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**IMA DOMBIVLI**

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# FROM THE PRESIDENT'S DESK

Happy new year to you all. I hope you celebrated the start of 2017 in good spirits with family and friends. Now that we're a few days into the new year, it's good to look ahead and think about what this year may bring us. I thank all of you for your relentless support in 2016.

We have witnessed the mega success of our EVECON -2016 Conference on 22nd & 23rd of October 2016. Congratulations to the whole team of EVECON-2016. We had 550 registrations. Credit of the success goes to the Planning committee. Your fine work & excellent planning resulted in an informative & entertaining EVECON-2016. The Cultural events with participants from all over Maharashtra were a great hit. The Scientific sessions were diverse, relevant & thought provoking. We have received IMA MS Presidential Appreciation Award for the same. We have set a new standard for future EVECON planners.

IMA is always taking care for the interest of medical fraternity and as part of that IMA (HQ) had given call for STOP NMC, SAVE MEDICAL PROFESSION and IMA SATYAGRAH on 16th November 2016. I thank all our members for their support for IMA Satyagraha Day. IMA will follow up for all our SIX demands to get fulfilled at the earliest.

MMC Elections marked the Year 2016. I congratulate our Vice President Dr. Archana Pate & whole of the IMA - MMC Panel for the magnanimous victory in terms of winning all 9 seats in MMC Elections. Let's hope the council gets formed at the earliest so that our representatives start their work in full swing.

Congratulations to Dr. Mangesh Pate for receiving IMA National President's Special Appreciation Award at Natcon-16, Amritsar. Congratulations to Dr. Archana Pate for receiving Presidents Special Appreciation Award for her extraordinary work as a Chairperson of IMA MS Women Doctors wing.

I request all of you to register your hospitals at the earliest under "ROHINI" if not done yet. In the long run, this registry will evolve as a one stop source of all information related to Health Insurance, Hospitals and beyond, for the Insurers, Medical services providers, customers and regulators. We have organised a Basic Life Support Workshop for our members on Sunday, 22 nd January 2016. I request all our members to take advantage of it.

Let us all join to make the IMA a stronger organisation.

Long live IMA

Yours in IMA

**Dr. Hemraj Ingale**
President IMA Dombivli

## IMA DOMBIVLI TEAM 2016-17

| President | I. P. President | President Elect |
|---|---|---|
| **Dr. Hemraj Ingale** | **Dr. Mangesh Pate** | **Dr. Niti Upasani** |

DYNAMIC
IMA DOMBIVLI ★ TEAM16-17

| Vice President | Hon. Secretary |
|---|---|
| **Dr. Archana Pate** | **Dr. Utkarsh Bhingare** |
| **Hon. Jt. Secretary** | **Hon. Treasurer** |
| **Dr. Raju Gite** | **Dr. Mandar Pawar** |

# EDITORIAL

At the outset let me wish each one of you a very **Happy New Year**. What a great beginning of the year! Our member Dr Archana Pate being elected to the coveted position in MMC with a huge margin is certainly the best new year gift IMA Dombivli has got. It is indeed a proud moment. Congratulations to Dr Archana and the entire IMA Panel. Oprah Winfrey once said 'New year is another chance for us to get it right'. We all look forward to many important issues being taken care of when MMC is safe in the hands of those who have been elected.

It is today which will form tomorrow, and tomorrow which will form the future. I believe that New Year isn't any end or a beginning, it's a continuation of life. But it does give us an opportunity to reflect back through the year that's gone by.

For us at IMA Dombivli, the year witnessed stupendous success of EVECON under the leadership of Pres Dr Hemraj Ingale ably supported by Women's Wing. A perfect blend of remarkably outstanding speakers to the stunning ramp models to the spectacular dance performances and the melodious singers, the conference was simply awesome.

When we look back in years, the conferences, programs and projects of IMA Dombivli are getting better with each passing year. And that is the reason that looking back in years is so very important. To learn from past experiences for the betterment of tomorrow, is an exercise which helps build a great organization. Let us resolve today that we shall bury the differences, put all negativities behind us and unitedly work together to have another productive year. I pray to the Almighty to give all of us good health, strength, and wisdom to attain all the goals.

In this 3rd edition of DIALOGUE, we have focused on the issues regarding nursing professionals who are our partners in providing health care. The articles give us an insight of the journey of 'evolution to revolution' of the profession. The research article on stem cell therapy with case studies, throw light on advances in applied medical sciences. History of Paediatric Surgery is a fascinating article to read. This time, organ donation revolves around Kidney and Pancreatic transplants.

I am sure you will find this issue very engaging. Makar Sankranti is around the corner. May the Sun God shower all his blessings on you.

See you again with the next issue. Till then Sayonara.

**Dr Leena Lokras**

## IMA DOMBIVLI WINGS

IMA Defence Cell
**Dr. Mangesh Pate**

IMA HBI
**Dr. Archana Pate**
**Dr. Nilesh Shirodkar**

IMA CGP &AMS
**Dr. Niti Upasani**
**Dr. Leena Lokras**

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Community Service Committee
**Dr. Archana Pate**
**Dr. Makarand Ganpule**

IMA Schemes
**Dr. Mandar Pawar**
**Dr. Niti Upasani**

Organ-Eye-Skin-Body Donation
**Dr. Sangeeta Dandekar**
**Dr. Sheetal Khismatrao**

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Womens' Doctor's Wing
**Dr. Meena Pruthi**
**Dr. Sheetal Khismatrao**
**Dr. Vijayalaxmi Shinde**

Clinical Estab. Act
**Dr. Sangeeta Dandekar**
**Dr. Hemraj Ingale**

IMA Finance
**Dr. Hemraj Ingale**
**Dr. Preeti Nanda**

---

IMA Patient-Doctor Grievance Cell
**Dr. Mangesn Pate**
**Dr. Niteen Dandekar**

IMA Awards Committee
**Dr. Hemraj Ingale**
**Dr. Utkarsh Bhingare**

## IMA DOMBIVLI COMMITTEES

EVECON 2016
**Dr. Archana Pate**
**Dr. Niti Upasani**
**Dr. Meena Pruthi**

CME & Conference
**Dr. Makarand Ganpule, Dr. Dilip Joshi**
**Dr. Vijay Shetty, Dr. Ashish Dhadas**
**Dr. Ghanshyam Shirali, Dr. Sunit Upasani**

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Dialogue
**Dr. Leena Lokras**
**Dr. Sangeeta Dandekar**

Cultural & Sports
**Dr. Vijay Aage, Dr. Preeti Nanda**
**Dr. Rashmi Phansalkar**

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Ex-Officio Members
**Dr. Leena Lokras, Dr. Mangesh Pate**
**Dr. Rahul Bhirud**

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Co-opted Member
**Dr. Arvind Bengeri**

# EVECON REPORT

**Dr. Archana Pate**
**(Reprint from Annual Reports published by IMA MS)**

***Dr. Archana Pate***
*M.D.(Medicine)*
*Consultant Physician and Intensivist*
*Chairperson, IMA MS Women Doctor's Wing*
*Organising Chairperson, Evecon*
*Elected MMC Member 2016-2021*
*Chairperson, National Doctors Spouses Wing, IMAHQ*
*Chairperson, IMAMS Women Doctors Wing*

May The Golden Moments Of Today Become The Treasured Memories Of Tomorrow-Mary Kay.

**Evecon 2016** — the 6"' Annual Conference of IMA Maharashtra State women Doctor's wing and 17th Annual Conference of IMA Dombivli, which was held on 22nd and 23rd October 2016 at Savitribai Phule Auditorium, Dombivli was a true blend of academic excellence and Cultural Extravaganza, which has left behind treasured memories etched in everyone's mind and heart.

We had a great **Core Team** — Dr. Hemrajlngale - President IMA Dombivli, Dr. Mangesh Pate - IPP IMA Dombivli, Dr Utkarsh Bhingare - Hon Secretary IMA Dombivli, Dr.Niti Upasani - President elect IMA Dombivli (Organising Secreatry, Evecon), Dr.Mandar Pawar -Treasurer IMA Dombivli, Dr Meena Pruthi - Chairperson WW IMA Dombivli (organising Secretary, Evecon), Dr. Medha Oak - executive committee member IMA Dombivli (Scientific committee Chairperson, Evecon) and Dr Archana Pate - Chairperson, IMA Maharashtra State Women Doctor's Wing (Organising Chairperson, Evecon). IMA MS President Dr. Jayesh Lele and Hon State Secretary Dr Parthiv Sanghavi were giving valuable inputs and guidance from time to time.

We were fortunate to have great team members with us in **Team Evecon** - Scientific committee was headed by Dr. Medha Oak, Cultural Committee - Dr Meena Pruthi / Dr Makrand Ganpule, Gifts / Delegate kits Committee - Dr Niti Upasani, Registration Committee — Dr. Utkarsh Bhingare / Dr Niti Upasani, Catering Committee - Dr. Preeti Nanda, Sponsorship Committee - Dr. Hemraj Ingale, Stage Committee - Dr. Suchitra Kamat, Accomodation and Transport Committee - Dr. Sunit Upasani, AV committee - Dr. Sandhya Bhat, venue and stall arrangements - Dr. Utkarsh Bhingare, Banquet Committee by Dr.Vijay Aage & Souvenir Committee - Dr. Sheetal Khismatrao. All the members of the team working in various committees contributed tremendously towards the success of the conference.

Excellent academic sessions on different topics like Gyenacology, Rheumatology, Oncology, Hematology, Medicine, Psychiatry, Pathology etc were arranged with excellent speakers. Dr. U. Prabhakar Rao Oration was given by renowned pediatrician and great teacher Dr. MrudulaPhadke.

The inauguration function was held on 22nd October, Saturday.lt started with a high powered, live wire Dhol, Tasha &Lazime program which was thoroughly enjoyed by everyone. Inaugural Dance was presented by Dr. Kala Eswaran. The function was presided by IMA Maharashtra State President Dr.Jayesh Lele. Chief Guest was Dr. Mrudula Phadke. The function was graced by Hon. State secretary Dr. Parthiv Sanghvi and many other dignitaries from IMA Maharashtra State. For the first time, awards were introduced at Evecon to acknowledge the good work done by different women's wing of IMA. The first prize was awarded to Women's wing IMA Bhusawal, 2nd prize to Women's Wing 1MA Yavatmal, and 3rd was given to Women's Wing IMA Virar.

The constant thought at the back of the mind was to do something different to make this Evecon unique. We as doctors are so held in our daily routine lives, that we

forget our hobbies, our passions. So for the first time, live events were incorporated into the program schedule along with academic sessions. We met experts in the field, understood the feasibility of introducing such events and then 7 different events were incorporated; Hub -The Essay Competition, Synaesthesia - The Poetry Competition, Moments - The photography Competition, Graffiti - The Poster Competition with 3 live events... Dil Se - The Singing Competition, The Dancing Divaas - Group Dance Competition and Jalwa, The Finale - Fashion show. It took tremendous efforts and great co-ordination on the part of Team Evecon to manage the events smoothly. We had an overwhelming response for competitions. The various places from where registrations came for Evecon were Kalyan, Ambernath, Badlapur, Bhiwandi, Ulhasnagar, Panvel, Thane, Mumbai, Boisar, Wada, Virar, Bhusawal, Nagpur, Baramati, Chandrapur, Yavatmal, Alibag, Amravati, Pune and many more... The competitions were judged by renowned judges. The enthusiasm of participants was unbelievable and palpable.. the preparation for participation must have surely demanded a lot of their time and energy..kudos to the tremendous efforts put in by everyone. The results of various events held at Evecon are as follows:

| Competitions | Judges | Winners | From |
|---|---|---|---|
| The Hub | Dr. Jayesh Lele<br>Shri Sudhir Joglekar | Dr. Ashish Dhadas (1st - medical)<br>Dr. Ashwini Dharmadhikari (2nd -medical)<br>Dr. Kalyani Dixit (1st - non medical)<br>Dr. Suchitra Kamat (2nd - non medical)<br>Mrs. Geeta Agarwal (2nd - non medical) | Dombivli<br>Dombivli<br>Chandrapur<br>Dombivli<br>Dombivli |
| Synaesthesia | Dr. Pralhad Deshpande | Dr. Sunita Oak (1st - English)<br>Dr. Deepa Kala (2nd - English)<br>Dr. Anita Patil (1st - Marathi)<br>Mr. Pratik Khismatrao (2nd - Marathi) | Thane<br>Nerul<br>Wada<br>Dombivli |
| Moments | Dr. Girish Bhirud<br>Shri Raju Mohite | Mr. Pratik Khismatrao<br>Dr. Prerna Kolte | Dombivli<br>Chandrapur |
| Graffiti | Dr. Jayesh Lele<br>Dr. Ganesh Choudhari | Dr. Vijayalaxmi Shinde (Scientific)<br>Dr Medha Bhave Khair (Scientific)<br>Women's Wing Badlapur (Non scientific) | Dombivi<br>Thane<br>Badlapur |
| Dil Se | Shri Vasant Aajgaonkar<br>Prof. Shyam Kshirsagar | Dr. Rahul Karandikar (1st)<br>Dr. Dushyant Bhadlikar (1st)<br>Dr. Karuna Ramteke (2nd)<br>Dr. Sumedha Chaudhary (2nd)<br>Dr. Meena Pruthi (3rd)<br>Dr. Priya Hardikar (consolation)<br>Mrs. Supriya Mane (consolation) | Dombivli<br>Dombivli<br>Chandrapur<br>Dombivli<br>Dombivli<br>Dombivli<br>Kalyan |
| The Dancing Divaas | Mrs. Kavita Kohli<br>Dr. Rupali Deshpande | Tadoba Tornadoes (1st)<br>Movers and shakers (1st Runner up)<br>Natkhat Rangeelay (2nd runner up)<br>Strikers (Consolation)<br>Diwani Mastani (Consolation) | Chandrapur<br>Dombivli<br>Dombivli<br>Badlapur<br>Dombivli |

| Competitions | Judges | Winners | From |
|---|---|---|---|
| Jalwa | Dr. Aditi Govitrikar | Dr. Varsha Sonawane (Evecon Queen)<br>Dr. Aparna Dewaikar (Evecon Empress)<br>Dr. Gauravui Deshmukh (Evecon princess)<br>Dr. Mandar Pawar (Evecon King)<br>Dr. Mrudula Ingale (Consolation) | Kalyan<br>Chandrapur<br>Badlapur<br>Dombivli<br>Dombivli |

The Dance event was spectacular.. 2 performances need special mention - The Aghori dance presented by team Chandrapur was mind blowing and mesmerising.. the kind of efforts they must have put in to get this act together is unimaginable ! The Uri theme based act presented by Team Badlapur was so touching and commendable, that they got a standing ovation from the audience! All the other dance sequences were simply superb!

The singing event was absolutely melodious.. it was amazing to see the hidden talent in all our fraternity members who lead their life in and out dealing with patients and emergencies! The grand finale came with Jalwa — the fashion show... all the participants walked with so much grace and elan ! Without any previous co ordination or practice walk, participants from different parts of sate carried out the event so smoothly.. it was unbelievable..even the judge Dr. Aditi Govitrikar was impressed!

Hats off to all the members of Team Evecon who worked relentlessly to make Evecon 2016 a huge success, and hats off to all the enthusiastic participants - without whom the event would not be what it turned out to be! All in all, Evecon 2016 has left behind some vividly unforgettable and heart warming memories that will be remembered by everyone for years to come !!

•••

Dancing Divaas - 1st Prize to Tadoba Tornados

The Hub - 1st Prize to Dr. Ashish Dhadas

The Hub - 2nd Prize (Non-Medical) to Dr. Suchitra Kamath

The Hub - 2nd Prize (Non-Medical) to Mrs. Geeta Agarwal

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Dr. Nilesh Patil MD (Path) Dr. Balkrishna Shenoy MD (Path) Dr. Sujata Mankame MD (Path)

Shop No. 115, C wing, 1st Floor, Sonata Complex, MIDC, Dombivli (E). Website: Pridelab.in Ph No. 0251-2442220

# EVECON 2016


OCIATION WITH KALYAN DOMBIVLI MUNICIPAL CORPORATION)
OF IMA MAHARASHTRA WOMEN DOCTORS' WING


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# EVECON 2016


EVECON 2016
Against All Odds...Together We Can
(IN ASSOCIATION WITH KALYAN DOMBIVLI MUNICIPAL CORPORATION)
17th ANNUAL CONFERENCE OF IMA DOMBIVLI


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# KIDNEY TRANSPLANTATION

**Dr. Nagesh Aghor**

*Dr. Nagesh Aghor is a consultant nephrologist at Wockhardt Hospital Nashik. He has done his M.D. in Internal Medicine from B.Y.L. Nair Hospital, Mumbai and DNB Nephrology from Mulgibhai Patel Urology Institute Nadiad. He has been awarded fellowship of Internation Society of Nephrology from prestigious Brigham & Women's Hospital, Harvard, Boston, USA. He has*

*been awardwed fellowship by Internation Society of Peritonial Dialysis. He is expert at various modalities of dialysis such as Intermittent Haemodialysis, SLLED, CRRT, Acute Peritonial Dialysis and Chronic Ambulatory Peritonial Dialysis (CAPD). He has been instrumental in starting kidney transplant programme at Nashik Wockhardt Hospitals.*

Kidney transplantation is the organ transplant of a kidney into a patient with end stage renal disease (ESRD). Kidney transplantation is classified as deceased donor ( cadaveric) or living donor transplantation depending upon the source of the donor organ. Living donor renal transplants are further described as being genetically related ( living- related) or non- related ( living unrelated ) transplants, depending upon whether a biological relationship exists between the donor and the recipient.

In Boston, on Dec 23, 1954, the first transplant of a kidney from one twin to another with renal failure was performed at Peter Bent Brigham Hospital by Dr Joseph Murray and the medical team. It was the first successful long-term organ transplant. The first successful renal transplantation was done in India at CMC Vellore on February 2, 1971. The crude and age adjusted incidence rates of ESRD are estimated to be 151 and 232 per million population respectively. The majority of the ESRD patients (>90%) in India die within months of diagnosis, as renal replacement therapy (RRT) is neither affordable nor readily available. The Indian Chronic Kidney Disease (CKD) registry (an initiative by Indian Society of Nephrology), shows that out of 35697 CKD patients, 26609 (74.5%) CKD patients were not receiving any form of RRT and only 880 (2.5%) received renal transplantation. It is estimated that currently India's deceased donation rate is only 0.08 per million population per year. The CKD registry also showed that the mean age of CKD patients was 50.1 years. Diabetics and hypertensive together comprised 44% of patients.

Advantages of kidney transplantation

1. Total recovery and better quality of life.
2. Freedom from dialysis
3. Longer life
4. Lesser dietary and fluid restrictions
5. Fewer complications compared to dialysis
6. Cost effective.
7. Improvement in sexual ;ife in male and higher chance of pregnancy in female

Disadvantages of kidney transplantation are,

1. Risk of major surgery.
2. Risk of rejection
3. Regular immunosuppressive medications on lifelong basis.
4. High risk of infections, side effects of drugs and malignancy
5. Stress of waiting for kidney donor before transplant, fear of losing function of the newly transplanted kidney.
6. Initial high cost for first year post transplant.

Contraindications for a kidney transplant are,

1. Presence of serious active infection
2. Active or untreated malignancy
3. Severe psychological problems or mental retardation
4. Unstable coronary artery disease or refractory congestive heart failure
5. Other end organ diseases such as end stage lung disease, cirrhosis of liver.

Kidney transplant is usually recommended for persons

from 5 to 65 years of age but there are no fixed age criteria.

Healthy persons with two kidneys can donate one kidney if blood group and tissue types are compatible with the recipient. Generally, donor's age should be between 18 and 55 years. Blood group compatibility is important in kidney transplantation. But kidney transplantation across blood groups is possible. It requires higher immunosuppression in initial post-transplant period with some increased risk of graft rejection compared to same blood group transplants.

A living donor is thoroughly evaluated medically and psychologically to ensure that the kidney donation is safe for him or her. Donors with diabetes mellitus, hypertension, HIV, HbsAg, HCV, cancer, kidney disease, major medical or psychiatric illness are usually rejected. Post kidney donation, the donors have normal healthy life.

Paired kidney is the strategy which allows the exchange of living donor kidneys between two incompatible donor/recipient pairs to create two compatible pairs. This can be done if the second donor is suitable for the first recipient, and the first donor is suitable for the second recipient. By exchanging the donated kidneys between two incompatible pairs, two compatible transplants can be performed.

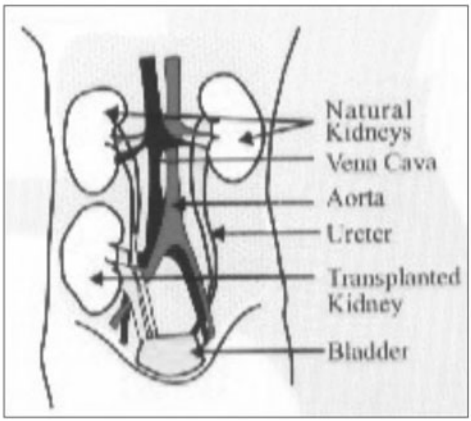
**Preemptive transplant**

Preemptive kidney transplantation is performed on the CKD patient before the initiation of dialysis. It avoids the risks, cost and inconvenience of dialysis. It is associated with better graft survival. A well informed patient with a family donor can undergo preemptive kidney transplantation.

**Transplant surgery**

Pre-transplant evaluation includes medical, surgical evaluation.

Psychological and social evaluation are important. Blood group and HLA matching is performed in recipient and donor. Patient and donor are explained in detail about the procedure and written consents are obtained. In living donor transplant surgery, both the recipient and donor are operated simultaneously. Both are major surgeries and last for three to four hours. Donor kidney can be removed by open or laparoscopic surgery. Usually left kidney is removed from living donor and is placed in right lower quadrant of the abdomen in the recipient. In most cases, the old diseased kidneys are left in the abdomen. In case deceased donor transplant the kidney is harvested from the brain dead donor and transported to the center where the recipient is admitted surgery. In living donor the transplanted kidney starts functioning immediately where as in deceased donor, the function may be delayed from hew hours to days. Post- surgery patient is shifted to surgical ICU where he is cared in an isolation room. The nephrologist is responsible for the care post -transplant.




**Post Transplant care**

Major complications post transplant are,

1. Kidney rejection-

a) Acute – Cellular,

b) Acute- Antibody Mediated (Humoral),

c) Acute - Combined

d) Chronic Rejection

2. Side effects of medications
3. Infections

Immunosuppressant Medications and their side effects

1. Prednisolone – Weight gain, high blood pressure, increased risk of diabetes, osteoporosis, cataract, gastritis
2. Cyclosporine- high blood pressure, tremors, excess hair growth, gum hypertrophy, diabetes mellitus, interstitial fibrosis in kidney
3. Azathioprine – infections, bone marrow suppression.
4. Mycophenolate mofetil – vomiting, diarrhea, infections , bone marrow suppression.

5. Tacrolimus- high blood pressure, diabetes mellitus, tremors, interstitial fibrosis
6. Sirolimus – high blood pressure, bone marrow suppression, diabetes, diarrhea, hypertriglyceridemia, hypercholesterolemia.

General Guidelines for kidney transplant patients

1. Take transplant medications regularly. Donot alter dosages without consulting the treating nephrologist.
2. Regular follow up as advised lifelong.
3. Daily liquid intake 3 litre per day.

•••

## CLINICAL CRITERIA FOR BRAIN DEATH IN ADULTS AND CHILDREN.

Coma

Absence of motor responses

Absence of pupillary responses to light and pupils at midposition with respect to dilatation (4-6 mm)

Absence of corneal reflexes

Absence of caloric responses

Absence of gag reflex

Absence of coughing in response to tracheal suctioning

Absence of sucking and rooting reflexes

Absence of respiratory drive at a $PaCO_2$ that is 60 mm Hg or 20 mm Hg above normal base-line values*

Interval between two evaluations, according to patient's age

Term to 2 mo old, 48 hr

>2mo to 1 yr old, 24 hr

>1 NT to <:18 vr old, 12 hr

≥ 18 yr old, interval optional

Confirmatory tests

Term to 2 mo old, 2 confirmatory tests

>2 mo to 1 yr old, 1 confirmatory test

>1 yr to <18 vr old, optional

≥18 yr old, optional

N Engl J Med, Vol. 344, No. 16April 19, 2001

# EVECON 2016: DANCING DIVAAS




# EVECON 2016: DIL SE - LIBERATE YOURSELF




# NURSING PRACTICES: AN OVERVIEW: WHY CHOOSE THIS TOPIC ?

Dr. Sangeeta Dandekar

**Nurses : Vital Component of Health Care Organization**

Nursing staff is an integral part of any health care organisation - whether a small nursing home or a big hospital. A nurse is the one who is responsible to actually implement the decisions taken by the medical practitioners. Nurse is the one who is in immediate contact with the patient. Interaction of the patients with the nurses contribute a lot to the opinion formed by the patients about any hospital. A good nurse can improve patient outcome manifolds. The competence, skill and knowledge of a nurse helps to build confidence in the patient that he is at the right place. Along with good doctor-patient communication, nurse-patient rapport is equally important. A lot many violence cases can be avoided if your nurse is compassionate with the patient, is prompt in her actions, skillfull in her job and is knowledgeable enough to answer multiple minor queries of the patient. I know I am talking about an ideal situation which may appear to be far from the truth at the moment. But this is not impossible. With bilateral symbiosis between Medical Council and Nursing Council we can achieve this and step towards the best patient care.

**Increasing Governmental Regulations on SHCOs (Small Health Care Organization)**

Over a past decade Indian government is trying to impose numerous regulations upon our health care system. Regulations are required for smooth functioning of any organization in any field. Health care sector is no exception. It is the duty of the government to ensure its citizens their right to good health. But whether these regulations are truely intended to be regulations or are they restrictions over the freedom or authority of medical practitioners is a debatable issue. To safeguard the patients rights is the duty of the govrnment. But is it not our duty also as health care provider? Yes, ofcourse. It is our duty too. We have never denied it in past neither are we denying this now. But the differnce is that previously doctor alone used to take decisions about patients management, he shouldered the complete responsibility of patient's betterment and cure from illness but now with changing times its a collective phenomenon involving patients, governing bodies, various NGOs , media and society in general.

The government is giving guidelines or in other words deciding each and every aspect of a clinical establishment right from the administration of a hospital, to furniture and fixture and medical equipment needed, to the area per bed and to the extent that even the standard medical treatment guidelines in all specialities are proposed in the draft of newer act.

The need of the hour today is to get well aquainted with the newer rules and regulations, try to implement them as far as possible and raise the voice unanimously if found inappropriate.

**Changing rules about nursing staff in SHCOs**

One major issue in the newer regulations is the changing rules about the nursing staff.

The ideal number of nurses in a hospital, quality and training of nurses, their responsibilities, their liability in medico legal matters needs to be discussed. Maharashtra Nursing Council is insisting to employ only registered nurses in the hospitals. The current registrar of Maharashtra Nursing Council has recently stated that registration of all the nurses is mandatory from legal point of view. Registration will impart her legal protection. She also stated that nursing without registration is a legal offence. MNC is also insisting on maintaining nurse:bed ratio. With the current statistics is it possible to have registered nurses everywhere? These are the matters to be discussed with priority.

We have our representative in Maharashtra Nursing Council representing IMA. Over past two years Dr. Anand Hardikar is representing IMA as a member of nursing council. He is actively participating in all the proceedings of nursing council and is giving feedback to IMA officials regularly. He has a major role in getting nursing college granted for Kalyan Dombivali area.

Through his inputs I realised that its an important issue and we all should pay attention to it, discuss it and put our views and put forth our difficulties and try to come out with solution.

I hope these articles will create awareness amongst all of us and we will think over it and act on it, if required fight unitedly if there is any injustice noticed.

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# EVA
## WOMEN'S CLINIC & LAB
*the case you deserve*

Shop No. 4, Om Neelkanth krupa CHS., Gopal Nagar Lane No.1, Kalyan Road, Dombivli (East).
**Contact :** 7709809774, 9920920926 **email id :** evaclinlab@gmail.com, www.ewawomenscliniclab.com
**Clinic Timing :** 11am to 1pm by appointment **Lab Timing :** 8:30am to 8:30pm (Sunday 9am to 2pm)

**Eva Women's Clinic**
- Infertility counselling and consulting
- General women's health screening
- Hormonal disorders, PCOD clinic
- Menopause counselling & consulting

**Eva General Clinic**
- General examination of patients
- Screening of common illness.

**Eva Clinical Lab**
- Specialised services in Diagnostic clinical Microbiology
- Bacteriology : Microscopy, culture and antibiotic susceptibility testing
- BACTEC Blood and Fluid cultures
- Mycobacteriology: Microscopy cultures, AFB cultures, DST, TB PCR, Genexpert

  Mycology: Culture and Microscopy
- Parasitology
- Serology & Immunology

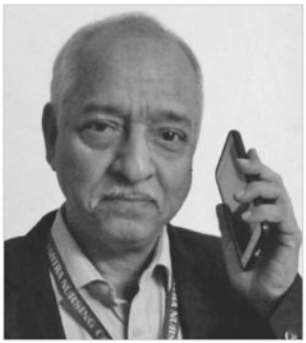
**Hospital Infection Control Services:**
- Operation theatre and critical area Surveillance testing
- Hospital Infection control Screening
- Training of Healthcare workers
- Infection control Surveillance activities

**Others :**
- *Pathology and biochemistry services also provided.*



# HISTORY OF NURSING - UNREGISTERED TO SMART CARD HOLDERS

**Dr. Anand Hardikar**



*He is a past president of dombivali IMA, has been chairman of Action Committee of IMA Maharashtra State for three years and is currently a state representative to IMA MS from IMA Dombivali. Since last two years he is representing IMA to Maharashtra Nursing Council as aMNC member. All throughout the years when he was holding some responsible position and also when not holding any position , he has been participating actiely for the betterment of fraternity. His writ petition against KDMC regarding water bills from KDMC to all the hospitals has been successful ( In 2001) and is mentioned in AIR.*

*Even today at the age of 70 he is struggling for many things. Some of the areas of his interest currently are -*

1. *'Struggle for Early Restarting of KDMC Dombivli 'PRASUTIGRAH'. He addressed this issue strongly in KDMC Meeting with MP, MLA, Mayor and high level KDMC Officials !*
2. *Modification in Nursing Education - Qualitative and Quantitative- for hospital orientation !*
3. *Approval for PERSPECTIVE PLAN for approving New Nursing Diploma colleges in State-under MNC - as put up by MNC !*

*No new nursing College application can be considered without approval of ' PERSPECTIVE PLAN ' !*

*Recently - 'SEVAVRAT JYESHTH NAGARIK SANGH ' Adviser !*

Nursing personnel is the fundamental part of any health care system. They form the main working force in any health care institution. May it be a primary health care centre or rural or urban health centre. May it be a teaching government hospital. May it be a private hospital whether small nursing home or big corporate set up. Nurses form the backbone of health care.

If we try to go into history of nursing in India it dates back to British period when religious sisters were called to give nursing care to soldiers. Later on civil hospitals were introduced to civilians.

In the year 1902 Nursing Association was started for training of nurses.

Bombay Presidency Nurses Association was started (BPNA) in 1909.

In 1935 Bombay Nurses Midwives and Health Visitors Registration act came into being. It's preamble was to standardize the nursing education and to regularize the nursing registration and took over the funds and functions of BPNA.

In the year 1947 Indian Nursing Council act came into force.

In 1954 the act of 1935 was revised replaced by Bombay Nurses Midwives and Health Visitors Act.

In 1966 Nursing council of Maharashtra was born by combining Vidarbh nurses council and Maharashtra Nursing Council (Bombay area) under Maharashtra Nurses Act 1966. The main functions of the nursing council were the registration of new nurses and their renewal and revising the syllabus of nursing.

In last 50 years there has been growth in nursing sector quantitative as well as structure wise.

In 1966 there were 34 ANM and 12 GNM institutes and 699 students passed out each year.

Between 1970 and 2000 students passed each year increased to 2673.

In 2009 to fulfil the demand by public health department Maharashtra the ANM seats were increased to double. As of today 15835 students pass out every year.

In addition 1300 students pass out with the degree of B.Sc. Nursing from MUHS Nasik.

| Year | GNM institutes | ANM institutes | Total students per year |
|---|---|---|---|
| 1967 | 12 | 34 | 699 |
| 1970-2000 | 74 | 42 | 2673 |
| 2000-2015 | 698 | 305 | 15835 |

In the year 2010 Bsc nursing was started by MUHS Nasik from which 1300 nurses pass out every year.

Total registered nurses as of December2015 are 203823.(Two lakh three thousand eight hundred and

twenty three).

The higher education courses have also started

They are as follows-

Msc. Nursing.

PhD nursing.

M. Phil nursing

Specialized nursing mainly

A. Cardio thoracic nursing
B. Psychiatric nursing
C. Oncology nursing
D. Paediatric nursing
E. Critical care nursing.

Now the latest is that they have started Nurse Practitioner (M. Sc.) Critical care nursing course.

The Maharashtra Nursing Council is made paperless and is digitized completely.

Continuing Nursing Education or CNE: Like we have our CME programs Maharashtra Nursing Council has started compulsory CNE or Continuing Nursing Education program from this year onwards. All the registered nurses are required to attend these programs. Each program will get credit points as per the contents of the program. Each registered nurse has to earn total 25 points in five years distributed as five points per year. Out of these twenty five points five points can be earned through on-line CNE program for the nurses residing in Maharashtra and those residing out of state can earn all the twenty five points through the online program.

These credit points are mandatory for further renewal of registration. Maharashtra Nursing Council holds the rights of accreditation of organizations for holding the CNEs. The purpose of these CNEs is for updating the knowledge and skills and fortify their competence to ensure the best possible care to the patients.

Smart Card Nurses:

They have introduced Smart card for all the registered nurses from the year 2016 which was the Golden Jubilee Years for MNC. Smart Card holds all the information of the nurses in cumulative form starting from joining date till today with proofs and certificates. A nurse can operate it from any corner of the world. Adding or removing information is possible for MNC authority.

Registration of nurses and their renewal has also become an online process now and can be done within just few days.

Moreover MNC is planning to undertake a public awareness program by which they will appeal to the people to verify whether the nursing services which they are getting is only through registered and smart card holder nurses.

They are equating unregistered nurses to unqualified and untrained nurses working in the uniform of nurses. Private sector is mainly held responsible for appointing so called untrained nurses.

Though the reality is that all unregistered nurses are not untrained. In fact they are quite efficiently doing their job with the experience and need based learning.

In spite of so much revolution in nursing field the current availability of the nurses is much less as compared to the requirements of the health sector. Some practical steps need to be taken to achieve the balance between demand and supply.

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**EVECON- 2016**

# SCARCITY OF NURSES : TO SEEK A QUICK FIX

**Dr. Sangeeta Dandekar**

*Practicing Ophthalmologist. Currently working in IMA Dombivli as Editor-Dialogue, Chairperson Organ Donation Committee and Clinical Establishments Act Committee. Current article states that as of today it is almost impossible to recruit smart card holder nurses in smaller nursing homes.*

Indian health care system is passing through a transitional phase. There are multitude of problems before the medical fraternity. Some genuine, some created by hostile forces against us.

Amongst the genuine problems scarcity of trained and registered nurses is one on the top of the list. We are experiencing this quite often. But what do statistics show?

As per the data available:

Total number of registered nurses : 2,03,823

A. N. M. : 0,73,108

G. N. M. : 1,17,457

B.Sc. : 0,12,717

So currently as of now there are two lakh registered nurses registered under Maharashtra Nursing Council.

The ideal "nurses:bed" ratio proposed by various expert committees is as follows:

1. Non teaching hospital 1:5
2. Teaching hospitals 1:3
3. ICUs it is supposed to be 1:1.
4. Add 30% to this as leaves reserve.
5. OPD nurses are considered separately.
6. Casualty nurses are considered separately.
7. Nurses: Population ratio as proposed by expert committee (Bhore) to avoid ill health is 1:400.

We can imagine that with the current number of registered nurses it's not possible to fulfil the demand of the entire health care system, if we consider above ratios.

I couldn't gather the actual data about the the number of hospital beds existing currently in entire Maharashtra under all categories of hospitals. But one can guesstimate. We can roughly categorize the hospitals as follows :

1. Teaching hospitals of government medical colleges: These include mainly very big hospitals like KEM hospital with 1800 beds, Sasson hospital with 1400 beds..etc Almost all such hospitals are above 1000 beds.
2. Hospitals attached to private medical colleges. Must be average 700 beds per hospital
3. Big private hospitals of corporate groups average of 300 beds
4. Civil Hospitals.
5. District hospitals
6. Urban and rural hospitals
7. ESIS hospitals
8. Medium sized charitable trust hospitals
9 Small nursing homes of less than 50 beds. (SHCOs)

One can easily understand that a manpower of 2 lakh nurses is grossly inadequate.

Over and above consider the following categories which also are fulfilled from the quota of current registered nurses.

1. Nurses engaged in primary health centres.
2. Nurses working in rural and remote areas.
3. Nurses posted on administrative posts like matrons and superiors,
4. Nurses engaged in nursing schools and colleges,
5. Nurses going abroad.
6. Those involved in private nursing bureau...and so on.

It is obvious that there is a very gross scarcity of trained nurses.

It's all the more difficult to get those for smaller nursing homes with bed strength less than 50 obviously because though they can get comparable salaries yet promotion opportunities are less.

It is proposed by nursing council itself that there is a shortage of at least one lakh nurses in Maharashtra alone. There is a shortfall of 23% nurses for all the hospital beds.

The experts committee of Maharashtra Nursing Council is soon coming out with this data, not to show that there is a shortage of nurses which is a fact already proven, but to actually estimate how many more nursing colleges are needed.

If we consider the WHO guidelines, the ideal requirement is as follows:

Ideal bed: population ratio.....5:1000

Average nurse:bed ratio.....1:4

Population of Maharashtra.....12,91,30,500

Nurses for hospital beds.....1,61,413

Nurses required for peripheral work.....2,,58,261.

So the backlog by ideal standards is unimaginable.

**Quality of skills and knowledge:**

Actual knowledge and training of even the qualified and registered nurses is far from satisfaction. There is a gap between the classroom knowledge and practical training. Practical training is lacking which affects when it comes to the actual patient care. Many a times a un- registered but well experienced nurse can be so much more useful than the qualified one.

The nurses who are working in small nursing homes get practical training right under the guidance of a qualified doctor. Their knowledge though in a limited field is much more precise in that particular sub speciality. The newer concepts of biomedical wastes, hand hygiene and importance of sterilization procedures can be easily taught to them.

**Qualified from state approved nursing schools but unregistered:**

Sometimes nurses coming from outside state have their degrees from recognized private or even government institutes but they are not registered with MNC just for some minor deficiencies like NOC from parent institute..etc . We should insist for their registration.

**Deemed Nurses:**

Many of the nurses are properly trained in their institutions but still they are not eligible for registration because that institute is not recognized by MNC. They are good in practical work. They have working experience of many years and possess all required skills. We should demand for some facility of distant learning and examination so that they can be registered. Or we may suggest to have some minor registry for such distant learning registration so that they don't compete with primary registered nurses for government jobs.

**Need of practical solution for today:**

Once the MNC committee recommends more number of colleges and more number of seats per college the nursing manpower will surely increase. But this is going to take at least 8-10 years till we get those nurses for actual working. Till that time some middle solution has to be arrived at. We must propose this to the government and to the nursing council. Government is putting new hindrances every day before medical fraternity and more so before the smaller nursing homes. We should be more proactive and try and put solutions before them. This will definitely improve the health care standards delivered at our nursing homes and will save our nursing homes from extinction.

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References:


1. Data received from MNC (courtesy Dr. Hardikar)
2. Official website Maharashtra Nursing Council.
3. Verbal communications with members MNC.


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# NURSING FORCE - NATION'S HEALTH

**Mrs. Meenal Arvind Rane**

**(Reprint with permission from "Golden Jubilee Souvenir of Maharashtra Nuring Council")**

*Mrs. Meenal Arvind Rane*
*M.Sc. Nursing (CHN), Mumbai*
*Senate member: MUHS Nashik. Member of educational council: MUHS Nashik.*
*Member: Maharashtra Nursing Council.*
*Publications : 6 paper publications at national level.*
*Has undertaken projects in rural and remote areas in geriatric nutrition and maternal feeding.*
*Awarded for her special works in :*
*1. Epidemic emergency management in cholera*
*2. Emergency management in earthquake in Latur district.*
*3. Emergency management in Mumbai bomb blast.*
*4. Emergency management in gas explosion in Solapur.*
*The Principal, College of Nursing,*
*ITM IHS, Plot 11, Sector 12, New Panvel- 410206*
*E-mail ID: meenalrane59@gmail.com*
*Residence : Grit Residence Co-op Hsg Society, A-Wing 703 Ghatkopar Mankhurd Link Road, Opp. Indian Oil Nagar, Chembur Mumbai - 400 043. Mobile : 9324515470*

World Health Organisation has stated that in order to achieve its goal of Health for all the nursing force must be brought in "fairly and squarely as leaders and managers of Primary Health Care team or Health For All Team". It is also mentioned that the countries where medicine has progressed and Nursing has not, the progress of health programmes get delayed or fail. Personnel involved in rendering nursing functions constitute the major manpower of every health system. Quality and quantity of this personnel available for the health needs determine the success, delay or future of health delivery.

While giving inaugural address in an international seminar at Madras the role of the nurse in the delivery of Primary Health Care, former health minister Mrs Mohsina Kidwai States, "Provisions of Primary Health Care is a natural extension of nursing practices especially as it is applied to community health". Mrs Indira Gandhi's words "A nurses is not merely an aid and assistant to a doctor. She has an independent part to play in many areas where doctors need not necessarily be present". In 1946 there were only 7000 registered nurses. The report of the health survey and development committee (Bhore committee) observed that "The sickness and mortality in the country can be halved by the employment of properly trained nurses, health visitors and midwives in sufficient numbers. Although the doctors should be increased by four folders a corresponding increase in nurses and health visitors should be a hundred times and midwives twenty times".

It proves that nurses are playing an important part in combating and controlling the health problems like communicable and noncommunicable diseases and high Infant and maternal mortality.

To reach successfully over to a destination following things are required

1. A vehicle
2. Fuel to run the vehicle.
3. A good driver who can drive the vehicle.
4. Directions and map.

**Vehicle :** Nursing leadership is a powerful vehicle able to move the large nursing force towards the goal.

**Driver :** Nurse's role is vital in two ways, firstly because she is the backbone of the health system and her position is closest to the people. Hence if sufficient numbers are available with good quality of education it will act as a driver of the vehicle.

**Fuel :** Policies regarding nursing services and nursing personnel if designed properly in regards to nurses and bed ratio, rewards and remuneration, continuing and in service education, specific job description and job specification, promotional prospects, social security, career development safety and security...etc. puts the impact on nursing energy, which will work as a powerful

fuel in the vehicle.

**Maps of Direction :** Specific nursing objectives towards health development helps nurses to work with confidence and towards the specific direction with achievable objectives. We can say that health for all will be possible with achievable objectives, otherwise health for all slogans will only remain as lips service and paperwork because without any root map vehicle will be blind.

We believe that the nurse must consider the total health of the person or the family and his needs as a whole which includes integrated physical, social, mental, emotional and spiritual needs. Nursing personnel must be assigned work in such a way that her knowledge and skills learnt are best used for the purposes for which she was trained.

In addition to that her positive attitude towards nursing work and towards the people she serves it is easy to deliver a very good Primary Health Care. All elements of Primary Health care if taken by nurses and start the work for people, to the people and by the people then this vehicle will run on the route without any accident. All milestones will be achieved successfully.

Nursing is vital for the nation's health. Manpower wise, nurses are most in numbers among the healthcare professionals. Taken away the nurses in any Hospital the whole Services would collapse. So nursing force has gigantic contribution in the development public health.

World Health Organisation has set the goal of health for all and is organising the governments to attain this goal (destination) through primary care activities (principal vehicle). The nurses are putting efforts to promote the people's right to health according to the conditions of the country and available resources. No one can stop our country to reach our destination health form from 1951 to till today. As per the policy of nation there are many changes that have come in nursing for example need based curriculum, huge trained nurses production, broad scopes are considered vital organs in health system. Good leadership, nursing manpower management, researches in nursing, increased education quality has brought a positive impact on our health indicators(IMR MMR CBR CDR..etc). These are our sensitive indicators but progressively it improved with great difference.

Hence nursing force and Nations health is having a positive relationship. Nursing as a profession will have to be accepted with responsibility for significant functions and develop abilities to prescribe preventive and rehabilitative and promotive care in a responsible and accountable way. Building a nation's health is a great task and challenge for the nurses. I conclude with a verse that will increase the teamwork which are essential for improving the Nation's health.

" Some has blended the plaster
Some has arrived the stone
Neither the man nor the master
Ever has built alone.
Only by working together
Things are accomplished by man
All have share in the beauty
All have part in the plan."

...

## NURSING COUNCIL - ANNUAL REPORT

**Dr. Anand Hardikar**

Thanks for opportunity given to me for working in MNC !

Its my pleasure to report about MNC activities -

I have attended all the meetings of MNC -except one !

I have submitted my Reports about all Meetings to State Office regularly .

Important points I raised in MNC –

1. There is tremendous shortage of Trained and registered Nurses in State posing challenges before Health Care Delivery system .
2. The clinical Knowledge of such Nurses is far from satisfaction .
3. They Should be more Hospital oriented !
4. In MNC --Male quota for admission for Diplomas Awarded by MNC- was only 10% of input -- which I requested to increase to 30 % and was accepted.
5. I had an opportunity to Inspect one Nursing College - as MNC Member-. - It was a unique experience . Cardinal Gracious Hospital College Vasai !
6. Many Applications for GNM diploma Courses are waiting in Q -- Permission to New Nursing Colleges should be expedited
7. Some Stringent Requirements of BSc - Nursing-by INC - course should be more liberal , I am surprised that --Due to such Stringent Conditions even BMC has no BSc Nursing College - (Ref - Talk with one Topmost Health Officer BMC).They have GNM only ! INC does not recognize R ANM for hospital duty !
8. Its my pleasure to inform --With my persistent Efforts with Kalyan Dombivali Mahapalika - The Hon Mayor - Our MP- DR. Shinde - MLAs -Leader of Opposition and MOH -- The KDMC GB has sanctioned Nursing College in Corporation area !
9. Some Members had personal Difficulties with working of MNC office - to which I could help them !
10. Practicing Nurse in Primary Health Care' will be allowed to Practice - prescribe drugs (36 in number) For RURAL INDIA as per Directives of WHO !

I expect that some information I have given to the State office should reach all our members though MAHIMA, which is the bulletin of IMA Maharashtra State, as this is the only statutory post for IMA.

I don't know why No Nominated member from MMC has attended these meetings. We too need Support in MNC for VOICING our members INTEREST TOO !

The Pressure from MNC on government for 'Smart and registered Nurse' under BNHRA is likely to harass doctors. NAVI MUMBAI MUNICIPAL CORPORATION has issued Notices to all hospitals to Comply strictly with qualified and Registered Nurse else Hospital Registration will be cancelled !

One more request -

The MNC nominated Member should be given chance to Report like other committee Members in State Executive Meetings !

• • •

**Team Evecon 2016**

Disha Kidney Care
Path To Quality Care

# Dr. DINESH P. MAHAJAN

MD ( Medicine , JJH ), D.M ( Nephrology,K.E.M Hospital )
Assistant Professor in Department of Nephrology, KEMH
Consultant Nephrologist & Kidney Transplant Physician

Disha Kidney Care Shop No. 12, Rajhans Co-Op Hsg soc, Opposite Hotel Rangoli, Char Rasta, Dombivli (East) - 421201 Call : 9320346426, 8433511374

# SPARSH

Multispeciality Hospital & I.C.C.U.

**ISO 9001:2008 CERTIFIED**

Hospital Reg. No. KDMC/HD/BNHRA/02/148

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Dombivli (E) 421 201
Tel.: 0251 - 2445044, 2448044
Email : sparshhospital12@gmail.com

## FACILITIES

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- 10 Bedded ICU
- 2 Ventiletor / 2 Bipap
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- Critical Care
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- 2D ECHO, Stress Test
- Xray, ECG
- Neurology
- Acute Stroke Centre
- Diabetes Care
- 24 Hours Pathology
- General Surgery
- Endoscopy
- Laproscopic Surgery
- Onco Surgery
- Urosurgery
- Neuro Surgery
- ENT Surgery
- Orthopedic Surgery
- Plastic Surgery
- Obstetric & Gyanecology (Normal Delivery)
- Pap Smear

## MEDICLAIM FACILITIES CASHLESS

- Mediassist India
- DHS (Dedicated Healthcare)
- Bajaj Allianz General Insurance Co.
- Paramount Health Care
- Apollo Munich
- Religare
- Star Health
- ICICI Lombard (OPD)

### Dr. Hemant S. Wahane

M.D. (Medicine)
Consultant Physician, Cardiologist & Diabetologist
(Special Interest Echocardiography)
**M. 9820272722**
Timing : 10 a.m. to 1 p.m. & 6 p.m. to 10 p.m.

### Dr. Amol U. Sonawane

M.S. (General Surgery)
Consultant Laproscopic, Endoscopic, General Surgeon
**M. 9820957970**
Timing : 10 a.m. to 1 p.m. & 6 p.m. to 10 p.m.

### Dr. Charusheela H. Wahane

D.A.
Anaesthesiologist

### Dr. Shalaka A. Sonawane (Mungekar)

M.D., D.G.O., F.C.P.S.
Consultant Obstetrics & Gynaecologist
**M. 9322825637**
Timing : 11 a.m. to 1.00 p.m.

# फुलस्केप

डॉ. संजय आर. रणदिवे

*Having completed his physiotherapy graduation from GSMC in 1977 he worked at Ulhasnagar central hospital. He was the first physiotherapist to start his priate practice in Dombivali. He has actively participated in amateur as well as professional theatre. He has won many awards for acting and has also worked in feature films, TV plays and documentaries.*

आश्रमावर शेवटची नजर फिरवून मी माझ्या खोलीवर निघालो. छोटी मातीची पायवाट त्यानंतर माझी बाग, मग माझी खोली. आजच्या भाषेत स्टुडिओ अपार्टमेंट. एखाद्याला एवढं पुरेसं असतं. आश्रम हाच माझा खरा संसार. सगळ्यांबरोबर माझंही जेवण झालेलंच असतं.

तेवढ्यात खिशातला फोन वाजला. रात्री दहा वाजता मला फोन कोण करणार ? नंबरही नवीन होता. पलिकडून आवाज आला – 'नमस्कार धुरु साहेब. मी नवल पाटील बोलतोय. वाईट बातमी हाय. निमाची आजी खपली. तसा म्हातारीनं काय तरास नाय दिला. चाळीतली माणसं. राहाळकर होते स्मशानात. तिथूनच आलो नं तुम्हाला फोन लावला. रहाळकर फोन करणार होते पन मी म्हनला माझं काम हायेच मीच करतो फोन. उद्या सकाळला खोलीवर याल का ? म्हातारीनं तुमच्या आश्रमासाठी काय वस्तु ठेवल्यात त्या घेऊन जा. खोली रिकामी झाली की मी दुसरा गिऱ्हाईक शोधन !'

'ठीक आहे, येईन १० वाजेपर्यंत.' मी मूकपणे खोलीवर निघालो. पावलं जड झाली होती. ओटीवरच्या आरामखुर्चीत बसलो. तशी निमाच्या आजीशी माझी जुनी ओळख नव्हती. गेल्या काही दिवसात झालेली. ती सुद्धा रहाळकरांमुळे. खरं तर आश्रमात रहायला येणारी एक अगतिक वृद्ध स्त्री याच भावनेनं मी तिला भेटलो. इथे येणारे बहुतेकजण तसेच असतात. पण काही माणसं तुमचे आडाखे चुकवतात.

एका चाळीतल्या कॉर्नरच्या खोलीत निमाची आजी रहात होती. दारावर पाटी – श्री. मा. शि. श्रृंगारपुरे व सौ. क. मा. श्रृंगारपुरे. कुणी खोडकर मुलाने श्री. श्रृंगारपुरे नावावर टोकदार वस्तूने आडवी रेघ मारली होती. दार बंद आतून जुन्या मराठी गाण्याचा आवाज येत असे. बेल वाजवली गाणं बंद झालं. साधारण पासष्ट–सत्तरच्या वृद्धेनं दार उघडलं. 'मी नाना – नाना धुरु – आपण श्रृंगारपुरे ? हो मीच....पण मला 'निमाची आजी' म्हणा. सगळे तसंच म्हणतात.

'मी स्नेह वृद्धाश्रमाचा संचालक'

'हो, रहाळकरांनी सांगितलंय सगळं ! चहा चालेल नां ?'

'हो चालेल'

'दोन मिनिटात आले'

अक्षरशः दोन मिनिटात चहा हजर.

'रहाळकर म्हणाले की तुम्ही वेळेला पक्के आहात म्हणून बनवून ठेवला नुकताच. बिस्किट पण घ्या. मी घरीच बनवलेत.'

चहा खरंच चांगला होता. बिस्किटंही माफक गोड, नीट खमंग भाजलेली होती.

'हा आमच्या संस्थेचा फॉर्म. सवडीने भरुन ठेवा.'

'ठेवा टेबलावर'

मी उठून टेबलावर फॉर्म ठेवला. वर पेपरवेट ठेवला.

'फॉर्म टेबलाच्या उजव्या बाजुला ठेवा.' मागून मला सूचना आली. खरंतर मी उजव्याच बाजूला फॉर्म ठेवला होता. तरी सांगायचं कारण?

'बरं, तुम्ही माझा आश्रम पहायला केव्हा येणार ?'

'नंतर आधी मला काही माहिती हवीय.' 'ठीक आहे विचारा.'

'किती लोकांची सोय आहे ह्या आश्रमात ?'

'साधारण शंभर'

'सध्या प्रत्यक्षात किती आहेत ?'

'नक्की आकडा पासष्ट'

'म्हणजे पस्तीस कॉट्स रिकाम्या आहेत.'

'डॉर्मेटरीज सगळ्या भरल्या आहेत. पंधरा बेडच्या चार आहेत. चार चार बेडच्या नऊ खोल्या आहेत. त्यातल्या बराचश्या रिकाम्या आहेत कारण त्याचा चार्ज थोडा जास्त पडतो.'

'मग उरलेल्या चार बेड्सच काय ?'

'दोन दोन बेड्सच्या दोन खोल्या आहेत.'

'मला एकटीला रहाता येईल असं स्वयंपाकघर असलेलं आहे कां ? म्हणजे माझं मी शिजवून खाऊ शकेन.'

'तसं म्हणजे एक स्टुडिओ अपार्टमेंट आहे. पण तिथे मी रहातोय. मी काही स्वयंपाक वगैरे करत नाही. तुम्हाला हवंच असेल तर ते खाली करुन देईन मी. मी स्वतः दुसऱ्या खोलीत शिफ्ट होऊ शकतो.'

खरं तर हे माझ्या स्वभावाविरुद्ध होते. पण निमाच्या आजीचा स्वभाव पहाता एक वेगळं व्यक्तिमत्त्व आश्रमात आल्यावर काय होईलते पाहण्यास मी उत्सुक होत होतो.

'त्याचं काय आहे धुरुसाहेब, मला मधे मधे नॉन व्हेज लागतं. त्यामुळे मला तसं अपार्टमेंट हवंय.'

'पण तुम्हाला आणावं लागेल ते चालेल ?'

'ते आणायला माझा माणूस आहे – रहाळकर. ते मला सगळं आणून देतात.मी फक्त बनवते.'

आश्रम पूर्ण शाकाहारी आहे. तिथे एकाला असं करायला परवानगी देणे माझ्या मनाला न पटणारं आहे. निमाच्या आजीच्या कोड्यात मी अडकतोय. माझ्या आश्रमाच्या अटी मान्य करुन सगळे वृद्ध तिथे रहायला येतात. ते बिचारे अगतिक असतात. ही अगतिक नाहीच शिवायती By Choice तिथे रहायला येतात. कदाचित हिच समाजाच्या होणाऱ्या बदलाची नांदी असावी. विचारात मग्न होतो तेवढ्याला आवाज झाला.

'निमा....बघ हं.....धुरुसाहेब विचार करतायत ही निमाची आजी आपल्याला जड तर जाणार नाही ना ? आत्ताच एवढ्या अटी तर नंतर रहायला आल्यावर काय होईल ? पण मला सांग निमा, आपल्याला दोघींना तिथे रहायला जायचंय. नीट सगळं विचारुन मगच व्यवहार केलेला बरं की नाही ?'

निमाची आजी त्या बाहुलीशी बोलत होती. तिचा एकटेपणा....ते बाहुलीशी बोलणं....मला दया आली. आश्रमात तिला खूप सोबत मिळेल. गप्पांना तिथे अंतच नसतो. मी आजीसमोर फार्म ठेवला. 'हा भरुन घ्या. तुमची तुम्हाला हवी तशी सोय करुन देईन, ठीक आहे ?'

'फॉर्म भरतील रहाळकर, कारण मला दिसत नाही. पाच–सहा वर्षांपूर्वी एका आजारपणात डोळे अधू झाले.'

'पण मग तो चहा, बिस्किटं तुम्ही केलीत. स्वैपाक करते म्हणालात...'

'तो इतक्या वर्षांच्या सवयीचा भाग. सुरुवातीला जड गेलं, पण मी जिद्दीनं सगळं जमवलं. रडत...दुःख करत बसण्याचा माझा स्वभाव नाही. माझ्या एकटीपुरतं मी करु शकते. बाजारहाट रहाळकरच करतात. भला माणूस. त्यानीच मला तुमच्या आश्रमाबद्दल सगळं सांगितलं. नाहीतर इथे मला फक्त निमाचीच....ह्या बाहुलीचीच सोबत. दिवसभर तिच्याशीच मी बोलत असते. तीच माझ्या स्वप्नातही येते. माझ्याशी बोलत असते.'

नकळत मी एक सुस्कारा सोडला.

'अजून काही विचारायचंय मला. तुमच्या आश्रमात डॉक्टर येतात का ?'

'हो. पण ते फॅमिली डॉक्टर. नेहमीची तपासणी. BP वगैरे. छोटे मोठे आजार या पुरतेच.'

'कुणाला ॲडमिट करायची पाळी आली तर ?'

'मग आम्ही घरचा मंडळींना बोलवून घेतो. त्यांच्यावर सोपवतो.'

'मला एक सांगा, ही वृद्धाश्रम चालू करण्याची कल्पना कशी आली तुमच्या मनात ?'

'त्याला कारण माझी आई. आम्ही पाच भावंडं. वडील पूर्वीच गेले. आई म्हातारी झाल्यावर एका कुणाकडे रहाणार.' त्यापेक्षा तीन तीन महिने एकाकडे असं वाटून घेण्याची चर्चा झाली तेव्हा तिला उबग आला. ती मला म्हणाली 'माझ्यासाठी एक चांगला वृद्धाश्रम बघ. मला माझ्या वयाची कंपनी मिळेल. जिथे रहायला प्रसन्न वाटेल, सगळ्या सोयी असतील, चांगली लायब्ररी असेल. हवं तर चांगलं संगीत ऐकता येईल, आसपास फिरायला जागा असेल. एकांत असेल.' मी शोध शोध शोधला पण समाधान वाटेल असा वृद्धाश्रम मिळेना. शेवटी मी विचार केला की हि एक प्रकारची गरज निर्माण होतेय....सुदृढ समाजात हे हवंस आहे. आपणच का सुरु करु नये ? सुरुवातीला एका फ्लॅटमध्येच सुरुवात केली. रिटायरमेंट घेतली. फंड त्यात घातला. माझं रहात घर, गावची जमीन सगळं विकून इथे या ठिकाणी नीट वृद्धाश्रम चालू केला. हे नाव 'स्नेह वृद्धाश्रम' तिनंच सुचवलं. ती स्वतः मृत्युपर्यंत इथेच राहिली. मी स्वतः एकटाच आहे. माझ्याबरोबरच तो होता. तिच्या इच्छेनुसार मी सर्व develop केलं. टीव्ही रुम, संगीत ऐकण्याची खोली सगळं. बागेतली कित्येक झाडं तिनेच लावली आहेत. आश्रमासाठी भाज्या पिकवण्याची कल्पना तिचीच. ती सांगेल तसं मी फक्त follow करत गेलो. सगळं पाहून वृद्ध येत गेले. मदत मिळत गेली. कुठे अडलं नाही. मार्ग मिळत...वाट मिळत गेली.

'छान...तुमचा हॉल किती मोठा आहे ? म्हणजे एखाद्या बाहेरच्या चांगल्या कलाकाराचा programme होऊ शकतो कां ?'

'अहो दर महिन्याला एक कार्यक्रम आम्ही ठेवतो. कधी संगीत, कधी कथाकथन, वाचन, कविता वगैरे. मध्यंतरी ज्यांना interest आहे त्यांना सगळ्यांना एक नाटकही दाखवून आणलं होतं थिएटरमध्ये. एक छोटा प्रोजेक्टर आहे. त्यावरुन फिल्म्स् दाखवतो. वेगवेगळ्या....देशी...परदेशी फिल्म्स्. इथे रहाण्याचे पैसे बाहेरच्या वृद्धाश्रम पेक्षा जास्त आहेत त्याचं कारण हेच.'

मग ठिक आहे, मग ठरलं तर. पुढच्या महिन्यापासून मी नक्की येईन. ह्या महिन्यात बाकीची सगळी मिरवामिरव करते. भेटूच आपण.'

पण तसं व्हायचं नव्हतं विषण्ण मनानं मी आरामखुर्चीतून उठलो.

दुसऱ्या दिवशी सकाळी ठरल्याप्रमाणे निमाच्या आजीच्या खोलीवर गेलो. सकाळी खोली विस्कटली होती. आश्रमासाठी न्यायचं सामान एका बाजूला ठेवलं होतं. माझ्या अपेक्षेप्रमाणे पुस्तक-सीडीज्-सीडी प्लेअर हे सर्व व त्याशिवाय ओव्हन, मिक्सर वगैरे इलेक्ट्रॉनिक वस्तू, पुस्तकांचं कपाट हे सर्व आश्रमाला दान केलं होतं. नवल पाटील म्हणाला हे आजच हलवा. मी मॅनेजरला फोन करुन हे सर्व हलवायला सांगितंल. आजीचं माझ्या आश्रमात रहायला यायचं स्वप्न भंगलं होतं. मला भरुन आलं. इथली पहिली भेट आठवली. आजीचं निमाशी बोलणं...एकदम मनात विचार आला. निमाला तरी आश्रमात घेऊन जाऊया. तिथल्या काचेच्या कपाटातून ती सगळं जग पहात राहील. मी तो बाहुला शोधू लागलो. खोलीत सगळा पसारा माजला होता. पण निमाचा पत्ता नव्हता. नवल पाटलाला विचारलं. तो म्हणाला 'बरचसं उरलेलं सामान. भांडीकुंडी, फर्निचर भंगारवाला उचलून घेऊन गेला. त्यात आहे का पहा !' मी बाहेर धावलो. दूरवर मला भंगारवाल्याची गाडी जाताना दिसली. धावतच त्या गाडीवडे गेलो. निमाच्या आजीचं सामान मी लांबूनच ओळखलं. पण त्यात निमा नव्हती. भंगारवाल्यानं मला विचारलं तसं त्याला सांगितलं की मी एक बाहुली शोधतोय म्हणून. गाडीच्या खालच्या कप्प्यातून हात घालून त्यानं तिला बाहेर काढलं. ती निमाच होती.

'ये मुझे चाहिए, इसकी जो किंमत हो मै दे दूँगा.'

'ये गुडिया मत माँगो साब, ये मैं मेरी बेटी केलिए ले जा रहा हँ। उसे गुडियों का बहोत शौक है लेकिन इतनी बडी गुडिया महँगी होती है । मैं उसके लिए कभी ला न सका ।'

त्याचं म्हणणं खरं होतं. खेळणी खेळण्याच्या वयातच त्या मुलीला बाहुली मिळण्याची मजा होती. तो ही खुश झाला होता. माझा हट्ट मी सोडला. आजीची निमा घर बदलत होती. योग्य हातात जाणार होती. माझ्याकडच्या कपाटात पडून रहाण्यापेक्षा बरं. मी खोलीवर परत आलो. रहाळकर भेटले. मलाच शोधत होते ते. म्हणाले मला चहा पिऊया. मला लक्षात आलं की त्यांना काही महत्त्वाचं बोलायचय. आम्ही दोघं चहाच्या टपरीपाशी आलो. रहाळकर बोलू लागले.

'निमाच्या आजीच्या मृत्युपत्रा संबंधात तुमच्याशी बोलायचं होतं. खरं तर त्यांचं वामन होणार आहे त्याआधी सांगू नये असा संकेत आहे. पण जबाबदारी माझ्यावरच आहे म्हणून सांगतोय. निमाच्या आजीची मनापासून इच्छा होती तुमच्या आश्रमात यायची. म्हणून त्यांनी मृत्यूपत्रात काही बदल केले. ज्यावर त्यांचा खर्च चालत होता अशा एफ.डी. च्या रकमा त्यांनी तुमच्या आश्रमाच्या ट्रस्टला देणगी म्हणून दिल्या आहेत. साधारण ३०-३५ लाखांपर्यंत जाईल ते. शिवाय निरवानिरव म्हणून गावची जमीन विकली. ते चाळीस लाख, तेही ट्रस्टला दिलेत.'

मला हा मोठा धक्का होता. सुखद धक्का. निमाच्या आजीनं आधी रहाळकरांकडून माझी पूर्ण माहिती घेतली होती. माझ्या भेटीत मला प्रश्न विचारुन तपासलं होतं. त्या सगळ्याचा अर्थ आता मला लागत होता.

ते सर्व पैसे वापरण्याबाबत मात्र काही अटी आहेत. पहिली अट म्हणजे त्यांच्यासारख्या.....म्हणजे ज्यांना कुणीही नाही अशा वृद्धांसाठी पाच कॉट्स् राखून ठेवायच्या. त्यांचा खर्च त्यातून चालवायचा. ती रक्कम साधारण वीस टक्के असेल. दहा टक्के रक्कम सांस्कतिक कार्यक्रम, चांगली पुस्तकं, सीडीज्, डिव्हिडीज् वगैरे खरेदीसाठी वापरायची. उरलेल्या रक्कमेतून ज्या वृद्धांना मोठ्या आजारपणाचा खर्च परवडत नाही त्यांचा खर्च चालवायचा.

'ह्या अटी मान्य करायला काही हरकतच नाही.'

'आणखी एक महत्त्वाचं....तुमचा जो हॉल आहे ना...संगीत ऐकण्याचा, कार्यक्रम करण्याचा वगैरे त्याचं नाव 'निमाचा हॉल' असं ठेवायचं, चालेल ?'

हे मानत्र गमतीशीर होतं. निमा त्यांची सोबती होती. त्यांचा विरंगुळा होती. मला काही पटेना बाहुलीचं नांव हॉलला देणं...

'रहाळकर बाकी सर्व ठीक आहे पण निमाचं नाव हॉलला....बाहुलीचं नाव....हॉलला... ?'

रहाळकरांनी एक सुस्करा सोडला. 'निमा बाहुली नव्हती. ती बाहुली जिची होती तिचं नाव निमा. एका कुमारी मातेची निराधार मुलगी. बाळ असल्यापासून आजींनी तिला सांभाळलं. तारुण्यातच ती गेली मेंदूज्वरानं. पाच वर्षांपूर्वी तिचा मृत्यू त्यांना खचवून गेला. त्यातच बी.पी. वाढून त्यांची नजर अधू झाली.....ती कायमचीच.'

'रहाळकर हे तुम्ही मला काहीच सांगितलं नव्हतं!'

'धुरुसाहेब...मुद्दाम सांगितलं असतं तर त्यांना ते आवडलं नसतं. कारण तुम्हची त्यांच्याकडे पहाण्याची दृष्टी बदलली असती आणि शेवटी प्रत्येकाचं आयुष्य एका फुलस्केप मध्येच संपते. तेच पुरवून पुरवून वाचलेलच बरं असतं....नाही ?'

• • •

# CARE AFTER BRAIN DEATH - A SLIDE SHOW

**Dr. Rahul Pandit**
MD, FCICM, FJFICM, FCCP, DA
Senior Consultant Intensive Care, Fortis Hospital
Visiting Consultant Gosford and Wagga Wagga base Hospital, Australia

**Solid organs such as the liver, kidneys and heart can only be retrieved from a brain-dead person and not from any body; only eyes and skin can be retrieved from any dead body.**

## Organ Failure Incidence in India

**Around 150,000 patients on waiting for kidney transplant**
3000 transplants done per year

**Around 50,000 heart transplant needed**
Less than 50 done per year

**Around 100,000 Liver needed**
Less than 500 done per year

## Physiological support *after* brain death

**Why do this?**

– To preserve best possible function of all organs that might be donated and transplanted

**How is this done?**

– ANZICS Documents, consultation with Organ Donation Agency
– Ventilation, fluids and inotropes, DDAVP, warming …
– Usual basic treatments for a critically ill patient (turns, suction, surveillance, infection control)
– Monitoring and investigations

## Overview of specific issues

**Respiratory care:**

- Routine suctioning, positioning and turning, ventilatory techniques that reduce atelectasis (e.g. PEEP, recruitment manoeuvres) and avoidance of interstitial fluid overload help to maintain adequate oxygenation and oxygen delivery to organs
- Such an approach is vital for optimising lung utilisation and for successful lung transplantation outcomes

## Overview of specific issues

**Management of the circulation:**

- **Autonomic storm** is transient. Use only short-acting agents (e.g. esmolol, sodium nitroprusside)
- Arrhythmias – Electrolytes, Volume, Temperature and drugs

  Bradycardia resistant to atropine; adrenaline, isoprenaline may be effective
- In cardiac arrest, CPR may result in recovery of cardiac function and successful transplantation

## Overview of specific issues

**Management of the circulation**

- Hypovolaemia – Volume state should be optimised by the administration of intravenous (IV) fluids.
- Competing requirements for optimising organ function may produce conflicting strategies for fluid replacement.
- Identifying early which organs are suitable for transplantation makes it possible to develop focused medical management strategies

## Overview of specific issues

**Management of the circulation**

- Hypotension and/or low cardiac output – An adequate perfusion pressure should be targeted (e.g. MAP > 70 mmHg) by optimising volume state and use of inotropic agents.
- >90% need inotropic support
- ~85% receive Noradrenalin

## Overview of specific issues

**Management of the circulation**

- Hormonal resuscitation – There is no Level I or Level II evidence to endorse the use of hormonal resuscitation
- Recommended if persistent hemodynamic instability/ EF <45%
- T3- 4 mcg IV , then 3 mcg/hour

**Steroids**

- Methylprednisolone 15 mcg/Kg Bolus

## Overview of specific issues

**Diabetes insipidus (DI)**

- **DDAVP or vasopressin** should be administered early.
- DDAVP usually given as IV bolus 2 to 4 µg (paediatric: 0.25 to 2 µg) every 2 to 6 hours, or as required.
- Vasopressin given as an IV infusion at a dose of 0.5 to 2.0 U/h (paediatric: 0.002 to 0.04 U/kg/h).
- Volume replacements

## Overview of specific issues

**Metabolic derangement**

- Appropriate IV fluid is required to maintain euvolaemia and electrolytes within normal range.
- Serum sodium and potassium should be monitored every 2 – 4 hours to guide fluid replacement and electrolyte supplementation.
- Insulin infusion may be given to maintain blood glucose in the normal range

**Hypothermia** is easier to prevent than reverse.

## Overview of specific issues

**Anaemia and coagulopathy**

- Blood, coagulation factors and platelets transfusion may be required to correct severe anaemia and/or coagulopathy.
- Procurement should be expedited if there is a worsening coagulopathy.

**Nutrition:**

- Continuing enteral feeding might have beneficial effects on organ function in transplant recipients.
- Gastric stasis

**Neuromuscular Blocking Agents, Adequate IV access, Continued monitoring**

## Overview of specific issues

**Donor management during organ retrieval:**

- Anaesthetist should ensure adequate monitoring.
- Blood products should be available
- Normal ventilatory and circulatory parameters maintained.
- Neuromuscular blocking drug.
- Sympathetic responses could result in myocardial injury and exacerbate bleeding.
- Opioid agents are also used but may not suppress catecholamine-mediated sympathetic activity.

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M.B.B.S., D.M.R.D.

**Dr. Mrs. Pallavi S. Babhale**
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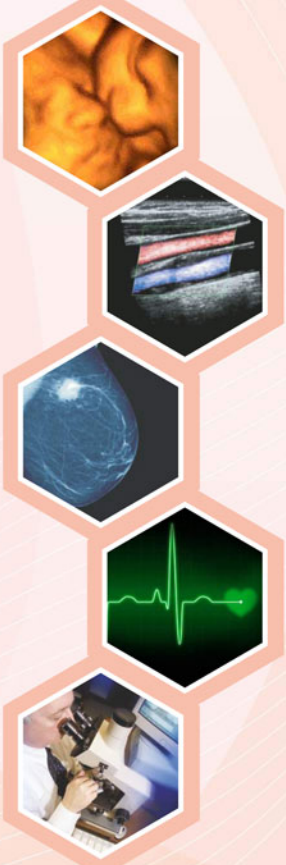

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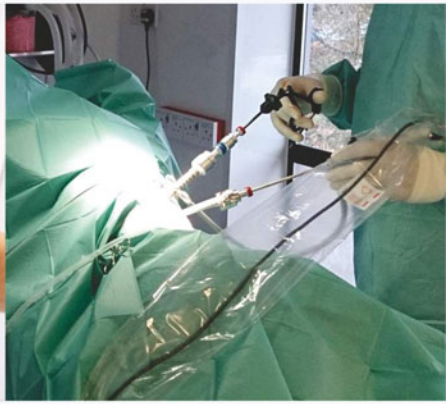

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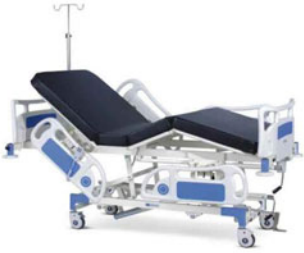

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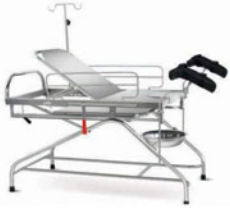

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# GRATITUDE

**Dr. Hemraj Ingale**
President, IMA Dombivli

I fall short of words to express my gratitude to Organising Team of Evecon & IMA Dombivli members. EVECON-2016 was a Simply Superb Conference.

I thank IMA MS President, Dr. Jayesh Lele for bestowing confidence in IMA Dombivli by offering us EVECON-2016. Thanks to all the IMA Leaders & Stalwarts who attended EVECON-2016. Every single dignitary appreciated our EVECON-2016.

Congratulations & thanks to IMA MS WOMEN DOCTORS' WING Chairperson & EVECON-2016 Chairperson, Dr. Archana Pate for meticulous & superb coordination of all the events & sessions at EVECON-2016.

We thank KDMC for getting associated with us for this conference. Our sincere gratitude to Additional Commissioner, Shri Sanjay Gharat & our very own Senior IMA Member & MOH, Dr. Smita Rode madam for putting things on the right track for us.

Sincere thanks to Organising Secretary & President Elect, Dr. Niti Upasani for her herculean efforts & planning. Thanks to Organising Secretary & IMA Dombivli WW Chair, Dr. Meena Pruthi for handling all the cultural events exceptional well.

Special Thanks to IPP Dr. Mangesh Pate for his valuable inputs, mobilizing the venue totally free of charge for both the days of EVECON-2016, Coordination with IMA Leaders, Planning & Preparations for Oration Ceremony & Inaugural ceremony, negotiations with caterer and many other happenings.

Dr. Medha Oak, Dr. Sandhya Bhat & Team EVECON-Scientific for awesome coordination, presentations & all. The topics were diverse, relevant and were enlightening for all of us.

Cultural Events turned out to be the main attraction of EVECON- 2016. Thanks & Congratulations to all event heads.

The Hub (Essay Competition) - Dr. Sheetal Khismatrao.

Synaesthesia (Poetry Competition) - Dr. Vijayalaxmi Shinde.

Graffiti (Poster Competition) - Dr. Anita Karnik.

Moments (Photography Competition) - Dr. Bhakti Lote

Live events were simply mind blowing. Thanks & Congratulations to Dr. Meena Pruthi, Dr. Niti Upasani & Dr. Archana Pate for masterly efforts responsible for success of Dancing, Singing & Fashion Show.

Dr. Sandhya Bhat for arranging Judges for 'Dancing Divaas' & glamorous Fashion Show, Dr. Nilesh Shirodkar for Shri Vasant Aagaonkar, Dr. Makarand & many more...

Excellent Compering by Dr. Makarand & Dr. Niti for Dil Se.., Dr. Meena Pruthi for Dancing Divaas, Jalwa comperes - Dr. Sandhya Bhat & Dr. Vijay Aage as Chota Chattri were truly entertaining.

EVECON INVITE & INAUGURAL VIDEO - Fantabulous.. Thanks to Dr. Archana Pate.

Very handy and useful Delegate Gift – Thanks to Dr. Archana Pate.

Gifts & Mementos - Dr. Niti, Dr. Meena, Dr. Sandhya, Adv Mrs Geeta Joshi. Great work eves...

AV Systems at EVECON was just awesome. Thanks to Dr. Sandhya Bhat & Team..

Congratulations to Editorial Team of EVECON Souvenir It has come up very nice & is appreciated all over. Thanks to Dr. Sheetal K, Dr. Meena Pruthi & Dr. Archana Pate.

Hats off to Stage & Backstage Team lead by Dr. Suchitra Kamat, Harshada Pradhan, Dr. Anita Karnik, Dr. Nayana Chaudhari, Dr. Alka G, Vijayalaxmi, Dr. Ashwini Acharya and others who were simply superb in terms of coordination of events.

Inaugural Dance was awesome. Thanks Dr. Kala. Welcome Rangoli with the IMA WW logo was very beautifully drawn created a first and ever lasting impression attracting everyone's attention.

Stalls & Pandals & Registration Counter handled very nicely by Hon. Secretary Dr. Utkarsh Bhingare & Team.

Sincere thanks to Dr. Priti Nanda, Dr. Bharti Chaudhari & Nayana C. for excellent food arrangements.

Accomodation & Travel Coordination— Thanks to Dr. Suneet Upasani, Dr. Vijay Shetty & Dr. Kelkar Prashant

Thanks to Dr. Mangesh Pate, Dr. Suneet Upasani & Dr. Prashant Kelkar for providing their personal vehicle for Dignitaries, Judges & Faculty.

Registering delegates for EVECON 2016 was the first & most important task. Thanks to the team of Anaesthetists - Dr. Kala, Dr. Preeti, Dr. Nayana & Dr. Sandhya Bhat along with Dr. Subhash Gadgil, Dr. Vijayalaxmi, Dr. Ambadas Rode, Dr. Makarand who strived hard to cover almost whole of IMA Dombivli and major chunk of Kalyan & Ulhasnagar. Thanks to Dr. Archana Pate for registrations from all over Maharashtra. We had a total of 510 registrations with almost 200 outstation registrations.

Thanks to Dr. Ketan Raj & Rajul Raj for a major contribution to EVECON-2016 in form of sponsoring all cultural events.

JADE - VIILBERY NIGHT - Yet another highlight of EVECON-2016. Excellent food & mesmerising music.

Thanks to Dr. Vijay Aage, Dr. Ambadas Rode, Dr. Makarand G, Dr. Mandar Pawar, Dr. Raju Gite & team. EVECON Banquet is the first Banquet in the history of IMA Dombivli to be totally supported by well-wishers. Thanks to the sincere efforts & hard work of our Hon. Treasurer Dr. Mandar Pawar.

Thanks to both the Treasurers – Dr. Mandar Pawar Treasurer, IMA Dombivli & Dr. Vandana Dhaktode Treasurer EVECON-2016. Receipts were delivered to all the delegates in their Registration ID.

Its Sponsorships that drives the conference. Thanks to Dr. Mandar Pawar, Dr. Mangesh Pate, Dr. Archana Pate, Dr. Niti Upasani, Dr. Medha Oak, Dr. Vijayalaxmi, Dr. Ambadas Rode, Dr. Dushyant Bhadlikar, Dr. Sanjay Pruthi, Dr. Adwait Padhye, Dr. Vandana Dhaktode, Dr. Prashant Kelkar and many others...

I request all of you to support our sponsors. They mean a lot to us. It increases their confidence in us and helps the incoming team to plan big events in a very good way.

I must have missed a few names. Kindly forgive me in that case. It was indeed a pride & a memorable moment to receive The IMA Maharastra State President's Appreciation award on 19th of November 2016 at Mastacon, Baramati. Thanks to Dr. Archana Pate, Dr. Mangesh Pate & Dr.Rahul Bhirud for being there with me.

It was real fun working with all of you. Each new day was full of challenges which were increasing day by day. It was only your support & motivation which gave the core team power to excel.

Once again, Thank you all IMA Dombivli members.

•••

**IMA MS President's Appreciation Award at MASTACON-16, Baramati**

# PANCREAS TRANSPLANT AND DIABETES MELLITUS: A CURE AND A REALITY

**Dr. Vrishali Patil**

*Dr. Vrishali Patil is ASTS (American Society of Transplant Surgeons) certified multi organ transplant surgeon (liver, pancreas, and kidney transplant), currently working as transplant surgeon, at Department of Hepatobilliary, Pancreas and Transplant Surgery, Deenanath Mangeshkar Hospital, Pune.*

*She has done specialization in Liver Transplant, Intestinal, Multi visceral transplants, Pancreas transplants- Simultaneous Pancreas and Kidney transplants, Isolated Pancreas transplants, Islet cell transplants, Total Laparoscopic Donor Nephrectomy, Single Port Laparoscopic Donor Nephrectomy.*

*She has substantial experience in complex Hepatobiliary and Pancreatic surgery, laparoscopic donor nephrectomy, laparoscopic assisted donor hepatectomy, kidney transplant, intestinal,islets, pancreas and multiviceral transplant, liver resection and liver trauma management.*

*She has earned this experience in renouned institutes across the globe, mainly*

1. *University of Wisconsin School of Medicine and Public Health*
2. *University of Wisconsin Organ & Tissue Donation*
3. *Henry Ford Hospital Transplant Institute. Detroit, Michigan*
4. *University of Rochester Medical Centre & Strong Memorial Hospital. Rochester. NY*
5. *St. Jude Children's Research Institute, Memphis, Tennessee*

*She has done her medical graduation and postgraduation from University of Pune with various merits and awards.*

*She has published and presented papers Nationally & Internationally. She is on the Review Board of Scientific Journals. She is postgraduate teacher in transplant surgery. With all this experience she recently performed the first pancreas tranplant surgery in Maharashtra at Deenanath Mangeshkar Hospital, Pune.*

Pancreas Transplant is a scientifically proven and evidence based treatment that is a cure for Type 1 DM. It is the only treatment that establishes normal glucose levels and normalizes glycosylated hemoglobin levels in type 1 Diabetic patients (Ferreira et al, Pancreas Transplantation: review; Einstein. 2015; 13(2):305-9). Pancreas Transplant halts the progression of secondary complications of Diabetes and brings about normoglycemia without the side effects as seen in long standing exogenous Insulin therapy. Though Pancreas Transplant began in 1960s, it has taken a while to reach beyond the western world to India and other countries, due to lack of expertise, surgical skill, lack of awareness among physicians, unawareness about this option in the Diabetic community in India.

**It is a universal truth that Diabetes is one of the oldest known disease (500 B.C.E). A third most common disease in the world, and the fourth leading cause of death.**

**Some FACTS**

| |
|---|
| India: 5 million children <15yrs of age with Type 1 DM. (Data from International Diabetes Federation 2006) |
| India has 10,900 new cases of type 1DM/per year |
| Impact of Type 1 DM : |
| 1. NEPHROPATHY |
| 2. RETINOPATHY |
| 3. VASCULOPATHY - Amputation |
| 4. CARDIOVASCULAR DISEASE |
| 5. NEUROPATHY |
| 6. PSYCHOLOGICAL MORBIDITY – Social & personal dysfunction, Loss of Independence & Freedom from fear of hypo/hyper glycaemia |

**Story of Pancreas Transplant & its Impact:**

The First Pancreas Transplant was done in December

1966 at University of Minnesota by Surgeons William Kelly and Richard Lillehei. The first transplant lasted for 2 months. It was not until early 20s, with the contribution of Prof Hans Sollinger who modified the surgical technique, and the availability of newer and better immunosuppressive medications that we have now good and long lasting results of Pancreas transplants.

As of 2010, more than 35,000 Pancreas transplants have been reported with majority of them being performed in the United States. Pancreas transplant recipients now enjoy an Insulin free life for even up to 15 years post-transplant.

Pancreas transplantations are divided into 3 categories:

Simultaneously with a kidney (SPK)

Pancreas transplantation alone (PTA)

After a previous kidney transplantation (PAK) (18%) - Pancreas after Living donor/deceased donor kidney transplant

**Who qualifies for a Pancreas Transplant (Indications)**

Type I diabetes with a functioning renal transplant

Type 1 diabetes with complications

End stage renal disease

Pre-uremic nephropathy (albuminuria with creatinine clearance > 50 mL/min)

Progressive retinopathy

Neuropathy

Life threatening hypoglycemia/ Hyperglycemic episodes

Type 1 DM or low serum peptide with disability in learning, working, and life

Brittle diabetes

**EXCLUSION CRITERIA FOR PANCREAS TRANSPLANTATION**

Significant cardiac disease

Substance abuse

Psychiatric illness

History of noncompliance

Extreme obesity

Active infection or malignancy

Age > 65 years.

**The Procedure and Its Impact: Risk & Benefits**

Presently there is no exogenous Insulin or mechanical Insulin -delivery method, along with an Insulin pump which can replace endogenous pancreatic insulin secretion well enough to achieve a good physiologic control of blood sugar and produce a constant and near euglycemic state without the risk of hypoglycemia. (Yi-Ming Shyr, Pancreas Transplantation Journal of Chin Med Assoc • January 2009 • Vol 72 • No 1). Pancreas Transplant is the only way that one can achieve this goal.

Pancreas Transplant can achieve Euglycemia, Normal HBA1C levels without the risk of blood sugar fluctuations.

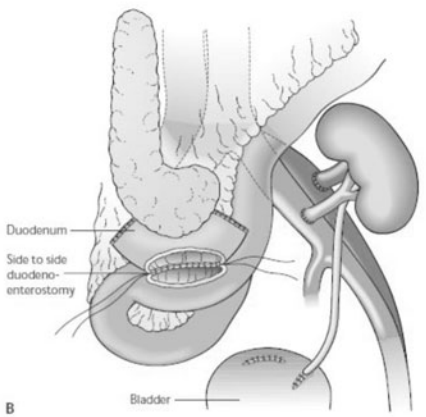
The goal of pancreas transplantation is to produce complete insulin independence, improve the quality and quantity of life, to halt the progress of secondary complications, and ameliorate or reverse diabetes-related complications.

Prior to the transplant, lymphocytic cross matches are done between the donor blood and the recipient blood sample of the same compatible blood group. Once the cross match is negative. The donor operation is performed and pancreas along with the duodenum is recovered from the donor along with its vascular supply.

This vascularized Pancreato duodenal graft is then carefully prepared in a separate operation at the back table and vascular reconstruction is done to allow for pancreas implant in the recipient. Arterial Y reconstruction is done along with a portal vein extension if necessary. The newly prepared graft is then ready for implant.

For the recipient surgery – a Midline abdominal incision is taken and the colon mobilized on the right (most commonly) or on the left to allow for space for the pancreas implant in the iliac fossa. The lower Inferior Vena Cava (IVC) is exposed along with the iliac veins and similarly the common iliac artery is exposed. The newly vascularized graft is now placed in the retroperitoneal space and the portal vein of the graft anastomosed to the Lower IVC or common iliac vein and the arterial Y graft to the common iliac artery. The graft duodenum is then anastomosed to the proximal ileum or distal jejunum to allow for drainage of the digestive juices. If the patient has nephropathy, then a kidney transplant is done in the opposite iliac fossa in a standard fashion.

Intra operative –Induction immunosuppression is given followed by maintenance immunosuppression based on calcineurin inhibitors like Tacrolimus, mycophenolate mofetil, steroids.




**Patient survival now reaches over 95% at one year post-transplant and over 83% after 5 years. Recipients of pancreas transplant have freedom from Insulin, and enjoy an independent life without the fear of hypoglycemic episodes. Patients need lifelong immunosuppression and regular follow up**

**Benefits of Pancreas Transplant**

Euglycemia without the need for exogenous insulin

- Normalizes HgbA1c levels
- Improves patient quality of life
- Reverses peripheral neuropathy
- Prevents recurrent diabetic nephropathy

**Our experience in India ;** We had a 28 years old young patient with type1 Diabetes for more than 20 years who was having secondary complications with End stage renal disease, Neuropathy, retinopathy. He had multiple episodes of hypoglycemia prior to transplant and was having difficulty with hemodialysis. He lost 3 jobs due to his clinical condition and was completely dependent on his family even for his daily routine and personal activities. He was found eligible and registered for Pancreas &Kidney transplant. A suitable donor was available 2 months ago, and we performed a simultaneous pancreas and Kidney transplant on this young man. His surgery was uneventful and lasted for 8 hours. Post-surgery patient did well and was discharged. His blood sugars have been normal since the day of his surgery, he does not need dialysis, he can eat a normal diet, and he can now lead a normal healthy life. His C peptide levels have already been normalized post-surgery. He has already received multiple job offers. In his own words-, he had initially given up hope and thinking about a future, and now he is energetic, full of life and eagerly plans for his future and can think about having a family and a career.

**CONCLUSION:**

Pancreas transplant is a life enhancing surgery, it is the only method which offers normal euglycemic control, and halts the progression of secondary diabetic complications. Recent studies have shown that over a period of time, pancreas transplant can even reverse changes seen in diabetic nephropathy, vasculopathy esp. microvascular changes. It has not known to reverse established retinopathy. Pancreas transplant leads to normal HBA1C levels and reduces the further risks that a diabetic experiences. It has a major impact on the psychosocial life of a type 1 diabetic post-transplant. Type 1 Diabetics can now have hope that after 10-20 years of Insulin, if they start developing secondary complications or have trouble with Insulin therapy, there is hope and they can dream and believe of having an Insulin free independent life and enjoy a normal lifestyle and normal diet without the fear of fluctuating blood sugars and risk of secondary complications. As in any transplant, the successful outcomes depend on the immunosuppression, acceptance of the graft and prevention of infections post-transplant. With good maintenance medication and follow up, it is easily achievable. The risk of rejection and infection remains, but with recent advances in medication, we hope to reduce the incidence of such episodes. Pancreas transplant is also done in select Type 2 diabetes patients with good results.

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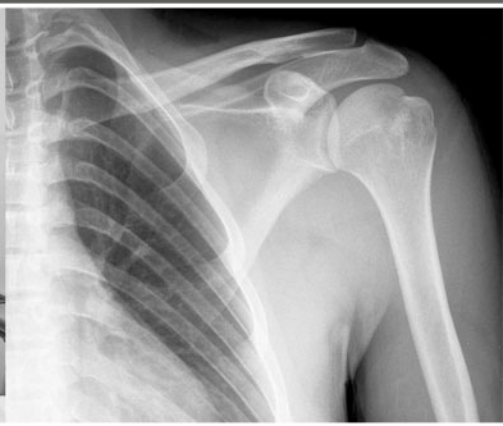

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**Dr. Rajesh Y. Mulay**

M.D. Radiology
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Consultant Radiologist

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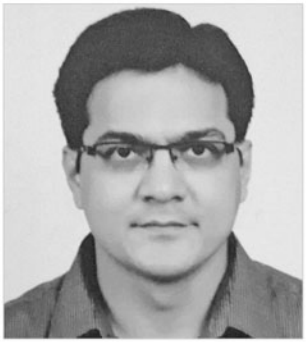
# EDUCATIONAL INSTITUTE CONTACT PROGRAMME

**Dr. Mandar Pawar**



*Practicing Paediatrician. Working for IMA Dombivli for past 3 years. Currently working as Treasurer IMA Dombivli and Chairperson EICP project. EICP projects of IMA has received tremendous response from school children, teachers and parents.*

This year we started this programme to fulfil the needs of students of different age groups and their respective parents and teachers.The purpose of this programme was to hold educative sessions for School teachers, Parents and school students. These sessions would be conducted by Psychiatrist, Physicians, Pediatricians & Gynecologists from IMA Dombivli.

The topics selected were from inputs we received from the teachers which included Health and Hygiene, Preventive care, Oral health, Diet and Nutrition, Ways to improve immunity, Latest Vaccines and their benefits,Healthy sleeping habits, Childhood habits which lead to lifestyle diseases in later life. Adult Education or sex education, Good touch and bad touch, Menstrual problems and their solutions,Life skills training,Concentration techniques, Goal setting and time management.

We selected 5 schools for the implementation of the programme, this year: **Holy angels school, St. Joseph High School, South Indian Assocciattion High School, Tilaknagar Vidyamandir and Manjunatha Vidyalaya.**

We divided the children in 3 age groups and the topics accordingly,

1. Preprimary to 4$^{th}$ std
2. secondary 5$^{th}$ to 7$^{th}$ std
3. Adolescent 8$^{th}$ to 10$^{th}$ std.

The programme was inaugurated by a lecture on **" Communicating with todays teens"** by renowned psychiatrist **Dr. Anand Nadkarni** on 7$^{th}$ July at Shubh Mangal Karyalaya, where parents and teachers of adolescent children were invited, about 250 people attended this programmed and the feedback we received was very encouraging from the audience as well as our very own IMA members who attended the programme.

Numerous educative sessions were conducted in schools undertaken by faculties from IMA dombivli.

The first school session was conducted at Holy Angels School, by myself Dr. Mandar Pawar on Health Hygiene and Disese Prevention for Std 6$^{th}$ to 7$^{th}$.

The second session was conducted by Dr. Medha Oak for Std 8$^{th}$ to 10$^{th}$ at Holy Angels school on Illness amongst Teenagers.

On 30$^{th}$ august a session on Adolescent Health was conducted at St. Joseph high school by Dr. Mansi Karandikar for Girls and Dr. Dushyant Bhadlikar for Boys, from Std 8$^{th}$ to 10$^{th}$.

On 31$^{st}$ August we had asession for students from 3$^{rd}$ to 5$^{th}$, the topics being

Health and Hygiene by Dr. Hemraj Ingale

Healthy Thinking(Story Telling) by dr. Adwait Padhye.

On 20$^{th}$ sept, we had 2 sessions at South Indian High school

Healthy sleeping habits byDr. Ramnathan Iyer.

Obesity and Life style illness by Dr. Arvind Bengeri

We will be having many more sessions in the coming days as many specific requirements are been sent by different schools. I thank President Dr. Hemraj Ingale for showing trust on me and also thank all the seniors members of IMA who guided me during the sessions as well as for all the encouragement.

Thank you and looking forward for more participation from our members.

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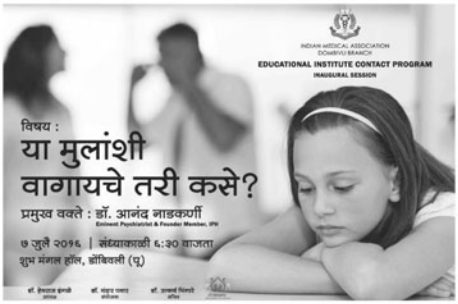


# ANTIOXIDANTS AND THEIR ROLE IN ANTI AGING AND CANCER PREVENTION

**Mrs. Rochita Date Gondhalekar**

*Mrs. Rochita Date Gondhalekar*

*CLINICAL NUTRITIONIST, MUMBAI*

*" YOU ARE WHAT YOU EAT" a young enthusiast with this belief finds her way to help the society be healthy and fit.*

*Completed her bachelors in Food science and Nutrition from SNDT university, Mumbai followed by PG in clinical nutrition from University of Roehampton, London (UK).*

*A member of INDIAN DIETETIC ASSOCIATION, MUMBAI for last 4 years. She has bagged various awards for her clinical research's in the field of nutrition and food since graduation. Has 4 published research articles in international journals. Has experience of working as Junior Dietician with Tata memorial hospital and LTMG sion hospital.*

*Currently established her own venture named "DIET DIVA" through which she undertakes workshops on healthy lifestyle and nutrition, A part of ongoing research on PCOS with fellow dieticians and consults various patients with specific disorders. Her interests are diet in pregnancy, childhood obesity and Geriatric nutrition. 9833548229*

## WHAT ARE ANTIOXIDANTS?

Antioxidants are chemicals that interact with and neutralize free radicals, thus preventing them from causing damage. Antioxidants are also known as "free radical scavengers."

The body makes some of the antioxidants it uses to neutralize free radicals. These antioxidants are called endogenous antioxidants. However, the body relies on external (exogenous) sources, primarily the diet, to obtain the rest of the antioxidants it needs. These exogenous antioxidants are commonly called dietary antioxidants. Fruits, vegetables, and grains are rich sources of dietary antioxidants. Some dietary antioxidants are also available as dietary supplements (1,3).

Examples of dietary antioxidants include beta-carotene, lycopene, and vitamins A, C, and E (alpha-tocopherol).

Antioxidants prevent a chemical process known as "oxidation," which is a natural part of living and aging. Oxidation damages cells and can lead to the development of disease, including Alzheimer's, heart disease, and cancer. Antioxidants are found in fruits, vegetables, nuts, beans, grain cereals, and other foods. Even dark chocolate is rich in antioxidants.

### Top 5 Benefits of Antioxidants in Skin Care

1. **Anti-inflammation:** One of the most desirable benefits of antioxidants in skin-care products is the calming of inflammation. Antioxidants, such as alpha lipoic acid and others found in pine bark and green tea, produce valuable anti-inflammatory results by increasing circulation and cell metabolism. Reducing inflammation promotes more even skin tone and helps keep acne and wrinkles at bay.
2. **Skin firming:** Another top benefit of antioxidant skin care is skin firming. Antioxidants may reverse the effects of aging by improving skin health and rejuvenating its appearance. Coenzyme Q-10, or CoQ-10, is a common skin-firming antioxidant and is great for use in eye creams and products that are meant to tone the skin. Try moisturizers and other skin treatments with skin-firming antioxidants.
3. **Reduced appearance of wrinkles:** Although it is nearly impossible to make wrinkles disappear, skin-care products with antioxidants can help plump out the skin and make it appear more youthful. Most antioxidants are great for reducing the appearance of wrinkles and fine lines, but vitamins C and E are especially beneficial. Many products and creams for use around the eyes or other problem areas incorporate these vitamins.
4. **Repair of sun damage:** We all know that too much sun is dangerous, but it can also be bad for your skin's appearance, drying it out and damaging cells. Sun damage can make skin appear tough and wrinkly. Antioxidants that stimulate blood flow in the skin can help encourage the growth of new cells and make sun-damaged skin appear younger. Many antioxidant-rich

beauty products are available for treating sun damage, including cleansers and moisturizers that you can use on your entire body.

5. **Scar treatment:** Reducing the appearance of scar tissue is another important benefit of antioxidants in skin care. Scar tissue has a different cell structure than that of healthy skin, making it rigid. Many types of antioxidants, including those found in aloe and an onion extract called allium, increase blood flow to scar tissue, minimizing the look of the scar and blending in the development of new skin. Antioxidant-rich scar treatment products are available in a variety of forms, including gels, patches and creams.

**FIVE antioxidants to look for when choosing a skincare product**

1. **Vitamin E :** Vitamin E (tocopherol) is an antioxidant that is present in the skin and found in various foods, such as vegetables, seeds and meat. (1) It helps the skin look younger by boosting collagen production and in turn reducing the appearance of fine lines, wrinkles and age spots.
2. **Lycopene:** Lycopene, a powerful antioxidant, is a carotenoid found in red fruits and vegetables. It is, in fact, responsible for their red colour. In addition to being a healthy choice for your diet, it's a great choice for improving skin texture because it promotes collagen production and reduces the DNA damage that leads to wrinkles.
3. **Coffee Berry:** As an ingredient in anti-aging formulas, coffee berry prevents collagen damage, reduces wrinkles and protects the skin against damage.
4. **Grape Seed:** Grape seed is extracted from vitis vinifera and is rich in proanthocyanidins, which belong to the flavonoid family. Proanthocyanidins are potent antioxidants with strong free radical scavenging activities.
5. **Vitamin C:** Vitamin C (L-ascorbic acid) is an essential nutrient that can only come from the healthy fruits and vegetables that contain it. Vitamin C is usually touted for its cold-fighting power, but it's also under study for its impact on preventing and reversing aging skin.

**Antioxidants and cancer prevention.**

**How might antioxidants prevent cancer?**

Antioxidants neutralize free radicals as the natural by-product of normal cell processes. Free radicals are molecules with incomplete electron shells which make them more chemically reactive than those with complete electron shells. Exposure to various environmental factors, including tobacco smoke and radiation, can also lead to free radical formation. In humans, the most common form of free radicals is oxygen. When an oxygen molecule (O2) becomes electrically charged or "radicalized" it tries to steal electrons from other molecules, causing damage to the DNA and other molecules. Over time, such damage may become irreversible and lead to disease including cancer. Antioxidants are often described as "mopping up" free radicals, meaning they neutralize the electrical charge and prevent the free radical from taking electrons from other molecules.

**Which foods are rich in antioxidants?**

Antioxidants are abundant in fruits and vegetables, as well as in other foods including nuts, grains and some meats, poultry and fish. The list below describes food sources of common antioxidants.

- Beta-carotene is found in many foods that are orange in color, including sweet potatoes, carrots, cantaloupe, squash, apricots, pumpkin, and mangos. Some green leafy vegetables including collard greens, spinach, and kale are also rich in beta-carotene.
- Lutein, best known for its association with healthy eyes, is abundant in green, leafy vegetables such as collard greens, spinach, and kale.
- Lycopene is a potent antioxidant found in tomatoes, watermelon, guava, papaya, apricots, pink grapefruit, blood oranges, and other foods. Estimates suggest 85 percent of American dietary intake of lycopene comes from tomatoes and tomato products.
- Selenium is a mineral, not an antioxidant nutrient. However, it is a component of antioxidant enzymes. Plant foods like rice and wheat are the major dietary sources o selenium in most countries. The amount of selenium in soil, which varies by region, determines the amount of selenium in the foods grown in that soil. Animals that eat grains or plants grown in selenium-rich soil have higher levels of selenium in their muscle. In the United States, meats and bread are common sources of dietary selenium. Brazil nuts also

contain large quantities of selenium.

- Vitamin A is found in three main forms: retinol (Vitamin A1), 3,4-didehydroretinol (Vitamin A2), and 3-hydroxy- retinol (Vitamin A3). Foods rich in vitamin A include liver, sweet potatoes, carrots, milk, egg yolks and mozzarella cheese.
- Vitamin C is also called ascorbic acid, and can be found in high abundance in many fruits and vegetables and is also found in cereals, beef, poultry and fish.
- Vitamin E, also known as alpha-tocopherol, is found in almonds, in many oils including wheat germ, safflower, corn and soybean oils, and found in mangos, nuts, broccoli and other foods.

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# रडायचं नाही....लढायचं

डॉ. राजू एस. गिते

*Dr. Raju S. Gite is a budding Orthopaedic Surgeon in Dombivli. Having passed M.B.B.S. from M.G.M. Medical College, Kamothe, he did his diploma in Orthopaedics at Holy Spirit Hospital followed by D.N.B. from P.D. Hinduja Hospital. He is Fellow of Osteoarticular Tuberculosis, Bombay Orthopaedic Society. He is working for IMA Dombivli for the past 2 years. Currently he is working as Hon. Jt. Secretary IMA Dombivli. He has a flair for writing and compering programmes.*

**रुग्णाच्या नातेवाईकांनी वॉर्डमध्ये मारहाण केल्यावर खिन्न मनाने देवाच्या गाभाऱ्यात अश्रु गाळणाऱ्या डॉक्टरची देवाने केलेली कानउघडणी**

येवू नकोस गाभाऱ्यात माझ्या
मान घालूनी खाली
ज्यांच्यासाठी जागलास रात्रभर
त्यांनीच मारली ना कानाखाली

कळतच नाही मला तू
सहन कसं करु शकतोस
ते मारतात तुला उघडउघड
आणि तू पाठ दाखवून पळतोस

ते चार मारतील तुला
तू एक तरी परत दे
चढलेल्या त्यांच्या आवाजाला
नजरेत नजर घालून उत्तर दे

माझ्यावरही त्यांचा रोष असतो
मलाही देतात ते शिव्या शाप,
तू तर तुझाच अंश आहेस
म्हणून धरतीवर तुला मनस्ताप

भिऊ नकोस मीच तुझ्या पाठीशी आहे
तू फक्त सुरुवात तर कर
बाकी मी समर्थ आहे

वेळ आली तर,
वर कर ती पांढरी कॉलर

उघड पहिलं बटण
सरसाव त्या बाह्या वरती
आणि काढ ते डाळ्यावरचं ढापण

सोडून दे ती मोबाईलवरची
खोटी सहानुभूती,
वायफळ बडबड खूप झाली
आता करुन दाखव कृती

अजूनही गप्प बसलास तर
वाढतील असले प्रकार,
प्रत्युतर दिलेस वेळीस तर
त्यांनाही करावा लागेल विचार

की जीवनदान देणारे हात
का बरं कोणाचा जीव घेतील
डॉक्टरांवर हात उचलून
का कधी प्रश्न सुटतील

शेवटचं सांगतो
सांग तुझ्या डॉक्टर बांधवांना,
पुरे झालं रडायचं
आता जर का कोणी हात उचलला,
तर बेधडक लढायचं

...

# A JOURNEY FROM PILLS TO CELLS

**Dr. Pradeep Mahajan**

*Dr P V Mahajan is graduate of SRTRMC medical college from Marathwada University with laurels of two gold medals, master in surgery MS from Marathwada University, Dip in Urology from Vienna university, member of American Medical Society as well many other academic and professional medical Institutes. Due to his thrust of innovation for new, he is always exploring new arithmetic ventures in medicine like - medicine & IT, Marine Medicine, Occupation related medicine, minimal invasive medicine & surgeries. He underwent multiple training in tissue culture, attended many CMEs & applied this innovative nature to develop STEM CELL THERAPEUTICS with his own protocols. Stem cell treatments developed and implemented by Dr P V Mahajan have shown definitive results. Through the StemRx Dr P V Mahajan now provides his patients autologous stem cell treatments. His patient focused comprehensive treatment regimens are specifically designed to improve the patient's overall well-being and quality of life.*

**Introduction:**

Human life has evolved over millions of years. Each one of us is born from a single cell fertilized egg that has tremendous potential for development into each and every cell of the body. Any living body very intelligently maintains a reserve of these original cells that have this multiplication and differentiation potential. These cells, hidden at many places in our body, perform an intrinsic function of routine wear and tear; as well as repair form injury. These cells having potential of differentiation and also proliferation to suffice body's requirements for repair are known as Stem Cells.

Stem Cells today come under the huge umbrella of Regenerative Medicine (RM), which in today's world is considered to the most exciting medical revolution. Replacement, Restoration and Rejuvenation are the three "R"s or arms of Regenerative Medicine that have a common goal of achieving body Repair.

We will here discuss the current scope and role of RM in health management.

**Current Health Crisis:**

Over past 2-3 centuries, the understanding of medical science is progressed with integration of biochemistry, biophysics, engineering, imaging technologies, pharmaceutical advances. All advances aim towards early diagnosis, early treatment, targeted treatments and least side effects. This has definitely led to a considerably increased life expectancy. No matter, genetically, human beings are eligible to survive for around 120-140 years; the currently increased life expectancy comes with a price tag of chronic disorders of ageing… Thus, even if there are more years to the life… there's no assurance of life to the years!! More elderly people with debilitating conditions like grade 3-4 osteoarthritis; Parkinson's disease, Alzheimer's disease and so on…

This is adding to the currently existing burden of diseases… the diseases of the metabolic imbalances, inflammatory disorders, autoimmune diseases, liver and kidney dysfunction, cancers, and so on…

Additionally there are some disorders like cerebral palsy, muscular dystrophy, spinal cord injury for which no definite cure exists and the patients suffering from these diseases can rely only on their fate.

In fact, the observation is that the typical lifestyle disorders set in very early in life; the modern medicine keeps only the signs and symptoms at bay; the disease continues to progress; the complications of the disease as well as due to heavy medication complicate the situation further. This is how, in today's health management domain, more years are added; but quality of life is drastically compensated for!!

What is the solution??

Think different!! Think innovative!!

We need to look at the pathological process at cell level, work towards maintaining the cell-level homeostasis.

Stem cells, and RM in recent years are offering promising solutions for disease modification at cell level, arresting

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**Dombivli Dialyses and Urology centre**

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the further degeneration, thereby postponing the onset of complications.

**Regenerative Medicine:**

This new branch of treatment deals with the use of self-renewal capacity of stem cells. Other characteristics of stem cells are they are undifferentiated; and can differentiate as per the environment they are in. Stem cells act as the basic tool of RM, and their various properties can be extended and extrapolated in field of cell therapy, transplants, tissue engineering as well as ex-vivo development of organs.

All tissues like bone marrow, blood, adipose tissue, umbilical cord, milk tooth of the baby have storage of stem cells, and can be used as sources of stem cells. The most reliable and self-replenished source of stem cells is human bone marrow.

Classification of stem cells:

Stem cells can be classified based on their

Characters: Hematopoietic or Mesenchymal

Source: Embryonic or Adult

Potency: Totipotent or multipotent

Use of embryonic stem cells is restricted to research only; and in today's scenario, adult derived (cord tissue, adipose tissue etc.) Mesenchymal stem cells are considered as the most promising types of stem cells for research as well as for clinical use.

Mesenchymal stem cells have proven to have multiple actions. They can be listed as:

- **Immuno-modulatory:** control immune function in favor of body
- **Anti-inflammatory:** reduce unwanted compensatory mechanisms
- **Anti-apoptotic:** Allow regeneration
- **Cell differentiation:** all functions regained
- **Protein and cytokine synthesis (through mRNA activation):** Micro-environment enrichment
- **Angiogenic:** assurance of continued effect

These make MSCs as futuristic Living Drugs!!

The scope of regenerative medicine is very broad, ranging from simple autologous cell therapies to their use in making gene-modified embryos available!! It also includes use for targeted drug delivery to taking their help to make organs in the laboratory!! Their clinical applications today are restricted to compassionate treatments for terminal conditions where current modalities of healthcare management have limitations; to cosmetic applications life face lifts.

In currently allowable practices, stem cells are derived from patient's body and are administered wherever necessary for controlling degenerative diseases. This treatment is extremely safe and has minimum risk. The main steps in the entire procedure are:

1. Discussion and counseling
2. Essential investigations
3. Cell harvesting
4. Cell processing
5. Cell dose administration

This may sound very simple, but it takes a lot of efforts, a GMOP-grade lab facility, highly technical and skilled personnel to make it happen. The stages 3, 4 and 5 are executed in well-equipped and highly standardized laboratories and operation theatres.

As mentioned, research in the area of RM can vary from very basic cytology to using stem cells for drug delivery!! The expanse and the possibilities are so wide and vast… currently, efforts are made to achieve global standardization in the cell manufacturing and making it available at the counters to all!! Also, scientists have invented a cellular vaccine highly personalized for cancer patients.

The regulatory bodies are also coming together, forming consortia so that the burning issues are discussed at a common platform and information is available uniformly.

In US, even if medical council has not shown green signal to these methods, they can be executed with the consent from the patient. Other countries where some regulations have been laid down are Japan and South Korea. Through painstaking efforts, few cell based products are already commercially available in Korea, Japan, and a couple of other east Asian countries.

In India as well, ICMR and National Apex Committee for Stem Cell Research keeps a close watch on activities in Indian institutes and other industry-based set ups. Stem Cell Society of India formed by like-minded stem cell experts is struggling for getting Indian Industry Guidance streamlined for the benefit of a larger population.

In near future, time may come that regenerative medicine is the only support of modern medicine. We will start taking cells instead of pills as a medicine....and we will have a 'medical safe deposit vault' where we can keep our

stem cells safe.

StemRx Bioscience Solutions Pvt Ltd is one such pioneer organizations founded with the interest in academics, research and therapy using the cell therapy science. It has joined hands with Ohio State University, USA for research and academic exchange programs; while it has been approved by the MUHS for conducting PG courses and research fellowships in regenerative medicine. Research and clinical teams come together to establish clinical protocols so that patients are benefited. Avascular necrosis, type I diabetes, cerebral palsy, multiple sclerosis are few of the indications where StemRx has experienced and proven protocols.

**CASE 1**

A 35 year old male patient came to our hospital with complaint of pain in left hip joint since 10 years. The patient had intermittent pain radiating to his right groin and antero-medial thigh region. He also complained of restricted hip movements with stiffness and mild pain in the lower back. History revealed that the patient had a fall from stairs 15 years ago. No other relevant medical/surgical history was reported by the patient. The patient had consulted an orthopedic surgeon who prescribed painkillers and nutritional supplements. However, relief from symptoms was minimal and temporary.

On the patients' first visit to our hospital, complete clinical, hematological and radiological investigations were done. Clinical scoring of the patients' condition was done based on Harris Score. A total score of 28 (poor) was calculated based on range of motion scores and the findings of marked pain, moderate limp, use of 2 canes/crutches, ability to sit on a high chair for 30 minutes, inability to put on shoes/socks and enter public transportation.

Radiological investigations revealed:

- Marrow oedema in left femoral head, left acetabulum,
- Small erosions in the acetabulum and femoral articular margins,
- Thinning of articular cartilage and reduction in joint space with synovial thickening.

A.P. view of pelvis with both hip joints reveal that left femoral head shows cortical irregularity of articular surface with gross narrowing of left hip joint space. The neck and the cortical head structure is maintained inspite of irregular erosion as described earlier. Osteopenia is visualized. Above findings are suggestive of AVN of left femoral head.

Based on the assessment a final diagnosis of Avascular necrosis of the left femoral head (Stage II as per FICAT and ARLET classification) was confirmed.

**Clinical Methodology & Treatment plan**

On the basis of clinical findings the patient was admitted for treatment in March 2014 and a personalized treatment protocol was made based on the severity of the condition and general factors such as age of the patient, body mass index etc. The protocol involved harvesting bone marrow concentrate, stromal vascular fraction (SVF) from adipose tissue and platelet rich plasma (PRP) from peripheral blood. Bone marrow concentrate contains mixed population of progenitor cells comprising of mesenchymal and hematopoietic cells along with mononuclear cells. Stromal vascular fraction isolated from adipose tissue consists of endothelial cells, adipocyte progenitors, immune cells, fibroblasts, pericytes and stromal cells. Platelet rich plasma is a platelet concentrate and a reservoir of cytokines and growth factors. Vascular endothelial growth factor (VEGF), fibroblast growth factor (FGF), platelet derived growth factor (PDGF), transforming growth factor (TGF-β), insulin-like growth factor (IGF) and epidermal growth factor (EGF) that are present in PRP play an important role in the healing process Transplantation dose was calculated on the basis of cell count and grade of the disease.

**RESULTS**

Following treatment, the patient was kept under observation for 48 hours at the hospital. This was a non-interventional period for homing of the cells and for monitoring the general condition of the patient. The patient was advised non weight bearing physiotherapy exercises (passive) such as stretching of the hamstrings, hip flexors and abductors followed by range of motion exercises for the hip and knee. Strengthening exercises were gradually instructed to strengthen primarily the quadriceps, hip abductors and hamstrings musculature. The patient was instructed to continue the rehabilitation exercise program for 1 year.

Follow-up was done periodically wherein clinical and radiological assessment was done. The patient showed gradual improvement in clinical parameters of pain and

movements. Harris hip score calculation was done at the 3rd, 6th and 12th month follow-up. At the end of the first year, the score was 89 (good). The patient was free of pain 6 months after treatment. The patient is now able to walk unlimited distances without using cane/crutches, can sit comfortably on any chair and is able to enter public transportation.

**Case 2**

17 year old Tania had a history of road traffic accident at the age of 12 years. When she was hospitalized, it was detected that she had high blood glucose level. However, the high level was considered as post trauma effect. She also had a history of repeated fainting episodes while at school, but this was usually attributed to weakness. At 14 years of age, Tania had complained of body and abdominal pain, weakness and she fainted on her way to hospital. This time, she was diagnosed with Type 1 diabetes mellitus based on her symptoms and blood investigation which revealed high blood glucose level (random blood sugar and HbA1C).

Type 1diabetes is becoming one of the most common illnesses in younger individuals. India is home to close to 97,000 children with type 1 diabetes. Although this type constitutes only 5-10% of the total population, it has serious short and long term consequences. The condition results due to pancreatic beta cell destruction which causes absolute insulin deficiency. Genetic and environmental factors as well as disorder of immune mechanism are thought to be the cause of type 1 diabetes. Treatment involves use of insulin/oral medicines, dose of which is adjusted based on regular blood glucose monitoring. Also, continuous monitoring of the general condition of the patient is of paramount importance so as to assess development of complications. Diabetes is associated with microvascular (retinopathy, nephropathy, and neuropathy) and macrovascular (cardiovascular, cerebrovascular, and peripheral vascular disease) complications.

Our patient, Tania was prescribed 2 forms of insulin. She achieved some control, though there was constant fluctuation in blood sugar level. Moreover, Tania continued to complain of general weakness, occasional abdominal pain, tingling sensation in toes and facial pigmentation.

For patients as young as Tania, or even younger, type 1 diabetes affects not just routine activities, but also takes a toll on their emotional well being. Medications and insulin are to be continued life-long as these agents do not cure the condition, which also poses financial burden to families. Tania started searching on the internet for advanced treatments for Type I diabetes. She read about Dr. Mahajan and StemRx Bioscience Solutions Pvt. Ltd. and decided to consult him.

Dr. Pradeep Mahajan of StemRx Bioscience Solutions Pvt. Ltd. says "You carry your own repairing kits in your body". He believes in the power of cellular therapy to address the root cause of many conditions rather than palliative management of symptoms. The rationale behind use of cellular therapy for diabetes is that, stem cells have tremendous regenerative capacity and the flexibility to grow into different types of cells. Progenitor cells in the human body are capable of differentiating *in vivo* to produce beta cells—the islet cells that manufacture insulin—as well as pancreatic islet cells. Cell-based approach to insulin replacement has been shown to ultimately improve glucose control in patients with type 1 diabetes. Furthermore, mesenchymal stem cells have immunomodulatory property that aids in restoring immune homeostasis/balance in the body.

Patients and their families are generally unaware of this recent form of therapy for diabetes. It is therefore mandatory, that the patient is explained about his/her disease condition and what benefits may be achieved through cellular therapy. At StemRx, during the patients' first visit, a detailed case history is taken. When the patient consents for treatment, he/she is directed to undergo hematological and radiological investigations specific to his/her health condition. This is followed by a second round of consultation during which reports of investigations and treatment protocol for the patient are discussed in detail.

Cellular therapy protocol at StemRx involves harvesting cells from the patients' own body (autologous stem cells) from bone marrow, fat tissue and peripheral blood. These sources are rich in mesenchymal stem cells and have the advantage of availability of cells and ease of harvest. After activation the cells are transplanted into the appropriate site in the patients' body. Hospitalization is advised for 48 hours after the procedure to monitor the general condition of the patient and to allow for homing of cells. Since the source of cells is from the patients' own body, treatment is safe and is not associated with any adverse events.

Lifestyle and diet are two other factors that play a major role in prognosis of diabetes. Food is a major concern for parents as children in particular tend to have specific tastes and can be quite demanding. This poses even greater difficulty when the child is diabetic. Meal

planning can get tricky, but should be consistent, flexible, and supply the necessary nutrients. The aim of diet planning is to satisfy the child's appetite along with balancing sugar and promoting normal growth and development. At StemRx, the patient discusses the diet followed by them with our in-house dietician. Based on the requirements, modifications may be advised to achieve a balanced diet, specific for the patient. A diet that is high in fiber, low in saturated fat and sugar is generally advised to diabetic patients.

Another important factor, physical activity has been shown to improve lipoprotein profile, cardiovascular health and reduce blood pressure. Prevention of long-term complications arising due to diabetes may be possible through physical exercise. However, it should be ensured that hypoglycemia be avoided, which occurs immediately or after prolonged intensive workout. Children in particular are more prone to variability in blood glucose levels. Therefore, we advise moderate intensity leisure activities, recreational sports as well as physiotherapy exercises depending on the overall status of the patient. The goal is to teach patients to incorporate exercise in their daily lives, in addition to diet management as a means to improve/maintain insulin sensitivity post treatment.

Results of cellular therapy are generally observed after 1-2 sessions of cellular therapy. Reduction in blood glucose levels are noticed along with improvement in general health of patients. However, changes in the patients' ongoing insulin doses/oral hypoglycemic drugs are made only after a steady state of blood glucose is achieved. Accordingly, dosage is adjusted and ultimately discontinuation of medications/insulin may be advised.

Tania was advised 2 sessions of cellular therapy with diet modifications and physiotherapy. Response to treatment was noticed immediately after 1st session of therapy. A gradual reduction in blood glucose level was noticed, but the main improvement within 10 days of treatment was reduced lethargy. During her 1st month follow up, insulin dose was reduced from 20 units to 16 units a day. Three months following treatment, Tania was advised to completely stop one form of insulin and dose reduction of the second form to 6 units (from previous 16 units) was advised. A year after cellular therapy, Tania has now completely discontinued both forms of insulin. Improvement in skin pigmentation and overall energy levels is also noticed.

Cellular therapy addresses the root cause of diabetes, ie: beta-cell destruction and insulin resistance. Therefore, results achieved, although gradual are permanent. The number of sessions of cellular therapy required differs with each individual, based on age, diabetic status and presence of co-morbid conditions as well as lifestyle. Additionally, patient compliance with respect to following diet and allied therapies is equally important to achieve optimum benefit from therapy.

Tania is now able to go through her daily routine comfortably. It is necessary to create awareness regarding this form of therapy so that more patients from every strata of the society can be benefitted.

**Case 3**

**Name:** Master. Shreshta Jain

**Age/Sex:** 2 years/ Male

**Diagnosis:** Duchenne Muscular Dystrophy

**History:**

The patients' parents had noticed around the age of 1.5-2 years that the child was unable to walk. He was able to stand with support for brief periods but would lose his balance while attempting to walk. They also noticed that Shreshta could not even talk monosyllables though he was 2 years of age. It was initially assumed that the child had delayed developmental milestones, however it was found that he also had weakness in his muscles which did not permit him to move around like a normal child. Doctors at the patients' hometown had advised blood and genetic analysis following which it was diagnosed that the child has Duchenne Muscular Dystrophy (DMD). An increase in creatine phosphokinase (CPK-MB) to a critical level was observed which denoted degenerative activity in muscles. Genetic analysis revealed dystrophin gene deletion in exon 45 which denoted the mutation responsible for DMD in this patient.

DMD is an **inherited genetic condition caused by mutation of dystrophin gene that results in muscle degeneration.** DMD is inherited in an X-linked recessive pattern which means, females are generally carriers for the disease while males will be affected. The incidence of DMD is 1:3500 live male births. **The condition is progressive and eventually affects all voluntary muscles as well as heart muscles which may result in premature death of affected individuals.**

Currently, there is no specific treatment for any of the forms of muscular dystrophy. Physiotherapy, low intensity anabolic steroids, prednisone supplements may help to prevent contractures and maintain muscle tone. However, these treatment modalities only offer temporary relief from the symptoms.

# EVECON 2016: JALWA - THE FINALE



**Facing challenges with strength, determination and confidence is what matters, and you have done it.**

## CONGRATULATIONS!

**Dr. Mrs. Archana M. Pate**

**Dr. Mangesh Pate**

**Dr. Hemraj Ingale**

Regenerative medicine and cellular therapy harness the potential of the bodys' inbuilt repair mechanisms to treat various acute and chronic disease conditions. Progenitor cells which are present in various tissues of the body are capable of differentiating into different cell types. Cellular therapy in MD has been shown to promote muscle regeneration and improve muscle function. Use of stem cells without the genetic defect as seen in DMD may aid in formation of healthy muscle fibers. Also, cellular therapy may reduce associated inflammation thereby preventing further muscle degeneration.

Shreshtas' family have consulted many specialists in Madhya Pradesh, New Delhi, Pune etc. but none could provide treatment that would enable Shreshta to grow as a normal child. He underwent speech therapy, however no results were achieved. They then researched on the internet about advances in treatment of DMD and decided to consult Dr. Mahajan with the hope that cellular therapy would bring about improvement in their childs' condition.

At StemRx, a protocol of 6 sessions of cellular therapy over a period of 18 months was advised. The child was also made to exercise under supervision of a physiotherapist. The purpose of physiotherapy exercises was to strengthen muscle groups. The parents were also instructed to aid the child perform the exercises regularly after discharge from the hospital. A diet specific to the childs' condition was advised which would aid in growth and overall increase in muscle strength.

The parents' willingness to comply with every instruction given by Dr. Mahajan for the betterment of their child was the most important aspect of the treatment.

After treatment, Shreshtas' parents say that there is improvement in his general condition. He is very active and moves around with ease. He can walk as well as run without support. He can climb stairs with support of railing on one side. Tremendous improvement has been noticed in muscle strength. He can get up from sitting position/squatting position on his own which he was unable to do prior to treatment. Fine motor skills such as grip strength, throwing, holding actions have also improved. He now speaks monosyllables clearly.

**Note:**

Whereas an empirical data gathered by the Muscular Dystrophy Association (MDA) of USA mentions the occurrence of MD to be one in every 2000 children, neither India as a country nor any of its states has specific data about it. Even our national population survey that ought to specify the population of Persons with Disabilities (PWDs) along with the case specific nature of disability do not have any specific data on MD.

**Case 4**

A 19 year old male patient reported to StemRx Bioscience Solutions Pvt. Ltd. with the complaints of recurring gait disturbances and inability to perform daily activities effectively.

Medical history revealed that he first experienced loss of consciousness while playing on a ground before 4 years. He was unable to lift his leg thereafter and consulted a local physician for the same for which he was given medication for a brief period. Six months later, the patient was admitted to a hospital with the complaint of heaviness in his right leg and gait disturbance. Blood and radiological investigations were done and MRI revealed that the patient suffers from Multiple Sclerosis. He was under steroid medication for 3 months and the symptoms were brought under control. Over the course of the following year, the patient repeatedly had the previously mentioned complaints in addition to uncontrolled movements of the neck, inability to write, talk clearly and urine incontinence. Steroid therapy was advised which temporarily relieved the symptoms, however, the patient gradually stopped responding to the medications (in about 2 years after therapy was initiated). Thereafter, immuno-modulatory therapy with beta-interferon was given for 6 months followed by alternative DOI: 10.9790/0853-1504011127130 www.iosrjournals.org 128 | Page medicine modalities for 1-1.5 years, none providing any improvement of symptoms. In July 2014, the patient was bedridden following an episode of fever and general weakness. On the patients' first visit, complete radiological and hematological investigations were done. Hematological assessment did not reveal any abnormalities with the exception of positive C-reactive protein level. The positive level indicates that CNS inflammatory response in MS is dependent on the peripheral immune compartment [5]. Fig. 1a & 1b show the MRI images taken before and after initiation of conventional treatment. Clinical assessment criteria have been presented in Table 1. A final diagnosis of Recurrent Relapsing Multiple Sclerosis was made. The relapsing-remitting subtype is characterized by new signs of disease activity.

Three sessions of stem cell therapy with an interval of 15 days between each session was planned for the patient during his initial stay at the hospital. Follow up was done after 3 months during which two more sessions of cellular therapy was advised. Approximately 100 ml of bone marrow from the right iliac crest, 70-80 ml of adipose

tissue from right gluteal region was aspirated under local anesthesia. 50 ml of peripheral blood was obtained from right cubital vein. Stem cell transplantation was done by intrathecal, intravenous and intranasal routes. In addition, intravenous dose of PRP, which is a platelet concentrate and a reservoir of growth factors was administered. Physiotherapy exercises, neuromuscular stimulation, yoga, nutraceuticals and a balanced diet specific for the patients' condition were advised. predictable relapses followed by periods of months to years of relative remission with no new signs of disease activity.

Clinically, positive effect of treatment was defined as a decrease in EDSS of 1.0 point or greater compared with baseline. The response to cellular therapy provided was seen during the first follow up period. The patient regained some of his abilities to perform routine activities with assistance. Graph 1 shows the improvement in functional system scores following cellular therapy. The improvement noticed in individual functional systems was gradual, but that was considered a positive effect on our part as the patient was bedridden when he first reported to the hospital.

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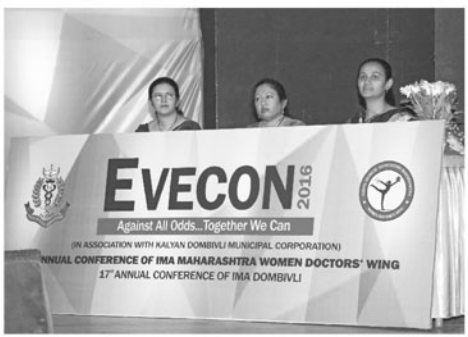
**EVECON - 2016 - Scientific Sessions**






# BRIEF HISTORY OF PEDIATRIC SURGERY IN INDIA

**Dr Lucky S Kasat**

*Dr Laxmikant Kasat (fondly called Lucky), is a pediatric surgeon who did his MBBS and MS in General Surgery from Nagpur, and MCh in Pediatric surgery from the prestigious KEM hosp in Mumbai. Practicing in THANE since 2000, he is attatched as consulting surgeon at Jupiter and Kaushalya hospitals. He has 15 INTERNATIONAL PUBLICATIONS IN INTERNATIONAL JOURNALS to his credit and 4 of them are now text book references.*

Willis Potts - one of the pioneers of pediatric surgery in North America, from the preface of his book "Surgeon and the Child" published in 1959, says,

**"If this baby could speak, it would beg imploringly of the Surgeon, please exercise the greatest gentleness with my miniature tissues and try to correct the deformity at the first operation. Give me blood and the proper amount of fluid and electrolytes; and plenty of oxygen to the anesthesia and I will show that I can tolerate terrific amount of surgery. You will be surprised at the speed of my recovery and I shall be always grateful to you."**

It was the general surgeons who operated on children in the times of Sushruta. Pediatric surgery remained limited due to high mortality. **It was in 1941** when Dr. Cameron Haight from Michigan reported the first survival of esophageal atresia in a 12-day- old baby using a primary single-stage extrapleural approach. It triggered the general surgeons to learn more about pediatric surgery.

39 general surgeons went abroad and returned to India in 1950s and 1960s after learning pediatric surgery as there were no teaching programs in India to obtain training in pediatric surgery.

**The challenges of the 1960s:** Do a venous cut down for insertion of a plastic cannula to administer intravenous fluid; getting the right sizes of endotracheal tubes to anesthetize the child and to find anesthetists who were confident and knowledgeable about pediatric anesthesia.These problems largely persist at many places even today! The success rate of complex surgery in newborns in 1960s was a dismal 20-30%. Today, it is 90 % in most.

**The first M. Ch course** was started in 1966 in Chennai under Dr. M. S. Ramkrishnan. Dr. T. K. Subramanian was the first to get M. Ch (Pediatric Surgery) under him. By 1972, there were 7 teaching departments, today there are almost 50 teaching departments across India and over 1,300 pediatric surgeons all over India.

**The B. J. Hospital for children** started in 1927 and was the first children's hospital in India and it is the part of Sir J J Group of Hospitals and Grant Medical College. The pediatric surgery department was added in 1967.

**The Department of Pediatric Surgery in KEM hospital, Mumbai** was established in 1967. In 1972, the University of Bombay instituted M.Ch. in Pediatric Surgery. The next important landmark was the establishment of separate neonatal and paediatric surgical intensive care unit in 1976. The department possesses a high frequency oscillatory ventilator system for ventilation of newborn children with congenital diaphragmatic hernia and pulmonary hypertension and adequate warmers and multipara monitors.

It has a ward with a capacity of 50 beds – including an 8-bed neonatal surgical ICU and a dedicated operation theatre complex with an endoscopy room. The department runs two operation theatres five days a week.

The total surgeries performed annually are about 2,000; 800 of which are major operations.

Every Thursday at 2.30 pm a specialty **Birth defect Clinic** is conducted at KEM, Mumbai; where all children with any congenital anomaly, pregnant ladies with antenatal USG showing fetus with congenital anomalies, ladies with bad obstetric history and also couples with family history of birth defect are seen in the clinic. The specialists from respective speciality have a joint consultation, outline management plan and counsel the children alongwith their families in this clinic. More than 300 families have attended the clinic. The clinic is conducted every Thursday afternoon at 2.30 pm in the Board Room, Department of Pediatric Surgery, 3 rd Floor, Old building, Gynecology Wing, K.E.M. Hospital.

**AIIMS Department of Paediatric Surgery** was created as an independent department in 1969. It was in 1968, that Dr. P. Upadhyaya, then Associate Professor of Surgery, returned after availing a WHO fellowship in Pediatric Surgery and took charge of the Pediatric Surgery unit within the department of General Surgery at AIIMS.

It was on 29th March 1971, that the umbilical cord was finally severed and the Department of Pediatric Surgery came on its own with Dr. Upadhyaya as its first head. It was a humble beginning with 24 beds. The first M.Ch. trainee, Dr. S.Chooramani was selected in July 1972 and has been bestowed with the honorable Padamshree award in 2011.

**The six years' integrated M.Ch. course** in Pediatric Surgery (after MBBS) was launched in AIIMS in 1979 and it continues till date. Original experimental work has been carried out in the field of splenic conservation, CSF shunts, embryo-toxic factors in congenital malformations, duplication cysts, metabolic responses to surgery, biliary atresia, intersex disorders, pediatric urological problems, intestinal atresia, esophageal atresia, to name a few. The Department has two laparoscopic endotrainers.

**In 1975, the first neonatal surgical ICU, in India, was established at the AIIMS. Today it has 10 beds.** From its inception the department has tried to take care of all surgical needs of children. The Upadhyaya shunt was the first of its kind in India, manufactured using an indigenously developed valve in the department. Currently, the Department operates around 2,500 cases per year including 1600 major cases, 600 minor cases and 300 cases at CHC, Bhallabhgarh where the Department runs an Operation Theatre once a week.

**The first ever national gathering of the country's Pediatric Surgeons** took place in 1976 during the Ist WHO/NAMS sponsored National Seminar on Pediatric Surgery at AIIMS. The recommendations of the seminar formed the blue print for the evolution of pediatric surgery. A follow-up on this was made during the 2nd WHO/NAMS National Seminar on Pediatric Surgery in 1982 at AIIMS. The department hosted the first International Workshop on Neonatal Surgery in 1980

**Some departments started focus on organ or systems.** In India, 40-50% of surgical work of a pediatric surgeon is related to pediatric urology. Dr. Sripathy and Dr. Namasivayam at Chennai started a one-year fellowship in pediatric urology. There are three more fellowship courses in pediatric urology under trained urologists at NU Trust (Bangalore), Karnatak Lingayat Education Society (KLES; Belgaum), and SGPGI; Lucknow.

**Laparoscopic surgery -** Dr. Vinod Kapur from B. J. Wadia Children's Hospital, Mumbai was one of the first one to perform laparoscopy in children in 1980s. The actual laparoscopic pediatric surgical work in India began in late 1990s. Dr. Rasik Shah with Dr Sandesh Parelkar who assisted him performed the first laparoscopic pull through for Hirschsprung's disease in India on Dec 22, 1998 at B. Y. L. Nair hospital. During the surgery, CO2 gas ran out and the rest of surgery was completed with air insufflation using hand pump used for sigmoidoscopy. This created a landmark event in the history of laparoscopic pediatric surgery in India.

In Mumbai, **laparoscopic pediatric surgery hands on training courses** were started in Ethicon Institute of Surgical Training in 2001 and since last year these courses are being carried out at Center of Excellence for Minimal Access Surgical Training (CEMAST). Dr. Sandesh Parelkar in King Edward Memorial (KEM) hospital, Mumbai and Dr. S. Ramesh in Indira Gandhi Institute of Child Health, Bangalore has started 1-year certificate course in Laparoscopic Pediatric Surgery.

Dr. Ashley D'Cruz and Dr. Sanjay Rao can be credited with starting liver transplant at Narayana Hrudayalaya. The first liver transplant was performed in 2005 and they have completed more than 55 liver transplantation. The youngest being 7 months old and weighing 3 kg.

## INDIAN ASSOCIATION OF PEDIATRIC SURGEONS

The group of pediatric surgeons requested office bearer of

Association of Surgeons of India to start a section devoted to pediatric surgery in the Silver Jubilee Conference of ASI in 1964 held at Mumbai. Dr. Arthur de Sa was the first president and Dr. R. K. Gandhi was first Secretary cum Treasurer. In 1979, the IAPS was converted as full-fledged separate speciality. West Bengal Chapter is the oldest state chapter in India. More than 9 state chapters' are active at present.

**Journal of Indian Association of Pediatric Surgeons (JIAPS)** is the official organ of Indian Association of Pediatric Surgeons has completed 20 years. Journal is published quarterly and articles can be submitted online at http://www.journalonweb.com/jiaps.

Dr. V. Ravikumar from Coimbatore started **IAPS YAHOO GROUP in 2003.**

Dr. Sanjay Kulshrestha has filed PIL for inclusion of congenital anomalies by insurance companies .

Pediatric Surgeons have been creating innovative ideas, e. g., Raina's romodrain, Irani's Clamp for Duhamel's pull through, Mohan Abraham's Valvotome, Upadhyaya shunt etc.

• • •

***Dr. Leena Lokras***
*Currently Member of 'Organ Donation Committee', IMA Dombivli and Editor of Dialogue. She has been a Past President of IMA Dombivli in the year 2014-15. This is a compilation for your easy referral.*

## SKIN DONATION

- In burns patients, primary cause of death is due to infection because of skin loss.
- Skin donation can help such patients survive.
- Min age of the donor should be 18 yrs.
- Patients suffering from HIV, Hepatitis B & C, STD, Skin cancer are unfit for skin donation.
- Skin is harvested within 6 hrs of death by skin bank team which comes wherever the donor is kept
- Only 1/8th layer of skin is taken and there is no bleeding or scarring at the site.
- Even if not pledged, skin can be donated with consent of next of kin

## EYE DONATION

- In India, we have an estimated 4.6 million people with corneal blindness.
- YOU can give vision to them.
- Anyone from the age of one. There is no age-limit for donating the eye. Those using spectacles and those diagnosed with diabetes and hypertension can also donate their eyes.
- People who die due to infections such as rabies, syphilis, infectious hepatitis, septicemia, and AIDS, cannot donate.
- The donor can pledge his/her eyes during lifetime or even the next of kin can donate the eyes of the deceased.
- Eyes need to be removed within six hours after death.
- Eye donation leaves no disfigurement.

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# मतदारराजा दार उघड

डॉ. सतीश अ. कानविंदे

१९७६ साली ग्रँट मेडिकल कॉलेज मधून एम.बी.बी.एस्. उत्तीर्ण. त्यानंतर प्राथमिक आरोग्य केंद्रात वैद्यकीय अधिकारी म्हणून काही वर्ष ग्रामिण जनतेची सेवा केली. १९८२ मध्ये आयरे गाव डोंबिवली (पूर्व) येथे स्वतःचा दवाखाना सुरु केला. शालेय जीवनातच कविता लेखनाचा प्रारंभ. आता पर्यंत तीनशेहून अधिक कविता लिहील्या. त्यापैकी २४० कविता लोकसत्ता, महाराष्ट्र टाईम्स, डायलॉग, नवशक्ति, सामना, सारस्वत चैतन्य या विविध नियतकालिकांमधून प्रकाशित झाल्या आहेत. तसेच लॉलीपॉप, ठक् ठक्, चंपक आणि ज्ञानरंजक टॉनिक या मुलांसाठीच्या मासिकांमधून प्रकाशित झाल्या आहेत. २०१३ मध्ये अमेरिकेत गेलो असताना, शिकागो येथील बृहन्महाराष्ट्र मंडळाच्या मासिकांमधूनही माझ्या चार कविता प्रकाशित झाल्या आहेत. बालकविता लेखनात विशेष रस असला तरीही मराठी तसेच मालवणी भाषेत आणि विडंबन गीतेही लिहीली आहेत.

**(कविवर्य मंगेश पाडगांवकर यांच्या स्मृतिस अभिवादन करुन)**

मतदारराजा दार उघड, दार उघड

दार असं लावून, नेत्यांवरती कावून
किती वेळ आत बसशील?
आपलंस मन खात बसशील ?
नोट खिशात यायलाच हवी,
दारु पोटात जायलाच हवी, दार उघड

निवडणूकीचं वातावरण तापू लागलंय पाहिलंस का?
नेत्यांच्या नावानं दिवसभरात एक तरी
लाखोली वाहीलीस कां?
गप्प बसून कसं चालेल?
तुला हे सारं करावंच लागेल !
'पाच वर्ष कुठे होता?' विचारायला विसरु नकोस!
काही झालं तरी आमच्या टक्केवारीवर घसरु नकोस!
मिठाईचा पुडा तुझ्या मुलाला द्यायचाच दार उघड!
मतदारराजा दार उघड, दार उघड

सगळंच केलं तुमच्यासाठी,
तर आमचं भलं कसं होणार?
राजकारणात शिरायला मग सांग,
कोण कसा पुढे येणार?
भूखंड आम्ही लाटले तर तुम्ही कां सुन्न व्हायचं?
टोलची कंत्राटं घेतली म्हणून त्यांनी कां खिन्न व्हायचं?
पेट्रोल पंप आणि बीअर बार
आम्ही नाही तर कोण टाकणार?
आम्ही फोकलेल्या पैशांपुढे
तुम्ही नाही तर कोण वाकणार?
फेकलेले हे पैसे, घ्यायला तरी दार उघड!
मतदारराजा दार उघड, दार उघड

आजपर्यंत माझ्या नावावर मी
एक घर नाही घेऊ शकलो!
आलीशान घरात राहिलो! पण मन नाही रमवू शकलो!
मर्सिडीझमधून फिरतो रे ?
पण नॅनो सुद्धा नावावर नाही!
आदर्शमधल्या माझ्या फ्लॅटबद्दल
मला काहीच माहिती नाही!
तुझ्या कानात बोळे घाल आणि
डोळ्यावरती बांध झापड
ब्र काढलेल्या तोंडातून तर करुन टाकीन तुझा पापड!
तुझ्या बायकोसाठी आणलीय साडी,
घे मुकाट, दार उघड!
मतदारराजा दार उघड, दार उघड

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# गोगलगाय

डॉ. सतीश अ. कानविंदे

एक होती गोगलगाय
पण पोटात तिच्या नव्हते पाय
चुकून एकदा खाल्ली तिने
दुधावरची दाट साय

साय खाताना तिने म्हणे
विचार नाही केला कसला
दुसऱ्या दिवशी कळले तिला
घसा आपला आहे बसला

अधूनमधून खोकल्याची
तिला मोठी उबळ यायची
पाच पाच मिनीटांनी गोगलगाय
'खो गो' ची एक गोळी घ्यायची

तरी देखिल खोकला तिचा
जरा सुद्धा जाईना
थकवा आला खोकून खोकून
ती काही सुद्धा खाईना

बसून ऱ्हायची तासन् तास
मुजपून आपले सारे पाय
मनात विचार करायची ती
'कशाला मी खाल्ली साय ?'

तेव्हांपासून सुस्त झाली
गरीब बिचारी गोगलगाय
लोक मात्र म्हणू लागले
'गोगलगाय नी पोटात पाय'

16th Nov. 2016 : IMA Satyagraha Day: Memorandum submitted to Hon. Tehsildar Shri Kiran Survashe

# देव पळाला

डॉ. सतिश कानविंदे

एका देवळात देव
भक्ताला एका पावला
लोकांना ते सांगायला
भक्त गावोगावी धावला

नवस बोलून लोकांनी
देवाची घेतली टेस्ट
काही जणांना पावला देव
लोक म्हणाले बेस्ट

ख्याती पसरली देवाची
भक्तांच्या लागल्या रांगा
दानपेट्या मग भरल्याशिवाय
कशा राहतील सांगा

पैसे आणि दागिन्यांसाठी
पेट्या पुरेना झाल्या
ऑर्डर गेली ताबडतोब
अन् नवीन पेट्या आल्या

भक्तांच्या मनात आता
नवीन विचार आला
काही महिन्यातच देवळाचा
जिर्णोद्धारही झाला

दगडाची मूर्ती जावून तिथे
सोन्याची मूर्ती आली
देवळाची पायरी सुद्धा
मग सोन्याचीच झाली

श्रद्धेच्या बाजारात अनेकांनी
आपली दुकाने थाटली
देवाला मग स्वतःलाच
स्वतःची लाज वाटली

अति झाले तेव्हा देव
मनातल्या मनात रडला
आणि एक दिवस गुपचुप
तो देवळातून बाहेर पडला

लांबून लांबून भक्त तरीही
मोठ्या श्रद्धेने येतात
तासंतास रांगेत राहून
मूर्तीचं दर्शन घेतात

हताश होऊन देव सारं
दुरूनच बघत बसतो
काही करावसं वाटतं
पण तोही अगतिक असतो



17th to 26th Dec. 2016 - Organ Donation Campaign at UTSAV Festival, Dombivli Gymkhana