuya Gopal	Dr. Manasi Karandikar
Dr. Nikhil Kulkarni	Dr. Milind Sakpal

Dr.Bharti Chaudhari and Dr. Madhav Baitule arranged for Hb estimation of the students. Dr. Nayana Chaudhari, Convener of IMA Dombivli women's wing coordinated the whole project.



17) 22nd July 2018 - ECG and Treadmill Workshop

IMA Dombivli CGP subchapter organized ECG and TMT workshop on 22nd July 2018 at Heritage Annexe, Dombivli - E. Dr. Harin Vyas, cardiologist, Fortis Hospital, Mulund conducted the workshop. Dr. Vyas explained the difficult concept of ECG and TMT in simplest possible manner. All delegates were given a booklet on the topic. The workshop was well appreciated by all the delegates. Quiz was conducted at the end of each topic and participants were given prizes for correct answers.

The workshop was attended by 40 delegates from Dombivli, Kalyan, Bhiwandi, Ambernath and Ulhasnagar.



18) 28th July 2018 – Dhikkar Diwas

IMA Dombivli conducted GBM to discuss all aspects of NMC bill and the reason behind the call given for suspension of routine medical services by IMA all over India.The GBM saw a huge turnout of members. IDA Dombivli attended our meeting and declared their support to our cause.

This was followed by press conference which was attended by many reporters from print and television media and they were made aware of the harsh realities of NMC bill and its overall effects on medical education and healthcare system in India.

A memorandum was submitted to Tehsildar, Kalyan.


19) 29th July 2018 - AHA certified BLS workshop

IMA Dombivli in association with Symbiosis institute of Health Sciences (SIHS - Pune) conducted 2nd AHA Certified BLS workshop on 29th july 2018, Sunday under Project Sanjeevan. Delegates learnt life saving skills of CPR, use of AED, first responder treatment in choking and drowning. 2 MMC credit points were granted to RMPs. All delegates appeared for a test at the end of workshop and passed with flying colours. They have been awarded with AHA certification with BLS provider card (Internationally The event was well appreciated by all delegates and boosted their confidence to handle emergencies.

40 Delegates from Dombivli, Kalyan, Bhiwandi, Ambernath, Badlapur, Shahpur attended the workshop.



20) 10th August 2018 - Aao School Chalein

Health Education at Holy Angel's School under Aao School Chalein was conducted on 10th August 2018 from 1.30 pm till 3.30 pm. Dr.DushyantBhadlikar, Chairman of ASC Committee took session on Reproductive health and Changes during adolescence for boys. Dr.Niti Upasani took session on Reproductive health, nutrition and hygiene for girls. The program was co-ordinated by ASC Convener Dr ManasiKarandikar.

About 300 students were benefited.



21) 12th August 2018 – Monsoon Picnic to Durshet Forest Lodge Resort, Khopoli

The cultural committee of IMA Dombivli organized a monsoon picnic on 12th August 2018 to Durshet Forest Lodge Resort, Khopoli. The picnic was attended by 42 members. It was a memorable picnic where everyone enjoyed the adventure games, forest trail, waterfall, Rain dance and many many more activities.



22) 22nd August 2018 – Medical CME

Medical CMEwith 1 credit point from MMC was organized on 22nd August. The topics were -Recognizing sleep Apnea in clinical Practice, Acute Kidney Injury and Understanding LFTs, which were presented by renowned speakers from Dombivli – Dr. S. RamnathanIyer, Dr. Dinesh Mahajan and Dr. Rakesh Patel. Dr. Ashwini Acharya was the moderator for the program.

The program was attended by 87 delegates.



23) 9thSeptember 2018 – Fu Bai Fu (Mangala Gauri program)

IMA Dombivli Women's wing celebrated MangalaGauri in a traditional way by organizing a cultural program Fu Bai Fu which was attended by 33 women members of IMA Dombivli. Dressed in traditional Navwari attire, the participants had a great time by enjoying the traditional Maharashtrian games, Ukhana competition and many prizes were distributed. Dr. LeenaLokras, Dr. NayanaChoudhari and Dr. ManasiKarandikar from team women's wing coordinated for the event.



24) 22nd September – BLS training at Holy Angels School

IMA Dombivli Sanjeevan Committee undertook BASIC LIFE TRAINING workshop for teachers of HOLY ANGELS SCHOOL Dombivli on 22nd September 2018.Lecture on BLS was given by SanjeevanCommitee Chairperson Dr.SandhyaBhat along with entire coordination of the program and demonstration of the BLS was given by IPP Dr. Niti Upasani.All the teachers were given Hands On training on Manikin by Dr.SandhyaBhat and Dr.Archana Pate. The program was attended by nearly 50 teachers from Holy Angels School.

25) 28th September – Organ Donation Awareness Session at Model College

Organ donation awareness program was on 28th September 2018 at Model College, Khambalpadawhich was attended by more than 100 NSS volunteer students and teachers.

Dr Archana pate took session on organ and body donation, Dr Sunit Upasanispoke about skin donation and Dr SheetalKhismatrao talked about eye donation. The program was very appreciated by students as well as teachers and we could clear their doubts.

26) 6th October 2018 - Educational workshop for Young Women at Model college

IMA Dombivli undertook Educational workshop for nearly 150 female students and teachers of Model College. The following topics were covered - ‡A healthy Mind - Psychological health issues in the Adolescent Age was covered by Dr. Adwait Padhye. Menstrual & Sexual Health & Hygiene was taken up by Dr. Niti Upasani. Cervical Cancer Awareness & Prevention was covered by Dr. Nilesh Shirodkar

27) 7th October 2018 - Self Defence Workshop for underprivileged girls

A Self Defence Workshop was conducted for underprivileged girlsat School in Golivli, Kalyan east by Beti Bachao Beti Padhao Committee (BBBP Committee) of IMA Dombivli in coordination with NGO Vacha group with the help of BBBP chairperson Dr. Vijayalaxmi Shinde.

35 underpriviledged girls of age groups 13 years to 16 years benefitted from the program.Selfdefence from I.I.K.F. took the sessions and gave live demonstrations on how to deal with common incidents. Importance of Good touch and bad touch with safe circle sharing was taught..Adolescent Nutrition and health needs were also explained.



28) 10th October 2018 –School Health under Women's wing and Aao School Chalein

IMA Dombivli WW and Aao School Chale teams conducted a comprehensive medical checkup camp and lecturers for 1st to 10th grade students of Kidsland School, Dombivli west. The following lectures were conducted:

1)Hand hygiene and general hygiene by Dr.Leena Lokras and Dr. Sandhya Bhat.

2) Menstrual problems and sex education by Dr. Niti Upasani

3) Challenges of adolescence in School children by Dr. Dushyant Bhadlikar

Medical checkup was done with the support of following members:

1) Dr. Revathi Iyer
2) Dr. Dilip Joshi
3) Dr. Ghanshyam Shirali
4) Dr. Niket Karnik
5) Dr. Sunit Upasani
6) Dr. Niti Upasani
7) Dr. Archana Pate




29) 13th October 2018 - Mission Pink Health at Mahatma Gandhi school , Dombivli West

IMA Dombivli Women's Wing conducted a camp at Mahatma Gandhi school, Dombivli West as a part of Mission Pink Health program under guidance from state co ordinator Dr. MeenaPruthi. The program was coordinated by WW Chairperson Dr. Leena Lokras and convener of WW Dr. NayanaChoudhari.

Hb estimation for Anaemia detection was done by Dr. Madhav Baitule. A lecture on Anaemia awareness, hand hygiene, good touch/ bad touch, adolescent health and hygiene was given by Dr. Manasi Karandikar & Dr. Netra Pachpande. General health checkup was conducted by Dr. Vandana Dhaktode, Dr. Anusuya Gopal, Dr. Sheetal Sagade, Dr. Anjana Parashar, Dr. Charusheela Deodhar, Dr. Priya Karande and Dr. Swati Gurav

Nearly 180 girls between the age group 12-16yrs benefitted from the program.



30) 14th October 2018 – IMA Dombivli DandiyaRaas

IMA Dombivli cultural committee organized DandiyaRaas on the occasion of Navratri. IMA members joined with family and friends. Great participation of members with great music and lovely ambience made the evening one of the most memorable one!



31) 30th November 2018 - Workshop on ICU Management For Non Intensivists

IMA Dombivli in association with Fortis Hospital, Mulund organised full day workshop on ICU Management for Non Intensivists. The workshop aimed at early identification and treatment of complications in indoor patients. It also included basic ventilation and hands on training for various procedures like central line, arterial line, intubation, tracheostomy etc. The workshop was attended by 50 delegates and was well appreciated by everyone. MMC granted 2 credit points for the workshop.



32) 30th November 2018- NAVRANG 2018

IMA Dombivli celebrated its cultural event NAVRANG 2018with great fanfare and super participation of members. There were 4 main events – Nupur (Dance competition), Taraana (Singing competition), IMA's got Talent (The Talent Competition) and Inaayat (The fashion Show). Experts in the fields were invited as judges. IMA members, their spouses, kids and family members participated enthusiastically into the event.



33) 1st and 2nd December 2018 - MAHAHOSPICON / IMAFEST 2018

Organising MAHAHOSPICON (IMA Maharashtra State Conference of HBI) along with IMAFEST 2018 (Annual Conference of IMA Dombivli) was an absolute honour and privilege. The conference witnessed a power packed package thanks to wonderful team work, great camaraderie and amalgamation of knowledge and culture. The highlights were -

- Eloquent speakers of National and International repute
- Highly informative panel discussions on issues encountered in day to day practice.
- Presence of National and State IMA leaders -

  National President Dr Ravi Wankhedkar, National Finance Secretary Dr Monga, National HBI Chairman & Hon. Secretary General elect Dr R V Asokan , Past National Presidents Dr. A Marthanda Pillai, Dr Ashok Adhao, National HBI Secretary Dr Jayesh Lele, Maharashtra State IMA President Dr Hozi Kapadia, Hon. State Secretary Dr Suhas Pingale, MMC President Dr Utture, National Vice President Elect Dr Anil Pachnekar...we are grateful to all IMA Leaders for gracing the occassion.
- The event was graced by presence of Hon Minister of State Shri Ravindra Chavan.
- Conference Souvenir was released by National President Dr. Ravi Wankhedkar, Hon. Shri Ravindra Chavan and dignitaries which is a complete handbook of relevant topics of day to day practice.
- Dr. U. Prabhakar Rao Oration was delivered by renowned psychatrist and theater /film personality Dr. Mohan Agashe.
- 4 credit points from MMC.
- Enthusiastic participation of delegates from all over Maharashtra was a great booster.
- Gala Banquet - JASHN - was a grand event in itself - masti, music and lots and lots of fun... the delegates enjoyed to their heart's content

It was an ultimate grand show of Team work, thoughtfulness, sincerity and hard work...



34) 4th JAN 2019 - ALL INDIA PROTEST DAY

In view of the All India Protest Day declared by IMA HQ and IMA MS to protest against 3 detrimental bills, IMA Dombivli observed Porotest. All IMA Dombivli members wore black band around their arm during work, Protest day posters were put up in OPDs and a memorandum was submitted to Hon MP Shri Shrikantji Shinde.




35) 19th January 2019 - Emotionally Intelligent Relations Through Time / Stress Management with Haldi Kumkum celebration

Women's wing IMA Dombivli under Dr. Leena Lokras and Dr Nayana Chaudhari conducted a workshop on EMOTIONALLY INTELLIGENT RELATIONSHIPS THROUGH STRESS AND TIME MANAGEMENT on 19th Jan 2019. Speaker DR KAVITA KAREER spoke on innovative ways of dealing with stress that we as professionals deal with in our various roles. The workshop was interactive and the audience was involved in various fun activities to understand and deal with our problems.The workshop was attended by 38 members. Makarsankranti was also celebrated by wearing black attire, applying haldi- kumkum & distributing tilgul.



36) 26th JAN 2019 - PROJECT DNYANDA - IMA DOMBIVLI BBBP

On 26th January 2019, on the auspicious occasion of Republic day, IMA DOMBIVLI under BBBP donated school supplies useful for science lab as part of Project Dyanada. Beneficiary school was Shivai balak vidya mandir, MIDC, Dombivli East. The project was arranged and coordinatedby BBBP chairperson Dr. Vijayalaxmi Shinde and BBBP convener Dr. Hemant Patil. Dr Sushil Shinde and Ms. Smira Shinde graced the occasion with their presence and support.

37) 27th JAN 2019 - LOHGAD TREK

For the first time ever, IMA Dombivli organised a trekking expedition - to the mighty Lohgad fort.

Though called easy by the standards of seasoned trekkers, for inexperienced and novice trekkers, it is a test of endurance and will power. The impregnable, robust fort situated at 3500 feet and the hard approach makes you respect the makers of it with bowed head.

30 enthusiastic trekkers from IMA Dombivli participated in the trek and it was an experience to be cherished for life. The age range of participation was from 7 years to 57 years. The trek was thoroughly enjoyed by everyone andthe next trek is already eagerly awaited. Dr Mangesh Pate, Dr Vandana Dhaktode, Dr Meena Pruthi and Dr Bhakti Lote helped with all the arrangements of the trek.




38) 29th JAN 2019 - ORGAN DONATION AWARENESS PROGRAM

IMA Dombivli conducted Organ Donation Awareness program at K.M.Patel college of commerce and science, Thakurli on 29th Jan 2019.The program was attended by teachers and nearly 100 senior college students. Dr.Sunit Upasani spoke on Body Donation with Eye and Skin Donation and Dr. Archana Pate spoke on Organ Donation in general. Dr Meena Pruthi graced the occasion with her presence. The program was well appreciated by teachers as well as students.



39) 30th Jan 2019 -MULTISPECIALITY CME

IMA Dombivli conducted Multispeciality CME on 30th Jan 2019. The topics and speakers were :

Varicose veins, an Enigma Simplified (Dr Ashish Dhadas), Infectious Diseases Diagnostics (Dr. Shamma Athalye –Shetye) and New trends in Spine (Dr. Nilesh Zope)

The CME was attended by 92 delegates. Dr. Bhakti Lote was the convener of the CME program. The sessions were moderated by Dr. Anasuya Gopal, Dr Susheela Aravindan and Dr. Bhakti Lote. 3rd issue of IMA Dombivli's quarterly magazine "Dialogue" was released by senior physicians Dr. Sunil Gadkari and Dr. Aruna Naik Desai. An extraordinary GBM was convened on the same day prior to CME for discussing the format for IMA Dombivli trust.




40) 6th Feb 2019 -MISSION PINK HEALTH

Mission Pink Health - School health check up and health awareness program was organised by IMA Dombivliat Dnyanmandir school, Dombivli East on 6th February 2019. Anaemia detection & treatment was conducted for around 170 girls and boys between the age group 11 to 13 yrs.A lecture on hand hygiene was taken by Dr.Vijayalakshmi Shinde. A lecture on Anaemia awareness, menstrual health & hygiene was taken for the girls byDr. Manasi Karandikar and adolescent health was taken for the boys by Dr.Vijay Chinchole.

General health checkup was conducted by

Dr. Archana Pate	Dr. Vijay Aage
Dr. Alka Gadgil	Dr. Bhakti Lote
Dr. Nayana Chaudhary	Dr. Vinay Byadgi
Dr. Swati Gurav	Dr. Vaishali Pagare

Hb estimation of the children was done on 4th Feb by Dr.Baitule .The entire program was organised and conducted under the supervision of Dr. Meena Pruthi - Chairperson, Mission Pink Health, IMA Dombivli




41) 8th Feb 2019 - NURSES' TRAINING WORKSHOP

IMA Dombivli through its HBI subchapter conducted Nurses' training workshop in association with IMA MS HBI - NABH Accreditation Initiative Technical Support team on 8th February 2019.

The session was attended by 107 staff nurses representing 25 hospitals from Dombivli, Kalyan, Ambernath, Badlapur and Ulhasnagar

The staff nurses were given training on various topics like

- Hospital Infection Control
- Management of Medication
- Hospital Patient and employee safety
- BMW management
- Emergency Medical codes
- Patient's Rights and responsibilities

These topics were as per requirements by hospitals (for staff training) to prepare for NABH accreditation entry level certification. The training was taken by expert trainers provided by technical support team of IMA MS HBI Accreditation Initiative. The staff nurses were given certificates on successfully completing the workshop.



42) 9th Feb 2019 - PLAY, PUB G, PARENTING & PARIKSHA (a counselling workshop on mental health of children for parents and teachers)

A unique program was organised by IMA Dombivli in a unique manner by inviting renowned psychiatrist Dr. Harish Shetty on 9th February 2019 for a workshop, where students, Parents and Teachers came together and were counselled regarding the do's and dont's for strong mental and psychological health of children.

There were many more golden pointers, which Dr Shetty gave in a very light play way method while interacting with children present in the workshop. More than 200 parents / teachers participated in the program. School heads / teachers from 12 schools in and around Dombivli participated in the program and were felicitated by IMA Dombivli for giving importance to mental health of children.

43) 20th February 2019 - CME on End TB Initiative & Others

IMA Dombivli conducted Multispeciality CME on 20th Feb 2019. The topics and speakers were : TB Diagnosis and Treatment guidelines by Dr Sandhya Kulkarni, Govt Guidelines on TB, beyond Treatment by City TB Officer Dr. Sameer Sarvankar, Hematological Surprises in Medicine by Dr Punit Jain and Metabolic Disorders in Children by Dr Prashant Patil.

The CME was attended by 74 delegates.Dr. Ashwini Acharya was the convener of the CME program. The sessions were moderated by Dr. Alka Gadgil, Dr.Dilip Joshi, Dr. Reena choudhary and Dr.Milind Sakpal. The CME was well appreciated by all delegates.

44) 24th Feb 2019 - Life Saver's Run 2019 (Awareness Run to Create Awareness about Importance of learning Life Support)

For the first time, IMA Dombivli organised an Awareness Run to create awareness about Importance of learning life support. Nearly 450 people participated in the run. Dr Ajit Oak, an ultra Marathon runner and member of IMA Dombivli flagged off the event. A skit on Life support was performed by IMA Dombivli members. Hands only Life Support for Lay rescuers was demonstrated to the participants. Zoomba session was taken. All in all, it was a super successful event.

45) 24th Feb 2019 -Annual general Body Meeting with Anand Mela (Annual get Together)

On 24th February Evening, AGM was conducted in Dombivli Gymkhana New Building. Welcome Address was given by President Dr archana Pate, secretarial Report was presented by Dr.Vandana Dhaktode. Provisional half yearly accounts were presented by Dr Sunit Upasani. Various issues were discussed. All committees presented their reports. Problems with IMA Dombivli Trust formation were informed to members. **For the first time, IMA Dombivli comprehensive directory Green Book was released** during AGM at the hands of Dr Mangesh Pate, Dr Yogesh Acharya, Dr G.V.Kulkarni and Dr Shyam Ghotikar.IMA Dombivli election results for the year 2019 – 20 were announced by Election Officers Dr mangesh Pate, Dr Dilip Joshi and Dr Vijay Aage. Incoming President Dr Meena Pruthi and her team were felicitated. IMA Dombivli awards for the year 2018 – 19 were given.

46) 6th March 2019 - Nurses Training Program

IMA Dombivli through its HBI subchapter conducted its 2nd Nurses' training workshop in association with IMA MS HBI - NABH Accreditation Initiative Technical Support team on 6th March 2019.

The session was attended by 54 staff nurses representing 13 hospitals from Dombivli, Kalyan and Ulhasnagar. The topics of training were as per requirements by hospitals (for staff training) to prepare for NABH accreditation entry level certification. The training was taken by expert trainers provided by technical support team of IMA MS HBI Accreditation Initiative. The staff nurses were given certificates on successfully completing the workshop.



47) 8th March 2019 – Women's Day Celebration (Workshop On Grooming)

IMA Dombivli WDW celebrated Women's day on 8th March 2019. A workshop was organised on Self Grooming. Renowned cosmetologist from Dombivli Dr Gayatri Bharadwaj and her team conducted the workshop for 31 female IMA members, where in following were included: Simple makeup, Self-do hairstyles and various styles of saree draping.

The theme was floral. Prizes were given for 3 best dressed members. The WDW members for the next year were introduced & felicitated. The function concluded with cake cutting.



48) 10th March 2019 – Participation in Glaucoma Awareness Rally

IMA Dombivli participated in "Glaucothon"- Glaucoma awareness Rally as per the directives of IMA Maharashtra State. The event was organised by Anil Eye Hospital under the supervision of Dr Anagha Heroor. Around 250 people took part in the rally. Slogans were raised and information on Glaucoma was given to the participants by Dr. Heroor.


49) 12th March 2019 – Health Awareness Program

IMA Dombivli WDW in association with Innerwheel club of Dombivli arranged a lecture on 12th March 2019 for staff & mothers of Rotary school for deaf students. The lecture was arranged by the school in view of Women's day. It was attended by Dr. Niti Upasani, Dr. Meena Pruthi & Dr. Nayana Chaudhari. A lecture on "parenting of children with special needs" was given by Dr. Niti Upasani. She covered menstrual health, diet & adolescent issues.



50) 16th March 2019 – BLS workshop for Lay Rescuers under Project Sanjeevan

Basic Life Support was taught to Lay Rescuers in a housing society of Dombivli by members of Team Sanjeevan for BLS training as a part of Community Service. Demonstration of Life Support with Hands on Training on Manikin was given to nearly 50 participants. Dr. Deepa Shukla, Dr Meena Pruthi and Dr Archana Pate trained the participants. Certificate of participation was given to the participants.



51) 17th March 2019 – DAAN KI ADALAT - A Mega Organ Donation Awareness program

IMA Dombivli organized a mega Organ Donation awareness Program on 17th March 2019. Through a moot court scenario and in the form of question answer session – all the nitty grittys regarding organ donation was explained in an extremely easy manner. ZTCC official Mrs Sujata Ashtekar, Transplanrt surgeons Dr Anvay Mulay, Dr Gaurav Gupta, Nephrologist Dr Haresh Dodeja, IMA HBI MS Chairman Dr Mangesh Pate, Intensivists from Fortis Dr Rahul Pandit and Dr Charudatt Vaity, Neurophysician from Pune Dr Sunil Bandishti (who has himself undergone heart transplant) participated in the program. Donor families and the recipients shared their first hand experience! The event was attended by 136 people and the immediate impact of the program was that more than 90% of the people took organ donation pledge forms for themselves and their family members. The program was very much appreciated by all those who attended the event.



52) BLS training for staff nurses – 20th March 2019

CPR training for staff nurses was given by Team Sanjeevan on 20th March 2019 at IMA Hall. 25 nurses from various hospitals across Dombivli attended the training. Dr. Deepa Shukla, Dr. Meena Pruthi and Dr. Archana Pate conducted the training.



Membership Development drive

Concessional rates for IMA Dombivli membership were announced from 15th January till 15th March 2019.

15 new life members were inducted.

Upcoming programs of March 2019:

1. 27th March 2019 - Medicolegal CME on Medical Ethics (by Dr. Sivkumar Utture, President, MMC and Overview of Laws relating to Medical Practice (by Dr. Vivek Tilwani, Medicolegal Consultant)
2. Installation of Team 2019 – 20 – 31st March 2019

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Consultant Plastic & Cometic Surgeon

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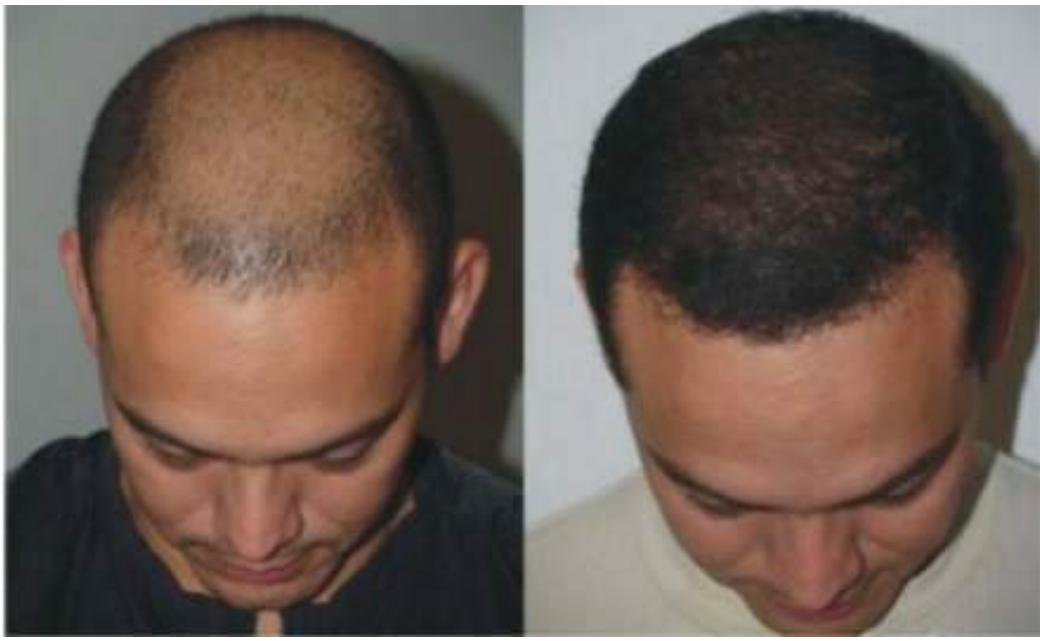

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- NEUROLOGY
- NEURO SURGERY
- OBSTETRICS & GYNAECOLOGY
- ONCOLOGY - MEDICAL
- ONCOLOGY - RADIATION THERAPY & BRACHYTHERAPY
- ONCOLOGY - SURGICAL (BREAST, GYNEC, GI & HPB, HEAD & NECK, URO, HAEMATO)
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- OPHTHALMOLOGY
- PEDIATRICS & NEONATOLOGY
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- PLASTIC & COSMETIC SURGERY
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IMA DOMBIVLI AWARDS (2018 – 19)

IMA Dombivli awards are presented every year to recognise the work done by our members and to encourage others to work better towards IMA and towards society in general. The awards for the year 2018 – 19 were presented to the following members of IMA Dombivli after meeting the selection Criteria, as per the decision of Managing Committee, during AGM held on 24th February at New Building, 3rd floor, Dombivli Gymkhana, Dombivli – E. The award recipients under various categories are:

LIFE TIME ACHIEVEMENT AWARD (2018 -19)

In Recognition Of Dedication to Medical Profession, Distinguished Work & Outstanding Contribution to Indian Medical Association, Dombivli, the IMA Dombivli Life time Achievement award for the year 2018 – 19 was awarded to **Dr. Dilip Joshi**

About Dr. Dilip Joshi :

- M.B.B.S., DCH)
- Consulting Paediatrician
- Undergraduate & Postgraduate Medical Education at Seth G.S.Medical college, KEM Hospital, Mumbai
- PROFESSIONAL EXPERIENCE
  - Paediatrician at Central Rly. Hospital Byculla and Kalyan for 7 years.
  - Worked in dept. of Paediatrics at Teaching Hospital, Missurata Libya for 5 years 6 months where developed interest in Neonatology.
  - After coming back to India joined Shastrinagar KDMC Hosp as Paediatrician in 1992 where he single handedly developed 12 bedded Paediatric & 8 bedded NICU Dept. From year 2000 to 2006 Paediatric Dept. was recognised by CPS through Terna Medical College for DCH Studies. During this period, he was involved in clinical training of Residents.
  - For last 12 years, Dr Joshi is Director & Consultant of Ace Children's hospital Dombivli which is a tertiary care centre for children
- IMA ACTIVITIES: Past President of IMA DOMBIVLI. First time started IMA Dombivli Conference. During tenure 1st time published 3 books for public health through IMA.

  Working actively with IMA Dombivli for last many years.
- SOCIAL ACTIVITIES: Active Rotarian for 25 years, Past President of Rotary, worked for malnourished children from tribal areas of Thane DIST.
- ACADEMIC ACTIVITIES: Delivered many lectures on health Training programs for doctors & nurses, twice was on DD TV Channel on child health.

HOBBIES : Travelling, Trekking, Dancing

IMA DOMBIVLI DOCTOR OF THE YEAR AWARD (2018 -19)

In Recognition Of Ongoing Commitment to Excellence, Selfless Contribution to Community and Appreciable Work Done For Indian Medical Association, Dombivli, IMA Dombivli Doctor Of the year award for 2018 – 19 was awarded to **Dr. Dushyant Madhav Bhadlikar**

About Dr. Dushyant Bhadlikar :

- MBBS 1995 SETH G S M C , MUMBAI
- MD(Psychological Medicine) 1998, GSMC
- Certified Trainer for EMDR Therapy
- Responded to natural disasters like Bhuj Earthquake, Srinagar floods, Nepal earthquake, Kerala floods.
- Has trained mental health professionals abroad in Afghanistan, Bangladesh, Vietnam, Philippines and Thailand.
- Also Practices Cognitive Behavior Therapy and HYPNOTHERAPY.
- Enjoys giving talks on Mental health

PRESIDENT'S APPRECIATION AWARD (2018 – 19)

In Recognition Of Outstanding Leadership, Selfless Contribution towards Betterment of Medical Fraternity and Unwavering Support and Commitment To IMA Dombivli – for being elected for 2nd consecutive year as Office bearer of IMA HQ and for being elected unopposed as Chairman, IMA HBI Maharashtra State - was awarded to IMA Dombivli's National Leader **Dr Mangesh Pate**

Woman Power

PRESIDENT'S APPRECIATION AWARD (2018 – 19)

In Recognition of her Contribution in adding a Feather to the Glorious Cap of IMA Dombivli With her Selection as Hon. Secretary of Women Doctor's Wing IMA MS And her Unwavering Commitment & Support to IMA Dombivli - **Dr Neeti Upasani**

IMA DOMBIVLI MOST ACTIVE MEMBER OF THE YEAR

For her Dedication, Commitment, and Spearheading / participating in maximum projects for the year 2018 – 19 was awarded to **Dr Meena Pruthi**

IMA DOMBIVLI PROMISING MEMBER OF THE YEAR

In Appreciation and Recognition of their Commitment To IMA Dombivli and For Fulfilling their Responsibilities with Utmost Sincerity was awarded to **Dr Deepa Shukla** and **Dr Nayana Choudhari**

PRESIDENT'S APPRECIATION AWARD (2018 – 19)

In Grateful Appreciation for their Whole Hearted Support, Strong backing and their Outstanding Contribution to the success of the year 2018 – 19 was awarded to **Dr Vandana Dhaktode** and **Dr Sunit Upasani**

PRESIDENT'S APPRECIATION AWARD (2018 – 19)

In Appreciation and Recognition of their Commendable Work And Contribution to the Success of the Year 2018 – 19 was awarded to the following members :

- Dr. Bhakti lote
- Dr. Makarand Ganapule
- Dr. Ashwini Acharya
- Dr. Suchitra Kamath
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HEALTH FIRST CAMPAIGN
BY INDIAN MEDICAL ASSOCIATION
(Health Manifesto by IMA)

OBJECTIVE

The health sector in India has never been given the priority it deserves, leading to grossly inadequate services at levels. The allocation of meager 1.1% of GDP for health services speaks volumes about the apathy of successive governments towards this most important determinant of social and economical progress of a nation. Health sector being one of the largest employer of the population and "the" largest employer of the female population certainly deserves more attention from policy makers.

Indian Medical Association, the national association of more than 3 lakh modern medicine doctors as direct members across the country ***and another 5 lakh indirect members through its wings such as junior doctor network, medical students network, federation of medical association , women's wing etc proposes*** to launch a **HEALTH FIRST** initiative. The aim of the **HEALTH FIRST** initiative is to provide a holistic approach to health care sectors, having **common man as focal point.**

Through this initiative ,we wish to offer our services as *a* think-tank, *support and pressure group* to the government both at national and state leve*l* so as to bring health *at the* forefront on the agenda of political parties.

After exhaustive discussions and deliberations with multiple stake holders and experts ,**Indian Medical Association** have prepared a document of health issues which need urgent attention of the government & political parties.

Here are some of the points presented as **"MAGNA CARTA FOR HEALTH"** ie, the **Health Manifesto** for our country.

MAGNA CARTA FOR HEALTH

1. Increased public expenditure in Health Care.

2. Universal Health Coverage through government funding

3. Private Public Partnership facilitated by not for profit institutions.

4. Emphasis on Primary Care and Rural Health Care

5. Structured Universal three tier reference system.– Primary, Secondary & Tertiary care

6. No Criminalization of Medical Profession.

7. Quality public funded medical education governed by autonomous democratic regulation.

CHARTER

1. GDP share in health care

Increase GDP *share* in health care from 1.2 % to 5%. Prioritize primary & preventive health, social determinants of health, medical education and research for fund distribution. Fund allotment has to be as per the percentage of patients seeking treatment in any particular system. Bring mechanism to ensure utilization & outcome.

2. Universal health coverage- to all irrespective of socioeconomic group or geographical location.

Attainment of universal health coverage and Sustainable Development Goals by 2025. Direct public funding for improving access , increasing infra structure and man power. Insurance based public funded programs have to be abandoned and direct government funding to be introduced. Right to health has to be embedded in the constitution.

3. Primary health care and rural health care

Increase number of Primary Health Centers to focus on preventive and primary health care. One sub center for every 10000 population in urban and semi urban areas, 5000 in rural areas and 3000 in hilly and tribal areas. Improve infrastructure and total manpower in subcentres. Reconcieve wellness centre concept. Wellness centers, if at all established to be manned by MBBS graduates.

4. **Co ordinated approach for improving *Social determinants of health***

Focus on **preventive and *public* health care**

Improve sanitation ensure safe drinking water , adequate ,nutritious & hygienic food. Ensure safe and healthy food policy by implementing stringent measures on adulteration, health tax on junk food, tobacco, alcohol etc, scientific slaughter houses, regulation of use of preservatives and pesticides, encourage safe transport and storage of food etc. Health impact assessment before starting industries and enterprises.

5. Medical education

To start more number of medical colleges in the goverment sector in states lacking in medical manpower.

Capping of fees of private medical colleges to make them affordable to all.

State based health manpower assessment to ensure equitable distribution of teaching centers.

No dilution of scientific concepts in curriculum and no traditional system of treatment should be main streamed.

Maintain autonomy, democratic nature & federal structure of regulatory bodies and academic institutions.

Self governance of medical and allied professionals to be ensured and representation of all States in decision making. Restore democratically elected Medical Council of India. The concept of National medical commission is unacceptable.

Continuous quality improvement and advancement in knowledge to be provided to all health providers.

6. Medical research

Medical grants commission to be set up for funding medical education , co-coordinating medical universities and ensuring advanced research in medicine.

7. Shortage of Medical Manpower

Addressing the perceived issue of **shortage of MBBS doctors** in rural, tribal and hilly areas *through* incentive based approach *with* improved *administration and infrastructure.*

Appropriate mechanism to address medical manpower shortage in some states.

Govt should ensure policy initiatives to increase qualified nurses and para medical staff.

8. **Reducing the Out of Pocket Health Expenditure for common man-**

Regulating the price & quality of drugs, implants, equipments and consumables. Restructuring taxes ,import duties by proper implementation of laws to aid price regulation.

One drug, One Price policy should be followed.

9.. **Safe environment for doctors**

Strong Central **act to prevent violence** against health care providers- National Health Care Establishment Protection Act *under IPC.*

Better working environment for **service and resident doctors** to reduce present high level of stress by Good Governance policies *& implementation of service rules and rights provided in the constitution*.

No Criminal liability in Medical Practice.

10. ***Steps to improve health care delivery***

Proper public private partnership in health care. Private sector should be allowed to play collaborative and complementary role in health care delivery rather than those sectors playing parallel roles now.

Restructure Ayushman Bharat program with realistic package rates and ensure timely disbursal of funds. Eliminate middlemen and avoid leakage of funds from public exchequer. Primary Care Access in Insurance sector.

11. ***Ensure scientific and authorized health care to people***

No unscientific mixing of treatment systems.

Abolish bridge course to prevent creating separate class of doctors for underprivileged section of society.

No Crosspathy.

Strong policy and legislation regarding unauthorized treatments, advertising and quackery.

12. Protection of Small & Medium Nursing Homes

Single window clearance for Laws & Regulations for Healthcare establishments.

Better policies to ensure viability & smooth functioning of small healthcare establishments which provide 24*7 affordable, accessible, ethical and accountable health services and are backbone in providing secondary health care.

Providing incentives to small and medium scale hospitals through concessional land allotment , tax sops and other benefits as provided for IT sector and small and medium scale industries.

13. Exemption *of* medical profession from **Consumer Protection Act**, capping of compensation in medical accidents*/ negligence* , fixing of premium of indemnity insurance for doctors specialty wise as in third party insurance for vehicles.

14. ***Involvement of stake holders***

Involvement of Indian Medical association in formulation and implementation of Health policies by Central and state govt.

15. ***Social justice and elderly care***

More policy initiatives for ensuring safe and comfortable living of elderly & marginalized population (tribal, costal, women, children, disabled, mentally challenged, etc)

Immunization Schedule Recommended by IMA[1–3]

The following is the recommended immunization schedule for children from birth through 18 years according to the recommendations based on recent evidence for licensed vaccines in our country (Table 1).

Table 1: Recommended immunization schedule for children aged 0–18 years[1,2]

Age	Vaccine	Dose	Route	Site	Remarks
Birth (within 24–72 h of birth)					
	BCG	0.05 mL	ID	Left upper arm	Conventionally given on this site
	OPV-0	2 drops	Oral		
	Hep B-0	0.5 mL	IM	Left thigh	Mandatory before discharge (preferably within 24–72 hours of birth)
6 weeks	DTwP/DTaP1	0.5 mL	IM	Anterolateral aspect of thigh	Use combination vaccines whenever possible
	Hib-1				
	IPV-1				
	Hep B				
	PCV10/13-1				
	Rota-1	0.5–2 mL	Oral	Squirt toward buccal mucosa	If RV5/RV116E, 3 doses one month apart If RV1, 2 doses one month apart First dose of rotavirus vaccine not be administered after 16 weeks Last dose of rotavirus vaccine not to be administered after 6 months for RV1, and not after 32 weeks for others
10 weeks	DTwP/DTaP2	0.5 mL	IM	Anterolateral aspect of thigh	
	Hib-2				
	IPV-2				2 doses of IPV instead of 3 doses if started at 8 weeks' age. If so, 2 dose to be administered 8 weeks apart
	Hep B				
	PCV10/13-2				
	Rota-2	0.5–2 mL	Oral	Squirt toward buccal mucosa	2 doses for RV1
14 weeks	DTwP/DTaP3	0.5 mL	IM	Anterolateral aspect of thigh	
	Hib-3				
	IPV-3				
	Hep B				
	PCV10/13-3				
	Rota-3	0.5–2 mL	Oral	Squirt toward buccal mucosa	RV5/RV116E is administered as 3 doses
6 months	Hep B	0.5 mL	IM		If following 0, 1, & 6 months schedule
	OPV-1	2 drops	Oral		
	IIV-1	0.25 mL	IM		High-risk groups
7 months	IIV-2	0.25 mL	IM		
9 months	OPV-2	2 drops	Oral		
	MMR-1/MR	0.5 mL	SC		After 270 completed days
	Meningococcal conjugate vaccine-1	0.5 mL	IM		High-risk groups
10 months	Typhoid conjugate vaccine-1	0.5 mL	IM		At least 1-month gap between MMR and TCV
12 months	Hepatitis A (killed or live)	0.5 mL	IM (killed) or SC (live)		Single dose for live hepatitis A
	JE-1	0.25 mL	IM		In endemic areas <3 years age
	Cholera vaccine		Oral		Hyperendemic/outbreaks: 2 doses administered 2 weeks apart and a booster dose after 2 years
13 months	JE-2	0.25 mL	IM		In endemic areas <3 years age
15 months	MMR-2	0.5 mL	SC		
	Varicella -1	0.5 mL	SC		
15–18 months	PCV- booster	0.5 mL	IM		
16–18 months	DTwP/DTaP (**Booster 1**)	0.5 mL	IM		Combination vaccines preferred
	IPV –Booster	0.5 mL	IM		
	Hib –Booster	0.5 mL	IM		
18 months	Hepatitis A (killed)-2	0.5 mL	IM		2nd dose only for killed vaccine
2 years	Typhoid conjugate-2 or Typhoid polysaccharide	0.5 mL	IM	Upper arm	Polysaccharide typhoid vaccines repeated every 2–3 yearly If a typhoid conjugate vaccine is being given the first time at/after 2 years, a single dose will suffice.
	Meningococcal-2	0.5 mL	IM		If meningococcal conjugate vaccine is being given at first time at/ after 2 years, a single dose will suffice
4–6 years	DTwP/DTap/Tdap (**Booster 2**)				OPV up to 5 years of age
	MMR 3				
	Varicella-2				2nd dose of varicella may be given 3 months after first dose
	OPV-3				
9 years onwards (girls)	HPV				If started before the 15th completed birthday, give 2 doses 6 months apart. If started after the 15th completed birthday, 3 doses to be given. If HPV4 -0, 2, 6 months. If HPV2- 0, 1, 6 months.
10 years	Tdap/Td	0.5 mL	IM		Tdap is preferred over Td
16 years	Td/TT	0.5 mL	IM		Repeat every 10 yearly

OPV: Oral polio vaccine; DTwP: Diphtheria tetanus whooping cough pertussis; DTaP: Diphtheria tetanus acellular pertussis; Tdap: Tetanus reduce dose of diphtheria (acellular) pertussis; Td: Tetanus diphtheria; DT: Diphtheria,Tetanus, and whole cell pertussis; Hib: *Haemophilus influenzae*; IPV: Inactivated polio vaccine; IIV: Inactivated influenza vaccine; Hep B: Hepatitis B; Rota: Rotavirus; iPCV: Pneumococcal Conjugate Vaccine; HPV: Human papilloma virus vaccine; MR: Measles-Rubella; MMR: Measles, mumps, and rubella; MMRV: Measles, mumps, rubella varicella; BCG: Bacillus Calmette–Guérin.

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GESTATIONAL DIABETES

Dr. Bharat Gokani

Introduction

Gestational diabetes is a condition in which a woman without diabetes develops high blood sugar levels during pregnancy.

Gestational diabetes generally results in few symptoms; however, it does increase the risk of pre-eclampsia, depression, and requiring a Caesarean section.

Babies born to mothers with poorly treated gestational diabetes are at increased risk of being too large, having low blood sugar after birth, and jaundice. If untreated, it can also result in a stillbirth.

Long term, children are at higher risk of being overweight & developing type 2 diabetes. Gestational diabetes is caused by not enough insulin in the setting of insulin resistance.

Risk factors include being overweight, previously having gestational diabetes, a family history of type 2 diabetes, and having polycystic ovarian syndrome.

Diagnosis is by blood tests. For those at normal risk screening is recommended between 24 and 28 weeks' gestation. For those at high risk testing may occur at the first prenatal visit.

Prevention is by maintaining a healthy weight and exercising before pregnancy. Gestational diabetes is a treated with a diabetic diet, exercise, and possibly insulin injections. Most women are able to manage their blood sugar with a diet and exercise.

Blood sugar testing among those who are affected is often recommended four times a day. Breastfeeding is recommended as soon as possible after birth.[2]

Gestational diabetes affects 3–9% of pregnancies, depending on the population studied. It is especially common during the last three months of pregnancy.

It affects 1% of those under the age of 20 and 13% of those over the age of 44. A number of ethnic groups including Asians, American Indians, Indigenous Australians, and Pacific Islanders are at higher risk. In 90% of people gestational diabetes will resolve after the baby is born. Women, however, are at an increased risk of developing type 2 diabetes.

Classification

Gestational diabetes is formally defined as "any degree of glucose intolerance with onset or first recognition during pregnancy".

This definition acknowledges the possibility that a woman may have previously undiagnosed diabetes mellitus, or may have developed diabetes coincidentally with pregnancy. Whether symptoms subside after pregnancy is also irrelevant to the diagnosis.

A woman is diagnosed with gestational diabetes when glucose intolerance continues beyond 24 to 28 weeks of gestation.

The White classification, named after Priscilla White, who pioneered research on the effect of diabetes types on perinatal outcome, is widely used to assess maternal and fetal risk.

It distinguishes between gestational diabetes (type A) and pregestational diabetes (diabetes that existed prior to pregnancy). These two groups are further subdivided according to their associated risks and management.

The two subtypes of gestational diabetes under this classification system are:

Type A1:

Abnormal oral glucose tolerance test (OGTT), but normal blood glucose levels during fasting and two hours after meals; diet modification is sufficient to control glucose levels

Type A2:

Abnormal OGTT compounded by abnormal glucose levels during fasting and/or after meals; additional therapy with insulin or other medications is required Diabetes which existed prior to pregnancy is also split up into several subtypes under this system.

Type B:

Onset at age 20 or older and duration of less than 10 years.

Type C:

Onset at age 10–19 or duration of 10–19 years.

Type D:

Onset before age 10 or duration greater than 20 years.

Type E:

Overt diabetes mellitus with calcified pelvic vessels.

Type F:

Diabetic nephropathy.

Type R:

Proliferative retinopathy.

Type RF:

Retinopathy and Nephropathy.

Type H:

Ischemic heart disease.

Type T:

Prior kidney transplant.

An early age of onset or long-standing disease comes with greater risks, hence the first three subtypes. Two other sets of criteria are available for diagnosis of gestational diabetes, both based on blood-sugar levels.

Criteria for diagnosis of gestational diabetes, using the 100 gram Glucose Tolerance Test, according to Carpenter and Coustan:

Fasting 95 mg/dl

1 hour 180 mg/dl

2 hours 155 mg/dl

3 hours 140 mg/dl

Criteria for diagnosis of gestational diabetes according to National Diabetes Data Group:

Fasting 105 mg/dl

1 hour 190 mg/dl

2 hours 165 mg/dl

3 hours 145 mg/dl

Risk Factors

Classical risk factors for developing gestational diabetes are:

Polycystic Ovary Syndrome

A previous diagnosis of gestational diabetes or prediabetes, impaired glucose tolerance, or impaired fasting glycaemia A family history revealing a first-degree relative with type 2 diabetes

Maternal age – a woman's risk factor increases as she gets older (especially for women over 35 years of age).

Ethnicity (those with higher risk factors include

African-Americans,

Afro-Caribbeans,

Native Americans,

Hispanics,

Pacific Islanders, and people originating from South Asia)

Being overweight, obese or severely obese increases the risk by a factor 2.1, 3.6 and 8.6, respectively.

A previous pregnancy which resulted in a child with a macrosomia (high birth weight: >90th centile or >4000 g (8 lbs 12.8 oz))

Previous poor obstetric history

Other genetic risk factors:

There are at least 10 genes where certain polymorphism are associated with an increased risk of gestational diabetes, most notably TCF7L2.

In addition to this, statistics show a double risk of GDM in smokers. Polycystic ovarian syndrome is also a risk factor, although relevant evidence remains controversial. Some studies have looked at more controversial potential risk factors, such as short stature.

About 40–60% of women with GDM have no demonstrable risk factor; for this reason many advocate to screen all women. Typically, women with GDM exhibit no symptoms (another reason for universal screening), but some women may demonstrate increased thirst, increased urination, fatigue, nausea and vomiting, bladder infection, yeast infections and blurred vision

Pathophysiology

Effect of insulin on glucose uptake and metabolism. Insulin binds to its receptor on the cell membrane which in turn starts many protein activation cascades. These include: translocation of Glut-4 transporter to the plasma membrane and influx of glucose, glycogen synthesis, glycolysis and fatty acid synthesis. The precise mechanisms underlying gestational diabetes remain unknown.

The hallmark of GDM is increased insulin resistance.

Pregnancy hormones and other factors are thought to interfere with the action of insulin as it binds to the insulin receptor.

The interference probably occurs at the level of the cell signaling pathway beyond the insulin receptor. Since insulin promotes the entry of glucose into most cells, insulin resistance prevents glucose from entering the cells properly.

As a result, glucose remains in the bloodstream, where glucose levels rise. More insulin is needed to overcome this resistance; about 1.5–2.5 times more insulin is produced than in a normal pregnancy.

Insulin resistance is a normal phenomenon emerging in the second trimester of pregnancy, which in cases of GDM progresses thereafter to levels seen in a non-pregnant person with type 2 diabetes. It is thought to secure glucose supply to the growing fetus.

Women with GDM have an insulin resistance that they cannot compensate for with increased production in the β-cells of the pancreas.

Placental hormones, and to a lesser extent increased fat deposits during pregnancy, seem to mediate insulin resistance during pregnancy.

Cortisol & progesterone are the main culprits, but human placental lactogen, prolactin and estradiol contribute, too.

Multivariate stepwise regression analysis reveals that, in combination with other placental hormones, leptin, tumor necrosis factor alpha, and resistin are involved in the decrease in insulin sensitivity occurring during pregnancy, with tumor necrosis factor alpha named as the strongest independent predictor of insulin sensitivity in pregnancy.

An inverse correlation with the changes in insulin sensitivity from the time before conception through late gestation accounts for about half of the variance in the decrease in insulin sensitivity during gestation: in other words, low levels or alteration of TNF alpha factors corresponds with a greater chance of, or predisposition to, insulin resistance or sensitivity.

It is unclear why some women are unable to balance insulin needs and develop GDM; however, a number of explanations have been given, similar to those in type 2 diabetes: autoimmunity, single gene mutations, obesity, along with other mechanisms.

Though the clinical presentation of gestational diabetes is well characterized, the biochemical mechanism behind the disease is not well known.

One proposed biochemical mechanism involves insulin-producing β-cell adaptation controlled by the HGF/c-MET signaling pathway.

β-cell adaption refers to the change that pancreatic islet cells undergo during pregnancy in response to maternal hormones in order to compensate for the increased physiological needs of mother and baby.

These changes in the β-cells cause increased insulin secretion as a result of increased β-cell proliferation. HGF/c-MET has also been implicated in β-cell regeneration, which suggests that HGF/c-MET may help increase β-cell mass in order to compensate for insulin needs during pregnancy. Recent studies support that loss of HGF/c-MET signaling results in aberrant β-cell adaptation.

c-MET is a receptor tyrosine kinase (RTK) that is activated by its ligand, hepatocyte growth factor (HGF), and is involved in the activation of several cellular processes. When HGF binds c-MET, the receptor homodimerizes and self-phosphorylates to form an SH2 recognition domain.

The downstream pathways activated include common signaling molecules such as RAS and MAPK, which affect cell motility, cell motility, and cell cycle progression. Studies have shown that HGF is an important signaling molecule in stress related situations where more insulin is needed.

Pregnancy causes increased insulin resistance and so a higher insulin demand. The β-cells must compensate for this by either increasing insulin production or proliferating.

If neither of the processes occur, then markers for gestational diabetes are observed. It has been observed that pregnancy increases HGF levels, showing a correlation that suggests a connection between the signaling pathway and increased insulin needs. In fact, when no signaling is present, gestational diabetes is more likely to occur.

The exact mechanism of HGF/c-MET regulated β-cell adaptation is not yet known but there are several hypotheses about how the signaling molecules contribute to insulin levels during pregnancy. c-MET may interact with FoxM1, a molecule important in the cell cycle, as FOXM1 levels decrease when c-MET is not present. Additionally, c-MET may interact with p27 as the protein levels increase with c-MET is not present.

Another hypothesis says that c-MET may control β-cell apoptosis because a lack of c-MET causes increases cell death but the signaling mechanisms have not been elucidated.

Although the mechanism of HGF/c-MET control of gestational diabetes is not yet well understood, there is a strong correlation between the signaling pathway and the inability to produce an adequate amount of insulin during pregnancy and thus it may be the target for future diabetic therapies.

Because glucose travels across the placenta (through diffusion facilitated by GLUT1 carrier), which is located in the syncytiotrophoblast on both the microvillus and basal membranes, these membranes may be the rate-limiting step in placental glucose transport.

There is a two- to three-fold increase in the expression of syncytiotrophoblast glucose transporters with advancing gestation. Finally, the role of GLUT3/GLUT4 transport remains speculative.

If the untreated gestational diabetes fetus is exposed to consistently higher glucose levels, this leads to increased fetal levels of insulin (insulin itself cannot cross the placenta). The growth-stimulating effects of insulin can lead to excessive growth and a large body (macrosomia).

After birth, the high glucose environment disappears, leaving these newborns with ongoing high insulin production and susceptibility to low blood glucose levels (hypoglycemia).

Screening

A number of screening and diagnostic tests have been used to look for high levels of glucose in plasma or serum in defined circumstances. One method is a stepwise approach where a suspicious result on a screening test is followed by diagnostic test.

Alternatively, a more involved diagnostic test can be used directly at the first prenatal visit for a woman with a high-risk pregnancy. (for example in those with polycystic ovarian syndrome or acanthosis nigricans).

Non-challenge blood glucose tests involve measuring glucose levels in blood samples without challenging the subject with glucose solutions. A blood glucose level is determined when fasting, 2 hours after a meal, or simply at any random time.

In contrast, challenge tests involve drinking a glucose solution and measuring glucose concentration thereafter in the blood; in diabetes, they tend to remain high. The glucose solution has a very sweet taste which some women find unpleasant; sometimes, therefore, artificial flavours are added.

Some women may experience nausea during the test, and more so with higher glucose levels. More research is needed to find the most effective way of screening for gestational diabetes.

Routine screening of women with a glucose challenge test appears to find more women with gestational diabetes than only screening women with risk factors. It is not clear how these screening tests affect the rest of the pregnancy. Future research should include how the method of screening impacts the mother and baby.

Pathways

Opinions differ about optimal screening and diagnostic measures, in part due to differences in population risks, cost-effectiveness considerations, and lack of an evidence base to support large national screening programs.

The most elaborate regimen entails a random blood glucose test during a booking visit, a screening glucose challenge test around 24–28 weeks' gestation, followed by an OGTT if the tests are outside normal limits. If there is a high suspicion, a woman may be tested earlier. In the United States, most obstetricians prefer universal screening with a screening glucose challenge test.

In the United Kingdom, obstetric units often rely on risk factors and a random blood glucose test. The American Diabetes Association and the Society of Obstetricians and Gynaecologists of Canada recommend routine screening unless the woman is low risk (this means the woman must be younger than 25 years and have a body mass index less than 27, with no personal, ethnic or family risk factors)

The Canadian Diabetes Association and the American College of Obstetricians and Gynecologists recommend universal screening. The U.S. Preventive Services Task Force found there is insufficient evidence to recommend for or against routine screening.

Some pregnant women and careproviders choose to forgo routine screening due to the absence of risk factors, however this is not advised due to the large proportion of women who develop gestational diabetes despite having no risk factors present and the dangers to the mother and baby if gestational diabetes remains untreated.

Non-challenge blood glucose tests

When a plasma glucose level is found to be higher than 126 mg/dl (7.0 mmol/l) after fasting, or over 200 mg/dl (11.1 mmol/l) on any occasion, and if this is confirmed on a subsequent day, the diagnosis of GDM is made, and no further testing is required. These tests are typically performed at the first antenatal visit.

They are simple to administer and inexpensive, but have a lower test performance compared to the other tests, with moderate sensitivity, low specificity and high false positive rates.

Screening glucose challenge test

The screening glucose challenge test (sometimes called the O'Sullivan test) is performed between 24–28 weeks, and can be seen as a simplified version of the oral glucose tolerance test (OGTT).

No previous fasting is required for this screening test, in contrast to the OGTT. The O'Sullivan test involves drinking a solution containing 50 grams of glucose, and

measuring blood levels 1 hour later.

If the cut-off point is set at 140 mg/dl (7.8 mmol/l), 80% of women with GDM will be detected. If this threshold for further testing is lowered to 130 mg/dl, 90% of GDM cases will be detected, but there will also be more women who will be subjected to a consequent OGTT unnecessarily.

Oral glucose tolerance test

A standardized oral glucose tolerance test(OGTT) should be done in the morning after an overnight fast of between 8 and 14 hours. During the three previous days the subject must have an unrestricted diet (containing at least 150 g carbohydrate per day) and unlimited physical activity. The subject should remain seated during the test and should not smoke throughout the test. The test involves drinking a solution containing a certain amount of glucose, usually 75 g or 100 g, and drawing blood to measure glucose levels at the start and on set time intervals thereafter.

The diagnostic criteria from the National Diabetes Data Group (NDDG) have been used most often, but some centers rely on the Carpenter and Coustan criteria, which set the cutoff for normal at lower values.

Compared with the NDDG criteria, the Carpenter and Coustan criteria lead to a diagnosis of gestational diabetes in 54 percent more pregnant women, with an increased cost and no compelling evidence of improved perinatal outcomes.

The following are the values which the ADA considers to be abnormal during the 100 g of glucose OGTT:

Fasting blood glucose level ≥95 mg/dl (5.33 mmol/L)

1 hour blood glucose level ≥180 mg/dl (10 mmol/L)

2 hour blood glucose level ≥155 mg/dl (8.6 mmol/L)

3 hour blood glucose level ≥140 mg/dl (7.8 mmol/L)

An alternative test uses a 75 g glucose load and measures the blood glucose levels before and after 1 and 2 hours, using the same reference values. This test will identify fewer women who are at risk, and there is only a weak concordance (agreement rate) between this test and a 3-hour 100 g test.

The glucose values used to detect gestational diabetes were first determined by O'Sullivan and Mahan (1964) in a retrospective cohort study (using a 100 grams of glucose OGTT) designed to detect risk of developing type 2 diabetes in the future. The values were set using whole blood and required two values reaching or exceeding the value to be positive.

Subsequent information led to alterations in O'Sullivan's criteria. When methods for blood glucose determination changed from the use of whole blood to venous plasma samples, the criteria for GDM were also changed.

Urinary glucose testing

Women with GDM may have high glucose levels in their urine(glucosuria).

Although dipstick testing is widely practiced, it performs poorly, and discontinuing routine dipstick testing has not been shown to cause underdiagnosis where universal screening is performed.

Increased glomerular filtration rates during pregnancy contribute to some 50% of women having glucose in their urine on dipstick tests at some point during their pregnancy.

The sensitivity of glucosuria for GDM in the first 2 trimesters is only around 10% and the positive predictive value is around 20%.

Prevention

A 2015 review found that when done during pregnancy moderate physical exercise is effective for the prevention of gestational diabetes. A 2014 review however did not find a significant effect.

Theoretically, smoking cessation may decrease the risk of gestational diabetes among smokers.

Management

Treatment of GDM with diet and insulin reduces health problems mother and child.

Treatment of GDM is also accompanied by more inductions of labour.

A repeat OGTT should be carried out 6 weeks after delivery, to confirm the diabetes has disappeared.

Afterwards, regular screening for type 2 diabetes is advised.

If a diabetic diet or G.I. Diet, exercise, and oral medication are inadequate to control glucose levels, insulin therapy may become necessary. The development of macrosomia can be evaluated during pregnancy by using USG.

Women who use insulin, with a history of stillbirth, or with hypertension are managed like women with overt diabetes.

Lifestyle

Counselling before pregnancy (for example, about preventive folic acid supplements) and multidisciplinary

management are important for good pregnancy outcomes.

Most women can manage their GDM with dietary changes and exercise. Self monitoring of blood glucose levels can guide therapy. Some women will need antidiabetic drugs, most commonly insulin therapy.

Any diet needs to provide sufficient calories for pregnancy, typically 2,000 – 2,500 kcal with the exclusion of simple carbohydrates.

The main goal of dietary modifications is to avoid peaks in blood sugar levels. This can be done by spreading carbohydrate intake over meals and snacks throughout the day, and using slow-release carbohydrate sources

Since insulin resistance is highest in mornings, breakfast carbohydrates need to be restricted more. Ingesting more fiber in foods with whole grains, or fruit and vegetables can also reduce the risk of gestational diabetes.

Regular moderately intense physical exercise is advised, although there is no consensus on the specific structure of exercise programs for GDM.

Self monitoring can be accomplished using a handheld capillary glucose dosage system. Compliance with these glucometer systems can be low. Target ranges advised by the Australasian Diabetes in Pregnancy Society are as follows:

fasting capillary blood glucose levels <5.5 mmol/L1 hour postprandial capillary blood glucose levels <8.0 mmol/L2 hour postprandial blood glucose levels <6.7 mmol/L

Regular blood samples can be used to determine HbA1c levels, which give an idea of glucose control over a longer time period.

Research suggests a possible benefit of breastfeeding to reduce the risk of diabetes and related risks for both mother and child.

Medication

If monitoring reveals failing control of glucose levels with these measures, or if there is evidence of complications like excessive fetal growth, treatment with insulin might be necessary.

This is most commonly fast-acting insulin given just before eating to blunt glucose rises after meals. Care needs to be taken to avoid low blood sugar levels due to excessive insulin.

Insulin therapy can be normal or very tight; more injections can result in better control but requires more effort, and there is no consensus that it has large benefits.

A 2016 Cochrane review concluded that quality evidence is not yet available to determine the best blood sugar range for improving health for pregnant women with GDM and their babies.

There is some evidence that certain medications by mouth might be safe in pregnancy, or at least, are less dangerous to the developing fetus than poorly controlled diabetes. Metformin is better than glyburide.

If blood glucose cannot be adequately controlled with a single agent, the combination of metformin and insulin may be better than insulin alone. Another review found good short term safety for both the mother and baby with metformin but unclear long term safety.

People may prefer metformin by mouth to insulin injections.

Treatment of polycystic ovarian syndrome with metformin during pregnancy has been noted to decrease GDM levels.

Almost half of the women did not reach sufficient control with metformin alone and needed supplemental therapy with insulin; compared to those treated with insulin alone, they required less insulin, and they gained less weight.

With no long-term studies into children of women treated with the drug, there remains a possibility of long-term complications from metformin therapy.

Babies born to women treated with metformin have been found to develop less visceral fat, making them less prone to insulin resistance in later Life.

Prognosis

Gestational diabetes generally resolves once the baby is born. Based on different studies, the chances of developing GDM in a second pregnancy, if a woman had GDM in her first pregnancy, are between 30 and 84%, depending on ethnic background. A second pregnancy within 1 year of the previous pregnancy has a large likelihood of GDM recurrence.

Women diagnosed with gestational diabetes have an increased risk of developing diabetes mellitus in the future. The risk is highest in women who needed insulin treatment, had antibodies associated with diabetes (such as antibodies against glutamate decarboxylase, islet cell antibodies and/or insulinoma antigen-2), women with more than 2 previous pregnancies, and women who were obese (in order of importance).

Women requiring insulin to manage gestational diabetes have a 50% risk of developing diabetes within the next

five years. Depending on the population studied, the diagnostic criteria and the length of follow-up, the risk can vary enormously.

The risk appears to be highest in the first 5 years, reaching a plateau thereafter. One of the longest studies followed a group of women from Boston, Massachusetts; half of them developed diabetes after 6 years, and more than 70% had diabetes after 28 years.

In a retrospective study in Navajo women, the risk of diabetes after GDM was estimated to be 50 to 70% after 11yrs.

Another study found a risk of diabetes after GDM of more than 25% after 15 years. In populations with a low risk for type 2 diabetes, in lean subjects and in women with auto-antibodies, there is a higher rate of women developing type 1 diabetes(LADA).

Children of women with GDM have an increased risk for childhood and adult obesity and an increased risk of glucose intolerance and type 2 diabetes later in life. This risk relates to increased maternal glucose values. It is currently unclear how much genetic susceptibility and environmental factors contribute to this risk, and whether treatment of GDM can influence this outcome.

There are scarce statistical data on the risk of other conditions in women with GDM; in the Jerusalem Perinatal study, 410 out of 37962 women were reported to have GDM, and there was a tendency towards more breast and pancreatic cancer, but more research is needed to confirm this finding s.

Concluding

Complications

GDM poses a risk to mother and child. This risk is largely related to uncontrolled high blood glucose levels and its consequences.

The risk increases witGhigher blood glucose levels. Treatment resulting in better control of these levels can reduce some of the risks of GDM considerably.

The two main risks GD imposes on the baby are growth abnormalities & chemical imbalances after birth, which may require admission to a neonatal intensive care unit. Infants born to mothers with GDM are at risk of being both large for gestational age(macrosomic) in unmanaged GDM, and small for gestational age and Intrauterine growth retardation in managed GDM. Macrosomia in turn increases the risk of instrumental deliveries (e.g. forceps, ventouseand caesarean section) or problems during vaginal delivery (such as shoulder dystocia).

Macrosomia may affect 12% of normal women compared to 20% of women with GDM. However, the evidence for each of these complications is not equally strong; in the Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study for example, there was an increased risk for babies to be large but not small for gestational age in women with uncontrolled GDM.

Research into complications for GDM is difficult because of the many confounding factors (such as obesity). Labelling a woman as having GDM may in itself increase the risk of having an unnecessary caesarean section.

Neonates born from women with consistently high blood sugar levels are also at an increased risk of low blood glucose (hypoglycemia), jaundice, high red blood cellmass (polycythemia) and low blood calcium (hypocalcemia) and magnesium (hypomagnesemia).

Untreated GDM also interferes with maturation, causing dysmature babies prone to respiratory distress syndromedue to incomplete lung maturation and impaired surfactant synthesis. Unlike pre-gestational diabetes, gestational diabetes has not been clearly shown to be an independent risk factor for birth defects.

Birth defects usually originate sometime during the first trimester (before the 13th week) of pregnancy, whereas GDM gradually develops and is least pronounced during the first and early second trimester. Studies have shown that the offspring of women with GDM are at a higher risk for congenital malformations.

A large case-control study found that gestational diabetes was linked with a limited group of birth defects, and that this association was generally limited to women with a higher BMI ($\geq$25 kg/m^2).

It is difficult to make sure that this is not partially due to the inclusion of women with pre-existent type 2 diabetes who were not diagnosed before pregnancy.

Because of conflicting studies, it is unclear at the moment whether women with GDM have a higher risk of preeclampsia. In the HAPO study, the risk of preeclampsia was between 13% and 37% higher, although not all possible confounding factors were corrected.

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NABH : PESHCO-2018-0319

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GLAUCOMA

Dr. Anagha Heroor

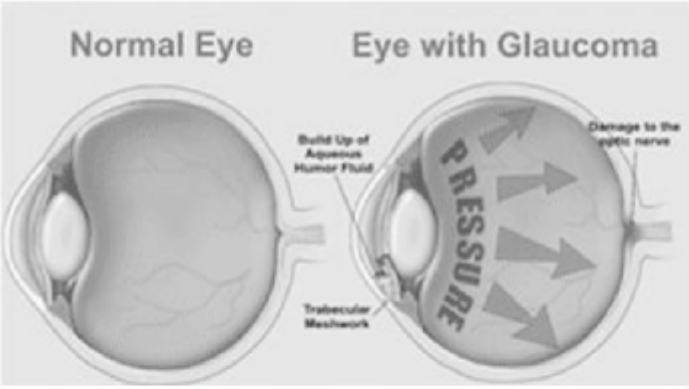
What is Glaucoma?

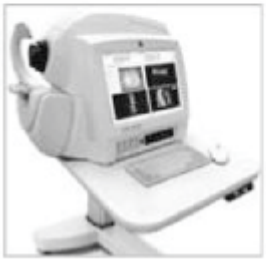
Glaucoma is an eye disease and a leading cause of blindness the world over. It is a condition which causes an abnormally high intraocular pressure inside the eye. The high pressure silently damages the optic nerve and blood vessels that nourish the retina. Once optic nerve is damaged, gradual loss of vision takes place. Damage to the optic nerve takes place slowly that the person usually is not aware of the gradual loss of vision. Vision gradually becomes more and more impaired until irreversible blindness sets in which is called Absolute Glaucoma.

What are the symptoms of Glaucoma?

90% of patients do not show any symptoms; hence it is called 'Silent killer' of the optic nerve.

Gradual loss of peripheral vision.





Dull pain around the eye after staying in dark e.g. after coming out of cinema theatre.

Seeing coloured rings around artificial light specially in early morning or at night.

Frequent changes in reading glasses.

Poor vision in the night.

Blurred or foggy vision.

How is Glaucoma detected or diagnosed?

Glaucoma is detected during routine and regular eye examinations.

The ophthalmologist performs

Tonometry i.e. measure intraocular pressure of your eye.

Gonioscopy i.e. inspect drainage angle of your eye.

Ophthalmoscopy i.e. examines and judge optic nerve damage of your eye, if any.

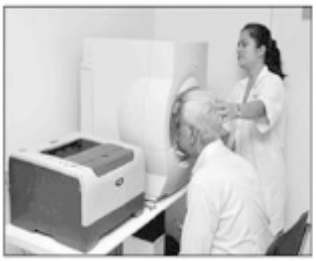
Disc Photography to record optic disc details.

Automated Perimetry i.e. test the visual field of each eye.

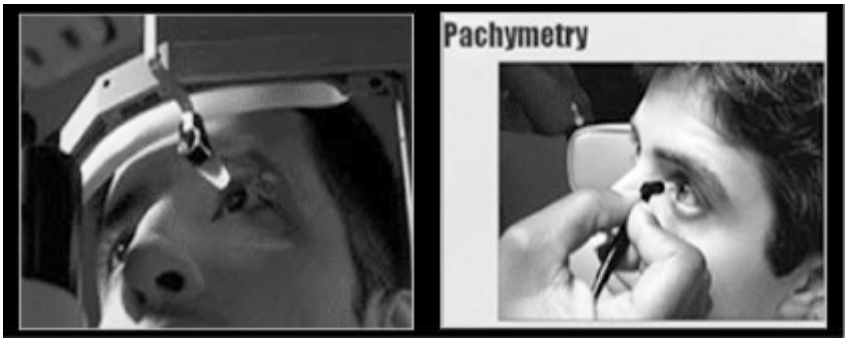
Pachymetry - Use to measure corneal thickness.

Optical Coherence Tomography (OCT) - It is non invasive imaging modality, for the earliest detection of Glaucoma, It gives exact measurement of retinal nerve fibre layer

Optical Coherence Tomography



Automated Perimetry



Who are at risk?

Anyone can suffer from glaucoma. But some people are at more risk than others and risk factors are:

Increasing age

Nearsightedness

Family history of glaucoma-children & siblings of known glaucoma patients should get their eyes checked regularly.

Family history of glaucoma-children & siblings of known glaucoma patients should get their eyes checked regularly.

Previous eye injuries or surgeries.

Other diseases such as diabetes or high blood pressure.

Thin Corneas are a risk factor for Glaucoma

How is Glaucoma treated?

However, early treatment can limit further loss of vision. The objective of treating glaucoma is to lower eye pressure and can be done with the help of

Medicines i.e. eye drops & tablets.

Laser Surgery

Filtration Surgery

Medicines

This part of the treatment is the most important. Some eye drops reduce the amount of fluid produced by eyes whereas others increase drainage of fluid from the eyes.

You must use your medicines as directed by your ophthalmologist. You must not stop medicines even if you do not have symptoms.

When glaucoma cannot be controlled with the help of medicines or when patients are unable to tolerate the side effects of the medicines, the following procedures maybe used to improve drainage of fluid by your ophthalmologist.

Laser Surgery

Laser produces high energy beam of light to increase drainage of excess fluid thereby lowering pressure inside the eye. Laser procedures may be effective only in certain cases.

Anti Glaucoma Filtration Surgery

In cases where medicines & laser do not help to reduce the eye pressure to the desired level, surgery may need to be performed. Filtration surgery can be done to create a new drainage channel to facilitate drainage of excess fluid, thereby lowering pressure inside the eye.

Can Glaucoma be prevented?

No, Glaucoma unfortunately cannot be prevented, but early detection and treatment can prevent loss of vision due to glaucoma. Hence, all patients past age of 40 yrs should get their eye checked once a year by a qualified eye doctor.

Anil Eye Hospital along with Maharashtra Ophthalmological society, All India Ophthalmological Society, Indian Medical association organized a walkathon for glaucoma called as glaucothon on the 10th of march 2019 as a part of the state wide drive to increase glaucoma awareness .

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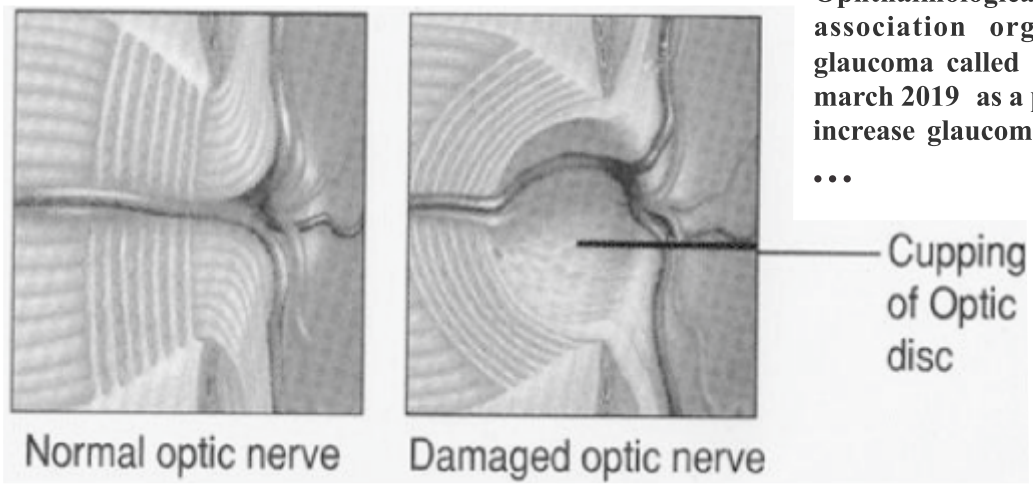

TESTS IN DIABETIC PATIENT

Dr. Anita Karnik
M.D.Pathology

PRE-DIABETIC TESTS

Screening of the pt.

1) blood sugar tests-f and pp

Fasting-100-125 mg/dl

Postlunch-140-199 mg/dl

This is consider pre-diabetic.

Who should be screened

1) family history of diabetes-screening above age of 30/once in a year

   Or

   Before that if any complaints of diabetes.

2) wt.loss history with no thyroid abnormality.
3) pregnancy
4) overweight with additional risk factors for type 2 diabetes.

HBA1C--- GYLCATED HAEMOGLOBIN TEST

- Indicate average blood sugar level for past 3 months.
- EDTA sample is necessary.
- Fasting not necessary.
- done only once in 3 months.

Principle of test

- it measures only percentage of blood sugar attached to the oxygen carrying protein in red blood cells.
- the higher blood sugar level,the more haemoglobin with sugar attached.

  Rbc live for 3 months ,so the test shows average level of glucose in the blood forpast 3 months.

METHODS

HBA1C BY HPLC (high performance liquid chromatography)

2) ion exchange HPLC method
3) boronate affinity HPLC
4) Enzymatic assays

BORONATE AFFINITY METHOD

- this method is advised when abnormal Hb variants like HbS,C,E AND D interfere with the readings.

Goals for HBA1C

- BELOW 7%FOR DIABETIC PT.
- check at least twice in a year

Limitations

- HBA1C estimation is affected in
- abnormal haemoglobinopathies(HbS,C,E and D)
- any condition affecting erythrocytic survival(haemolytic anaemia,blood loss etc)
- vit C and vit E treatment
- liver and kidney disease and anaemia
- abnormal presence of HbF more than 25%

MPG-ESTIMATE

- what is mean plasma glucose estimate ?
- MPG converts percemtage HBA1C to mg/dl,to compare blood glucose.

-MPG gives an evaluation of blood glucose for last couple of months.

- MPG is calculated ,AS

MPG(mg/dl)=28.7Xhba1c-46.7

HBA1C RANGE

5.7 to 6.4 %	pre -diabetic
> 6.5 %	diabetic
>8%	action suggested

Oral glucose tolerance test

In whom it should be done

- in pregnancy(geatational diabetis)between 24 to 28 wks of gestation.

METHOD

75gms of glucose+dissolve in 200 to 300 ml of water

Mix it

Finish by pt.within 5 min

ESTIMATE PROCEDURE STEPS

1) collect fasting sample=1st sample
2) give oral glucose=step 2
3) collect blood sugar =1 hr
4) collect blood sugar =2hr

Prediabetic diabetic geatational diabetic

F-100-125 mg/dl	more than 126	more than 92
1 hr		more than 180
2 hr 140-199	200 or more	more than 153

(salicylates,diuretics, anticonvulsants and oral contraceptives affect the glucose tolerance test)

3) blood sugar levels(normal screening test)

- 8 hrs fasting is necessary.

Normal	pre-diabetic	diabetic
F 70-110	100-125	126OR MORE
PP UPTO 140	140-180	MORE THAN 180

URINE MICRAL TEST

- signal of early reversible renal damage
- albumin/creatinine ratio is more reliable
- this ratio corrects for variation in urinary concentration due to hydration.

Interpretation

Less than 30 mg = normal

30-300 mg = microalbuminuria(early kidney disease)

More than 300 mg=macroalbuminuria

URINE KETONE

- Urine ketone it indicates that body is using an alternative source of energy.
- it is seen during starvation or more commonly in type 1 DM.
- Production of ketone bodies ia a normal response to a shoetage of glucose ,meant to provide an alternate source of fuel from fatty acids.
- when diabetic treatment is switched from insulin to oral hypoghycemic agents,pt urine should be monitor for ketonuria
- the development of ketonuria after 24 hrs of insulin withdrawal indicates a poor response to oral hypoglycemic agents.
- urine ketone increases before blood ketone level ,so important to monitor,to prevent ketoacidosis.

SR CREATININE

- creatinine is a chemical waste product that is produced by muscle metabolism and to a smaller extent by eating meat.
- it is recommended once in a year in diabetic pt.
- amount of creatinine in the blood increases with muscle mass-men usually have higher creatinine than woman.
- (dehydration ,large meat consumption,certain medication and high muscle mass can increase the creat level.)

E-GFR test

- estimated glomerular filtration rate test.
- normal sr creat doesn't rule out renal function impairment in early stage.
- it varies with age,gender and ethnic background.
- so these variations can be reduced by an estimation of the GFR using an equation that includes ,age,gender and creat .

It is measured 1.73 sq m surface area,so units are ml/min/1.73 sq .m.

Stages according to national kidney foundation

Stage1 normal = more than 90 ml/min/1.73 sq.m

Stage 2 = 60-90(mild decline in kidney function)

Stage3a = 45-59(mild to moderate decline

Stage3b = 30-44,moderate to severe decline

Stage4 = 15-29,severe decline in kidney function

Stage 5 = less than 15,kidney failure,

SR ELECTROLYTE

- diabetic pt have electrolyte imbalance
- diabetic ketoacidosis or nonketotic hyperglycemic hyperosmolar syndrome.

LIPIDS

- dyslipidemia is common in DM
- Dislipidemia is associated with increase risk of cardiovascular disease.

SR INSULIN TEST

- fasting =diagnosing prediabetic and metabolic syndrome
- insulin resistance causes high cholesterol,high glucose and high blood pressure.
- a high level of fasting insulin indicates insulin resistance
- it evaluate insulin production by the beta cells in the pancrease.
- diagnose insulinoma
- cause of low glucose
- indentify insulin resistance.

C-PEPTIDE

C Peptide is a short 31 amino acid polypeptide that

connects insulin A chain to its B chain in the proinsulin molecule.

- Beta cells in the pancrease make insulin and they also release C peptide.

Why C peptide test

- to find out type 1 or type 2 DM
- when you have type 1 and your dr needs to know how much insulin pancrease still makes
- to find out time to start insulin in apatient with type 2 DM
- to find out cause of hypoglycaemia
- to diagnose insulinoma

Normal C peptide =0.5 to 2 nanograms per mililiter.

These levels can be high when body makes more insulin, Levels are low when body makes less insulin.

High C PEPTIDE

- In insulin resistance
- in insulinoma
- in kidney disease

LOW C PEPTIDE

- type 1 or 2 DM
- PT on insulin shots suppressing the release of insulin from pancreas
- very low blood sugar

GAD ANTIBODIES AND DIABETES.

- pancreas needs the enzyme glutamic acid decarboxylase (GAD) to function normally.
- antibodies that target this enzyme are called GAD antibodies.
- more than 70% of type 1 DM have GAD autoantibodies.

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One interesting case study

Importance of seeing peripheral smear

12 yr old boy for CBC

	RESULT	UNITS	REFERENCE RANGE
HB	6.8	gm%	12-14
RBC COUNT	3.21	X10^6/ul	4-5.5
Haematocrit	20.9	%	37-45
MCV	65.11	fl	77-91
MCH	21.18	Pg	27-32
MCHC	32.54	gm/dl	32-36

Total WBC COUNT 9200 /ul 4000-10000

Differtial count was normal

Platelet adequate 1,80,000/cmm

RDW 22.8% 9.5-14.5

As you see from CBC printout and RBC indices it suggests only iron deficiency anaemia,but pt had very interesting peripheral smear findings.

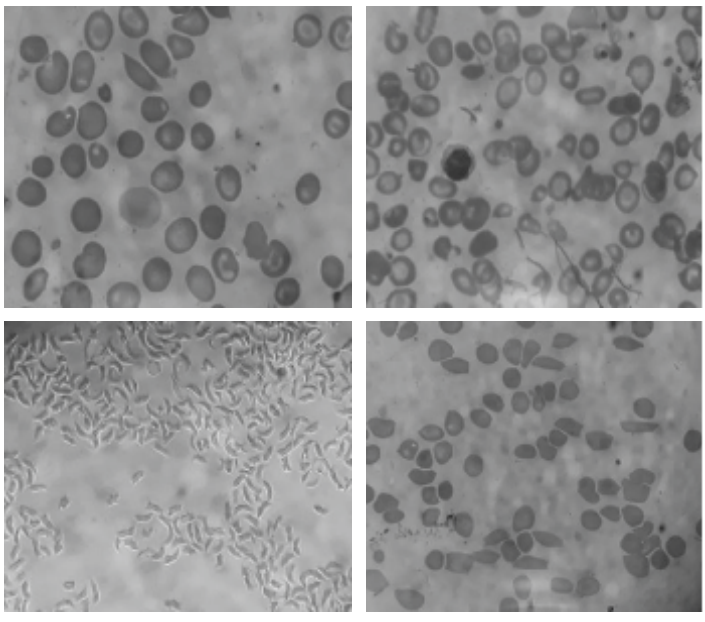
Peripheral smear findings in this case

- target cells +++
- tear drop cells++
- polychromasia+
- anisocytosis++
- pookilocytosis
- nucleated RBCS (N RBCS)+ and
- ? SICKLE CELLS
- occasional microcytic hypochromic

DIAGNOSIS FROM PERIPHERAL SMEAR

-HAEMOLYTIC ANAEMIA-POSSIBILITY OF SICKLE CELL ANAEMIA.

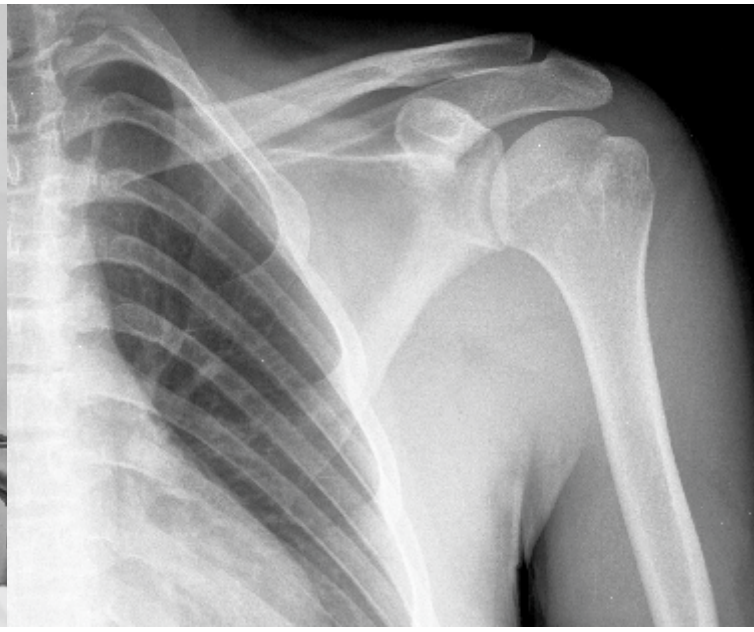
HB ELECTROPHORESIS WAS ADVISED FOR confirmation



SPECTRUM

DIAGNOSTIC EXCELLENCE

SONOGRAPHY | DIGITAL X-RAY | 2D ECHO | PATH | ECG



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वैद्यकीय शिक्षणातील आरक्षण

या विषयावर गुरुवार दिनांक १४ मार्च २०१९ रोजी मुंबईत येथे पत्रकार संघ हॉल मध्ये दुपारी तीन वाजता पत्रकार परिषद आयोजित केली होती. रोही कपूर यांनी उपस्थितांचे स्वागत करून परिषदेला सुरूवात केली. व्यासपीठावर काही खाजगी व्यवसायातील डॉक्टर्स होते. डॉक्टर असित शहा, डॉक्टर उदय ढोपळे व डॉक्टर सुबोध शिरूर हे वैद्यकीय कायदेतज्ञ आहेत. हे सर्व डॉक्टर्स खाजगी प्रॅक्टिस करतात. पत्रकार, डॉक्टर्स, पालक, काही वैद्यकीय महाविद्यालयातील विद्यार्थी व काही इंटर्न्स या सभेला उपस्थित होते. चर्चेचा मुख्य विषय होता वैद्यकीय पदव्युत्तर अभ्यासक्रमासाठी गुणवत्तेच्या निकषावर प्रवेश घेऊ इच्छिणाऱ्या विद्यार्थ्यांसाठी घसरत गेलेले जागांचे प्रमाण. काळानुसार वैद्यकीय शिक्षणक्रमात काही उल्लेखनीय बदल घडत गेले. एकोणीसशे ऐंशीच्या दशकात एम बी बी एस चा अभ्यासक्रम तीन वर्षांचा होता. एक शैक्षणिक वर्ष म्हणजे इंग्रजी कॅलेंडर मधील दीड वर्ष परंतु आता तसे नाही. तसेच पूर्वी पदव्युत्तर शिक्षणासाठी इन्स्टिट्यूशनल प्रेफरन्स होता म्हणजे एल टी एम एम सी मध्ये हे पदवी घेतलेल्या विद्यार्थ्यांना त्याच कॉलेजमध्ये एमडी किंवा एम एस साठी प्रवेश घेणे शक्य होते. कॉलेजची क्षमता १०० विद्यार्थी पीजी सीट्स ठरलेल्या, त्यामुळे सर्व मुले एकमेकांना विचारायची 'ए, पी. जी. के लिए ये क्या लेने वाला है ?' असं सर्वांना विचारून ते एक तक्ता बनवायचे की त्यामुळे बाकीच्या विद्यार्थ्यांना आपल्याला कुठली सीट मिळू शकते हे याचा अंदाज येत असे तसेच मागच्या वर्षी एमडी गायनॅकसाठी किती मार्क लागले ते शोधून काढणे शक्य होते. ही ऍडमिशन एमबीबीएस वरील मार्ग बघून व्हायची त्यामुळे थर्ड एमबीबीएस चा रिझल्ट लागल्यावर पीजी ऍडमिशन चे चित्र बरेचसे स्पष्ट व्हायचे.

मग आले पहिले स्थित्यंतर कॉमन पुलिंग म्हणजे जे मुंबईतील तीनही वैद्यकीय महाविद्यालयातील विद्यार्थी कुठल्याही कॉलेजमध्ये पीजी एडमिशन साठी अर्ज करू शकणार जी एस मेडिकल कॉलेज किंवा लोकमान्य टिळक वैद्यकीय महाविद्यालय किंवा टोपीवाला मेडिकल कॉलेज अर्थात नायर हॉस्पिटल गुणवत्ता यादी जाहीर झाल्यावर मिळेल त्या कॉलेजमध्ये ऍडमिशन घ्यायची. त्या काळातही जातीनिहाय आरक्षण होते परंतु आता त्याचे प्रमाण अतिशय जास्त झाल आहे.

मग राज्यातील सर्व विद्यार्थ्यांसाठी कोटा ठरविण्यात आला तसेच ऑल इंडिया कोटा आला. जातींचे आरक्षण वाढत गेले व खुल्या वर्गासाठी गुणवत्तेच्या निकषावर आधारित जागांचे प्रमाण कमी होत गेले. चर्चेत सर्वजण अशा निष्कर्षाप्रत आले की ही परिस्थिती फारच चिघळली आता तर आर्थिक दृष्ट्या दुर्बल वर्गातील विद्यार्थ्यांसाठीही काही जागा राखीव ठेवण्यात येतात. परिणामी ओपन मेरिट मधील मुलांचे काय झाले.

१९९१ पर्यंत जातीनिहाय आरक्षण नव्हते नंतर हे सर्व चालू झाले आहे. १ जानेवारी १९५० रोजी ११० मागासवर्गीय जाती होत्या आणि आज ४५० च्या जवळपास आहेत. याचा अर्थ असा होतो का की लोकं स्वतःला मागासवर्गीय म्हणवून घेण्यात कमीपणा मानत नाहीत ? या सर्वात देशाची प्रगती होते आहे की अधोगती ? डॉक्टर बाबासाहेब आंबेडकर म्हणाले होते की आरक्षण दहा वर्षे ठेवा पण आज देशाला स्वातंत्र्य मिळून ७० वर्षे झाली तरी जातीयतेच्या मुद्यावर आरक्षण ठेवणे हे खरेच प्रगत समाजाचे लक्षण आहे का ?

एक सर्जन म्हणाले की १९८४ मध्ये हे त्यांच्या बरोबरच्या त्यांच्या एका मित्राने आरक्षणा खाली एम एस ओर्थपेडीक सीट घेतली मग तो माझ्या बरोबरच सर्जन झाला. आम्ही दोघांनी मुंबईमध्ये इतके वर्षे प्रॅक्टिस केली. आता आम्ही ही एका पातळीवर आलो ना मग आता त्यांचा मुलगा जातीय आरक्षणा खाली प्रवेश घेऊ शकला नाही पाहिजे. जातीय आरक्षण हे ये वोट बँक पॉलिटिक्स खालीच येते असाही सूर काहीजणांनी लावला.

वैद्यकीय शिक्षणासाठी मिलिटरी रुल ऑफ रेक्रूटमेंट लावला पाहिजे. वैद्यकीय शिक्षण हे फक्त गुणवत्तेच्या निकषावर आधारित असावे. असाही एक मुद्दा मांडण्यात आला की सुप्रीम कोर्टने जर वैद्यकीय शिक्षणातील जागा वाढल्या तर आरक्षणाला मंजुरी दिली होती, परंतु सीट्स न वाढवता आरक्षण जाहीर केले.

हा लढा चालूच राहील. गरज पडली तर सुप्रीम कोर्टाच्या पायऱ्या चढायची तयारी ठेवली पाहिजे. त्या साठी निधी गोळा केला पाहीजे. आजचे वैद्यकीय विद्यार्थी अजून वीस वर्षांनी प्रॅक्टिस करतील. राजकीय नेते, श्रीमंत लोक उपचारासाठी परदेशात जातील पण बाकीच्यांचे काय ? आपल्यालाही अजून वीस वर्षांनी यांच्याकडूनच इलाज करून घ्यायला लागणार आहे. शेवटचा एक मला आवडलेला असा मुद्दा मांडला होता की आज सभागृहात फक्त वैद्यकीय विद्यार्थी आणि डॉक्टर्सच होते तरी या चळवळीत सामान्य लोकांनाही सामील करून घ्यावे.

महाराष्ट्र दुकाने व आस्थापना (नोकरीचे व सेवाशर्तीचे विनियमन), अधिनियम, २०१७ नुसार नोंदणी प्रमाणपत्राचे नुतनीकरण करण्याची आवश्यकता काढून टाकण्याबाबत.

महाराष्ट्र शासन
उद्योग, ऊर्जा व कामगार विभाग
शासन निर्णय, क्र.- एमएसए ०२/ २०१९/ प्र. क्र. ३३ (भाग-१)/ कामगार - १०
मंत्रालय, मुंबई ४०० ०३२.
दिनांक :- २ मार्च, २०१९.

वाचा - १) महाराष्ट्र दुकाने व आरथापना (नोकरीचे व सेवाशर्तीचे विनियमन), अधिनियम, २०१७.
२) महाराष्ट्र दुकाने व आस्थापना (नोकरीचे व सेवाशर्तीचे विनियमन), नियम, २०१८.

महाराष्ट्र दुकाने व आरथापना (नोकरीचे व सेवाशर्तीचे विनियमन), अधिनियम, २०१७ च्या कलम ६ (३) व ६ (४) मध्ये या अधिनियमांतर्गत देण्यात आलेल्या नोंदणी प्रमाणपत्राचे नुतनीकरण करण्याची मुदत दहा वर्षांची असल्याबाबत तरतूद करण्यात आली आहे. तसेच या अधिनियमांतर्गत नियम ६ व ७ मध्ये नोंदणी दाखल्याचे नुतनीकरण करण्याबाबतचे नियम करण्यात आले आहेत. राज्याने दुकाने व आरथापना अधिनियमांतर्गत नोंदणी दाखल्याचे नुतनीकरण करण्याची आवश्यकता काढून टाकण्यात यावी, अशी केंद्र शासनाच्या औद्योगिक धोरण व प्रोत्साहन विभागाने (डीआयपीपी) शिफारस केली आहे. त्या अनुषंगाने दुकाने व आस्थापना अधिनियमांतर्गत नोंदणी प्रमाणपत्र नुतनीकरण करण्याची अट काढून टाकण्याची बाब शासनाच्या विचाराधीन होती.

शासन निर्णय :-

महाराष्ट्र दुकाने व आस्थापना (नोकरीचे व सेवाशर्तीचे विनियमन), अधिनियम, २०१७ च्या कलम ४ मध्ये शासनास या अधिनियमातील कोणत्याही आस्थापनेस किंवा कोणत्याही वर्गवारीतील आस्थापनांना किंवा कामगारांना किंवा व्यक्तींना कोणत्याही तरतूदीतून सूट देण्याचे अधिकार आहेत. उक्त अधिनियमाच्या उपरोक्त कलम ४ (१) च्या तरतूदीन्वये प्रदान करण्यात आलेल्या अधिकाराचा वापर करुन, या अधिनियमाच्या कलम ६ अन्वये नोंदित करण्यात येणा-या सर्व आस्थापनांना दहा वर्षांनी नोंदणी प्रमाणपत्राचे नुतनीकरण करण्याच्या तरतूदीतून सूट देण्यात येत आहे. त्यानुसार महाराष्ट्र दुकाने व आरथापना (नोकरीचे व सेवाशर्तीचे विनियमन), अधिनियम, २०१७ अधिनियमाच्या कलम ६ अन्वये नोंदित सर्व आस्थापनांना नोंदणी प्रमाणपत्राचे नुतनीकरण करण्याची आवश्यकता यापुढे राहणार नाही.

सदर शासन निर्णय, महाराष्ट्र शासनाच्या www.maharashtra.gov.in या संकेतस्थळावर उपलब्ध करण्यात आला असून त्याचा संगणक सांकेतांक २०१९०३०५१६४९५६८९१० असा आहे. हा शासन निर्णय डिजीटल स्वाक्षरीने साक्षांकित करुन काढण्यात येत आहे.

महाराष्ट्राचे राज्यपाल यांच्या आदेशानुसार व नांवाने,
MAHENDRA KALYANKAR
(डॉ. महेंद्र कल्याणकर)
सह सचिव, महाराष्ट्र शासन.

प्रत,

१. महालेखापाल (लेखा व अनुज्ञेयता/ लेखा परिक्षा) महाराष्ट्र-१, मुंबई.
२. अधिदान व लेखा अधिकारी, मुंबई.
३. निवासी लेखा परीक्षा अधिकारी, मुंबई.
४. कामगार आयुक्त, कामगार भवन, बांद्रा कुर्ला संकुल, बांद्रा (पूर्व), मुंबई ४०० ०५१.
५. अवर सचिव (कामगार -१), उद्योग, ऊर्जा व कामगार विभाग.
६. निवड नस्ती (कामगार-१०).

खाजगीकरण

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नवीन भरती करून सुद्धा
स्टाफ कमी पडू लागला
यम म्हणाला थोडे दिवस
घ्या जरा दमाने
यमदूतांना ओव्हरटाईम
देऊ केला यमाने
कित्येक लोक मागत होते
तरी नव्हते येत मरण
यमाने मग जाहीर केले
आपल्या सेवेचे खाजगीकरण
खाजगीकरण जाहीर होताच
अनेक कंपन्या तयार झाल्या
रागरंग पाहून इथला
वाल्मिकीचाही झाला वाल्या
या कंपन्याच माणसांना आता
यमसदनाला धाडून देतात
कमिशन घेताना यमदूत फक्त
फिगर टॅली करून घेतात

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वजन

चिमण्याने बांधला
गवताचा वाडा
पालिकेचा हुकुम आला
ताबडतोब पाडा
कां? तर म्हणे
अधिकृत नाय !
चोरण्यात आलाय
एफ. एस.आय.!
हुकुमावर सही
कावळ्याची होती
चिमण्याची झाली
पंचाईत मोठी
चिमणा चिडला
रागाने पेटला
कागदपत्र घेऊन
कावळ्याला भेटला
कावळ्याने कागद
वरवर पाहीले
पुटपुटला वजन
ठेवायचे राहीले
वजन ठेवताच
हुकुम फिरला
चिमण्याचा वाडा
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डॉ. सतीश अ. कानविंदे

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