CONTENTS

IMA DOMBIVLI

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Typset and Printed : Pooja Paper Trading Co., Dombivli (E). Cell : 9324790100

FROM THE PRESIDENT'S DESK

As the sun sets on the IMA Dombivli Calender 2016-17, I sit back to reflect on the year that just got over so quickly. I am filled with mixed emotions of happiness, joy, gratitude, contentment and great friendships developed through the year.

Being somewhat apprehensive when first asked to be President I was reassured by several PPs that I would enjoy the experience, and although unconvinced at the time I can confidently say that I am enjoying myself now! I am proud to be a member of our branch and particularly proud to have been afforded the honour of being your President.

My thanks to you all for making these things happen. I am mindful that I have just been the person holding the microphone. Alongside me are those who toil unceasingly to keep our branch moving and to whom I am ever grateful. Thanks to Dr. Mandar Pawar, for keeping tight hand on the purse and ensuring that we end the year with money in the kitty. We all know that any good branch is really run by a good secretary and we have been fortunate to have Dr. Utkarsh Bhingare.

IMA Office staff remains a great challenge to us. We were fortunate this year to use IMA Office to its fullest. We have conducted all our executive meetings, Sub committee meets at the IMA Hall. We somehow managed to run the show. We have now started renting out our Hall for academic activities of other organisations too.

I believed in the resources, talents, & suggestions of all committees and gave them a free hand to shape up programs whether it be CME, EVECON, Dialogue, Women's wing, Rural Health team, BLS Team, Tree Adoption Team or EICP. And believe me, every program turned out to be a huge success.

I am so proud that they all gave more than their 100% to contribute towards making the year a memorable one. I share all the accolades and appreciation with every member of my executive team.

Constitution & Byelaws of IMA Dombivli were approved in the Annual General Meeting dated 19th March 2017 this year. Record of 34 new life members inducted to IMA Dombivli in a single month of May 2016. We were successful in inducting a total of 43 life members (25 life single & 9 life couple) in the year 2016-17 Record addition of 14 new members to the existing 37 members in the Social Security Scheme.

IMA Dombivli was conferred upon the CGP Subchapter at the ICON Conference in June 2016. 6 new clinical establishments added to existing 27 members of HBI Dombivli. IMA HBI NABH Cluster based Accreditation program has been initiated.

Dialogue had a bouquet of various topics which covered almost all faculties of medicine. Our members participated enthusiastically to showcase their artistic interests. Best was the cover pages which were different and very vibrant.

7 Scientific sessions as a part of Continuing Medical Education along with IMA MS Women Doctor's Wing State conference EVECON 2016 was conducted successfully this year. We were successful in sending the CME Excel Sheet Summary and the CME charges in time for all our educative sessions.

55 Delegates attended the Basic Life Support Workshop which was carried out for the first time in IMA Dombivli. Meeting with Hon. MP Dr. Shrikant Shinde on recommended amendments to PCPNDT act IMA Dombivli Womens Wing has been very enthusiastic this year. Apart from their active role in EVECON 2016, a lot of social programs namely the Mission Pink Health, CAER project, Medical camp for special children & the Old age home project. They also had fellowship programs including Mother's Day Picnic, Women's Day celebration & an interactive program Marriage is Marksheet by Dr. Harish Shetty.

Historic victory at the MMC elections. Our Vice President, Dr. Archana Pate won with a thumping majority votes of 8,222 at no. 4 position out of the 9 elected seats at the MMC.

Assisted successfully 201 members in MMC registration renewal process. Blood Donation Drive, World Hypertension Day, World Health Day, IMA National Satyagrah Day, IMA National Soildarity Day, IMA National "No to NMC, No to NEXT" movement were carried out with good response from our members.

We participated in protest "Dharna" at Azad Maidan with a record attendance on 17th March 2017 Mass Rally was organised on 23rd March 2017 where more than thousand doctors from all pathies participated & came on streets to show their strength and solidarity in protest to suspension of resident doctors & violence attacks on Doctors.

Online Interactive Organ Donation Forms are made available on IMA Dombivli Website. We had elaborated articles in all issues of Dialogue – Brain death & Organ Donation for our members. ORGAN DONATION CAMPAIGN at UTSAV festival in association with Dombivli Gymkhana was super hit.

Rural Health Program "Aao Gaon Chale" was revived in the year 2016-17. We conducted 4 medical camps with phenomenal response from our members, chemist association & Mreps at the remote areas near mamnoli village, Taluka Murbad.

Educational Institute Contact Program was the biggest hit of the Year 2016-17. We had a fantastic inaugural program by Dr. Anand Nadkarni followed by 14 educative sessions in the 5 enrolled schools. Tree Adoption Project has added a feather in a cap of IMA Dombivli. Thirty trees have been planted and taken care off along the 90 feet Thakurli Kalyan road.

Proud of our members for providing free first aid and emergency resuscitative treatment to the victims of chemical blast at Dombivli MIDC factory on 26th May 2016. Provided first aid and were equipped to handle life threatening emergencies at the Dombivli Pride Run Marathon in association with NSSA.

But of course, the journey was not of roses All the time. There were difficult times, hard decisions to be taken and tricky situations to be dealt with. It was saddening that two of our members receiving show cause notices from the IMA MS. It certainly leaves a bitter taste that a senior, sincere member get show cause notice after working devotedly for various causes and whole heartedly supporting and guiding Presidents for years together and for me as President who has toiled hard to give this branch a successful and memorable year.

I thank all executive members who reposed faith in me and supported me against the show cause notice. Here I would like to mention that the notice has been replied to and we anticipate that the matter will be resolved at the earliest without any judicial intervention.

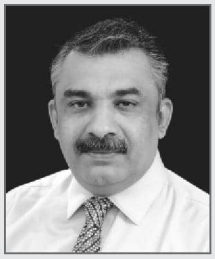
I have been fortunate to have a very dynamic team which believed in my leadership and so at the end of the day I feel at peace with myself. The year has given me a lot of experience which has made me a better person.

I would like to now compensate for the indefinite hours I was away from work and especially from my family. Dr Mrudula has been a quiet yet strong support all through and I am amazed at the maturity shown by my children at such a young age.

Wish you all happy times ahead.
Long Live IMA Dombivli
Dr. Hemraj Ingale
President
IMA Dombivli
2016-17

IMA DOMBIVLI TEAM 2016-17

President
Dr. Hemraj Ingale



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Vice President
Dr. Archana Pate

President Elect
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Hon. Secretary
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Hon. Jt. Secretary
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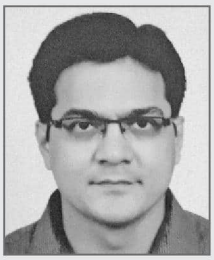

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Dr. Archana Pate

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Dr. Mangesh Pate
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Thank you for your support and now it's time to say Good bye...!

EDITORIAL

This is the last issue of this year and time to say goodbye to all of you. We at the editorial team tried our best to give you variety of articles, scholastic, stress busters, social, medico legal and medico social….enlightening you on various issues, updating your knowledge and entertaining you. I hope you enjoyed them. No duty is more urgent than that of returning thanks.

I am thankful to all the guest authors who wrote and shared their valuable knowledge with us. My special thanks to advocate Mr. Anant Bobe who discussed the legal aspects of medical profession in depths, the celebrity cartoonist Dr Ganesh Chaudhari for his cartoons which he drew specially for our Dialogue and Mr. Dilip Gund,chief fire officer, kalyan for his informative article.

I thank all the other stalwarts who have contributed with speciality articles to our bulletin. I am grateful to our own creative and talented IMA members both established and new who added charm to the bulletin. I thank them all. I am thankful to our President Dr Hemraj Ingale who has been so helpful to us all throughout the year. He gave us complete freedom as editors to select the topics and to put forth new ideas which kept our moral high all the time.

It would have been impossible to publish this bulletin without financial support. My task remains incomplete without acknowledging them. I thank all our supporters namely Jeevanshree hospital ENT and Minimal Access Surgery Centre, Icon hospital, Shivam hospital, Plasma blood bank, Axis imaging centre, AIMS Hospital, J K Women hospital, Jeevandeep Hospital and Critical Care Centre, Medimek Redefining Ideas, Shruti Hearing Care, Spectrum Diagnostic Excellence, Eva women's clinic and lab, Sparsh Multispeciality Hospital and ICCU , Disha kidney care, Skinart skin/laser/hair, Sattv the nutrition centre, Yash super speciality clinic and Pride speciality diagnostics.

Last but not the least is a heartfelt thanks to all of you readers who appreciated us from time to time and encouraged us to give you more and more. Please forgive me for unintended lapses.

Thanks again and wish all the best to the new team.

Congratulations President for the successful year

**Leaders become great, not because of their power,
but because of their ability to empower others.**
- John C Maxwell

**Leaders become great, not because of their power,
but because of their ability to empower others.**
- John Maxwell

IMA Dombivli has witnessed the most outstanding leadership giving a memorable year with all - encompassing activities. Hemraj is a very cool, level- headed ever smiling person, who always will try to innovate the routine stuff so it becomes more interesting. With an eye for detailing, all programs, events and activities were very well planned and executed smoothly. Another thing I noticed about Hemraj is that he is very focused. A leader needs to identify the strengths of the team and assign jobs accordingly.

He had numerous meetings with committees where he shared his vision and was also open to suggestions from them to make every event flawless. With Hemraj's encouragement all committees proved to be DYNAMIC in true sense. I am sure you have been an inspiration to your fellow members.

You have displayed extra ordinary courage to stand by the committees decisions. Leadership is to be taken with a pinch of salt. It cannot be a smooth journey always. But I admire your quality of being firm and supporting what is correct.

I would say that Hemraj you are a very good Doctor and an amazing leader but to top it all you are a fine human being. I wish you continue being just that.

I wish you and Dr Mrudula all the very best.

Dr. Leena Lokras

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IMA DOMBIVLI WINGS

IMA Defence Cell	IMA HBI	IMA CGP &AMS
Dr. Mangesh Pate	**Dr. Archana Pate** **Dr. Nilesh Shirodkar**	**Dr. Niti Upasani** **Dr. Leena Lokras**

Community Service Committee	IMA Schemes	Organ-Eye-Skin-Body Donation
Dr. Archana Pate **Dr. Makarand Ganpule**	**Dr. Mandar Pawar** **Dr. Niti Upasani**	**Dr. Sangeeta Dandekar** **Dr. Sheetal Khismatrao**

Womens' Doctor's Wing	Clinical Estab. Act	IMA Finance
Dr. Meena Pruthi **Dr. Sheetal Khismatrao** **Dr. Vijayalaxmi Shinde**	**Dr. Sangeeta Dandekar** **Dr. Hemraj Ingale**	**Dr. Hemraj Ingale** **Dr. Preeti Nanda**

IMA Patient-Doctor Grievance Cell	IMA Awards Committee
Dr. Mangesn Pate **Dr. Niteen Dandekar**	**Dr. Hemraj Ingale** **Dr. Utkarsh Bhingare**

IMA DOMBIVLI COMMITTEES

EVECON 2016	CME & Conference
Dr. Archana Pate **Dr. Niti Upasani** **Dr. Meena Pruthi**	**Dr. Makarand Ganpule, Dr. Dilip Joshi** **Dr. Vijay Shetty, Dr. Ashish Dhadas** **Dr. Ghanshyam Shirali, Dr. Sunit Upasani**

Dialogue	Cultural & Sports
Dr. Leena Lokras **Dr. Sangeeta Dandekar**	**Dr. Vijay Aage, Dr. Preeti Nanda** **Dr. Rashmi Phansalkar**

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

Co-opted Member
Dr. Arvind Bengeri

OVARIAN CANCER – CURRENT TRENDS IN MANAGEMENT

Dr Sanjay Dudhat

Dr. Sanjay Dudhat is a surgical oncologist and has work experience of 24 years in this field. For last 15 years he has been working as head of the department of surgical oncology at Nanavati Superspeciality Hospital, Mumbai.

He has 22 publications in national and international journals and has two research papers in his name. He was a coordintor for 2 international drug trials. He has organized many local, national and international conferences. He has given many lectures and orations. He has given many live telecasts on Cancer Awareness on television channels as well as radio on the occasions of World Cancer Day, World Anti Tobacco Day.

Currently he is the President of IMA Mumbai West branch and is chairman of Medical Education Committee of IMA Maharashtra state. He is the recepient of various awards at state and national level for his appreciable work in various IMA activities.

Introduction

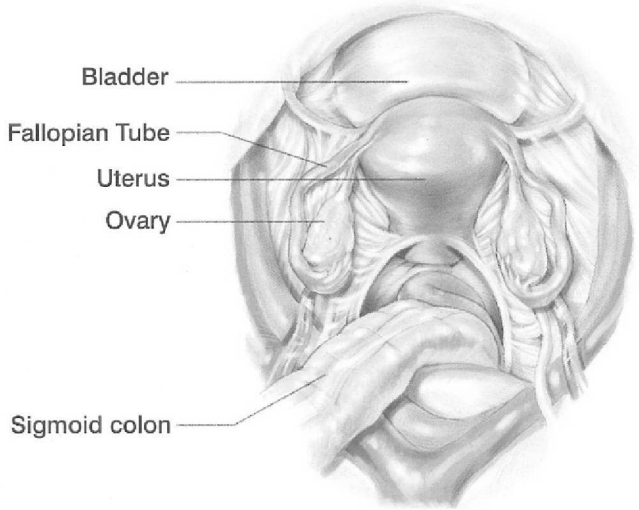
Ovarian Cancer has emerged as one of the common malignancies affecting women in India, with nearly 30,000 new patients being diagnosed every year. It is second commonest gynecological cancer globally. The age specific incidence rate for ovarian cancer revealed that the disease increases from 35 years of age and reaches a peak between the edges 55-64. The rise in the incidence is not only in western countries but also in India, probably because of copying of the western life styles. Since most of the patients present with advanced disease , overall survival rate remains low. There are no accurate screening methods for ovarian cancer despite of all the trials of screening. Because of vague symptoms, lack of good screening methods majority patients are presented in stage III or IV. During past decades there are lot of advances in surgical techniques (radical and debulking surgeries), newer and effective chemotherapeutic drugs and targeted therapies resulted in improving survival and in more effective treatment of relapsed disease. Tumour marker CA-125 is very useful in monitoring the efficacy of the treatment and prognostic significance. In addition, a better understanding of genetic risk factors has permitted a tailored approach to preventive strategies, such as bilateral salpingo-oophorectomy in selected patients. Efforts should be made to detect ovarian cancer at an early stage by educating population about the risk factors. Newer therapeutic modalities in recent years have shown promise for improving survival rates and significantly better quality of life.

Incidence

- 25% of all cancers of female genital tract
- Second commenest gynaecological cancer
- 75% are diagnosed at advanced stage.
- Approx. 20000 new patients diagnosed every year in India
- Peak age : USA : 60 - 65 Yrs, Asia : 50 – 55 Yrs

Risk Factors

- Increasing age
- Nulliparous women
- Personal history of breast or endometrial cancer results in increased risk of ovarian cancer



- Family history – History of breast cancer & ovarian cancer in family (close relatives).
- Hereditary Predisposition : A strong family history of either breast or ovarian cancer is the most important risk factor for the development of epithelial ovarian cancer.10 to 15% of all epithelial cancer will have hereditary predisposition Most commonly seen in breast ovarian cancer family syndrome because of mutation of BRCA1 or BRCA2. Also associated with HNPCC. The lifetime risk of ovarian cancer in women with germ line mutation in BRCA1 – 40% Germline mutations in BRCA2 – 10 to 20%
- HRT (Hormone Replacement Therapy)

Risk Reduction

The identification of women at high risk of ovarian cancer is essential for individualized tailoring of risk-reducing strategies. Bilateral salpingo-oophorectomy (BSO) is recommended for women with mutations BRCA1 or BRCA2 in approx. 30 to 40 yrs. Of age. Prophylactic BSO reduced the risk of ovarian cancer >90%. High risk patients with mutations BRCA1 & 2 can still develop primary peritoneal cancer which develops in 4 to 5% women at 20 yrs after BSO High risk patient who do not undergo BSO, surveillance with pelvic examinations, CA 125, pelvic sonography is recommended every 6 months starting at the age of 35. Unfortunately there is no evidence that

CA 125 or pelvic ultrasound alone or in combination is able to detect ovarian cancer at an early stage.

Early Detection

Early detection is rare due to lack of accurate screening methods, late symptoms & signs, non specific symptoms. Frequent periodic pelvic examination is recommended. Trans-vaginal ultrasound + CA 125 evaluation may be useful in diagnosis but not recommended for routine screening. Further screening trials are on going to find out better screening methods for ovarian cancer.

CLASSIFICATIONS OF OVARIAN TUMOURS (WHO Classification)

I. Common epithelial tumors – 90%

Cyst adenocarcinoma, endometroid adenocarcinoma, clear cell carcinoma, mucinous etc.

II. Sex cord – stromal tumors
   - A. Granulosa stomal cell
   - B. Androblastomas; Sertoli-Leydig cell tumors
   - C. Lipid cell tumors (Steroid cell tumors)
   - D. Gynandroblastoma

III. Germ cell tumors
   - A. Dysgerminoma
   - B. Endodermal sinus tumor (yolk sac tumor)
   - C. Embryonal carcinoma
   - D. Choriocarcinoma
   - E. Teratomas
   - F. Mixed forms
   - G. Gonadoblastoma

IV. Soft tissue tumors not specific to the ovary

V. Unclassified tumors

VI. Metastatic (secondary) tumors

VII. Tumor like conditions

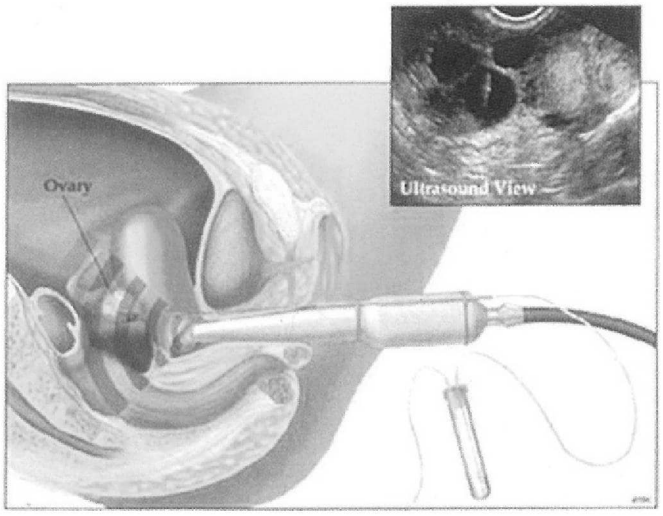
SYMPTOMS & SIGNS

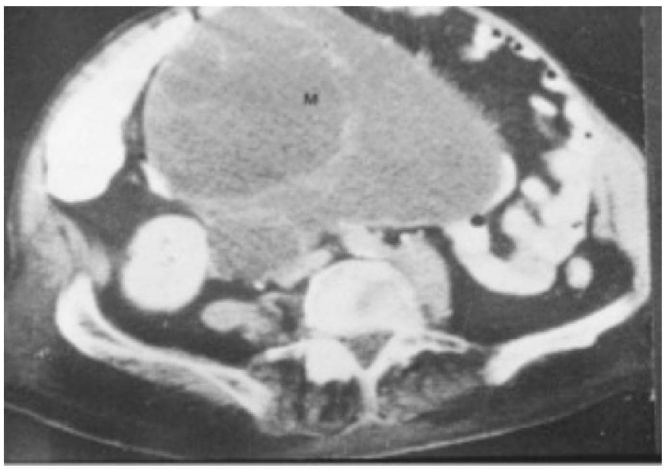
The symptoms of ovarian cancer are fairly nonspecific and often occur when the disease is already spread throughout the abdominal cavity. Abdominal discomfort or vague pain, abdominal fullness, bowel habit changes, early satiety, dyspepsia and bloating are frequent presenting symptoms. Occasionally patient may present with bowel obstruction due to advanced disease. The signs include, palpable mass, ascitis, pleural effusion, neck nodes, per vaginal examination - mass palpable in fornices, per rectal examination may show involvement of the rectum

INVESTIGATIONS

Tumour markers : CA 125, after its initial discovery in early 1980s, it has been widely used as a marker for a possible epithelial ovarian cancer in the primary assessment of adenexal/ pelvic mass. But false positive results may derive from many conditions like peritoneal inflammation, such as endometriosis, adenomyosis, pelvic inflammatory disease, menstruation etc. Primary use of CA125 is to monitor chemotherapy response and detecting early recurrence. New other markers like mesothelin, HE4, VEGF, Interleukin 8 are under investigations. Tumour markers, ß-hCG, œ-fetoprotein and LDH can be used in diagnosis of Germ cell tumours of the ovary. None of these markers is useful for screening purposes.

ULTRASONOGRAPHY (USG) it is the primary test been advised in all adenexal masses. Sonography will determine origin & characteristic of the mass, homogenous solid mass, complex cyst , Nodularity or soft tissue thickening from walls of cystic mass, ascites or peritoneal nodules. Ultrasound doppler & trans-vaginal USG can help in detection of small ovarian tumours.





CT Scan abdomen & pelvis is the gold standard and widely used for the diagnosis as well as the staging of ovarian cancer. It can detect ovarian mass & its extent ascites, peritoneal nodules, mesenteric implants, lymphadenopathy and Involvement of small or large bowel.

MRI can detect ovarian mass & its extent but it has difficulty in detection of peritoneal mets, mesenteric & bowel implants.

Positron Emmission Tomography (PET Scan) used for staging of a disease and monitoring the chemotherapy response.

FNAC – (Fine Needle Aspiration Cytology) – Should not be done in clinically and radiologically diagnosed stage I and stage II disease. Please do not aspirate any ovarian cyst, as it causes spillage of tumour cells in the abdominal cavity and will lead to spread of disease in the abdomen.

USG / CT guided biopsy – Used as an out patient procedure to establish a diagnosis in stage III & stage IV ovarian cancer when the surgeon would like to give chemotherapy upfront to downstage the disease.

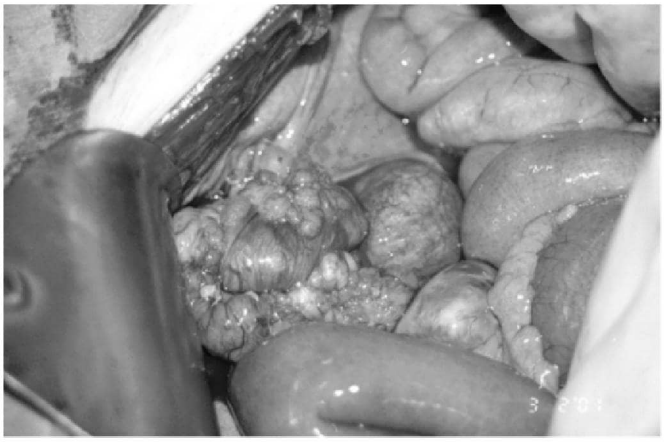
OVARIAN CANCER STAGING

Stage I—confined to the ovaries

Stage II—one or two ovaries with pelvic Extension

Stage III—tumor in pelvis but with metastases to abdomen (ascitis, peritoneal nodules, etc.)

Stage IV—distant metastases (pleural effusion, lung nodules, bone metastasis, etc



Ovarian Tumour

TREATMENT

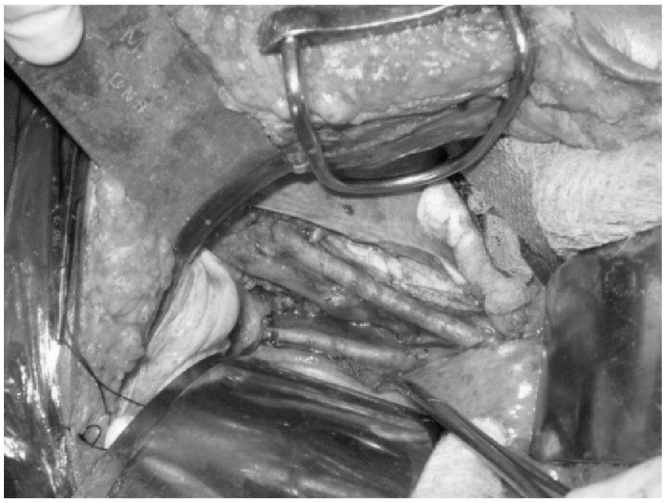
A) Surgery

B) Chemotherapy

A) Surgery

Surgery is the mainstay of ovarian cancer treatment. In **stage I & stage II** complete radical hysterectomy (includes removal of uterus and both ovaries, removal of pelvic lymphnodes and

omentum). **Complete surgical staging** (Peritoneal cytology, pouch of douglas, undersurface of diaphragm, surface of liver, serosal surface of bowel, peritoneal surface Pelvic & para-aortic nodes, omentum) should be performed. After adequate surgical staging nearly 30% patients are upstaged from stage I to Stage III. Rupture of the tumour should be avoided during primary surgery of Ovarian cancer confined to the ovaries. Removal of para-aortic lymphnodes removal when not involved is debatable in every case of ovarian cancer. The ongoing trials will tell us in near future regarding feasibility and effectivity of para-aortic node dissection.)



Pelvic Lymphadenectomy

For **stage III & stage IV** disease, Neo-adjuvant chemotherapy is given to reduce the tumour burden and it also helps to make the disease operable. In this type of treatment, first 3 cycles of chemotherapy are given and response is monitored. After assessing response patient is operated (radical hysterectomy). After surgery remaining 3 cycles of chemotherapy are given. In stage III disease primary cytoreductive surgery may be considered. **Cytoreductive surgery** is removal of primary tumour and metastatic disease as much as possible so as to leave behind minimal or no residual disease so that chemotherapy can act much better on this minimal metastatic residual disease. It also improves quality of life and immunological status of the patient. Chemotherapy will have much better effect when this hypoperfused masses are removed. This depends upon surgeons clinical judgment whether to do cytoreductive surgery upfront or neoadjuvant chemotherapy to downstage the disease upfront.

Conservative / fertility preserving surgery for early stage disease can be indicated in young women with low malignant potential tumours / well differentiated tumors (Stage IA)/ Germ cell tumors. Frozen section is essential for this procedure. Careful monitoring is required since recurrence rates in such cases are around 9%. Uterus & remaining ovary should be removed after completion of child bearing.

Laproscopy in ovarian cancer is not considered as a standard of treatment at present. It can be used as a diagnostic, extent of involvement, surgical restaging. Therapeutic interventions need to be investigated for oncologic adequacy and safety

B) Chemotherapy :

Cytotoxic chemotherapy has come a long way in the history of epithelial ovarian cancer. The introduction of platinum salts in 1970s was a path breaking discovery .Use of this drug in the therapy if ovarian cancer catapulted 5-year survival of this disease from 5 % to 15 %. Subsequently many new drugs came on horizon including drugs like paclitaxel, which form the corner stone of therapy of epithelial ovarian cancer.

Chemotherapy resonates at every stage of epithelial ovarian cancer .It is applied as neoadjuvant therapy ,given prior to cytoreductive surgery, as adjuvant therapy post surgery. Chemotherapy is indicated for all patients except stage IA,IB (low grade) tumors. Clear cell carcinoma even in stage IA advised chemotherapy as it is very aggressive tumor. The scientific evidence suggests that chemotherapy not only prevent chances of relapse, but also improves survival by 15 to 20%. In relapsed setting, where surgical options are limited, chemotherapy continues to play a major role on therapy of these patients.

There are newer concepts evolving in the field of

oncology and ovarian cancer is no exception! With the rapid understanding of oncogenesis, antiangiogenic approaches are exploited. The recent data has thrown some provocative results by addition of antiangiogenic agents like bevacizumab to conventional cytotoxic in improving relapse free survival, especially in subotimally-debulked disease. Their newer approaches and drugs, which are in various phases of clinical trial and should expand therapeutic options for this highly mortiferous illness.

SURVIVAL

5 Year survival

Stage I	90%
Stage II	70 - 80%
Stage III	20 – 30%
Stage IV	15%

CONCLUSION

Symptoms of ovarian cancer are nonspecific and more than 80% of the patients are diagnosed in stage III/ IV disease. The predominant use of CA 125 is to monitor chemotherapy response and detecting early recurrences. The first step in the management of ovarian cancer is an accurate diagnosis and thorough staging, with optimal surgical cytoreduction of metastatic disease. Platinum / taxane combination therapy yields in better responses in majority patients of ovarian cancer. With the newer treatments cure rates are improving and mortality, morbidity from the treatment has come down considerably. Numerous avenues are being pursued to identify new systemic therapies for this disease.

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NABH ACCREDITATION SEMINAR : 21stFeb. 2017

IMA-HBI-NABH Initiative
Date: 21stFeb. 2017
Attendance: 122
Joint Seminar in association with IMA Kalyan
Dr. Mangesh Pate & Dr. Jayesh Lele
Convener: Dr. MeenaPruthi

Consult the Expert
GI Super Specialist (Gastro Surgeon)

YASH
Superspeciality Clinic

Gastroenterology & Cancer Surgery Centre

Dr. Bhushan Bhole

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- ✧ Abdominal / GI Cancers
- ✧ Piles, Fissure, Fistula

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Timing : Mon. to Sat. 6 p.m. to 9 p.m.
Attached to **Lilavati Hospital**, Bandra - By Appointment only.
For Appointment Call : + 91 - 9167097059

FIRE SAFETY NORMS

Dr. Sangeeta Dandekar
Editor, Dialogue

(All the data given below is with courtesy from Mr. Dilip Gund, Fire Officer Kalyan.)

Over past few years much has been talked about fire N.O.C. and the rules and regulations about fire safety measures applicable to smaller hospitals. Even today the ambiguity still exists as to what are the mandatory norms which have to be followed.

In the first place why this issue of fire N.O.C. came up? You will come to know about the gravity of the problem if you read the following news about the major fire disasters in recent past.

August 2011: Fire accident in Psychiatry hospital in Tamilnadu claimed 28 lives.

December 2011: Amri hospital Kolkata 90 dead in fire blaze. Majority of deaths are due to asphyxia due to smoke.

The road leading to the hospital was very narrow and therefore fire fighting engine could not reach the spot. One engine has reached closest to the hospital and they are trying to douse the fire from the distance.

August 27, 2016 : Three people have been killed and 50 children injured in a fire broke out at the Murshidabad Medical college and hospital in West bengal. The dead included one new born, one relative of a patient and one staff member of the hospital. The fire started from an air conditioning unit, sparking panics among the people who ran out in panic, leading to near stampede.

October 19, 2016 : 80% government hospitals in Delhi don't have fire safety measures in place. Overcrowding, lack of trained manpower and poor maintenanceore other problems that put the city hospitals at risk.

In government hospitals deficiencies in compartmentalization to prevent spread of smoke and fire, lack of smoke management system and unreliable fire management system were noticed during the review after Amri fire in kolkata in 2011. Some of the hospitals have not addressed these problems even today.

However almost all private hospitals have the basic fire safety measures in place and maintain them.

CAG reported that emergency exit gates were locked, many gates and doors were locked, fire safe doors were not according to the standards and fire systems were not functional in many big hospitals like RML and DDU hospitals in Delhi.

OCTOBER 17, 2016: A blaze engulfed a high profile SUM hospital and medical college in Bhubaneshwar, killing 22 people, more than 40 in critical condition were admitted to different hospitals. Reports suggest that Fire saftey mechanisms were not in place here despite a warning issued three years back, when the fire audit was conducted.

The National Human Rights Commission (NHRC) issued a notice to government of Odisha, over a fire incident at SUM hospital in Bhubaneshwar.

The hospital owner of SUM hospital Bhubaneshwar Mr. Manoj Nayak was ARRESTED along with five other officials from hospital management.

The Director of Fire services gave valuable inputs after this event in an interview given to television channels. He has given many important comments on this issue and has discussed various aspects of it in details which are briefed here as follows:

INTERVIEW WITH DR. D. C. MISHRA DIRECTOR OF DELHI FIRE SERVICE AFTER BHUBANESHWAR INCIDENCE:

"We don't learn much after any incidence. We have not learnt anything after Amri Hospital, Kolkata Fire Incidence of 2011 when 90 people had lost their lives.

National Building Code of India 2005, has put forth important fire safety norms which should be stringently followed in the structures of newly built hospitals and other buildings like shopping malls and other multistoreyed buildings.

Number of patients admitted should not exceed the admission capacity of the hospital.

Add ons in the hospitals situated in old buildings increase the risk of fire manyfolds.

Structural changes should be made in old buildings of big hospitals to make them fire safe.

Smoke management should be effectively made.

Means of egress should be liberally made. Stair cases should not be included in calculation of FAR and should not add to tax liability. This will encourage construction of multiple stair cases which in turn will facilitate entry of fire brigade people and will also help in evacuation process should the mishap take place unfortunately.

Number of entrants to the premises should be restricted and should be within the expeced capacity of the premises. This will prevent panic and stampede in case fire accident occurs.

Fire brigade people can enter speedily without any hindrance.

To fight fire externally with the help of fire engines is not possible beyond 20-21 floors. Internal arrangement is necessary in cases of buildings taller than this. Sprinkler systems should be installed in buildings taller than 20 floors. The ceiling height should not be to low and should provide good natural venting.

There is 97% shortage of fire stations in India. 65% shortage of vehicles. Due to heavy traffic on the roads time of arrival or response time of fire brigade is increasing."

All these shortcomings will have to be tackled to minimise the fire mishaps and to manage the fires effectively and successfully should any arise.

Along with the above references Mr. Dilip Gund has also given his inputs and has guided us over the fire safety rules which we need to follow and are included on next page.

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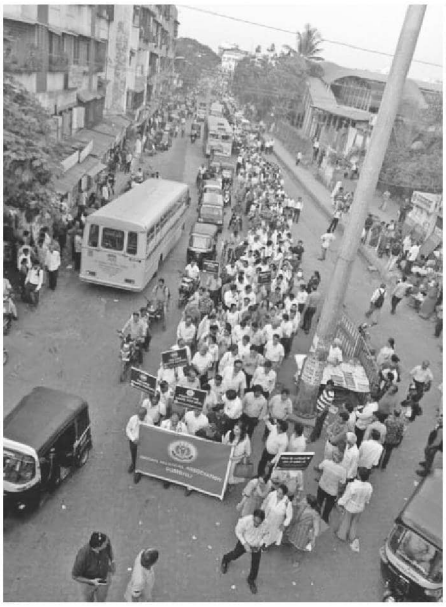
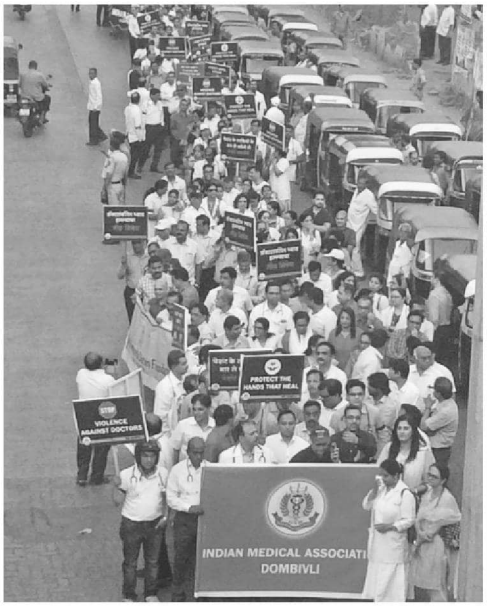
IMA DOMBIVLI : AGITATION AGAINST VIOLENCE : 22nd to 24th March 2017





Silent protest march lead by IMA Dombivli along with IDA,
NIMA, DHRPA & Ayurved Vyaspeth & IMA Kalyan on 23rd March 2017
More than 1000 members participated in the rally

Installation Ceremony - Executive Team 2016-17

Blood Donation Drive on 3rd July 2017

Doctors Day Celebration on 3rd July 2017

Inauguration of EICP - Dr. Anand Nadkarni's session for Parents _ Teachers of Teenagers

Third Rural Health Camp at Village Mhaskal

Tree Adoption Project

Dr. Archana Pate Won with thumping majority of 8222 votes to secure No. 4 position at the MMC Elections held in Dec 2016

IMA Dombivli - MMC Regn Renewal Assistance Drive

महाराष्ट्र आग प्रतिबंधक व जीवसंरक्षक अधिनियम २००६ व नियम २००९ – हॉस्पिटल सुरक्षितता

दिलीप नागनाथ गुंड

मुख्य अग्निशमन अधिकारी
कल्याण डोंबिवली महानगरपालिका
मो. न. ९८२०४५२४६६

हॉस्पिटलमध्ये रुग्ण उपचारासाठी येत असतात. क्वचीत अपरिहार्य परिस्थितीमध्ये रुग्ण दगावतात. तथापी, आग, धूर व आपत्कालीन परिस्थितीत रुग्ण अथवा हॉस्पिटलमधील कोणतीही व्यक्ती दगावणे योग्य होणार नाही. त्यासाठी हॉस्पिटलमध्ये अग्नि सुरक्षितता व अग्नि प्रतिबंधक दोन्ही बाबी करणे आवश्यक आहे.

अग्निशमन कायदा व हॉस्पिटल याचा संबंध कलकत्ता हॉस्पिटल आग सन २०११ पासून प्रकर्षाने आला. हॉस्पिटल इमारत व अग्निसुरक्षा याचा एनबीसी, डी.सी. रुल, अग्निशमन कायदा असा संबंध पूर्वीपासून आहे. परंतू, बहुतांशी हॉस्पिटल इमारतीमध्ये नसून वापर बदल केलेल्या इमारतीमध्ये म्हणजेच निवासी इमारतीमध्ये असतात. त्यामुळे अग्निशमन कायदा व हॉस्पिटल यांची सांगड घालण्यासाठी अडचणी आहेत. तरीसुद्धा कार्यरत हॉस्पिटलमध्ये साधारण यंत्रणा म्हणजेच हायड्रंट सिस्टिम, फायर एक्स्टींग्युशर तसेच डिटेक्शन सिस्टिम, स्प्रिंक्लर इत्यादी आवश्यक आहेत. तसेच बांधकाम व्यवस्था, मार्गिक या अग्नि प्रतिबंधक योजना आवश्यक आहेत.

या सर्व यंत्रणा आवश्यक आहेत का ? शक्य आहेत का ? निश्तितच नाही. मुळात यंत्रणा इमारतीचे प्रकार, आकारमान व उंची यानुसार निश्चितच होतात. परंतु बहुतांशी हॉस्पिटल वापर बदल केलेल्या निवासी इमारतीमध्ये असल्याने, त्याचे आकारमान कमी प्रमाणात असल्याने कायद्यानुसार यंत्रणा सुचविताना प्रकरणनिहाय निर्णय घ्यावे लागतात. ही वस्तुस्थिती आहे.

अग्निशमन ना हरकत दाखला/अभिप्राय याचे नूतनीकरण करावे का? नूतनीकरण करावे अथवा नोंदणीकृत अग्निशमन यंत्रणा बसविणाऱ्या एजन्सीकडून आपल्या हॉस्पिटलमध्ये बसविलेली अग्निशमन यंत्रणा तपासून, कार्यान्वित करुन अधिनियम तरतुदीनुसार सहामाही ब प्रमाणपत्र अग्निशमन विभागाच्या फीसह सादर करावे.

डोंबिवली शहर व परिसर येथे अग्निशमन यंत्रणा बसविणाऱ्या स्थानिक नोंदणीकृत एजन्सी खालीलप्रमाणात आहेत.

१) मे. महावीर एजन्सी – ०९८२०४८८५२९

२) मे. इंटिग्रल एजन्सी – ०९२२३५०००८८

३) मे. फायर इंडिया एजन्सी – ०९८९२१७९२०४

अथवा www.mahafireservice.gov.in या संकेतस्थळावरुन एजन्सीची माहिती घेऊन अग्निसुरक्षादृष्टीने कार्यवाही करावी. अग्निशमन यंत्रणा पुरवठाधारक एजन्सीकडून सदरची यंत्रणा चालविण्याची माहिती घ्यावी, वेळोवेळी सराव करावा, आपत्प्रसंगी बाहेर सुरक्षित स्थळी पोहचण्याचा व रुग्णांना हालविण्याची कवायत करावी. (Evacuation Mock Drills) विद्युत जोडण्या व उपकरण उच्च प्रतिचे असावेत.

अग्निसुरश्रा सप्ताह २०१७ घोषवाक्य

"FIREMAN-YOUR PARTNER FOR SAVINGLIFE AND PROPERTY"

'फ्रफायरमन – जीवन और संपत्ती को बचाने में आपकी साथी'

'आपले जीवन व संपत्ती वाचविणारा खरा सोबती–अग्निशमनफ

कृपया आपत्प्रसंगी अग्निशमन व आणिबाणी विभागास संपर्क करावा.

१) ०२५१–२४७०३५७/२४००४४७/२३६५१०१/२३१५१०१ /२३१०१५५

२) ०९००४३४५१०१/७७९८१२५३०९/९०२९५४६५१२ /७४९८३३२४७२

Ignite the real"fire"in your mind. Then no fire in the world would be hard to extinguish.

•••

घरबसल्या

डॉ. प्रमोद बेजकर
एम.बी.बी.एस. डी.सी.एच

गेली ३३ वर्षे जनरल प्रॅक्टीस, २५ वर्षे कविता, गीत, लेखन. लोकसत्ताच्या बालरंग पुरवणीत आरोग्य विषयक लिखाण, हास्यरंग पुरवणीत अनेकदा विनोदी साहित्य प्रकाशित.
हिंदी, मराठी गाण्यात आल्बम, काही मराठी चित्रपयांसाठी गीत लेखन.

मला आपल्या देशाबद्दल प्रचंड म्हणजे प्रचंड प्रेम आहे, आणि येता जाता भेटेल त्याला हे सांगितल्याशिवाय मला चैन पडत नाही. मी असं उतू जाणारं देशप्रेम दाखवलं कि माझा खवचट मित्र नन्या मला लगेच म्हणतो, 'म्हणजे काय, आम्हाला देशाबद्दल प्रेम नाही असं तुला वाटतयं का ? पण तुझ्यासारखं आम्ही ते सारखं बोबंलून सांगत नाही.' 'हे बघ नन्या, तुझं लग्न झालं नाही त्यामुळे तुला कळणार नाही. पण आपलं बायकोवर कितीही प्रेम असलं तरी रोज आय लव्ह यू म्हटलं नाही तर बायकोला प्रेम कमी झाल्यासारखं वाटत, त्यामुळे ही रोज रोज देशप्रेमाला कल्हई लावायची सवय लागलीये.

माझी देशभक्ती खरंच अस्सल आहे. या देशप्रेमामुळेच मी कधीही परदेशाच्या भूमीवर पाय ठेवलेला नाही. मला परदेशी जायला आवडत नाही, असं नन्याला लाख वाटू दे, पण खरी बाब हि आहे की मला तिथे एक दिवसही चैन पडणार नाही, आणि 'ने मजसी ने परत मातृभूमीला' म्हणत मी रात्र जागवीन याची मला खात्री आहे. १५ ऑगस्ट आणि २६ जानेवरीला उपवास करणारा अख्ख्या भारतात एकमेव मी असणार हे नक्की. पूर्वी वाटायचं की मीच खरा राष्ट्रप्रेमी आहे. पण हा भ्रमाचा भोपळा हळ्हीहळ्हीच फुटला.

व्हॉट्स ॲपमुळे आपल्यासारखे बरेच देशभक्त महाभाग आहेत हे मला समजलं. आम्ही आमचा आता एक ग्रूपच बनवला आहे. ५६ इंच छाती असल्याशिवाय तिथे मेम्बरच होता येत नाही. शरीफ आणि कम्पनीची आम्ही रोज इतकी खिल्ली उडवतो की त्यांना मराठी येत असतं तर ते सारे पाकी नक्कीच खजील झाले असते. त्यांनी सीमेवर हल्ला केला की आम्ही ग्रूपवर असा काही शाब्दीक प्रतिहल्ला केला की त्यांची पळता भुई थोडी होते. दुसऱ्या दिवशी 'पाक सैन्याची माघार' हा मथळा पेपरात अगदी नक्की ठरलेला.

शहीदांसाठी आम्ही पूर्वी रस्त्यावर कॅण्डल मार्च काढायचो. आता ग्रुप झाल्यामुळे एवढा वेळ काढायला लागत नाही. आम्ही ग्रूपवरच कॅण्डल पेटवतो.

आता काय काय टेक्नॉलॉजी निघालीय. आम्ही अखंड भारताचा नकाशा बनवलाय. त्यात आपल्या आजुबाजूचे सारे देश, अगदी चीनसह आपलेच म्हणून दाखवलेत. पण आमचा निषेध करायची कोणाचीच अजून हिम्मत झाली नाहीये, त्यावरुन आम्ही किती पॉवरफूल आहोत ते लक्षात येईल. मधून मधून आम्ही पाकिस्तानचा ध्वज सहज गंमत म्हणून जाळतो. आम्ही सकाळी गुड मॉर्निंग वगैरे मेसेज पाठवत नाही. सकाळी एकजण 'भारत माता की' असे मेसेज पाठवतो, की आम्ही सारे 'जय' असा बोल्ड अक्षरात प्रतिसाद देतो. माझ्या अंगावर त्यामुळे रोज सकाळी रोमांच फुलतात. नवीन टेक्नोलॉजीला कोणी काहीही शिव्या देवोत, पण इतकं सारं देशप्रेम घरी बसून नाहीतर कसं काय शक्य झालं असतं ?

आता स्वतःबद्दल सांगायला बसलोय तर सांगूनच टाकतो. मला लहानपणापासून गरीबांचा प्रचंड कळवळा. मला तेव्हा जर कधी चुकून चार पैसे मिळालेच तर त्याची लिमलेटची गोळी किंवा ग्लुकोज बिस्कीट आणून मी गट्टम करायचो. कारण तेव्हा आम्हीच गरीब होतो. नंतर नंतर आम्हाला गरीब म्हणून घ्यायची लाज वाटल्याने आम्ही स्वतःला नवश्रीमंत समजायला लागलो. त्यामुळे गरीबांना मदत कशी करायची हा मोठाच प्रश्न मला पडला होता. पण आता मी गरीबांबद्दल प्रचंड कळवळा दाखवणाऱ्या आणि श्रीमंतांना शिव्याशाप देणाऱ्या कविता वरचेवर व्हाट्स ॲपवर टाकून माझे सामाजिक कर्तव्य पार पाडतो. ज्येष्ठ नागरीकांचे हाल मला बघवत नाहीत. त्यांना मोफत औषधोपचार मिळावेत म्हणून मी व्हाट्स ॲपवर चळवळ उभारलीये. मी बालरुग्णतज्ञ असल्यामुळे मला हा पुळका आल्याचं नन्या म्हणत असला तरी त्यात काही तथ्य नाही.

माझं कवितेचं प्रेम सर्वश्रुत आहे. त्यामुळे लोक मला टाळत असले तरी मला कविता करायचा प्रचंड सोस आहे. मला कविता करण्यात जेवढा आनंद मिळतो, तेवढाच आनंद माझ्या कविता साभार परत पाठवण्यात संपादकांना मिळतो. त्यातून मी आता मार्ग काढलाय. माझ्याच कविता मी संत तुकाराम, कुसुमाग्रज, भट यांच्या नावावर ग्रुपवर टाकतो. सारेजण न वाचताच माझ्या नावाने वाहवाचा गाजर करतात, तेव्हा मला साऱ्या संपादकांवर सूड मिळवल्याचा आनंद मिळतो.

प्रासंगिक कविता करण्यात तर माझा कुणी हात धरु शकत नाही. 'नको तिथे गळू, आता कसा पळू?' हे मॅरेथॉनच्या दिवशी लिहिलेलं काव्य वाचून कित्येकांच्या डोळ्यात पाणी आलं होतं. 'त्याचसाठी सोडले मेसेज मी अर्थतज्ञ माझे, बायकोने भाजले होते घरी बोंबील ताजे' हे गटारीच्या दिवशी लिहिलेलं चमचमीत काव्य तर लोकांनी चकण्याबरोबर एन्जॉय केलं होतं.

हल्ली मी तसा निवांतच. दोन्ही मुलांचं इंग्रजीत व्यवस्थित शिक्षण झालं असल्यामुळे माझं मराठी प्रेमही उफाळून आलय. मराठीतून शिक्षण कम्पलसरी करावं म्हणून मी तावातावाने चर्चा करतो.

एकूण काय, या व्हॉट्स ॲपचे माझ्यावर अनंत उपकार आहेत. ते नसतं तर देशप्रेम, सामाजिक बांधिलकी, कवितेची हौस, मराठीचं प्रेम आणि असंख्य गोष्टी मी घरबसल्या कशा काय करु शकलो असतो ?

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AROGYADEEP

'Arogyadeep – Directory of medical services in Dombivli' is an ongoing community project of Rotary Club of Dombivli East.

That's how this 4 th edition was released on 26 th March. Considering the recent needs and overall wide use of mobile phones, android based mobile application was also launched along with this edition.

The editorial board has made genuine efforts to include all the medical facilities in and around Dombivli in this book and App. But the participation by doctors being voluntary, few have not responded.

Area wise groups of general practitioners and index as per the surname is also provided so that one is able to locate desired doctor immediately.

As the App will become popular, the printed book may not be required in future. The ease, access and ability to edit and to add data in app will help to keep this app usable for a longer period of time.

In short, the book and the app are equally useful to general public and also the medical fraternity. The cost of book is Rs.100 only and the app is available for free download from Google store.

Contact for book - 7738249797/ 9820689154

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एक आठवण

डॉ. मृदुला इंगळे
एम्.डी. (पीडियाट्रिक)

बालरोग तज्ञ.
आय.एम.ए. प्रेसिडेंट डॉ. हेमराज इंगळे यांच्या पाठीमागे ठामपणे उभी राहून त्यांना साथ देणारी त्यांची सुविद्य पत्नि.

आपणा सर्वांच्या मनात आठवणींचे एक पुस्तक जरुर असतं. काहींची छोटी तर काहींची मोठी. हे पुस्तक आपणच आपलं वाचत असतो. काही बोध त्यातून घेतो किंवा ते अनुभव आपल्या जवळीकांना सांगतो.

अशाच माझ्या आठवणीतल्या पुस्तकातलं एक पान आपणासोबत मी शेअर करणार आहे.

'आओ गाव चले' चा पहिला कॅम्प. शनिवारी रात्री मी कॅम्पला जायचं ठरवलं. रविवारी सकाळी सात वाजता चार रस्त्याजवळ भेटायचे ठरवले होते.

सकाळी जेव्हा मी चार रस्त्याजवळ गेले तेव्हा आश्चर्यचकीतच झाले. माझ्या आधी सर्व डॉक्टर्स हजर होते. काही तर अर्ध्या तासापासून आलेले होते. वेळेचं महत्त्व पाळणं हे डॉक्टरांच्या यशाचं पहिलं गुपित मला कळलं.

सहा डॉक्टरांनी कार पुलिंगचे सहकार्य केले. सर्व मिळून २४ जण जमलो. सकाळच्या त्या उत्साही वातावरणात ६ गाड्या पाठोपाठ निघाल्या.

आम्ही मुरबाड जवळच्या मामणोली गावात गेलो. तिथे हिंदू सेवा संघाचे कार्यकर्ते जगे यांनी आमचे स्वागत केले. सर्वांनी पोहे व चहाचा नाश्ता केला. जगेंनी आम्हाला ती जागा दाखविण्यासाठी नेले. तिथे आदिवासी मुलांसाठी शाळा व वसतिगृह आहे. वसतिगृहातली यी मुलांची दिनचर्या व व्यायामाला दिलेले महत्त्व ऐकून बरं वाटल. काही कारणास्तव जी मुलं घर सोडून जातात अशा मुलांचा हि संस्था सांभाळ करते व मानसोपचारतज्ञ व त्यांचे कार्यकर्त्यांतर्फे मुलांची समजूत घालते व मुलांना परत आईवडिलांकडे पाठवते. हे सर्व बघून समाजकार्य करणाऱ्या या संस्थेबद्दल अभिमान वाटला.

निसर्गाच्या सानिध्यातल्या या जागेत आमराई, वाटिका, बोरांची व करवंदाची झाडं, झाडांच्या फांदीवर बनवलेला झोका या सर्व गोष्टींनी मन प्रसन्न झाले.

तिथे त्यांनी विद्यार्थ्यांसाठी नवीन हॉल बांधला होता. त्याचे उद्घाटन IMA Dombivli तर्फे करण्यात आले. रुग्णांची तपासणी सुरु झाली. थोड्याच वेळात लाईट गेले. एप्रिल महिन्याच्या त्या उष्णतेत सर्वजण घामाघूम झाले तरी 2½ तास बिना फॅनने sincerely आपापले काम करीत होते. डॉक्टर्सच्या या sincerity ला माझा सलाम.

आम्ही सर्व जणांनी जमिनीवर जेवणाचा आस्वाद घेतला.

शेवटी सर्वांनी मिळून एक Group Photo काढला. अशा प्रकारे सर्वांच्या सहकार्याने कॅम्प सुरळीत पार पडला.

माझ्यासाठी हा कॅम्प म्हणजे एक छोटी सहलच झाली होती.

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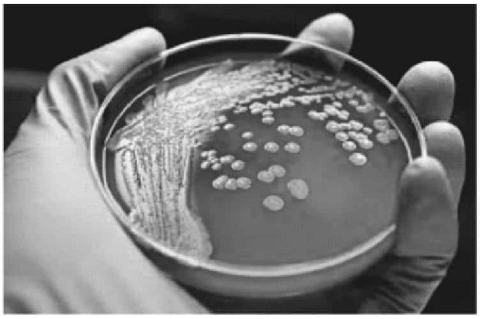
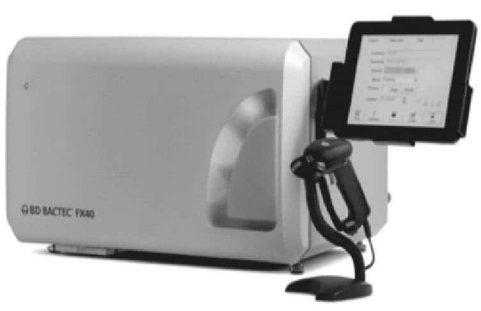



माझं काय चुकलं

डॉ. घनःश्याम शिराळी

Completed post graduation from LTMMC, Sion and then worked as Fulltime Lecturer & Asssociate Professor for 10 years in same college.
Practicing ENT Surgery in Dombivli for last 24 years.
President of Association of Otolaryngologists of India (AOI), Kalyan branch (2015-17)
Has Passion for community service, active Rotarian since 2004

''डॉक्टर तुमच्यासाठी कॉल आहे.''

रात्री 8.30 च्या सुमारास टिटॅनस वार्डमध्ये tracheostomy संपवून post-op orders लिहीत होतो तेवढ्यात कॅज्युल्टी वॉर्डबॉयने आवज दिला.

कॉल घेतला. '75 year old male - epistaxis.'

'पेशंटला वॉर्डमध्ये सोडलाय', वॉर्डबॉय म्हणाला.

जवळजवळ पळतच मी निघालो. टिटॅनस वॉर्ड पहिल्या मजल्यावर एका कोपऱ्यात तर ई एन टी वॉर्ड तळमजल्यावर दुसऱ्या कोपऱ्यात.

पळाता पळात डोक्यात चक्र. 75 वर्षे म्हणजे hypertension, posterior bleeding, anterior packing ने bleeding न थांबल्यास postnasal Foleys, postnasal packing under GA, मेडिसिन लेक्चररला कॉल, ब्लड फॉर ग्रुपींग क्रॉसमॅचींग....

वॉर्डमध्ये पोचलो. पेशंट profusely bleeding. टिपिकल हिस्टरी Known Case of hypertension not taking medicines for last 3 months.
पल्स पाहिली, bounding, tachycardia. चलो हायपो तरी नाही अजून. सिस्टर ने पॅकींगची तयारी केली होती. Anterior nasal packing केल. बी. पी. 230/130.

Head raised पोझिशन दिली. थोडा postnasal trickle होता तोही थांबला. स्टॅड्रीन इंजेक्शन दिलं. मेडीसीन लेक्चररला फोन लावला. त्याच्या advice प्रमाणे ट्रीटमेंट चालू केली. ब्लड कलेक्शन करुन पाठवून दिले आणि थोडासा विसावलो.

'डॉक्टर जेवायला जा. 10 वाजले, 10.30 ला बंद होईल.' सिस्टर म्हणाली. या सगळ्या गडबडीत दिड तास कसा गेला समजलेच नव्हते.

R M O's Strike चालू होता. मेस बंद होती. फुलटाईम डॉक्टरांसाठी पेईंगवॉर्डमध्ये जेवणाची व्यवस्था होती. तेथे गेलो तर कुणीच नव्हते. जेवायला घेतले तेवढ्यात लेक्चरर आला. जेवता जेवता म्हणाला 'तुमच बरं आहे, ई.एन.टी. मध्ये ईमर्जन्सी नसते.' आलेला राग तोंडातल्या घासाबरोबर गिळून मी तिथून निघालो.

त्याला कारणही तसेच होते. आर.एम.ओ. स्ट्राईकमध्ये सगळे फुलटाईम डॉक्टर राबत होते. सायन हॉस्पिटलच्या ई.एन.टी. डिपार्टमेंटमध्ये त्यावेळी एकच युनिट आणि मी एकटाच लेक्चरर. माझ्यावरती तीन Honorary डॉक्टर आणि खाली 3 Residents. Honorary डॉक्टरांनी सकाळी 8 ते दुपारी 2 ही वेळ तिघात विभागून घेतली होती. माझी ड्यूटी दुपारी 2 ते दुसऱ्या दिवशी सकाळी 8 पर्यंत..... 18 तास.

सर्जरी डिपार्टमेंटमध्ये 6 युनिट एक फुलटाईम प्रोफेसर, 3 असोसिएट प्रोफेसर आणि 6 लेक्चरर असा ताफा होता. मी आठवड्याचे 7 ही दिवस राबत होतो तिथे सर्जरी लेक्चररला 2 च दिवस पूर्णवेळ काम असे.

K E M आणि Nair हॉस्पिटलमध्ये देखील ई.एन.टी. डिपार्टमेंटमध्ये एक प्रोफेसर, एक असोसिएट प्रोफेसर आणि 2 लेक्चरर असे 4 फुलटाईमर होते.

ई.एन.टी.त इमर्जंसी नसते हा देखील एक मोठा गैरसमज होता.

आजचीच गोष्ट घ्या. दुपारी दोन वाजल्यापासून 4 ट्रॅकिओस्टॉमी (2 ट्रोमा वार्ड, 1 बर्न्स आणि 1 टिटॅनस वार्ड), 2 फॉरेन बॉडीज (एक नाकातून बटन, कानातून पाखरु) CLW Pinna, bleeding dental socket, मेडीसीन वॉर्डमध्ये Ryle's tube टाकण्यासाठी कॉल. 5 मिनीटांची फुरसत मिळाली नव्हती. आणि हे सगळं single handedly. गेले दहा दिवस हे असच चालल होत. सगळ्या प्रकारच्या FBs मी काढल्या होत्या. डेंचर, मटन बोन, फिश बोन अन्ननलीकेतून, कानातून मणी, पाखरु, नाकातून शेंगदाणे वाटाणे चॉक वगैरे. हॉस्पिटल मुंबईच्या एन्ट्री पॉईंटला हायवेवर असल्याने ट्रोमा केसेस भरपूर त्यामुळे nasal, facial fractures, epistaxis अशा केसेस, कोळीवाड्यातून तलवारीने नाक कान कापलेली एक तरी केस रोज असायची. मॅस्टॉयड, abscess, कानदुखी, एपीस्टॅक्सीस यांचा स्त्रोत चालूच असायचा.

आणि लोक म्हणायचे कि इ.एन.टी. मध्ये इमर्जन्सी नसते.

स्ट्राईकचा अंत काही दृष्टीपथात नव्हता म्हणजे पुढेही हे असंच चालणार होत.

आतल्याआत धुमसतच मी वॉर्डमध्ये आलो. पेशंट सेटल झाला होता. ब्लीडींग नव्हते. पल्स आणि बी पी पण 180/100 वर आला होता. 10.30 वाजले होते. घरी बायकोला फोन लावला. आमच्या लग्नाला जेमतेम तीन आठवडे झाले होते. आठवडाभर बेंगलोरला जाऊन आल्यावर ती पुन्हा कारवारला गेली होती. तिथे job resume करुन relieving लेटर घेउन परत येईपर्यंत स्ट्राईक सुरु झाला होता. मुंबई ऑफीसला ती जॉईन झाली होती. मी सकाळी 9 ला घरी पोचेपर्यंत ती office ला निघालेली असायची. गेल्या 2 रविवारी 2-3 तास जी भेट झाली तेवढीच. त्याकाळी मोबाईल नव्हते. Operator ला नंबर देऊन कॉल लागण्याची वाट पहात होतो. नशीबाने कॉल लवकर लागला. एकमेकांचा दिवस कसा गेला हे बोलतच होतो तेवढ्यात Operator ने डिसरप्ट केलं. म्हणाला असिस्टंट डिनचा सिस्टरसाठी फोन आहे. मनातल्या मनात शिव्या देत फोन सिस्टरला दिला.

आता सगळीकडे सामसूम झाली. 30 कपॅसीटीच्या वॉर्डमध्ये 7 च पेशंट होते. पेशंटची जेवणं आटोपली होती. जेवणाचे रिकामे ॲल्यूमिनीयमचे ड्रम ट्रॉलीवरुन नेतानाचा घडघड आवाज आसमंतात घुमू लागला. तो विरतो न विरतो तोच 11 च्या ड्युटीवर येणाऱ्या, मेट्रनपाठून लगबगीने चालणाऱ्या बाबांच्या (स्टुडंट नर्सेस) सँडल्सचे टक टक टक टक आवाज येऊ लागले. पुन्हा सगळं शांत झालं. मधूनच लेबरमधल्या बाईची किंकाळी शांततेला चिरत गेली.

'डॉक्टर थोडावेळ रुमवर जाऊन थोडा आराम करा' सिस्टर म्हणली. रुमवर जाताच मिनीटात कॉल येणार हे ठरलेलं म्हणून वॉर्डमध्ये बसून राहिलो.

बारा वाजायला आले होते. अचानक लांबून खोकल्याची उबळ ऐकू येऊ लागली. 'आपला पेशंट आला वाटतं' मी सिस्टरला म्हणाले.

कॅज्युल्टी वॉर्डबॉय पेशंटबरोबर दाखल झाला. पन्नाशीतली पंजाबी बाई nonstop खोकत होती. बरोबर पंचविशीतलं जोडप (मुलगी आणि जावई). जेवणानंतर बडीशेप खाताना ठसका लागला तो खोकला 2 तास झाले तरी थांबतच नव्हता. सततच्या खोकण्यामुळे तपासणी कठीण होते. घशात लोकल ॲनेस्थिशियाचा स्प्रे मारुन तपासले. Gross काहीच नव्हते. Chest clear होती. तरी as a precaution एक्स रे साठी पाठवले.

पेशंट परय येईपर्यंत 2 वाजले होते. तेवढ्यात एक कानदुखीचा एक पेशंट येउन गेला होता. एक्स रे नॉर्मल होता. आता खोकलाही थांबला होता. मी त्यांना सांगितले '"Observation साठी ॲडमिट करा, सकाळी लवकर पाठवून देतो.'

It was a case of suspected F B in tracheobronchial tree. जेव्हा एखादी loose F B श्वासनलीकेत असते ती श्वासाश्वासाबरोबर हलत रहाते आणि सतत खोकला येतो. ती एका जागी settle झाली की खोकला थांबतो पण पुन्हा dislodge झाल्यास खोकला पुन्हा सुरु होतो.

पेशंटची तयारी नव्हती. ती दिल्लीहून मुलीकडे पाहूणी आली होती. घरी नवरा एकटा होता. मी बरेच समजावले. म्हटले घरी गेल्याबरोबर खोकला सुरु झाला तर परत पळत येणार. फक्त 4 तासांचा प्रश्न होता. 6 वाजता डिस्चार्ज देतो. पण ती काही ऐकेना. शेवटी नाईलाजाने म्हटले Agaist Medical Advise अशी सही करुन जा. तेव्हा जावयाने समजूत काढली आणि पेशंट एकदाची तयार झाली. ॲडमिशनचे सगळे सोपस्कार झाल्यानंतर मुलगी पेशंट बरोबर राहिली. जावई घरी गेला. 3.30 वाजले होते. मी तिथेच केबिनमध्ये टेबलावर डोकं टेकून झापलो. 'डॉक्टर, डॉक्टर' अशी हलकेच हाक मारल्याचा भास झाला आणि मला जाग आली. पेशंटची मुलगी खरोखरच हाक मारत होती. टाईम पाहिला तर 4.30 वाजले होते.

ती मुसमुसत मला म्हणाली, 'मम्मीको डिस्चार्ज दे दो.' मला समजेना एवढी काय घाई आणि रडतेय कशाला. विचारल्यावर ती म्हणाली 'पापाजी का एक्सीडंट हो गया है, ट्रोमा वॉर्डमे ॲडमिट किया है.' मी चक्रावलोच.

त्याचं असं झालं होतं, जावयाने घरी जाऊन सासूला ॲडमिट केल्याचे सांगितल्यावर सासऱ्याने हॉस्पिटलमध्ये जाण्याचा हट्ट धरला. ते दोघेही येत असताना हॉस्पिटल समोर हायवे क्रॉस करताना भरधाव ट्रकने सासऱ्याला उडवले.

मी ताबोडतोब ट्रोमा वॉर्डमध्ये फोन लावला. ट्रोमा लेक्चरर म्हणाला, 'पेशंट bad आहे, multiple fractures, depressed fracture skull, patient in deep coma, prognosis poor'
सुन्न मनाने डिस्चार्ज दिला.

6 वाजता पुन्हा ट्रोमा वॉर्डमध्ये फोन लावला. सिस्टर म्हणाली. "That patient expired." मनात काहूर माजलं.

पेशंटला admit केल नसतं तर पुढचं घडलं नसत. Admission जरुरी होती का ? मी केलेला विचार सयुक्तिकच होता. पेशंटच्या भल्यासाठी होता. त्यात माझा वैयक्तिक फायदा काहीच नव्हता. पुढे जे घडलं त्यात माझी काहीच चूक नव्हती. मनाची समजूत घालण्यात दिवस गेला. पुढच्या 4-5 दिवसात स्ट्राईक संपला.

Bonded लेबरमधून सुटका झाल्यासारखं वाटलं. आता घरी शांतपणे झोपता येणार होत.

पण....

पहिल्याच दिवशी पहिल्यांदा ती पंजाबी पेशंट स्वप्नात आली.

आणि त्यानंतरही अनेक वेळा.....अजुनही अधूनमधून येते....छाती बडवत म्हणते. 'तुझ्याच मुळे...तुझ्याच मुळे'

आणि मी दचकून जागा होतो.

आता तुम्हीच सांगा माझं काय चुकलं होतं ?

•••

NEW BORN HEARING LOSS AND COCHLEAR IMPLANT

Dr. Pradeep Uppal

Dr. Pradeep Uppal is a practicing ENT surgeon practicing at Thane since last 25 years. Having done his MBBS and M.S. from LTMC Sion, he stood first in all his ENT exams, namely DORL, DNB and M.S. and won Gold Medal. He is the recepient of prestegious Late Sir D.M.Seth Award of Mumbai University for his scholastic credentials. He has also won DR. Manubhai Mehta Prize of College of Physicians and Surgeons. For his original work on "Study Of Patients Presesnting with Throat Problems" he bagged Dr. S. G. Joshi Memorial Prize. His work is published in many international jornals.

He is the pioneer of Cochlear Implant programme in Thane city. He has done 50 implants so far. He was felicitated with Shri Sidhhivinayak Sushrut Puraskar for this work. He was also felicitated by noted poet Gulzar for the same cause. His name has also appeared in Limca Book of World Records for operating upon the youngest baby with orbital cellulitis. He was also nominated by Lokmat media as Icon of Thane.

Out of every 1000 births, 3-- 4 children are born with hearing defect. A vast majority of them remain deaf and mute whole life if not treated on time.

Today it is possible to offer them correction in the form of cochlear implant and if done on time, these babies can hear and speak and attend regular school and be in the mainstream like normal children. However very few can afford the high cost of the implant (about Rs 6 lacs) and hence are deprived of this corrective treatment. Forcing them to remain handicapped throughout life.

A lot of advances have taken place in the field of medicine to detect diseases early enough, so that we get the best outcome of our treatment. One abnormality (defect) which is badly neglected is hearing loss in newborn babies. Medical fraternity as well as society has ignored this important issue.

Some congenital diseases like Hypothyroidism, PKU, Galactosemia are routinely screened in new born babies. Hearing loss is 10 times more prevalent than the above diseases; still hearing screening is not done in our country!!!

Western countries follow universal **infant hearing screening program** which states that "Every baby has to be tested for hearing loss within 3 months of birth and intervention should be done in 6 months". In many parts of the USA, legislation is passed making it a law to perform tests for newborn hearing loss. As a result, these babies are detected and treated early for hearing loss , and therefore can speak like normal children and go to a normal school.

In our country, average age at which deafness is detected is 3-4 years (which is too late).At this age, even with the best treatment, babies cannot get normal speech and remain handicapped throughout the life.

This delay is due to lack of awareness and lack of facilities to do hearing tests in babies in India.

1) **WHY SHOULD A BABY BE TESTED SO EARLY FOR HEARING LOSS ?**

   Every baby is born with a speech center in the brain which teaches the baby to speak. This center is initially in a sleeping or inactive state. This center will get active only if sound enters the brain. If a baby is born deaf and parents do not realize it, then no sound will enter the brain and the speech center will remain inactive. If hearing loss is not diagnosed by 4-5 years of age, then no device or surgery can give the child normal speech. But if this same baby's parents identified his/her deafness early & started the treatment early, this child could develop normal speech and attend normal school.

2) **WHAT IS INCIDENCE OF HEARING LOSS IN NEWBORN BABIES ?**

   Approximately 3-4 newborns per 1000 have permanent hearing loss. Incidence is 20 times more in high risk babies i.e. babies who are admitted in NICU , babies on ventilators, babies with hyperbilirubinaemia (severe jaundice) and with family history of hearing loss.

3) **WHAT TESTS ARE DONE AND ARE THEY PAINFUL/SAFE ?**

Tests like OAE and BERA/ABR are available to identify hearing loss. These tests are simple and safe. Hearing can be tested even in a one day old baby. It is no longer necessary to wait until a child is old enough to take a formal hearing test in order to check for hearing loss. Two different types of hearing screening tests are used to screen hearing in babies. Both of these tests are safe and comfortable.

Otoacoustic Emissions

One of the tests is called otoacoustic emissions or OAEs. For this test, a miniature earphone and microphone are placed in the ear, sounds are played and a response is measured. If a baby hears normally, an echo is reflected back into the ear canal and is measured by the microphone. When a baby has a hearing loss, no echo can be measured on the OAE test.

Auditory Brainstem Response

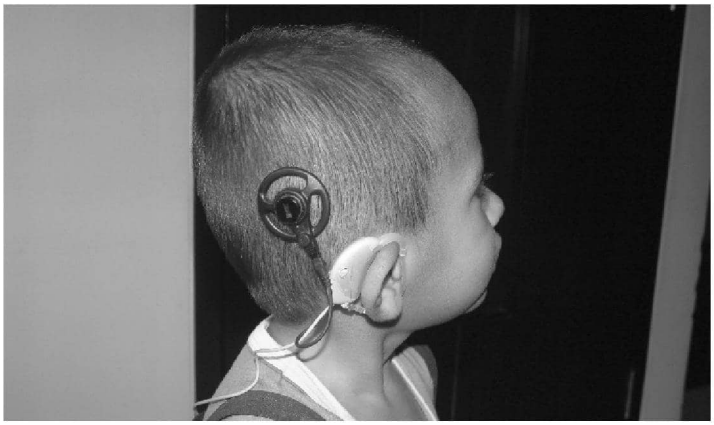
The second test is called the auditory brainstem response or ABR. For this test, sounds are played to the baby's ears. Band-aid like electrodes are placed on the baby's head to detect responses. This test measures how the hearing nerve responds to sounds and can identify babies who have a hearing loss.

The two tests can be used separately or together. In some hospitals, babies are first screened using OAEs. Babies who do not pass on the first OAE test can be given a second test using the ABR.

Both tests are reliable. Hospitals choose the type of screening tests that they use based on costs, personnel and the number of babies born.

4) IF HEARING LOSS IS DETECTED ..... WHAT NEXT???"

If a severe to profound hearing loss is detected, & hearing aid is not helpful then Cochlear implant is recommended.



5) WHAT IS A COCHLEAR IMPLANT?

Cochlear Implant is a small complex electronic device that can help to provide a sense of sound to the babies who are profoundly deaf. Cochlear implant has two components . 1-Internal component is Implanted is surgically placed under the skin behind the ear. 2-External component which is worn by the patient like a hearing aid. It has a microphone and a speech processor.

Even if babies are detected early, next problem is the treatment which is very expensive.

Cost of the cochlear implant is between 5-6 lakhs which is difficult to arrange even for well to do family.

Parents of these babies do not get help from society easily, as the handicap of these babies is not visible like blindness or cancer.

Now thane Municipal Corporation along with Dr Uppal ENT hospital has started a initiative EVERY EAR CAN HEAR, under this initiative every child who needs cochlear implant surgery is funded upto 4.5 lakh.

Surgery is done free at Dr.Uppal ENT Hospital.

• • •

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Date: 22ndJan 2017
Shubh Mangal Karyalaya
Attendance: 55
Faculty :
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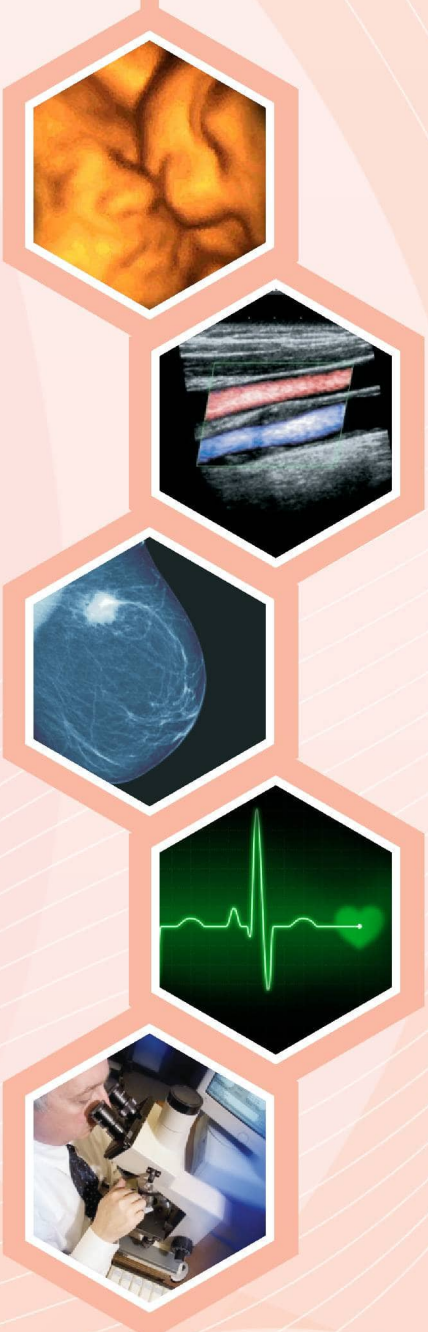

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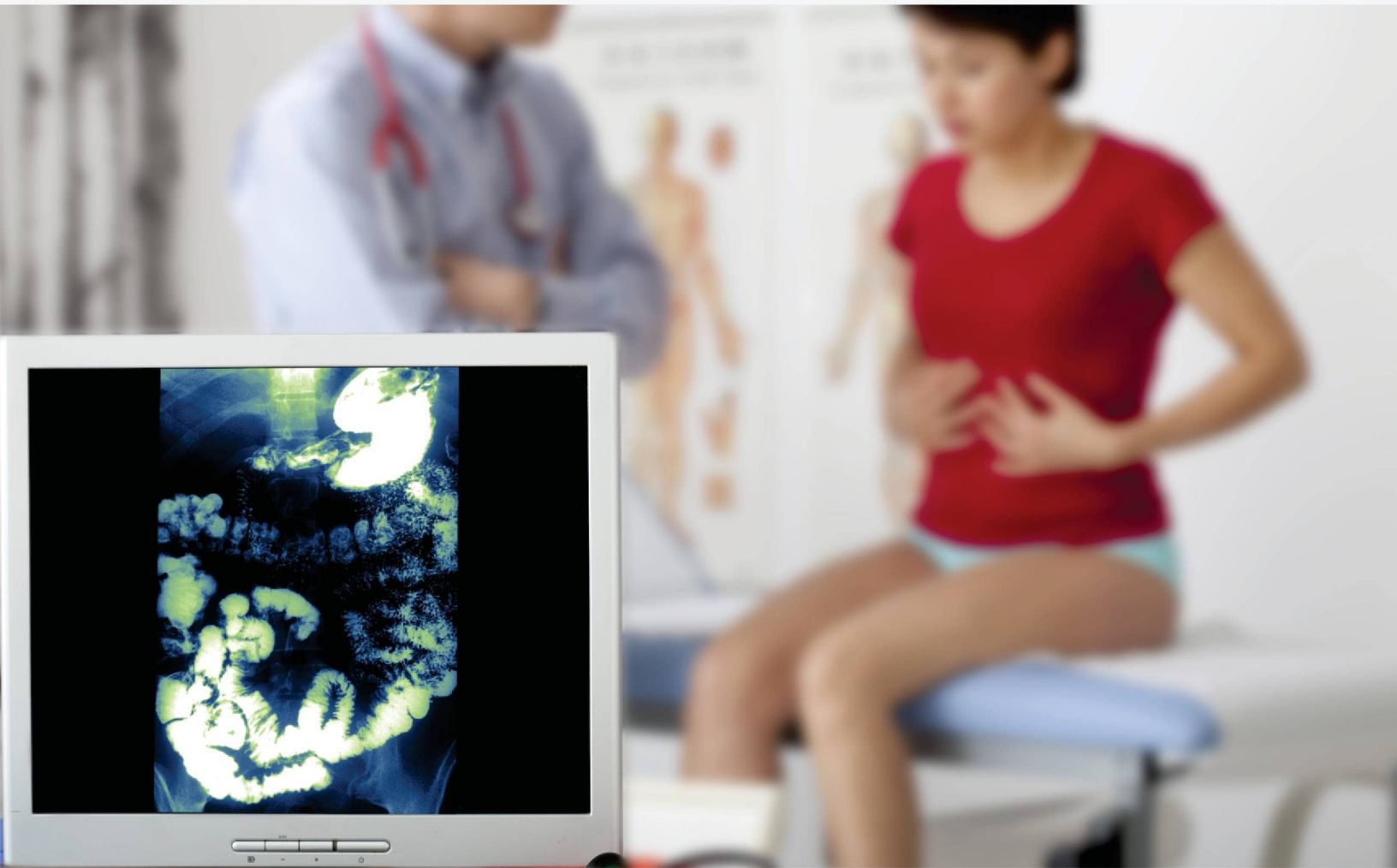

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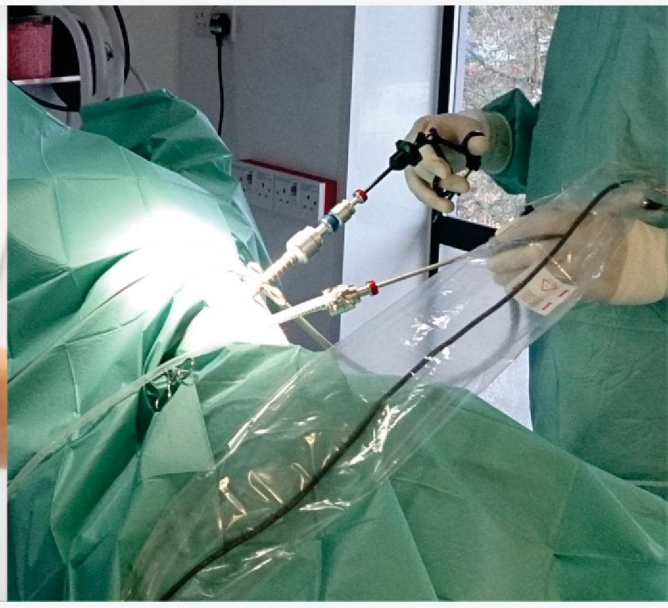

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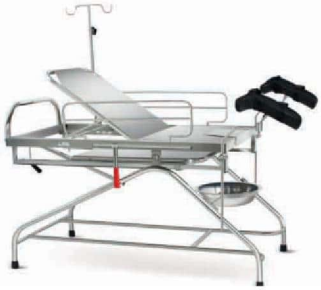

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माझ्या कविता

डॉ. सतीश अ. कानविंदे

प्रिय रसिक वाचक,

आज माझ्या चार कविता घेऊन मी आपल्या भेटीस येत आहे. या चार कवितांनी माझ्या डायलॉग मधल्या कवितांची पन्नाशी पूर्ण होईल. १९९२ साली डॉ. विजय नेगलूर यांच्याकडे डायलॉगचे संपादकपद आल्यानंतर त्यांनी डायलॉगमध्ये असे साहित्य घ्यायचे ठरवले आणि माझ्याकडे कवितेची मागणी केली. माझ्यासाठी तो एक आनंदाचा क्षण होता. जबाब नाही ही माझी डायलॉगमधली पहिली कविता. डॉ. नेगलूर यांच्यानंतर आलेल्या सर्वच संपादकांनी माझ्या कवितांना डायलॉगमध्ये मानाचे स्थान दिले. त्या सर्वांचा मी ऋणी आहे. माझ्या कविता आपल्यासारख्या रसिकांच्या पसंतीस उतरल्या हे माझे भाग्यच. डायलॉगमधील कवितालेखनाला पंचवीस वर्षे पूर्ण होत असताना कवितांची पन्नाशी होण्याचा हा दुग्धशर्करा योग आहे असेच मला वाटते. पुन्हा एकदा सर्वांचे आभार.

देव पावला नवसाला

आला जेव्हा पावसाळा
सुरुवात झाली पावसाला
देव पावला दुष्काळातल्या
शेतकऱ्यांच्या नवसाला

वाहू लागल्या नद्या आणि
विहिरी भरल्या पाण्याने
वातावरण जीवंत झालं
शेतकऱ्यांच्या गाण्यानं

पेरणी झाली, लावणी संपली
पीक वाढलं शेतातलं
स्वप्न जणू साकार झालं
शेतकऱ्यांच्या मनातलं

ढवळ्या पवळ्या शेतकऱ्यांचे
ताईत होते गळ्यातले
खुशीत आले धान्य पाहून
शेतकऱ्यांच्या खळ्यातले

गधडा पुन्हा जहाला

गधडा पुन्हा जहाला नापास एसेस्सीला
फुटके नशीब त्याचे कॉपी जमे ना त्याला
गधडा पुन्हा जहाला...

कोणता मी क्लास लावू ? पैसेच संपलेले
कुठलाच क्लासवाला घेईना आता त्याला
गधडा पुन्हा जहाला...

लाडात वाढला तो, हा भार त्यास मोठा
वाऱ्या करुनी हल्ली बारीक फार झाला
गधडा पुन्हा जहाला...

हासून त्यास कोणी करिती टवाळी त्याची
पंढरीस गेला नाही पण वारकरी तो झाला
गधडा पुन्हा जहाला...

बेवड्यात राया तुम्ही

बेवड्यात राया तुम्ही कसे गेला वाया
कसे गेला वाया

करुनिया खून काही, पचविले सारे बाई
करा तुम्ही माझ्यावर जीवापाड माया
बेवड्यात राया तुम्ही कसे गेला वाया

नाही ठसे नाही डाग,
काढीला ना कोणी माग
पोलीसांची शर्थ सारी गेला की हो वाया
बेवड्यात राया तुम्ही कसे गेला वाया

बेवड्याने झाला धुंद अवसान झाले मंद
जेलामध्ये जाल तुम्ही खडी हो फोडाया
बेवड्यात राया तुम्ही कसे गेला वाया

कामावर जायला

कामावर जायला उशीर जायला
येईना रिक्षेवाला एकपण येईना रिक्षेवाला

रिक्षावाला थांबलाय पण तो
रिक्षात माझ्या गॅस नाही म्हणतो
कम्प्लेंट केली तर साक्षीदार त्याचे येतील मारायला
एकपण येईना रिक्षेवाला

टी एम टी ची बस एक आली
बघता बघता भरुन गेली
धावू कसा मी ? चढू कसा मी ? पाय माझा दुखावला
एकपण येईना रिक्षेवाला

रातभर बापानं धमाल केली
झिंगून आला आणि शिवीगाळ केली
सकाळी सकाळी लागला डोळा, उठायला उशीर झाला
एकपण येईना रिक्षेवाला

रिक्षा नाही, बसही नाही
कामावर जाण्यात आता अर्थच नाही
घरी जातो नी झोपतो आता, तासभर फुकट गेला
एकपण येईना रिक्षेवाला

IF ONLY DHULE MEDICAL COLLEGE HOSPITAL WAS FOLLOWING SOPs AS PER ACCREDITATION NORMS

Dr. Sangeeta Dandekar
Editor, Dialogue

Friends you must have realized that I am talking about recent unfortunate incident leading to cruel beating and loss of eye of a young doctor, Dr Rohan mamunkar. You must also be thinking that I am crazy to correlate that with some irrelevant thing like accreditation. You might think I should rather go and educate people how to behave, avoid anger and destructive attitude. But friends mob psychology and bullying by hooligans is something which we can't make right. What we can deal with is only our side. And in this case the government side.

One who has erred in this case is the management of the hospital and that is the government. The consumer and service provider relationship very much exists even in government hospitals as it does so in private hospitals. And basic fault is that government doesn't realize this. In today's time the responsibility of patient care doesn't lie with the doctor alone. It is shared by all the personnels working in the health care delivery system. Had this system in proper order in this hospital, every patient's responsibility would have been shared by multiple people as follows and not by the doctor alone.

1. To display the services available in the hospital is the first norm and the services which are not available are also to be displayed very prominently and biliguially. Once it is well depicted the doctor's intentions are not doubted.
2. As per the protocol the hospital has to have designated transfer patients ward where care of the emergency patient is taken until transfer facility is arranged. Had been existing there the relatives would not have felt left alone to their own responsibility of the critical patient. There would be less chance of sudden rage on patient's side.
3. It would be the responsibility of the front desk staff and clerical staff to enquire about the availability of the beds in appropriate facility, inform about the available options to the relatives with probable cost involved and help them take decision.
4. On duty nurse had duty to accompany the patient.
5. Having the facility for grievence redressal round the clock is mandatory for big hospitals. The complaints of the patient's relatives if could be expressed out to proper authority, it would have not got vented out in the form of brutal beating of the doctor.

You will be surprised to know that all above things are the necessities required for NABH accreditation and few are basics requirements even for entry level small hospitals.

When the NABH body was formed by the Government of India long back in the year 2006, why did they not implement these accreditation norms in the government hospitals and more so to the medical college hospitals which are the teaching hospital is the question to be asked. Not only had it saved the doctors from violence but the young doctors passing out from the medical colleges would be so much well oriented to these protocols that they would have automatically followed the same norms in their practice also and slowly by now the entire healthcare system would be working under proper disciplined protocols avoiding today's scenario.

But it is never too late. We must now learn lesson, introspect ourseleves and get ourselves disciplined. Things are changing fast. Now we should not shoulder the complete responsibility of the patient care as we used to do it in past days which has given us the grade of Godliness. Let us now delegate our work and create a system of health care with multiple people sharing equal responsibility. That is the need of the day today.

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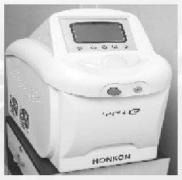


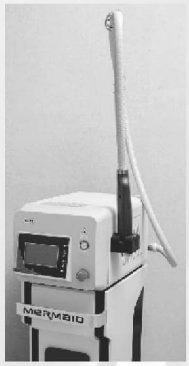

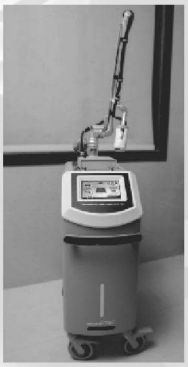

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LET US GEAR UP FOR NABH ACCREDITATION

Dr. Sangeeta Dandekar

- Classify every single step from patient entry to patient exit into different groups and name each group as one **Standard**.
- Define steps to follow to achieve that particular standard. These steps are named the **Objective Elements**
- Form teams of your staff members and allot the various standards to them.
- Train them to follow the objective elements stringently to accomplish the standards without any loopholes.
- Make them realize that they are accountable for the given task and any lapses in them is their responsibility.
- The above process is NABH Accreditation.

Accreditation is all about putting in systematic manner all those things which you are already doing every day. The only difference is that currently you are doing it in a manner suitable to you and now they want us to do it as per their guidelines to bring uniformity of working in all health care facilities. Until recently patient cure was a complete responsibility of the treating doctor and the other elements were just to assist him in his procedures as per his instructions. And still the health care imparted WAS QUALITY HEALTH CARE. But things changed drastically over a period of time, we doctors became just service providers and patients became consumers who started blaming that there is no transparency in the working of health care service providers making it necessary to rearrange our methodology of working. Now it has become mandatory to carry out our daily work in a manner acceptable to insurance companies, courts of law and society in general.

That's exactly where NABH accreditation comes into action. Since it is going to be compulsory for all the health care organizations sooner or later, better to gear up ourselves to start the procedure.

Initially I looked at it as one more compulsion from the government. But after studying it I realized that there are several advantages of this system for us too as this method addresses every minute detail of patient health care, and for others it's quite transparent method of working.

The accreditation process gives you complete working guidelines right from entry of the patient to the completion of his treatment and enables us to give Quality Health Care.

The complete health care process is divided into various steps which they call it as Standards. These standard includes actual patient care as well as supporting elements like medical record keeping, fire safety, patients rights and education...etc. They have included 41 such standards for pre accreditation entry level for SHCO.

Each standard consists of specific number of objective elements. The objective elements are the actual working guidelines to fulfil the requirements of that standard. There are total 149 such objective elements under 41 Standards.

To carry out smooth functioning as per the objective elements given, the responsibilities have to be delegated to various people working in our organization. We should designate one team to carry out one responsibility.

Some examples of the teams that we should have are as follows:

1. **Head of the SHCO and Top management :** To decide the policies and define various processes required to give optimum services to all the patients in the organization.
2. **Training Cell or Quality Team :** Consists of personnels (may also include the head of the SHCO and top management in small set ups) designated to train the staff to understand and carry out their responsibilities allocated to them efficiently.
3. **Hospital Infection Control Team :** Should consists of a doctor, a staff nurse or OT nurse and a microbiologist. They should teach the other staff how to maintain hand hygiene and how to restrict the rate of hospital acquired infections.
4. **Pharmacy team :** Responsible for ordering, proper storage and maintenance of medicine stocks. Two or three staff nurses and one clerk may be trained by Training Team to carry out this responsibility as per the policy decided by The Top Management Team.
5. **Patients Grievance Redressal Cell :** One or two

people should be designated whom patients can approach 24*7 for their difficulties.

6. Administrative department looking after getting and renewing various licences like hospital registration, AERB and MPCB licences, PCPNDT license...etc. They are expected to keep a track of all changing rules and regulations.
7. Registration department responsible to register all the patients entering the SHCO and allotting them Unique Hospital Identifier and maintaining proper registers
8. Admission clerks: To prepare case sheet of IPD patients and to maintain their register.
9. Nursing Staff and ward attendants: Along with giving actual care to the patients they are also supposed to maintain proper documentation of treatment they given.
10. Housekeeping services should be taught importance of maintaining cleanliness, hygiene and disinfection.
11. Consultants, duty RMOs and Emergency RMOs
12. Engineering team for maintenance of all the equipment which may be outsourced.
13. Medical Record maintenance team should be looking after the proper maintenance of records in safe and secure environment. They follow the top management policies as to how to identify the records, period upto which to preserve the records...etc.
14. Security team.

.....So on and so forth.... The teams may vary as per the scope of the services offered by the organization.

With these teams various objective elements are undertaken to fulfil the requirement of that particular standard.

- The various standards can be classified as
- Access, assessment and continuity of care (AAC) standard: The first element of it is to display the services available in the organization in at least Two languages one of them has to be the state language and the staff should be oriented to the services and should be able to guide the patient to other organization if the resources avilable don't match to the patient's needs. The other elements deal with registering OPD, IPD and emergency patients, giving them unique number (UHID) which identifies that person every time in future, raising the bills and preparing discharge summary as per the policies made by the Top Management Team.
- Care of patients (COP) This standard has objective elements guiding the care of patients in different departments like Care of obstretics patients, Care of Paediatrics patients, Rational use of blood and blood products, guide for administration of anaesthesia, Care of patients undergoing surgical procedures....etc. taking care of special requirements of each speciality. For example in Care of pediatric patients special measures are mentioned to prevent abduction and child abuse,footprints of newborn are imprinted on bedside record; for patients undergoing surgery very special precautions are described where the identification of patient, identification of side and site of surgery are verified at various levels from ward to preoperative reception area, before taking patient on table, before inducing anaesthesia, and before taking incision so that correct patient, correct side and site, correct procedure done, correct radiographs, correct implants and equipment are used.
- Management of medication(MOM) standards : Along With the guidelines about purchase, storage and prescription format of drugs this standard addresses two important objective elements: LASA (Look Alike Sound Alike drugs) are listed, labelled and stored very far apart. High risk drugs are listed, protocol is followed for its usage and anti dotes of these drugs are made available.
- Hospital Infection Control (HIC) standard: Each SHCO needs to have its own HIC manual which should include following things. 1. Standard precautions and universal precautions that should be ideally practiced. 2. Focus on importance of hand hygiene. 3. Guidelines for CSSD and for other high risk areas like ICUs and OTs. 3. Methodology to be followed in case of spills. 4. Biomedical waste guidelines.....etc.
- Continuous Quality improvement (CQI) standard: The objective element of this standard is to collect clinical and non clinical KPI that is Key Performance Indicators as suited for the scope of that particular SHCO. For example incidence of catheter associated UTI, surgical site infection, OPD waiting time, billing errors...etc.
- Facility mangement and safety (FMS) standard: The objective element gives guidelines to identify and prevent hazards from fire, hazardous chemicals and gases....etc and to tackle them in appropriate manner should they arise. Mock drills for various emergencies are advised.
- Information Managements Systeme (IMS) standard:

The objective element of this standard is to deal with proper medical records and systems to preserve them in safe environment in such manner that record can be easily retrieved if required.

- Alongwith these patient oriented standards there are many standards for the benefit of employees and smooth working of the organization

Above is the general outline about what exactly is NABH Entry Level Pre Accreditation Programme.

Once the patient enters the hospital the working pattern as per the standards and objective elements is as follows :

Registration Team : gives UHID and registers the patient as OPD/emergency/mlc raises bill and guides to consultant (Standard AAC is followed)

Registration Team: Takes admission note, register IPD patient, takes admission fees and sends patients to ward.(AAC Followed).

Medication orders are written clear and legible capital words in the designated location in the medical records (Standard MOM OR MANAGEMENT OF MEDICATION IS FOLLOWED)

Pre Anaesthesia assessment is done by qualified anaesthesiologist.

(Standard COP that is Care of Patients is followed)

Informed Consent is obtained from the patient by the surgeon. (Standard COP is followed). Operating surgeon documents operation notes and posted operative plan of Care. (Standard COP followed).

Discharge summary prepared in the manner defined by Top Management. (Standard AAC followed). Medical record is prepared in manner prescribed by the top management. (Standard IMS that is Information Management System is followed)

Medical record is sent to appreciate department. (Standard IMS followed).

During the stay patient gets safe drinking water, uninterrupted electricity.

(Standard FMS that is Facility Management and Safety is followed)

Fire extinguisher present at suitable places. (Standard FMS followed)

Hygienic surroundings maintained. (Standard HIC that is Hospital Infection Control is followed.)

Staff nurses follow good hand hygiene and standard aseptic precautions. (Standard HIC followed).

Thus every minute requirement of any patient is taken care of in such a systematic way that there is no inconvenience to the patient whatsoever. While working with the trained staff who understands and shoulders his own responsibility ably, the doctor also can carry out his job peacefully.

We should look forward to such ideal outcome of this whole accreditation process.

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MEETING WITH INCOME TAX OFFICIALS

Date: 27thJuly 2016 • Attendance: 102

Topic: Voluntary Disclosure of Undisclosed Income

माझ्या कविता

डॉ. (सौ.) अंजली अरुण वैद्य

१९७८ साली मिरज मेडिकल कॉलेज मधून एम.बी.बी.एस उत्तीर्ण. १९८१ सालापासून प्रथम आयरे रोड व मग शिवमंदिर रोड, डोंबिवली (पूर्व) येथे, एकूण सदतीस वर्ष फॅमिली फिजिशियन म्हणून कार्यरत. शाळेत असल्यापासून मराठी साहित्याची आवड. शालेय जीवनातच कविता लेखनास सुरुवात. छंद व स्वानंदासाठी कविता लेखन. त्यामुळे प्रकाशित करण्यासाठी कुठे पाठविल्या नाहीत. डायलॉग हे तुम्हा सर्वांशी डायलॉग साधण्यासाठी आपलंसं व योग्य माध्यम वाटल्याने आजपर्यंत डायलॉगमध्ये मधून मधून कविता पाठविते.

समजत नाही का तुला ?

प्रस्तावना

प्राचीन काळी गार्गी, मैत्रेयी यासारख्या पंडिता स्त्रिया होऊन गेल्या. त्याकाळी स्त्रियांना फार आदराने, सन्मानपूर्वक वागविले जाई. स्त्री पुरुषांना समान हक्क होते, असे आपण आपल्या प्राचीन वाड़यात वाचतो. पण काळाच्या ओघात ते सारे नाहीसे झाले. पुरुषप्रधान संस्कृतीचा पगडा समाजमनावर बसला. स्त्रीला शिक्षणापासून वंचित केले गेले. घराच्या उंबराच्या आत तिला डांबले गेले. 'चूल व मूल हेच तिचे कार्यक्षेत्र' असे तिच्या मनावर बिंबवले गेले. मधल्या फार मोठ्या कालखंडात स्त्रीची गळचेपी झाल्यामुळे तिचा आत्मविश्वास, तिचे तेज मंद झाले. स्वातंत्र्यकाळापासून झालेल्या सुधारणांनी रानडे, आगरकर, फुले इ. च्या प्रयत्नांनी स्त्रिया शिकू लागल्या. आता २१व्या शतकात तर डॉक्टर, वैमानिक, शास्त्रज्ञ, लष्कर, राजकारण इ. अनेक क्षेत्रे स्त्रीने पादाक्रांत केली. पण हे सारे समाजातील एका विवक्षित थरापुरते मर्यादित आहे.

रोजच्या वर्तमानपत्रात समाजात घडणाऱ्या अनंत घटना आपण वाचतो. उदा. लिंग तपासणी करुन स्त्री गर्भाचा नाश करणे, हुंड्यासाठी नवविवाहित महिलांना छळणे, जाळणे, मूल न झालेल्या स्त्रियांना अपमानास्पद वागविणे व त्यांच्या नवऱ्यांनी दुसरे लग्न करणे इ. इ. स्त्रियांचा छळ, त्यांना मारझोड, त्यांचा अनादर, लहान मुलींपासून म्हाताऱ्या स्त्रियांपर्यंत होणारे बलात्कार या रोगानी समाजाचा मोठा हिस्सा पोखरलेला आहे. अनेकदा असे जाणवते कि या सर्वात स्त्री स्त्रीशी शत्रूसारखी वागते. या सर्वांवर उपाय म्हणून स्त्रीने सक्षम व मनाने बळकट झाले पाहिजे. लहानपणापासूनच आपल्या मुलांवर व मुलींवर असे संस्कार केले पाहिजेत कि ती प्रत्येक स्त्रीचा योग्य आदर करायला शिकतील आणि हे परिवर्तन समाजातील प्रत्येक स्त्रीत झाले पाहिजे. तरच आपण अभिमानाने म्हणू शकू कि आम्ही प्रगत समाजाचा एक घटक आहोत.

मागे वळून पाहताना
कळत नाही का तुला ?
कुठल्या रस्त्याने धावतेस
समजत नाही का तुला ?

तुझ्या स्वप्नांचा मखमली रस्ता
राहिलाय खूप दूर
ह्याची सुद्धा वाटेना का
तुझ्या मनी हुरहुर
कुठल्या जबाबदाऱ्या कुठली कर्तव्ये
भावनाच नाही तुला.....कुठल्या रस्त्याने

सुशील, गुणी, कर्तव्यदक्ष
गृहिणी म्हणे झालीस
रांधा, वाढा, उष्टी काढा
त्यातच ना गुंतलीस
मुले प्रसवा, मुले वाढवा
कंत्राट दिलेय तुला.....कुठल्या रस्त्याने

मुक्त होण्या, स्वतंत्र होण्या
अर्थार्जन करतेस
घरी, दारी, कचेरीतही
मरमर मरतेस
धावून धावून तारुण्यातच
वार्धक्य आले तुला.....कुठल्या रस्त्याने

नव जन्माचा गर्भपाताने
हक्कच नाकारला
हुंड्यासाठी जिवंत जाळून
जीव तुझा घेतला
जगणे मरणे असह्य केले
आणली ही अवकळा.....कुठल्या रस्त्याने

(पुढील पानावर)

देहाचे अन् मनाचे तुझ्या
बाजारच मांडले
वस्तु मानुन ह्या बाजारी
तुलाच की विकले
माणुसकीला फासून काळे
सैतानच नाचला.....कुठल्या रस्त्याने

या पुरुषाला जन्म तू दिला
वाढविला अन् समर्थ केला
कृतघ्नतेने वागून तरिही
मोबदला हा दिला
स्वशक्तिची आण घालते
कधी जाग येणार तुला.....कुठल्या रस्त्याने

निसर्गाने बहाल केले
सृजन सामर्थ्य तुला
तनीमनी निरोगी प्रजा घडविणे
जमेल सहज तुला
सृजन म्हणजे प्रसवणे नव्हे
कधी कळेल तुला.....कुठल्या रस्त्याने

संस्कारांचे चाक फिरवुनी
घडव सुबक तू प्रजा
नारीच्या उत्तुंग मनाला
ना देईल ती सजा
सुसंस्कृत तो समाज घडण्या
देई प्रसवकळा.....कुठल्या रस्त्याने

जगणं

प्रस्तावना

जीवन म्हणजे जगणं. कसं असावं आपलं जगणं ? जणू एक सुरेल गाणं. ईश्वराने आपल्याला बहाल केलेलं अमूल्य लेणं. मंद सुगंधित वाऱ्याच्या झुळुकीवर अलगद विहरणारी त्या सुरेल गाण्याची आनंददायी लकेर. पण खरंच का या पृथ्वीतलावरील प्रत्येकाचं जगणं असच असतं ? थोडी मान इकडे तिकडे फिरवून पाहिले, आपले कान डोळे उघडे ठेवले, मनाची कवाडं थोडी जरी किलकिली केली तर आसपास पसरलेले दारिद्र्य, अस्वच्छता, अशिक्षितपणा, असंस्कृतपणा आणि त्यापोटी निर्माण झालेली हाव, द्वेष, मत्सर, कपटीपणा यांचा उद्रेक, सामान्य जगण्यासाठी केलेल्या तडजोडी, अन्न-वस्त्र-निवारा यांसारख्या मुलभूत गरजा भागवण्यासाठी करावा लागणारा संघर्ष 'बळी तो कान पिळी' यात बळी जाणारे निष्पाप कोवळे जीव, आसपास हे सारे घडत असताना, उघड्या डोळ्यांना दिसत असताना मुर्दाडपणे जगणारे आपण सारे. सध्याच्या या 'रॅटरेस' च्या जमान्यात प्रत्येक व्यक्तीला स्वतःच्या आयुष्यावर नजर टाकायला तरी वेळ व इच्छा आहे का ? या साऱ्याचं थोडक्यात भान देणारे हे जगण्याबद्दलचं कथन.

जगणं

असच असतं का जगणं ?
क्षणोक्षणी नव मरण मरणं
त्या मरणाचे भान नसणं
अन् नव्या क्षणांमागे धावणं.....असंच असतं का जगणं ?

प्रवाहाबरोबर गटांगळ्या खाणं
प्रवाहातच गुदमरणं
प्रवाहपतित असणं
पण याचंही दुःख नसणं.....असंच असतं का जगणं ?

अहंकाराचं तुणतुणं
प्रत्येकापुढे वाजवणं
वीस इंची छाती फुगवणं
अन् दांभिक बढाया मारणं.....असंच असतं का जगणं ?

कळीकळीचं विकृत फुलणं
त्याआधीच चुरगळलं जाणं
साऱ्या जगाचं पोतेरं करणं
अन् उन्मत्तपणानं झुलणं.....असंच असतं का जगणं ?

या जगातलं येणं जाणं
पण मरणालाच विसरणं
मग सारं सारं ओरबाडणं
हे सारं सारं किळसवाणं.....असंच असतं का जगणं ?

आपली गरज समजणं
दुसऱ्याची गरज जाणणं
गरजेपुरतच घेणं
बाकी इतरांसाठी देणं.....असंच असतं का जगणं ?

अंतर्मनाचं पूर्ण फुलणं
हे फुलणं सुगंधित होणं
एकमेकांस फुलु देणं
सर्वांसवे दरवळणं.....असंच असतं का जगणं ?

हे सारं सत्यात उतरणं
आपल्याच हाती हे जाणणं
पळत्याच्या पाठी न धावणं
शाश्वतात ठाम उभं राहणं.....असंच असतं का जगणं ?

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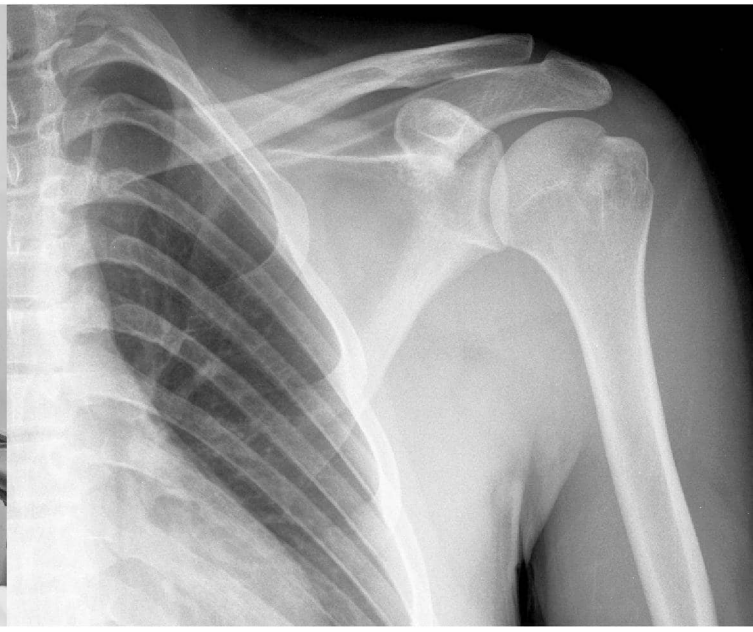

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ITE In the Ear

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CIC Completely in the Canal

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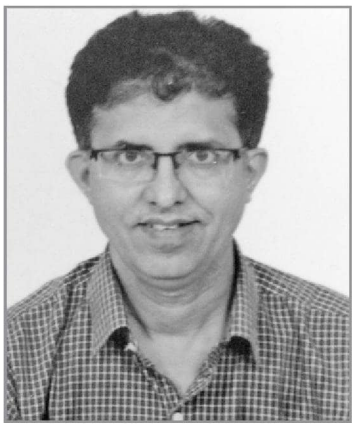
DIABETIC RETINOPATHY

Dr Suresh Ramchandani



He has passed MBBS from Grant Medical college and Sir J.J. hospital Mumbai and MS in Ophthalmology from the same institute winning the silver medal. After doing DNB in Ophthalmology he did super specialization that is fellowship in Vitreoretinal surgery from Sankara Netralaya Chennai and took working experience in the same institute for three years. After that he has been in private practice till date. He also works as honorary lecturer at MGM Hospital, Kamothe. He has over 15 publications in peer reviewed journals. He has given talks at many regional, national and international conferences.

Diabetic retinopathy is a disorder of the retinal vessels that eventually develops to some degree in nearly all patients with long standing diabetes mellitus. Diabetic retinopathy contributes 4.8 % of the 37 million cases of blindness throughout the word. It is the commonest cause of bilateral severe visual loss in working age group in the US. In India, a study has shown that the prevalence of Diabetic retinopathy is as high as 18% in adult diabetics

What are the risk factors for developing diabetic retinopathy?

1. Longer duration of diabetes increases the risk of developing diabetic retinopathy. 50 % will develop DR by 10 years and 90% will develop by 30 years of diagnosis
2. Patients with poor control of diabetes will develop DR earlier than others with good control
3. Pregnancy causes exacerbation of preexisting DR or causes it to develop de novo
4. Associated Hypertension, dyslipidemia, Nephropathy, and Anemia are additional risk factors

Pathogenesis of Diabetic Retinopathy (DR)

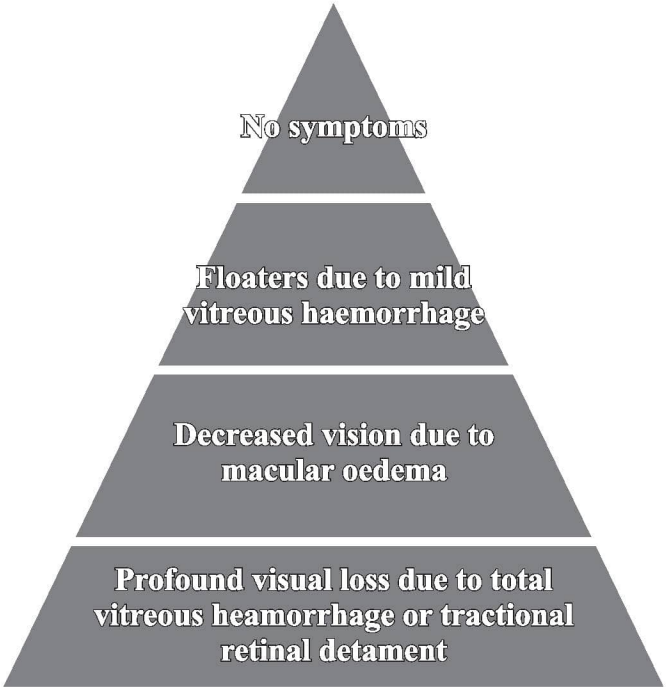
High blood sugar causes micro vascular changes through chemical processes like accumulation of sorbitol, free radical formation and protein Kinase C activation. This results in micro angiopathy due to either direct damage or due to hematological /rheological changes.

This causes retinal ischaemia with resultant release of several factors which either stimulate angiogenesis or inhibit it. The most commonly known angiogenic factor is the Vascular Endothelial Growth factor (VEGF)

This results in retinal haemorrhages, retinal oedema, neovascularisaton, vitreous haemorrhage and tractional retinal detachment.

What are the symptoms of DR?

Many patients may have no symptoms of diabetic retinopathy. Macular oedema presents with decreased vision. Vitreous haemorrhage will result in floaters while a retinal detachment will cause profound visual loss.



What are the stages of diabetic retinopathy?

DR passes through the stage of non-proliferative DR to Proliferative DR and finally to end stage disease

The watershed zone in this scenario is the development of Neo vascularization which prompts the retina surgeon to start treatment

Macular oedema is classified as diffuse, focal or ischemic.

How often should a diabetic undergo eye examination?

No diabetic retinopathy or Mild non proliferative (NPDR)
• **Every Year**
Moderate (NPDR)
• **6 months**
SevereNPDR,PDR or Macular oedema
• **Every 2-4 months or as necessary**

Investigations

FFA (Fundus Fluorescein Angiography). This is a test in which a dye is injected and serial photographs are taken of the eye. It is used to determine the extent of ischemia, detect Neo vascularization and retinal oedema,

It is an invasive test and is a fairly safe test. It can have some complications which are innocuous in most cases (such as urticaria, skin rashes or vomiting) **but can be life threatening if the patient develops an anaphylactic shock. Hence facilities for a full resuscitation should be available at all times**

OCT. (Optical Coherence Tomography). This is a test which gives us an in vivo cross section of the retina and is invaluable to diagnose Macular oedema and interface or sub retinal abnormalities

Treatment of Diabetic Retinopathy

Most importantly – **Tight control of Blood Sugar with a good HB1AC levels is mandatory** (though it is easier said than done)

Correction of Dyslipidemia

Control of Renal abnormalities

Eye Treatment

Main premise of the treatment is to reduce the Angiogenic factors .This is either done by laser photocoagulation or giving intravitreal anti VEGF injections

Laser destroys the hypoxic retina which reduces the release of VEGF and hence causes regression of neovascularization or reduction of macular oedema

Laser may be done in several sittings. Laser is inherently destructive but by destroying abnormal retina we are trying to preserve normal retina. Common side effects are worsening of vision and field defects

To overcome the inherently destructive nature of Laser – pharmacological treatment is becoming popular. This consists of giving periodic injections of Anti VEGF injections such as Bevacizumab (Avastin), Ranibizumab (Lucentis or Accentrix) or Aflibercept (Eyleae or Zaltrap).

These injections have to be given at monthly intervals initially and then as and when necessary.

The main problem with these injections is the cost of the injections which is prohibitive for most patients. Complications are infections, lens or retinal damage, haemorrhage and retinal detachments

Diabetic Retinopathy is an epidemic now with India becoming the diabetes capital of the world

It can be managed effectively if detected and treated early.

• • •

P G NEET PATTERN NEEDS TO BE REFORMED

Dr Medha Bhave

M. S.(Surg)-B. J.M.C. - Dr V. G. Joshi, Late Dr.M.J. Joshi M. Ch.(plastic surgery) - Grant medical and J. J hospital Director - Param hospital and ICU, Thane Lasercosmesis - Aesthetic and laser clinic First Thesis on liposuction in India First cosmetic and Laser clinic in Thane Publications liposuction Comprehensive care - original concept of abdominal fat mapping Axillary breast - Nikolay Serdev's textbook on body contouring Gynaecomastia - Many lectures and podium presentations Ex IMA execo, legal cell member, IAAPS execo Social service - 93 bomb blast, Nepal earthquake, Lifeline express, burns restore, signal school , diabetic foot camps and lectures.
Active ex committee and Medicolegal cell member of IMA Thane. Lot of charitable work done. Successfully tried to get registration fees by TMC cancelled.
Formed whatsapp group and QRT for Thane hospitals. Intervened to curb violence in a few situations.

Total number of MBBS seats—53,330 (30,000 NEET)

Colleges 426

PG NEET ---17,000 seats --- Candidates appearing ---1 lakh. (Many are REPEATERS)

Registered doctors --- 9.29 lakhs as per MCI records

Available in practice --7.4 lakhs (assuming 80% availability at one time)

Ratio recommended by WHO — 1/1000 patients

Ration in India ---1/2000 patients

"We cannot stop doctors from going outside for work and studies, but we can certainly provide doctors with good opportunities and lucrative offers to retain them."

Suicide after PG NEET

It really breaks one's heart to see a young student commit suicide after an unsatisfactory result. It happens in all fields and after results of many examinations. Traditionally it is either blamed on parents who pressurise the children to achieve or on immaturity and weakness of personality of the student. None of the education systems are ideal. Students from various backgrounds find it difficult to cope with the social and or family pressure. Everyone's heart goes out to the grieving parents. Then is there anything more than this about the students committing suicide after NEET?

The most important reason why the society should sit back and ponder over the problem is that it is a LOSS OF COVETED HUMAN RESOURCE THAT WAS TRAINED UPTO GRADUATION IN A SECTOR WHERE WE SEVERELY LACK MAN AND BRAIN POWER.

A cursory look at the statistics is enough to tell us how short is the manpower in medical and paramedical fields. The fact that government wants to allow non-modern medicine (AYUSH) graduates and even dentists to work in modern medicine says it all. They can accept such a desperate solution on one hand whereas on the other, they are not doing anything to avoid loss of precious brains that have already crossed the hurdle of entrance at 12th and managed to endure a hard course and cleared the final examination.

Why do students want to go for post- graduation?

1. There is no good course available to become a respectable family practitioner.
2. Medical knowledge has grown by leaps and bounds. I wonder if it is possible to start family practice without much directed practical training just after MBBS. The practical training during M.B.B.S. is abysmal.
3. It is difficult to go to rural areas due to severe lack of infra-structure. A doctor in rural area can practise only limited range of skills because electricity, water, staff, schools are unpredictable and unavailable. No, don't blame doctors alone---these are the very reasons why rural population tries to move to the cities; every government official tries for a transfer to cities. And mind you, our definition of city is a place where water, electricity and schools are available. Actually speaking cities need to be much more than this. And

even on these criteria, very few places qualify as cities.

4. With permission being granted to all AYUSH doctors to write modern medicines, practice in city as a family practitioner will be a nightmare -with further decline in prospects.

Why are post graduate seats so less in number?

The government scrapped the honorary system thus reducing the number of teachers. The 1:1 student teacher ratio is 2:1 now thus leading to deterioration in the quality of teaching.

PG seats in private colleges are not affordable. Parents need to take loan in crores near their retirement in order to sponsor the ward's education. I don't think it is fair. The students themselves cannot get education loan as they are not permanently employed. The students who buy seats may feel they have bought the degree. They do not realise the need to work and acquire skills.

What is the problem with PG NEET?

It is conducted after 1 year internship period which is meant to train young graduates in practical skills. The precious period is wasted in being a bookworm in prime of their lives. Mind well, we are talking of a 24 or 25-year-old whose non-medical friends have already finished post-graduation and are employed or about to be.

Students spend around 2-3 years in prime of their youth studying for PG NEET which does little good to add to their knowledge. In fact these young doctors remain unavailable to work in the field. That is a loss to the society already deprived of doctors.

NEET resorts to extremely theoretical set of questions with randomly computer generated separate question paper for each student.

In short , instead of learning how to give intra-muscular injection or cardiac massage, the student wastes time in mugging up irrelevant facts of minimal significance like the date on which oral polio vaccine was released for the first time in the world. Mind you, it is not even who, but "when" as if it is a history examination, leave alone asking about the mechanism of action. This is short-coming of MCQ tests. The skills of practical importance are not assessed and are liable to be ignored by students.

Everyone has to study during internship thus wasting precious time which should be better utilised in acquiring set of motor skills. The latter are better learnt earlier. This is because NEET expects you to learn all the 19 subjects in minute details necessary to solve MCQs (requires extremely detailed preparation). And then those who cannot make it to PG become family doctors with a feeling that they have been losers or failures. How can they be good family doctors then?

THIS IS THE REASON FOR SUICIDE AND LOSS OF HUMAN RESOURCE.

How can this be solved?

As all boards conduct certification examinations at national or state level, the third M.B.B.S. examination should be nationwide. The same examination should be used for ranking for PG admissions and for licencing to practice as M.B.B.S. doctor for students who complete their graduation abroad. This exam should also substitute the NEXT or exit exam proposed at the end of internship (meant to be licentiate examination before starting general practice and also to assess foreign graduates before they join post MBBS studies or practice.)

What should be the pattern?

I understand that such examination cannot be subjective so as to avoid bias. It needs to be in MCQ pattern. It should include only third M.B.B.S. clinical subjects because they are the most relevant ones. The examination should be only for theory. But the theory examination can still test prowess of the student by asking to solve MCQs on given clinical problems. They can be distributed evenly over all third M.B.B.S. subjects. There can be 5-8 questions about decision making and treatment in given cases. This is similar to concept of JEE advance where questions are never straightforward and are based on application of principles.

Every college should conduct a preliminary practical examination which will decide whether the student is qualified to appear for the abovementioned nation-wide theory examination. The practical marks should not be counted anywhere during PG admission -to eliminate favouritism.

A properly crafted PG program should include periodic MCQ exams to refresh knowledge of relevant 1 st and 2 nd M.B.B.S. by the college where the P G course training is offered. These could be state level examinations if deemed practical by medical teachers' association or universities.

If more family physicians are deemed to be required, there should be a well-designed course for minimum two years with rotation through various speciality departments and should include training in handling basic

medical and surgical emergencies and lifesaving procedures like central line insertion, tracheostomy, minor suturing etc. in relevant departments. They should be trained in psychiatry, sociology and medical economics. In current scenario of medical advances, family practice also needs to be a post-graduate speciality----------a highly respectable and difficult branch to handle. I strongly believe that everyone needs some training after M.B.B.S. NEET should decide only the branch. This will not only revive the long lost glamour of family physician by introducing better quality but also improve quality & remuneration in family practice. The costs of basic care will improve due to better screening. Who knows --it may become most popular branch.

The whole exercise will shift the paradigm of medical entrances in right direction.

(Ref—1.read:http://indiatoday.intoday.in/story/grim-picture-of-doctor-patient-ratio/1/654589.html)

•••

LIFE MEMBERS INTRODUCED in Year 2016-17

LIFE SINGLE Members

1 Dr. Attarde Jitendra
2 Dr. Chadda Rishi
3 Dr. Chaudhari Abhishek
4 Dr. Chaugule Yojana
5 Dr. Date Sudeep
6 Dr. Dave Sandeep
7 Dr. Hardikar Anand
8 Dr. Johari Sonia
9 Dr. Kamat Nutan
10 Dr. Kene Bhushan
11 Dr. Kene Nandkumar
12 Dr. Kotambe Uttam
13 Dr. Krishnakumar Rohan
14 Dr. Kulkarni Nikhil
15 Dr. Kulkarni Ujval
16 Dr. Mahajan Vivek
17 Dr. Mishra Sanjeev
18 Dr. Parte Pooja
19 Dr. Patil Nilesh
20 Dr. Patil Sanjay
21 Dr. Sawant Sarvesh
22 Dr. Solanki Nirmal
23 Dr. Somnath Shreyash
24 Dr. Sonvane Kanchan
25 Dr. Thakur Nirmaldutt

LIFE COUPLE Members

26 Dr. Bhabale Somnath
27 Dr. Bhabale Pallavi Somnath
28 Dr. Bhadlikar Dushyant
29 Dr. Bhadlikar Poonam
30 Dr. Bharambay Himanshu
31 Dr. Bharambay Savitri
32 Dr. Bharambe Vivek
33 Dr. Bharambe Sujata
34 Dr. Chaudhari Vishal
35 Dr. Chaudhari Sumedha
36 Dr. Gurav Sharad
37 Dr. Mittal-Gurav Swati
38 Dr. Kamath Prasad
39 Dr. Kamath Suchitra
40 Dr. Patil Sushil
41 Dr. Patil Lalan Sushil
42 Dr. Shingade Vishal
43 Dr. Shingade Suchitra

COMMON HEALTH ISSUES OF SENIOR CITIZEN'S AND GERIATRIC MEDICINE

Dr. Sriniwas B. Thakur
M. D. Geriatric Medicine

All India Institute of Medical Sciences (AIIMS), New Delhi, India
Elderly Care Specialist Physician

Dr. Sriniwas Thakur is Consultant in Geriatrics Practice at Fortis Hospital, Mulund, Mumbai. He is a distinction holder and topper of medical college in Final Year. He has done his externship from Seth G. S. Medical College and KEM Hospital, Parel, Mumbai. Did his M. D. in Geriatric Medicine from All India Institute of Medical Sciences (AIIMS), New Delhi; the best and most prestigious medical institute in our country. He has attended various National and International conferences and presented his research and won prizes. He is Life-Member of Indian Academy of Geriatrics (IAG), Indian Medical Association (IMA), Association of Physicians of India (API) and Association of Medical Consultants (AMC). He has been recently invited to give talk on Geriatric Medicine at Regional Resource Training Centre for Old Age Care Division, organized by National Institute of Social Defence (NISD) under Ministry of Social Justice and Empowerment, Government of India. He has started the First and Dedicated Geriatric Services in a private hospital setup in Mumbai, at Fortis, Mulund; led by a specialist geriatrician.

Perhaps two of the greatest human achievements to have occurred, particularly in the last two centuries, are the increase in human populations worldwide and the extension of human longevity. Never in the human history have so many humans lived longer. Today we are seeing more and more number of people living up to 70 years, 80 years, 90 years and beyond. According to World Health Organization (WHO), the number of older persons is expected to quadruple in next 50 years.

But ageing is a dual edged sword. On one hand, we gain from the tremendous experiences of our senior citizens, but on the other hand, they suffer not only from increasing medical problems, but also from social, psychological and ethical issues.

We so often hear from younger individuals towards their older counterparts as "*granny*", "*senile*", "*good for nothing*" and so on. This type of language is often rooted in the misunderstanding in the realities of ageing.

Elderly are not considered fit to be employed once they reach a certain age and this increases burden of dependency ratio. Health professionals sometimes overlook age-related diseases, increasing misdiagnosis and unfortunately mismanagement of health-related issues.

There are many ***myths about ageing***: *Old age is a disease; Old age always brings memory problems; Elderly are similar in the decline of their health status; Old people are powerless; Most disabilities in old age are universal or inevitable or irreparable.*

But ageing makes an individual, sensitive to certain conditions. Common problems faced by senior citizens include:

- Multiple and Frequent acute and chronic health problems like Diabetes, High blood pressure, asthma, heart problems, prostate problems, etc.
- On multiple medications (typically more than 5 in a day)
- Memory problems
- Decreased mobility and Falls
- Sleep problems
- Loss of appetite and Malnutrition
- Loss of urine control
- Difficulty with bowel movements
- Depression and other mood disorders
- Decrease in ability to perform their daily activities like getting up from bed, going to toilet, having a bath, changing clothes, eating their food, managing their household, finances and even difficulty taking their own medications
- Increasing dependence on their family members and caregivers to take care of them

The specialty of **Geriatric Medicine** focuses on healthcare of elderly (senior citizens ≥ **60 years**) with goal of promoting health by preventing and treating diseases and disabilities in elderly. A **geriatrician** is a physician who specializes in the senior citizen's healthcare. They deal with *all the diseases seen in General Medicine, with added health-related issues*

common in elderly people.

Instead of treating each of the many medical conditions separately in elderly, geriatricians focus specifically on those conditions that affect patient's functional status, keeping in mind *the goal of improving functionality and providing the best quality of life.*

The elderly should seek help of a Geriatrician as early as possible if any of the below is their trouble:

1. Are you having ***multiple chronic medical conditions*** like Diabetes, high blood pressure, asthma, joint problems or ***taking multiple medications***?
2. Are you suffering from ***frequent acute health related problems***?
3. Are you ***forgetting things more often*** than in the past 6 months?
4. Are you ***having difficulty walking*** or ***feeling dizzy*** or ***had a fall*** in past 1 year?
5. Are you having ***unintended weight loss*** or ***loss of appetite***?
6. Are you having ***difficulty falling asleep*** on most days of the week?
7. Are you suffering from ***change in bowel habits or having urinary problems***?
8. Are you experiencing ***decrease in your ability to do your daily activities or increasing dependence on others***?

But it is always better to know that "***Prevention is the Best Cure***!!!"

Certain Health promotion activities which can help us all achieve a successful ageing:

- ✓ Eat healthy diet on regular times of the day
- ✓ Consume more green leafy vegetables and fresh fruits or salads
- ✓ Regular exercise or at least 30 min walk daily
- ✓ Perform mind-stimulating activities: crosswords, puzzles, Sudoku, help your grandchildren in their homework
- ✓ Create a hobby like drawing, reading, writing, dancing or cooking
- ✓ Avoid being alone and socially withdrawn
- ✓ Join peer groups like senior citizen's association, rotary clubs, etc.
- ✓ Adequate sleep of minimum 8 hours in the night
- ✓ Share your experiences in life with younger population
- ✓ Get vaccinated against the common infectious diseases in elderly
- ✓ Lead an active life
- ✓ If in need of medical attention, seek help from your Geriatrician and don't buy over the counter medicines from local medical shopkeeper, even if for small problems

Geriatric Medicine is a relatively new specialty of medicine in our country and even more so, there is a lack of qualified M. D. Geriatric Medicine physicians. But, this situation will improve with time. Geriatricians are not a competition to general physicians, but rather our ultimate motto is to provide the best quality of care for our elderly people.

We need to understand that the attitudes of our communities and societies are not malleable overnight and it is a gradual process. It involves multi-dimensional participation from right from policy makers, caregivers, healthcare professionals down to the senior citizens themselves. Impressionist minds of young children need to be fostered to show gratitude towards their elders. Any matter of elder neglect or abuse should be downright reported to concerned authorities, healthy and active ageing attitudes need to be promoted among all age groups. The senior citizens should be made to feel that they are the strong bases of our society, from whom we can gain and build a more meaningful and strong bond in our society.

The most valuable thing to remember is that "no one should regret growing old. It's a privilege denied to many". Therefore, it is important to foster a community which respects its older people and continues to consider them as unique individuals, even as they age, rather than marginalize them into some negative stereotypes.

Let us all take a pledge to provide the best care for our elderly. "The closest thing to be cared for, is to care for someone else…"

As rightly said by Mark Twain, "Age is an issue of mind over matter. If you don't mind, it doesn't matter."

It is worthwhile to quote physician Oliver Wendell Holmes, "To be seventy years' young is sometimes far more cheerful and hopeful than to be forty years old."

Growing old gracefully is a work of a lifetime…

To care for those, who once cared for us, is one of the highest honours…

•••

"THE YEAR GONE BY...."

Dr. Utkarsh Bhingare
Hon. Secretary, IMA Dombivli

Administration

Membership:

May 2016 was observed as Membership development month. 34 new life members were introduced to IMA Dombivli in one month (>10%).

Total New Life Members inducted till date: 43 of which Life Single: 25 (3 were Annual single converted Life Single) & Life Couple: 8X2= 16 (2 Annual Couple converted to Life Couple)

Social Security Scheme: Dr. Mandar Pawar

Record enrolments of 14 new members in the Social Security Scheme this year. members to this Scheme.

Doctors Day Celebration: Dr. Makarand Ganpule & Dr. Sandhya Bhat.

Date : 3rd July 2016 at New Gymkhana Hall, Dombivli Gymkhana, Dombivli (E).

The Program took place in the presence of Shri. Rajendra Deolekar Hon. Mayor, KDMC

Chief Guest: Dr. Avinash Supe Dean, Seth G.S. Medical College & KEM Hospital

Guest of Honour: Dr. Ram Prabhoo PE Indian Orthopedic Association Director Mukund Hospital

5 Doctors completing 25 years of Practice were felicitated.

Doctor members with Academic excellence & Extra-Curricular excellence were felicitated.

Children of Doctors who have passed out 10 th & 12 th Board exams were felicitated.

The program was followed by HASYA KAVI SAMELAN Famous Hindi Poet Subhash Kabra & Laughter Challenge Winner Dr. Mukesh Gautam Program.

The program was attended by family members.

Awards: IMA Dombivli

IMA MS PRESIDENTIAL APPRECIATION AWARD (EVECON) : IMA DOMBIVLI

IMA NATIONAL PRESIDENTIAL SPECIAL APPRECIATION AWARD : DR. MANGESH PATE

IMA MS PRESIDENTIAL SPECIAL APPRECIATION AWARD : DR. ARCHANA PATE

CGP Subchapter:

IMA Dombivli was conferred upon CGP Subchapter at the hands of National CGP Dean Dr. Monga ICON Conference on 25 th of June 2017.

We have enrolled 27 members to the CGP.

Assistant Director: Dr. Niti Upasani

Assistant Secretary: Dr. Leena Lokras

IMA Dombivli HBI Subchapter: Dr. Archana Pate

6 New enrolments making a total of 33 members

IMA-HBI Cluster based NABH Accreditation drive: enrolments in full swing

Dialogue : Dr Leena Lokras & Dr Sangeeta Dandekar

Dialogue had a bouquet of various topics which covered almost all faculties of medicine. Our members participated enthusiastically to showcase their artistic interests. Best was the cover pages which were different and very vibrant.

IMA Dombivli Defence Cell Dr. Mangesh Pate

- Couple of calls were averted
- Fortunately, no major incidence of violence in the year 2016-17

EVECON 2016

The 6th Annual Conference of IMA Maharashtra State women Doctor's wing and 17th Annual Conference 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.

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.

Excellent academic sessions on different topics like Gyen acology, Rheumatology, Oncology, Hematology, Medicine, Psychiatry, Pathology etc were arranged with e xcellent speakers. Dr. U. Prabhakar Rao Orationwas given by renowned pediatrician and great teacher Dr. MrudulaP hadke.

For the first time, live events were incorporated into thepr

ogram schedule along with academic sessions. 7 different events were incorporated;

Hub The Essay Competition, Synaesthesia -

The Poetry Competition,Moments -

The Photography Competition, Graffiti - The Poster Competition along 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 coordination on the part of Team Evecon to manage the e vents smoothly. We had an overwhelming response for competitions.

Evecon 2016 was attended by 501 delegates from all over Maharashtra.

CME

1st CME Convener: Dr. Makarand Ganpule

Date: 27 th April 2016 Attendance: 116

Dr. Prashant Chhajed – Management of Obstructive Airway Disease

Dr. Sachin Bhosale – Minimally invasive Mx of Hip fracture & Approach to Osteoporosis

2nd CME Convener: Dr. Ashish Dhadas

Date: 15 th June 2016 Attendance: 142

Dr. Jayanti Mani Dr. Pradyna Gadgil Dr. Abhaya Kumar

New frontiers in Epilepsy Management

Convener: Dr. Ashish Dhadas

3rd CME Convener: Dr. Suneet Upasani

Date: 13 th July 2016 Attendance: 136

Dr. R.G Torsekar – Dermatological Problems in Office Practice

Dr. Purnima Mhatre – Adv. Treatment for Anti-aging

4th CME Convener: Dr. Dilip Joshi

Date: 10 th Aug. 2016 Attendance: 139

Dr. Samir Parekh – Management of Fatty Liver Disease

Dr. Chetan Kantharia – Pancreatitis: Acute & Chronic

5th CME Convener: Dr. Vijay Shetty

Date: 21 st Sept. 2016 Attendance: 105

Dr. Kaushal Malhan – Evaluation & Treatment of Shoulder Injuries

Dr. Rajat Bhargava – Interpretation of Xrays, CT Scan & MRI

6th CME Convener: Dr. Ghanshyam Shirali

Date: 18 th Jan 2017 Attendance: 155

Dr. Bharat Shah – Mood Disorders in Adults

Dr. Alka Subramanyan – Mood Disorders in Adolescents & Children

7th CME Convener: Dr. Makarand Ganpule

Date: 15 th Feb. 2017 Attendance: 102

Dr. Sudhindra Kulkarni – Management of Diabetes in Special Situations

Dr. Sriniwas Thakur – Geriatric Medicine

NABH Accreditation Seminar Convener : Dr. Meena Pruthi

IMA-HBI- NABH Initiative

Date: 21 st Feb. 2017 Attendance: 122

Joint Seminar in association with IMA Kalyan

Dr. Mangesh Pate & Dr. Jayesh Lele

BLS Workshop

Date: 22 nd Jan 2017 Attendance: 55

Shubh Mangal Karyalaya

Faculty: Dr. Meena Pruthi, Dr. Preeti Nanda, Dr. Prasanna Mahajan, Dr. Pallavi Padhye, Dr. Amarish Nanda, Dr. Shruti Pataki & Dr. Ashwini Dharmadhikari

Meeting with Income Tax Officials

Date: 27 th July 2016 Attendance: 102

Topic: Voluntary Disclosure of Undisclosed Income

PCPNDT Meeting

Interactive Meeting at IMA Hall with Hon. MP Dr. Shrikant Shinde on PCPNDT issue on Amendments to the PCPNDT Act

Date: 16 th Sept. 2016 Attendance: 12

IMA Dombivli Women's Wing Activities

Continous Projects:

1. Old Age Home: Four free health check camps for 10-12 inmates.
2. Caer School for Special Children: Three Free health check camps conducted for 10-15 children.
3. MISSION PINK HEALTH: 2 free health check-ups, Health education, Anaemia detection and treatment camp for underprivileged adolescent girls. (150 girls of 8 to 16 years.)
4. Kshitij School Camp: 1 free health check camp for >80 special children.

Social Events:

1. Workshop "MARRIAGE IS MARKSHEET" by Dr Harish Shetty.

2. Childrens day celebration at Orphanage in Ulhasnagar, Party and painting of premises.

Fellowship Events:

1. International Women's Day Celebration 2016
2. Mother's Day Picnic 2016 at Nagaon.
3. International Womens day celebration 2017

IMA MS Chairperson Women's Wing: Dr. Archana Pate

Chairperson WW: Dr Meena Pruthi

Secretary WW: Dr Sheetal Khismatrao

Secretary WW Dr Vijayalaxmi Shinde

World Health Day

7 th April 2016 at Shubh Mangal Hall, Dombivli East.

Theme was "BEAT DIABETES"

Chief Guest: Dr. Mrs. Padma Menon – Ex Prof & HOD, Dept of Endocrinology, KEM Hospital.

27 Fresh medical graduates were felicitated of which 7 are MBBS.

MMC Registration Renewal:

A total of 201 MMC Registration renewals were completely assisted in association with Archiac Graphics, an Event management company.

The assistance camp was carried out from 15 th Jan to 20 th Feb. 2017.

IMA MS & IMA HQ Programs

Hypertension Day

Date: 17 th May 2016

Theme for year: Know your Numbers

Free Blood Pressure Check-up Camp at member Clinics & Hospitals

Total Patients Screened: 329

New cases Detected: 9

Old cases on treatment found to be hypertensive: 21

National IMA Satyagraha Day

Date: 16 th Nov. 2016 6 Demands

1. Memorandum was read out & submitted to Hon. Tehsildar Kalyan Taluka Shri Kiran Survashe
2. Poster display of background of Satyagraha Day in waiting rooms of member Clinics & Hospitals Online Petition was signed by all members.
3. Protest: Members wore black badges in their OPDs
4. Letter sent to PMO, New Delhi
5. Press release
6. Explain, Promote & Motivation of our friends on the agitation.

IMA DOMBIVLI – VICTORY AT MMC ELECTIONS

Dr. Archana Pate won with thumping majority of 8222 votes to secure No. 4 position at the MMC Elections held in Dec. 2016.

IMA Solidarity Day

Date: 18 th Jan.2017

Effort to unite the entire Medical Fraternity with our colleagues who have been killed, assaulted & booked under IPC 304.

No to NMC No to Next Movement

Date: 1 st Feb. 2017

Memorandum submitted to KDMC Commissioner Shri. E Ravindran, Hon. MP Dr. Shri Shrikant Shinde & MLA Shri Ravindra Chavan

Press release

Chalo Mumabi: Azad Maidan Date: 17 th March 2017

Strong representation of IMA Dombivli.

More than 70 members participated in the agitation at Azad Maidan.

RURAL HEALTH PROGRAM: Aao Gaon Chale Project

Aao Gao Chale - 1st camp: 15th June 2016 @ Hindu Seva Sangh Kendra, Mamnoli

127 patients were examined and given free medicines.

Hb% check-up was done for young female patients above age of 13 years. 49 samples were collected.

Blood sugar test was done for 72 patients. 7 were detected to have high sugar levels.

18 ECGs were done and only one showed old infarct

One corneal foreign body was detected and treated (removed) then and there only. Delay in treatment could have led to serious complications.

Cataracts were detected. 4 bilateral and 4 unilateral - total 12.

2 pterygiums and one operable corneal opacity was detected.

1 case of uterine prolapse requiring surgery detected

1 case of hemorrhoids and 1 incisional hernia detected.

1 patient is advised to undergo OGD scopy

02 cases of **hypertension** were detected.

Aao Gao Chale - 2nd Camp: 19th June 2016 @ Village

Pioneering Innovations In Women Care For Over Three Decades

Kumars' J K Women Hospital

MULTISPECIALITY ★ ENDOSCOPY ★ FERTILITY

Woman's Health - Family's Wealth

OUR SPECIALITIES

Total Fertility Solutions Under One Roof

*Menorrhagia cure - Diagnosis to treatment same day

*Ambulatory Outpatient Hysteroscopy

*Day Care Hysterectomy

(*In properly selected cases only)

Gynaec & Obstetrics | General Surgery | Orthopedics
Urogynecology | Onco Surgery | Cosmetology
First of its kind Hospital for Women Wellness
PUVA phototherapy, First in the region (Disha Institute)
3D OR-1, First time in India
Built as per NABH guidelines

CBC Unit at JKWH

Complete Breast Care Centre

- Breast Care during Pregnancy: For Effective Lactation
- Breast Tumor Screening: FNAC, True cut biopsy, Mammography

- Breast Cosmetic Surgery: Augmentation, Reduction
- Breast Cancer Surgery

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Shree Prasad, Ground Floor, Opp. Nehru Maidan, Ganesh Mandir Road, Dombivali (E) Thane - 421201. Tel: 0251-2448693 / 9833922942

Maitri Raghukul, Opp. Saraswat Bank, Shaheed Bhagat Singh Road, Dombivali (E) 421201
T: 0251-2444421/31/03/05 • M: 7045947047

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Dombivli Dialyses and Urology centre

Jeevandeep Maternity Home

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JOINT REPLACEMENT CENTRE
PATHOLOGY
ONCOLOGY
TRAUMA CARE
BURNS UNIT
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UROLOGY CENTRE

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Laxmidarshan, Off.Manpada Road, Shrikhande Wadi, Dombivli (E).
Tel.: 2444522 / 2800190.

Mhasale

259 patients were examined and given free medicines. A team of 16 IMA Members, 5 Paramedical staff (Lab Technician, ECG Technician, Tech. for Bone Marrow Density, Optometrist) & 9 Medical Representatives conducted the camp. **(Total 30)**

Hb check-up was done for young female patients above age of 13 years. 58 samples were collected.

72 ECGs were done which revealed 5 VPC, 5 global st t changes,1 angina with T wave inversion and ST segment depression

One post traumatic post-surgical iris prolapse was detected and advised surgery.

Total 30 cataracts were diagnosed out of which 1 case was of developmental cataract.

1 case of uterine prolapse and 4 cases with metro / menorrhagia detected requiring surgery.

One case of fibroadenoma breast was also diagnosed

Ex-MLA Shri Digambar Vhise visited the camp and appreciated IMA Dombivli's work.

Aao Gao Chale – 3 rd Camp: 28 th August 2016 @ Village Mhaskal

323 patients were examined and given free medicines. A team of 20 IMA Members, 3 Paramedical staff (Lab Technician, ECG Technician, Optometrist) & 15 Medical Representatives conducted the camp. (Total 38)

Distribution of Iron & Folic acid tablets

Administration of Vit. A & Albendazole to children

Aao Gao Chale – 4 th Camp: 19 th Feb. 2017

159 patients were examined and given free medicines. A team of 14 IMA Members, 4 Paramedical staff (Lab Technician, ECG Technician, Optometrist) & 11 Medical Representatives conducted the camp. **(Total 29)**

Distribution of Iron & Folic acid tablets

Administration of Vit. A & Albendazole to children

EICP

Inaugural Session

Date: 7 th July 2016, Shubh Mangal Karyalaya

Renowned Psychiatrist & Founder member IPH, Dr. Anand Nadkarni

Topic: "How to communicate with Today's Teens"

Total 236 people including teachers & Parents of teenagers attended the program.

Five Schools were enrolled - 1. Holy Angels School, 2. St. Joseph School, 3. South Indian School, 4. Gurukul – The Day School, 5. Manjunatha School. Educative sessions for children were conducted in these schools.

1st EICP Session Dr. Mandar Pawar

11th Aug. 2016

Holy Angels School, Std 5 th to 7 th

Health, Hygeine & Disease Prevention

2nd EICP Session Dr. Medha Oak

17th Aug. 2016

Holy Angels School, Std 8 th to 10 th

Illnesses amongst Teenagers

3rd EICP Session Dr. Dushyant Bhadlikar

30 th August 2016

St. Joseph School, Boys of Std 8th to 10th

Adolescent Health

4th EICP Session Dr. Manasi Karandikar

30th August 2016

St. Joseph School, Girls of Std 8 thto 10th

Adolescent Health

5th EICP Session Dr. Hemraj Ingale

31st Aug. 2016

Holy Angels School, Std 3rd to 5th

Hygiene & Healthy eating habits.

6th EICP Session Dr. Adwait Padhye

31st Aug. 2016

Holy Angels School, Std 3rd to 5th

Healthy Thinking

7th EICP Session Dr. Ramnathan Iyer

20th Sept 2016

South Indian School, Std 8th to 10th

Healthy Sleeping Habits

Dr. Ramnathan Iyer

8th EICP Session Dr. Arvind Bengeri

20th Sept 2016

South Indian School, Std 8th to 10th

Obesity & Lifestyle illnesses

9th EICP Session Dr. Manasi Karandikar

1st March 2017

Gurukul – The Day School, Girls of Std 7th to 9th

Adolescent Health & Gender sensitisation

10th EICP Session Dr. Adwait Padhye

1st March 2017

Gurukul – The Day School, Boys of Std 7th to 9th

Adolescent Health & Gender sensitisation

11th EICP Session Dr. Rupali Bhingare

2nd March 2017

Manjunatha School, Girls of Std 7th to 9th

Adolescent Health & Gender sensitisation

12th EICP Session Dr. Dushyant Bhadlikar

2nd March 2017

Manjunatha School, Boys of Std 7th to 9th

Adolescent Health & Gender sensitisation

13th EICP Session Dr. Medha Oak

16th March 2017

Gurukul Day School, Std 5th to 7th

Healthy Diet

14th EICP Session Dr. Vijayalaxmi Shinde

16th March 2017

Gurukul Day School, Std 5th to 7th

Hygiene & Healthy Habits

TREE ADOPTION PROJECT

Inaugural Program

14th August 2016 at 9.30am

Chief Guest Hon. Mayor, KDMC Shri Rajendra Devlekar

Guest of Honor Corporator, KDMC Shri Shivaji Shelar

Special thanks KDMC Official Mr. Sanjay Jadhav

30 Neem Trees for Adoption at 90 Feet Thakurli Railway Parallel Road, Thakurli.

We did replantation on 30 th November 2016 becoz the Neem trees had dried up.

Chemical Blast at Dombivli MIDC Factory

26th May 2016

IMA members visited hospitals around the blast area.

IMA member hospitals provided Emergency services & First aid care without charging professional fees.

Disaster Management team IMA Kalyan arrived at blast site immediately & offered services at Shastri Nagar Hospital.

Blood Donation Drive:

Unique Blood Donation Drive with special tattoo for all donors during blood donation

Record 112 Bottles collected.

Project Chair: Dr. Raju Gite

Deworming & Vit A Supplementation:

10th Feb. 2017

IMA Dombivli issued letters to 10 schools to inform parents to administer Syp. Albendazole after consulting their respective paediatricians.

Dombivli Pride Run

5th March 2017

IMA Dombivli in association with NSSA

Emergency Medical Services and First aid to the runners of Dombivli Pride Run.

4 medical booths across the track. Physiotherapists were also involved. Fortunately, no major casualty

One runner felt giddy at finishing line. He was given head low position. Minor abrasions were dealt.

Organ Donation:

Dr. Sangeeta Dandekar Dr. Leena Lokras

Dr. Sheetal Khismatrao Dr. Rashmi Phansalkar

Online Interactive Form made available on IMA Dombivli Website.

Collaboration with Anatomy Dept of Kalwa Medical College. 5 Body Donor cards issued.

Elaborated articles in all issues of Dialogue – Brain death & Organ Donation for our members.

Guided Relatives of 3 people on Organ Donation who were on death bed. Though actual donation didn't happen since none fitted the criteria of Brain Death. (2 had eye donation)

Guided School children to prepare posters on Organ Donation for their 26 th Jan. Republic Day Program.

Organ Donation Campaign

17 th to 26 th December 2016

IMA Dombivli has associated with Dombivli Gymkhana at their Utsav Festival Audio Announcements

Promotional Material at Dom. Gymkhana Stall

Organ & Body Donation Enrolment forms were made available at the stalls.

53 people registered over 10 days.

It was used as an excellent opportunity to create awareness amongst the general public & increasing the enrolment to our registry.

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संप

डॉ. मकरंद गणपुले

एम.डी. (पॅथोलॉजी), तेजस लॅब.
गेल्या १५ वर्षापासून डोंबिवलीत प्रॅक्टिस.
गेल्या अनेक वर्षांपासून डोंबिवली आय.एम.ए. मध्ये विविध पदांवर कार्यरत.
रोटरी क्लब (डोंबिवली मिडटाऊन) आणि आय.एम.ए., डोंबिवलीचे अध्यक्षपद देखील भूषविले आहे.

१२ मार्चला रात्री आपण जेव्हा एकमेकांना आज होळी आहे. होळीत आपल्या सर्व वाईट भावना, वाईट विचार यांचे ज्वलन करा, एकमेकां विषयीचा मत्सर जाळून, प्रेम वाढवा वगैरे वगैरे असे मेसेज वरुन, फेसबुक वरुन पाठवत होतो. त्याच वेळी धुळे इथल्या भाऊ साहेब हिरे मेडीकल कॉलेज मध्ये एका ऑर्थोपेडिक रेसीडेंटला २० ते २५ दारु प्यायलेले. विशी पंचविशीतले तरुण बेदम मारत होते. त्यांनी त्याला इतके मारले की त्या डॉक्टरला डॉक्टरी पेश्याचीच भिती वाटायला लागली. त्या रेसिडेंटचे नाव होते डॉ. रोहन माम्हुनकर. तब्बल दोन दिवस ह्या गोष्टीची कोणालाच माहिती नव्हती. दोन दिवसानंतर ह्या मारहाणीची क्लीप viral झाली आणि मग ह्या प्रकरणाला वाचा फुटली. सगळीकडे वैद्यकीय विश्वात एक बेचैनी आणि हलचल सुरु झाली. लागोपाठ ठाण्याला, नाशिक आणि सायनला डॉक्टरवर हल्ल्याच्या अशाच घटना घडल्या मग मात्र सर्व डॉक्टर्स अत्यंत बेचैन झाले. प्रत्येक जणच आगतिक झाला होता. प्रत्येकाच्या मनात ह्या अशा हल्यापासून कसं वाचायचं ही भीती, सरकारी अनास्थे बद्दल राग, निवासी वैद्यकीय विद्यार्थ्यांच्या राहण्याच्या अत्यंत हीन दर्जाच्या सोर्यीविषयी चिंता अश्या दाटून आल्या होत्या.

१७-३-२०१७ रोजी IMAMS चे आवाहन होते चलो मुंबई. डॉक्टरांविषयी हल्या विरोधात, डॉक्टरां विषयी असलेल्या सरकारी अनास्थेच्या विरोधात चलो मुंबई-आझाद मैदान. ह्या आवाहनाला प्रतिसाद देत डोंबिवलीचे बरेच डॉक्टर्स आझाद मैदानच्या निषेध रॅलीत सहभागी झाले. संख्या वाढत वाढत सत्तरच्या वर गेली. निषेध फलक भराभर बनवले गेले. आझाद मैदानावर मुंबईतले बरेच डॉक्टर्स जमले होते.

IMAMS च्या बऱ्याच जणांची भाषणे त्यात झाली. वानगी दाखल नावे घ्यायचीच झाली तर डॉ. उत्तुरे, डॉ. पाचमेकर व IMAMS प्रसिडेंट डॉ. अशोक तांबे ह्यांची घेता येतील. ह्या निषेध सभेत वातावरण अगदी भारुन जाऊ असेच होते पण सरकारला जाग येत नव्हती. डॉक्टरांवरील हल्ले तर थांबत नव्हते.

.....आणि अखेर मार्ड संपात उतरले. त्यांना सपोर्ट म्हणून IMA MS ने ही संपात उडी घेतली. पूर्ण राज्यथरातल्या OPD सर्विसेस, (Emergency Services सोडून), Elective Surgeries वगैरे बंद ठेवायचा निर्णय २३/३/२०१७ दुपारी चार वाजता घेण्यात आला.

डोंबिवलीतही IMA Dombivli प्रेसिडेंट डॉ. हेमराज इंगळे संपकाळात कश्या पद्धतीने व्युहरचना करायची ह्या विचारात होते. Kalyan IMA च्या संपर्कात होते. तेवढ्यात ह्या संपाला IDA Dombivli Branch ने पाठींबा जाहीर केला. IDA च्या प्रेसिडेंट डॉ. तेजल थोरवे ह्यांनी स्वतःहून फोन केला आणि सांगितले IMA च्या संपाला IDA Dombivli पाठिंबा देत आहे. IMA डोंबिवलीच्या पदाधिकाऱ्यांनी ठरवले की चोवीस तारखेला सकाळी भेटायचे. डोंबिवलीतील इतर वैद्यकीय शाखेच्या अध्यक्षांना पण बोलविण्यात आले. ह्यात IDA, DHRPA, NIMA आयुर्वेद व्यासपीठ ह्यांचा समावेश होता. चोवीस तारखेला एक सर्व समावेशक सभा घेऊन नंतर डोंबिवलीतील विविध पोलिस स्टेशन्स, कल्याण-डोंबिवली महानगरपालिकेचे आयुक्त, उपायुक्त, MOH, तहसीलदार, पोलिस आयुक्त व सहाय्यक आयुक्त ह्या सर्वांना एक परिपत्रक देण्याचे ठरले. सकाळी साडेदहाला सभा सुरुवात झाली. डोंबिवलीतील सर्व वैद्यकीय शाखांचे डॉक्टर अत्यंत उत्साहाने सहभागी झाले. डोंबिवली जिमखान्याचा हॉल खचाखच भरला होता. इतके उत्स्फुर्त वातावरण तयार झाले होते की अवर्णनीय हा एकच शब्द म्हणता येईल. डॉ. हेमराज इंगळे ह्यांनी प्रास्तविक केले. त्यानंतर IDA President डॉ. तेजल थोरवे, DHRPA President मनोज कुमार पाटील, NIMA च्या अध्यक्षा डॉ. गायत्री कुलाली व आयुर्वेद व्यासपीठ च्या डॉ. वर्षा जोशी ह्यांची भाषणे झाली. IMA चे पदाधिकारी डॉ. निती उपासनी, मेडीकल कौन्सीलच्या नवनिर्वाचीत सदस्या डॉ. अर्चना पाटे आणि IMA चे National आणि State Leader डॉ. मंगेश पाटे ह्यांची जोरकस भाषणे झाली. सर्वानुमते असे ठरविण्यात आले की संध्याकाळी एक निषेध यात्रा काढण्यात यावी. (ही सूचना IMA चे माजी अध्यक्ष Dr. Pramod Bahekar ह्यांनी मांडली) ह्या सभे नंतर काही ठराविक IMA मेंबरर्सचे गट करुन ते परिपत्रक देण्यासाठी रवाना झाले. पोलीस सहाय्यक आयुक्त फारच चांगल्या स्वभावाचे व उमदे असे व्यक्तीमत्त्व निघाले. त्यांनी डॉक्टरांवरील हल्ल्यांचा निषेध तर केलाच पण निषेध यात्रेला डोंबिवली पश्चिम भागशाळा मैदान येथून काढा असा सल्ला आणि परवानगी दोन्ही दिले.

निषेध यात्रा संध्याकाळी निघाली. एकूण १२०० वैद्यकीय व्यावसायिक या यात्रेत सहभागी झाले होते. सर्वांमध्ये दिसणारी एकी हा महत्त्वाचा मुद्दा ह्या यात्रेतून सर्वांसमोर आला. ह्या यात्रेचा समारोप शास्त्रीनगर रुग्णालयात झाला. ह्या वेळी देखील IMA अध्यक्ष डॉ. हेमराज, डॉ. निती, डॉ. अर्चना पाटे, कल्याणचे डॉ. राजन माने, डॉ. नंजप्पा, डॉ. गायत्री कुलाली, डॉ. मनोज कुमार पाटील, डॉ. वर्षा जोशी ह्यांची भाषणे झाली.

डोंबिवलीतील सर्व वैद्यकीय व्यावसायीकांनी उतस्फुर्तपणे बंद पाळला. ही एकी सर्व समाजाला दिसली. हा ह्या संपाचा महत्त्वाचा लाभ होता. कठीण प्रसंगी वैद्यकीय व्यावसायिक एकत्र येतात हे जगाला ह्यातून समजलं.

ह्या संपा अगोदर ह्या डॉक्टरांवरील होणाऱ्या हल्ल्याचा निषेधार्थ १६ नोव्हेंबर रोजी IMA ने सत्याग्रह व १८ जानेवारीला IMA Solidarity Day ह्या दोन गोष्टी केल्या होत्या. पण डॉक्टर्स वरील हल्ले काही थांबले नाहीत. मग नाईलाजाने संप पुकारावा लागला. आता सरकारने ह्या संपातील सर्व मागण्या मान्य करुन, उपाय योजना करण्याचे आश्वासन दिले आहे. संप तर मिटला आहे. आता सरकारला त्यांचे काम करायचे आहे..... बघुयात काय होतं ते.

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