DIALOGUE

BULLETIN OF
INDIAN MEDICAL ASSOCIATION
DOMBIVLI BRANCH
VOLUME - 29 ISSUE 1

DYNAMIC

स्वास्थ्य ... एक चिंतन

BRAIN STIMULANTS

Sepsis

Haemophilia

Revolutionary Surgeries in Gynaecology

जरा हलकं फुलकं
कविता कथा व ललित लेख

SKIN DONATION
A NOBLE ACT

INDIAN LAW & MEDICAL PROFESSION
A TELESCOPIC VIEW...

IMA DOMBIVLI's ACADEMIC ENDEAVOR
CGP

EDITOR :
DR. LEENA LOKRAS & DR. SANGEETA DANDEKAR

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FROM THE PRESIDENT'S DESK

Dr. Hemraj Ingale

At the outset let me thank all of you for giving me opportunity to serve this esteemed organization, INDIAN MEDICAL Association, Dombivli. It's worth mentioning the role of IMA played in the history of patient care in our country since 1928. IMA serves the humanity by endeavouring to achieve the highest standards in medical education, medical ethics and care. With over 2.5 lakh doctors as members, IMA is the largest scientific NGO in the world.

After 45 presidents and their teams, who have established such a high standard and decorum for this great branch, I am aware of responsibility to keep up this accomplishment.

I seek blessings from all the Past Presidents and all my senior colleagues. I shall require your timely inputs for better functioning of IMA.

I feel blessed to have many able and passionate IMA members as office bearers in my team. This has only added to my conviction that we can not only meet the expectations but can even exceed!

More Brains and More Hands will make a strong IMA. For any association to grow we should make it stronger by enhancing the number of members in an organized way. Effective functioning is possible only by combining experience of seniors and energy of juniors. My aim is to mix this experience and energy together creating a dynamic association. My ultimate aim is that every member should feel proud to be a part of this family. IMA should unite and fight against some anti doctor acts. As a president it is my duty to disclose what is going on in my mind for association. For the year ahead,

other than the ongoing projects, IMA Dombivli will be reviving the "Aao Gao Chale" project in an all new capsule. We have an "Educational Institute Contact Program" ready to be implemented. IMA will strive to strengthen the Inter Doctor and Doctor - Patient relationship.

The effective communication with the general masses needs support from media. We shall strive to create awareness amongst general public about our activites through print & social media.

We have to be aware that it is the team effort that has reaped the fruit of success in this great organisation. As I look forward, I am excited by the commitment of our members & my executive board. It is rewarding to see how we all unite and work as one to address the issues that impact the health care environment and the patients and the communities that we serve.

The **DYNAMIC** team 2016-17 will certainly strive to make the new IMA year filled with 3Es…an EASY; EFFECTIVE and ENJOYABLE thru 3Ts…Total commitment, Team work and Transparency.

I once again thank Dombivli IMA for bestowing such a honour to me.

Thankyou.

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EDITORIAL

Dr. Sangeeta Dandekar

'हि मौक्तिकांची माळ पाणीदार
आहे तुझाच पुरस्कार
परंतु करावी लागेल पार,
वाट काट्यांची ही'

मुखपृष्ठीवरील चित्र पाहिल्या पाहिल्या या ओळी मला आठवल्या. मुखपृष्ठावरील चित्र माझ्या पाहण्यात आले तेव्हा काटेच दिसले प्रथम मला. त्यानंतर मला दिसली पाण्याच्या थेंबांनी बनवलेली नक्षी. मग लक्षाते आले की काटेरी कुंपण पार करावेच लागेल आपल्याला काहीतरी चांगले मिळविण्यासाठी. त्या चित्राची सांगड आपल्या व्यवसायाशी घातल्या शिवाय मला राहवले नाही. आणि वरील ओळी माझ्या मनात आल्या. वर्षानुवर्षे देवत्वाचा मुकुट परिधान करुन फुलांच्या पायघड्यांवरुन चालण्याची सवय होती आपल्याला. अचानकपणे फुलं जाऊन काटेरी वाट कधी सुरु झाली समजलंच नाही आपल्याला.

पण अचानक कुठे ? हे समाजमंथन हळुहळु सुरु झालं अनेक वर्षांपासून. पण आपण डॉक्टर मंडळी आपल्या कोषात गुरफटून गेलो होतो. जगाशी काही घेणं–देणचं नव्हतं आपल्याला. आपला व्यवसाय बरा की आपण बरे असा आपला खाक्या. आपल्या रुग्णावर योग्य ते इलाज करणं आणि त्याला रोगमुक्त करणं हे पूर्वीही आपण आपलं आद्य कर्तव्य समजत होतो आणि आजही समजतोय! कोणी बेजबाबदारपणाचे कितीही आरोप केले तरीही ! आपलं चुकलं हे की या आरोपांना उत्तर द्यायचं भानच आपण ठेवलं नाही. Lack of Communication किंवा रुग्णाबरोबर संवादाच अभावच आपल्याला भोवला. आपण उत्तर देत नाही म्हणजे आपल्या वर्तनात Transparency नाही असा अर्थ काढून समाज आपला मोकळा होतो. उत्तर देत नाही म्हणजे आपण आरोप मान्य करतो अशी समाजाने धारणा करुन घेतली.

त्यातच वैद्यक क्षेत्रात नव नवीन शोध लागू लागले. तंत्रज्ञानाने वैद्यकशास्त्र काबीज केले. Technology ने आपले काम सुकर केले खरे पण महागडेही केले. पण हे लक्षात कोण घेतो ? End of Result काय दिसला ? वैद्यकीय सेवा अव्वाच्या सव्वा महागली. मग समाजाने त्याचे खापर कोणावर फोडले ? Equipment कंपनीवर ? वाढत चाललेल्या महागाई निर्देशांकावर? वाढत चाललेल्या जागांच्या किंमतीवर ? लोकांच्या luxurious hospital services च्या अपेक्षांवर ? नाही. आरोप झाला तो फक्त 'डॉक्टर' वर. Soft Target !! मग डॉक्टरवर आरोप करण्याची समाजाला सवय लागली. आणि हा समाज म्हणजे कोण ? तर अपवाद न वगळता सर्व स्तरावरील लोक. मग ते राजकारणी असोत, वकील किंवा न्यायाधीश असोत, नोकरशहा असोत, पत्रकार वा पोलिस असोत, समाजकंटक असोत की तथाकथित समाजसेवक ! सर्वच आपल्या विरोधात !!

या सर्वांवर मात करुन आपलं गेलेलं स्थान परत मिळवणं हे एक शिवधनुष्य आहे जे आपल्याला पेलायचं आहे. त्यासाठी आपल्याला गरज आहे समाजाभिमुख होण्याची. अलिप्तपणा सोडून समाजात मिसळण्याची. आपली बाजू सतत लोकांपर्यंत पोचवण्याची. आपला दृष्टिकोन, आपल्या समस्या, आपली बाजू आपण ठामपणे मांडली पाहिजे. लोकांसमोर, न्यायसंस्थेसमोर, सरकार समोर आणि राजकारणी लोकांना अस्पृश्य न समजता त्यांच्या समोरही. कारण तेच आपले policy makers आणि decision makers आहेत. याही पुढे जाऊन मी म्हणेन की या policy makers मध्येच आपण स्थान मिळविले पाहिजे.

समाजसेवा करणं तर आपल्याइतकं सोपं कुणालाच नाही. आपल्या profession चा तो एक फायदा आहे. त्याचाही उपयोग करुन घेतला पाहिजे. संघटित राहण्याचं महत्त्व तर एव्हाना आपल्या सगळ्यांना समजलेलंच आहे. वरील सर्व गोष्टींना आपल्या IMA projects च्या माध्यमातून आपण सुरुवात तर केलेलीच आहे. आता त्यात सातत्य राखणं महत्त्वाचं. या सर्व प्रोजेक्टस्ना भरघोस प्रतिसाद देऊन आपले उद्दिष्ट साध्य करण्यात आपला खारीचा वाटा आपण उचलूया आणि पुढील पिढीचा मार्ग सोपा करुया.

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DIAGNOSTIC TOOLS TO DETECT SEPSIS

Dr Vijayalaxmi Sushil Shinde
M.D. (Microbiology)

Dr Vijayalaxmi Shinde is a Microbiologist and is Lab Director of "Eva Women's Clinic and Lab", since June 2012. She has done her M.B.B.S. from Vaishampayan Medical College, Solapur and M.D. Microbiology from K.E.M. Hospital and Seth GSMC. She has done her "Quality Management and Internal Audit Training" at KEM Mumbai. Infectious disease Certificate course from Hinduja Hospital and Certificate workshop on Virovitals. Hospital infection surveillance, Outbreak analysis & teaching staff and civilians are her areas of interest.

Sepsis is a life-threatening medical condition that arises when the body's attempt to fight an infection results in the immune system damaging tissues and organs. This response, designed to protect us, causes widespread inflammation, leaky blood vessels, and abnormal blood clotting resulting in organ damage. In severe cases, blood pressure drops, multiple organ failures ensue, and the patient can die rapidly from septic shock.

Approximately 20 thousand people die every day from preventable sepsis (this corresponds to 14 deaths per minute). About 18 million cases of sepsis occur each year. A large part of these deaths are from developing countries that have constrained resources. The mortality rates for sepsis was eight times higher than mortality rates from other hospitalization stays. One out of every four patients in Intensive Care Unit in India suffers from sepsis and almost 35% of it is hospital acquired. In India, Sepsis accounts for 80% of lost lives a year in childhood with more than 6 million affected neonates and children and more than 100,000 cases of maternal sepsis.

Sepsis occurs as a result of infections acquired both in the community and in hospitals and other health care facilities. The majority of cases are caused by infections leading to pneumonia, urinary tract infections, skin infections like cellulitis. Other frequent sites of infection include abdomen, abscesses, and wound or surgical sites. Central line associated bloodstream infections (CLABSI) are also of significant concern, as infectious agents can enter the bloodstream through intravenous devices. Sepsis in community, ICUs and Nosocomial infections are very much related to factors like Uncontrolled use of antibiotics, over the counter distribution of antibiotics, lack of awareness of protocols of ICU care, unskilled staff, poor knowledge of infection control measures and surveillance in ICUs and spread of resistance bugs. Lack of information due to unavailability of data does not give true figures of mortality and mobidity due to sepsis.

Laboratory Tools for Sepsis detection

Apart from commonly described clinical features, guidelines of sepsis or septic shock laboratory tests for screening and confirmation play an important role in saving patient life. Physicians order a wide range of tests to help diagnose the causative organism and guide their treatment decisions. Sepsis is an emergency disease, every hour delay in initiation of appropriate antibiotic therapy in septic shock increase mortality by 7%. Diagnostic test requests required for sepsis management are given the highest priority for processing, analysis and reporting.

Hematology, serology, bacteriology and molecular diagnostics in Sepsis diagnosis and monitoring. All tests may not be precise to start sepsis

managements. Some are just indirect indicators of screening methods. Hematological Parameters,serum lactate, CRP measurement are widely used methods for screening for any inflammation in body . Procalcitonin: use is largely limited to private hospitals because of high cost. Other biomarkers (Interleukins, IL-1, IL-6, TNF etc) have limited use. Molecular methods are not in widespread clinical use in India. Detection of source of infection and tests for evaluation of organ failures are equally important to monitor patients.

Blood culture is considered as gold standard for diagnosis of sepsis. Bacterial, fungal sepsis can be easily detected by blood cultures. Conventional blood cultures required longer incubation time and repeated subcultures leading to high turn around time (TAT)or contamination. Availability of fully automated closed systems like BACTEC/BactAlert have been a boon for Microbiologist and Intensivist and has dramatically improved the TAT, quality and isolation of pathogenic bugs. Paired set of blood cultures of 7 to 10 ml blood volume for adults and 1 to 3 ml for paediatric age group gives better yield of Bacteria. Aerobic, anerobic, fungal organisms all can be screened depending upon the clinical condition. 2 sets (aerobic + anaerobic) recommended for sepsis diagnosis. 3 sets recommended for Bacterial endocarditis. 1 Set includes of 2 bottles consisting each of approxminately 10 ml blood in each.

Gram negative bacilli (GNB) are commonly associated with sepsis in India. Gram positive cocci(GPC) like staphylococcus aureus have been commonly associated with sepsis worldwide. Fungal infection with yeast are also seen on rise. There has been a rise in isolation of resistant bugs due to lack of infection control practises ,training in smaller hospitals, lack of antiobiotic data to formulate antibiotic policies. Microscopy reports can be generated as early as 4 hours if the Blood culture bottles flag positive. Positive bottles are screened by microscopy and cultured. Identification and Antibiotic susceptibility testing follows and report can be generated in < 48 hours For accurate therapy if a pathogenic organism is isolated. Commonly isolated GNB are *Escherichia coli, Klebsiella spp, Salmonella spp, Pseudomonas and Acinetobacter spp.* Gram positive consist mainly *Staphylococcus aureus ,Coagulase negative Staphylococci(CONS),Enterococcus species .CONS commonly associated with contamination at time of blood collection.*

CRP is a well-established biomarker of infection and inflammation. It is one of a group of acute phase reactants mentioned previously – proteins whose synthesis in the liver is up-regulated by IL-6. CRP's role during acute inflammation is not entirely clear. It may bind the phospholipid components of microorganisms (and damaged host cells), facilitating their removal by macrophages. Because the levels of CRP rise much more significantly during acute inflammation than the levels of the other acute phase reactants, the test has been used for decades to indicate the presence of significant inflammatory or infectious disease, especially in pediatrics. Although its low specificity may be its primary drawback as a biomarker of sepsis in adults, it is commonly used to screen for early onset sepsis (occurring during the first 24 h of life) because its sensitivity is generally considered to be very high in this setting. CRP is also often used to monitor patients after surgery; levels are typically elevated compared to pre-operative levels, but they fall quickly unless post-operative infection is present

Pentraxin 3 (PTX3) is another protein with structural similarity to CRP, which may be produced primarily by inflammatory cells rather than the liver, elevated levels of PTX3 have been shown to correlate with the severity of sepsis

Role of Serum PCT for sepsis screening: PCT normally produced in the C-cells of the thyroid gland, is the precursor of calcitonin. A specific protease cleaves serum PCT to calcitonin, catacalcin, and an N-terminal residue. Normally, all serum PCT is cleaved and none is released into the blood stream. Serum PCT levels are therefore undetectable (<0.1 ng/ml) in healthy humans. During severe infections with systemic manifestations, however, serum PCT levels may increase to over 100 ng/ml. In these conditions, serum PCT is probably produced by extra-thyroid tissues. The patho- physiological role of serum PCT during sepsis is not clear. Serum PCT levels increase during severe generalized bacterial, parasitic or fungal infections with systemic manifestation. In severe viral infections, or inflammatory reactions of non-infectious origin, serum PCT levels do not increase or only show a moderate increase. Compared to the relatively short half-lives of cytokines such as tumor necrosis factor (TNF)-a and interleukin

(IL)-6, the half-life of serum PCT in the systemic circulation is 25-30 hours rather long. Because of these properties, serum PCT has been proposed as an indicator of severe generalized infections or sepsis. Serum PCT is not a Marker of infection as such since localized infections or infections with no systemic manifestation cause a limited, if any, increase in serum PCT levels. Although elevated serum PCT values during severe infections may decrease to very low levels with appropriate therapy, this does not always indicate complete eradication of the infection but only that generalization of the infection or the systemic response is under control. Systemic inflammatory syndrome of non-infectious etiologies also leads to increases in serum PCT levels. Patients after major trauma or surgery and patients after cardiopulmonary bypass may present with increased serum PCT levels without any evidence of severe infection. However, the median values under these conditions are usually lesser than those found during severe sepsis and septic shock.

Procalcitonin (PCT) has emerged as the most studied and promising sepsis biomarker. For diagnostic and prognostic purposes in critical care, PCT is an advance on C-reactive protein and other traditional markers of sepsis, but is not accurate enough for clinicians to dispense with clinical judgement.

The use of PCT as an antimicrobial stewardship tool is extremely attractive in the current climate of increasingly antibiotic-resistant microbes. The theory is that with daily or serial PCT measurements, antibiotics can be safely stopped once the PCT level declines below a certain cut-off point or reduces to a certain percentage of its initial value. The use of PCT in the avoidance of antibiotic initiation and in reducing antibiotic course length has been extensively studied outside of the critical care environment.

Various biomarkers CRP,PCT, Interleukins, IL-1, IL-6, TNF, Chemokines, Cytokines etc Molecular methods like PCR or septic panels for viruses bacteria fungi are now available. Encouraging the use of a combined panel of novel biomarkers and traditional markers of sepsis need to be studied for results and cost effectiveness. There is stronger association for use of proper diagnostic tools to diagnose sepsis, to reduce antibiotic course length and decrease mortality.

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Biomarkers Of Sepsis

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IMA Dombivli:
World Health Day Celebration on 7th April 2016

The WHO Theme for the year 2016 is "Beat Diabetes".

Hon. Dr. Mrs. Padma Menon who is the Ex Prof. & HOD of Dept. of Endocrinology at Seth G.S. Medical College & KEM Hospital, Mumbai was the chief guest for this function. This was the 27th year of Celebration. We felicitated 26 fresh graduates on this day.

Till date we have felicitated 1122 fresh medical graduates.

साठी ओलांडलेल्यांसाठी

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वाटतं एकदम कूल
अशा वेळी ब्लॅडर मात्र
लौकर होते फूल

डायबीटीस असेल जोडीला
तर आणखीन भीती असते
तासभर सुद्धा सलग झोप
नशीबातच नसते

प्रोस्टेटचाही त्रास असेल
तर वाढत जाते हालत
नाईलाजाने म्हणावं लागतं
'मला एसी नाही चालत'

प्रोस्टेट आणि डायबेटीसवाल्यांना
सांगतो नका कोपू
कितीही उकाडा असला
तरी एसीत नका झोपू

– डॉ. सतीश अ. कानविंद

केव्हांतरी पहाटे

केव्हांतरी पहाटे लुटूनी ही बँक नेली
पिटले असे मला अन सगळीच कॅश नेली
केव्हांतरी पहाटे

सांगू कसे ते आले गाडीतून निळ्या त्या
उतरुन आधी खाली बंदूक माझी नेली
केव्हांतरी पहाटे

कळले मला ना तेव्हा फुटली कशी ही कवटी
कळले मला ना केव्हा हरपून शुद्ध गेली
केव्हांतरी पहाटे

उरले ऊरात वाटे थोडेच श्वास आता
उचला तुम्ही मला हो गात्रे गी सारी मेली
केव्हांतरी पहाटे

स्मरते मला न काही बेजार झालो आता
होते धरायचे पण निसटून संधी गेली
केव्हांतरी पहाटे

डॉ. सतीश अ. कानविंदे

डॉ. सतीश अ. कानविंदे

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

सैराट

राणी आणि राजू
एकाच कॉलेजात जायचे
अधूनमधून हसणे आणि
बोलणे त्यांचे व्हायचे

हळूहळू त्यांच्यातली
मैत्री लागली वाढू
एकमेकांना चिठ्ठ्याचपाट्या
मग ते लागले धाडू

राजूच्या ओठात सिग्रेट
कधीकधी शिलगायची
बाईकवरची राणी
राजूला हळूच बिलगायची

राजू आवडला राणीला
राणी आवडली राजूला
प्रेमात पडले दोघे आणि
अभ्यास राहीला बाजूला

एक दिवस तिने त्याला
न्यूज दिली बॅड
कानात त्याच्या पुटपुटली
तू होणार आहेस डॅड

न्यूज सांगताना राणी जरी
फारच होती हरखली
राजूच्या मात्र पायाखालची
जमीन तेव्हा सरकली

मुलांचे लाड पुरवायला
आधीची पिढी झगडतेय
वाईट वाटतं तरुण पिढी
डोळ्यादेखत बिघडतेय

डॉ. सतीश अ. कानविंदे

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REVOLUTION IN GYNAECOLOGY
LAPARASCOPY : HYSTEROSCOPY : ROBOTIC SURGERIES

Divyesh V Shukla MD
Shilpi D Shukla MD

Divyesh V Shukla and Shilpi D Shukla are the directors of "Isha Hospital" a Gynaecological Endoscopy Training Centre, Vadodara. This centre is recognised by FOGSI and supported by Karl Storz. They have conducted many training programs , operative workshops and conferences. They have many papers and publications to their credit. They have delivered more than 150 guest lectures at state, national and international conferences.

Gynaecological minimal access laparoscopic & hysteroscopic surgeries have revolutionized the surgeries in gynaecology.

It is available since more than 5 decades.

Today, laparoscopy is one of the most common surgical procedures performed by gynaecologists.

It is a surgical technique which is applied to urogynaecology, reproductive medicine, gynaecological oncology and all benign gynaecological surgeries.

It isn't false everybody quoting, the days are here where we will not have to open women's abdomen other than carrying out cesarean section.

With improvement in optics and availability of HD and 3D camera, light source quality, improvements in hand instruments, newer and safe energy sources used for the surgeries together with robotic approach, these minimal access surgeries have significantly improved the prognosis of the patient as they are more accurately done for the diseases, treated in **Trained Hands**.

Here the last two words are very important.

ROBOTIC SURGERY

With these advances it is possible for a remote surgeon to operate in India with the help of robotics. Improved surgical field visualization, superior ergonomics, instrument articulation, decreased tremor, and apparently shortened learning curve make robotic-assisted surgery potentially advantageous. In the morbidly obese patients who present a significant challenge for laparoscopic and open surgery, robotic surgery has the potential for decreased postoperative complications. Robotic surgery with its better ergonomics may reduce problem of surgeon fatigue.

Robotic surgeries are costly as disposables used are recurrent costly expense. Application of robotics in gynaecology are same as laparoscopy.

In India & world over minimal access surgery training and fellowship programs are available for doctors to learn this technique of surgery.

As a different hand eye coordination learning is required with available 2D vision without haptics, out of many who are trained only a few of them acquire the desired skill which is required to perform these type of surgeries.

We do not have institutional check with this regard in our country before some doctor offers these surgeries.

There is another important aspect, surgeon heavily is dependent on the available technology & the assistants. It is mandatory for the surgeon to remain updated and be using the latest available technology, as the advancement are made to make these surgeries safer for the patients.

It isn't false if I tell these surgeries are unsafe in absence of expert & the latest equipment's available for patients safety.

HYSTEROSCOPY

In gynaecology hysteroscopic surgeries are performed to treat various intrauterine pathologies. This avoids need for hysterectomy and can treat many pathologies or cavity malformations causing infertility. These days they are further safe as newer methods use saline & bipolar energy.

LAPARASCOPIC SURGERIES

Various intrauterine pathologies which can cause infertility or abnormal uterine bleeding are polyps, fibroids, endometrial hyperplasia, septum, intrauterine adhesions, tubal blocks etc. are effectively treated by expert hysteroscopic surgeon. Hysteroscopic surgeon needs to learn more technical skill as he has to operate in limited space and smaller diameter optics. Hysteroscopic surgeries also require authentic electrosurgical generator or other mechanical instruments to treat intrauterine pathology.

Gynaecological laparoscopic surgeries have replaced abdominal surgeries completely, whether it is for benign, malignant pathology or they are fertility enhancing surgeries.

In addition, the technology and range of minimal access surgery skills have expanded to the level of radical hysterectomy and pelvic and para aortic lymphadenectomy as a routine practice in many centers.

With the advent in the entry techniques it is possible to insert trocars through the abdominal wall safely to enter peritoneal cavity without complications especially in cases of previous one or multiple open surgeries. In fact laparoscopic surgeries are more suited for patients with one or many previous laparotomies or history of repair of abdominal wall hernia.

Magnification used helps in treating pathology precisely and the blood loss during surgery is less.

Two common energy sources are used in gynaecological laparoscopic surgeries electrosurgery & high frequency ultrasound generators.

Exceptional conditions may require conversion to laparotomy or primary laparotomy.

It is proven laparoscopic surgeries can be performed safely with pregnancy upto 28 wks for adnexal pathology or for surgical reasons. There are different laparoacopic surgical principles used. Here I would to mention heterotrophic pregnancy which is more common with IVF offered. Laparoscopic surgery treats tubal pregnancy successfully & intrauterine pregnancy continues.

OTHER ASPECTS

In clinical practice although there is a big investment in term of equipments & instruments, increased recurrent expense, yet can be made affordable for all class of the patients.

This should be done by an expert as a matter of practice as his expertise should benefit everyone.

Laparoscopy and hysteroscopic surgeries and robotics have brought about revolution in gynaecological surgery because of being more & more safe and less invasive. Most importantly the prognosis of the disease treated by both types of minimal access surgeries do not differ.

The introduction of any new technology implies a learning curve experience which certainly applies to Laparoscopic & robotic surgery. The important issues in establishing these type of surgical program are associated with organizational challenges, training, team building, and cost measured against benefit to the patient, surgeon, and institution.

Inadequate basic and advance training obtained with acquiring less surgical skill has not enabled many centers to perform skillful and advance laparoscopic surgeries or have more number of complications reported.

General anaesthesia and patient monitoring are important during laparoscopic surgery. Newer techniques have evolved & with availability of newer inhalation & intravenous drugs along with better airway management methods, many at risk patients are suitable for laparoscopic surgeries now. Patients post-operative recovery is also faster.

We should not forget at the end the patients benefit in terms of faster recovery, less complications as compare to open surgeries and early return to work in expert hands.

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INDIAN LAW AND MEDICAL PROFESSION : A TELESCOPIC VIEW

Anant B. Bobe
B.E., MBA, LL.B.
ADVOCATE HIGH COURT

Originally Engineer by education and occupation. He did his B.E. in Electrical Engineering and M.B.A. in Finance. He has held various managerial posts in various indistries viz., IT, Health, Media, Engineering before he did his education in law. Currently he is working as a lawyer in Mumbai High Court. Hospital and establishment related matters and medical negligence cases are his areas of interest.

All our acts and conducts are regulated by law except a few. We have all sorts of laws like civil, criminal, personal, family, international law etc. Law can be statutory, customary, moral or ethical etc.

While starting medical practice one must follow the various statutory laws like :

1) Laws governing qualifications and conduct of professionals.

2) Laws governing patient management like birth and death registration, epidemic disease act, PCPNDT Act, Transplantation of Human Organs Act, MTP Act, Mental Health Act and many more.

3) Laws governing sale and storage of drugs and safe medication.

4) Laws governing environmental safety - which include along with MPCB, Public health bye laws, Water Act and even IPC section 278 and section 279 which indicate criminal liability.

5) Laws governing safety of patients, staff and public which include Radiation Safety Rules and AERB safety rules, fitness certificate for operation of lifts, fire safety etc.

6) Laws governing employment and manpower like minimum wages Act, payment of bonus, payment of gratuity, PPF Act, etc.

IGNORANCE OF LAW IS NOT AN EXCUSE

Any breach of provisions of the above acts attracts appropriate civil or criminal liability as provided in the act. 'Ignorance of law is not an excuse'. It is based on the Latin Maxim “ignorantia legis neminem excusat” or “ignorantia juris, quod quisque, saire tenetur neminem excusat ”. We are not permitted to plead ignorance as a legal defence to escape the clutches of law. If one is practicing certain profession, he/she is expected to know the related laws.

Medical Negligence

Medical Negligence can be further divided in two types:

(a) Medical Negligence in Civil law

(i) Includes Consumer Protection Act

(ii) In Tort laws

(b) Medical Negligence in Criminal law

Let us try to understand each one in brief.

Medical negligence in Civil Law

Before looking at what is the meaning of negligence and more particularly medical negligence let us first understand basic concept of contract and tort.

Contract : Consumer Protection Act

A contract is an agreement enforceable by law. Contractual liability, therefore, arises out of agreement between the parties. Any dispute between the parties is settled by way of civil suit or appropriate civil proceedings. In patient- doctor or patient-hospital relationship there is implied contract and Consumer Protection Act,1986 contemplates simple and faster option of disputes redressal than traditional civil proceedings.

TORTS LAW

Where Consumer Protection Act ends, law of torts takes over and protects the interests of patients even if medical professional/hospital provide free services which do not fall in the ambit of service as defined in Consumer Protection Act. The onus is on patient to prove the negligence of doctor to claim compensation.

A tort is a civil wrong which is not exclusively the breach of contract. Tortious liability, on the other hand, arises out of a breach of duty which is not a breach of contract.

Meaning of Negligence :

Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. (Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh)

1. 'duty',
2. 'breach' of duty and
3. 'resulting damage'.

Before we move forward let us get ourselves familiar with facts in brief of two landmark cases which had laid down the law in medical negligence cases under civil as well as criminal law.

Bolam Case

John Hector Bolam suffered from depression and was treated at the Friern Hospital in 1954by E.C.T. (electro-convulsive therapy). He was not given any relaxant drug, however, nurses were present on either side of the couch to prevent him from falling off. When he consented for the treatment, the hospital did not warm him of the risks, particularly that he would be given the treatment without relaxant drugs. He sustained fractures during the treatment and sued the hospital and claimed damages for negligence. Experts opined that there were two practices accepted by them: treatment with relaxant drugs and treatment without relaxant drugs. Regarding the warning also, there were two practices prevalent: to give the warning to the patients and also to give the warning only when the patients ask about the risks. The court concluded that the doctors and the hospital were not negligent.

Jacob Mathew Case

In this case a patient was admitted to CMC Hospital, Ludhiana. He felt difficulty in breathing. No doctor turned up for about 20-25 minutes. Later two doctors – Dr. Jacob Mathew and Dr. Allen Joseph – came and an oxygen cylinder was brought and connected to the mouth of the patient. Surprisingly, the breathing problem increased further. The patient tried to get up. The medical staff asked him to remain in bed. Unfortunately, the oxygen cylinder was found to be empty. Another cylinder was brought. However, by that time the patient had died. The matter against doctors, hospital staff and hospital went up to the Supreme Court of India. The court discussed the matter in great detail and analysed the aspect of negligence from different perspectives – civil, criminal, torts, by professionals, etc. It was held that there was no case of criminal rashness or negligence.

In the landmark Bolam case, it was held that: In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. who this 'reasonable man?' He is common man or ordinary man on the street. who is reasonably educated and intelligent but is a non-specialist. The courts used to judge the conduct of any defendant by comparing it with that of the hypothetical ordinary man.

Negligence by professionals

The Supreme Court of India has discussed the conduct of professionals and what may amount to negligence by professionals in Jacob Mathew's case:

“In our opinion, the factor of grossness or degree does assume significance while drawing distinction in negligence actionable in tort and negligence punishable as a crime. To be latter, the negligence has to be gross or of a very high degree.

In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings:

1. either he was not possessed of the requisite skill which he professed to have possessed, or,
2. he did not exercise, with reasonable competence in the given case, the skill which he did possess.

The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices.....A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional.

The Bolam case very clearly distinguished between the negligence by an ordinary man and negligence by a professional in the following words: But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man ordinary man, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

The degree of skill and care required by a medical practitioner is so stated in Halsbury's Laws of England (Fourth Edition, Vol.30, Para 35):-

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.

Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."

When negligence becomes crime under Criminal law:

Negilgence becomes offence punishable under criminal law only if degree of negligence is gross and injury is direct result of such gross negligence and presence of mens rea (guilty mind).

Criminal complaints are being filed against doctors alleging commission of offences punishable under :

- Section 304A of IPC : causing death by negligence or
- Sections 336 of IPC : act endangering life or personal safety of others
- Section 337 of IPC : causing hurt by act endangering life or personal safety of others
- Section 338 of IPC : causing grievous hurt by act endangering life or personal safety of others

Honourable Justice R.C. Lahoti, his lordship then Chief Justice of India, authoring the judgment for the bench in Jacob Mathew vs State Of Punjab (supra) categorically stated as follows:

"The order of reference has enabled us to examine the concept of 'negligence', in particular 'professional negligence', and as to when and how it does give rise to an action under the criminal law. We propose to deal with the issues in the interests of settling the law".

The relevant discussion and summary alongwith guidelines framed by Honourable Apex court are reproduced herebelow:

"No sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career. Even in civil jurisdiction, the rule of res ipsa loquitur(the thing speaks for itself) is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors. Else it would be counter productive. Simply because a patient has not favourably responded to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable per se by applying the doctrine of res ipsa loquitur.

A medical practitioner faced with an emergency ordinarily tries his best to redeem the patient out of his suffering. He does not gain anything by acting with negligence or by omitting to do an act. Obviously, therefore, it will be for the complainant to clearly make out a case of negligence before a medical practitioner is charged with or proceeded against criminally. A surgeon with shaky hands under fear of legal action cannot perform a successful operation and a quivering physician cannot administer the end-dose of medicine to his patient.Such timidity forced upon a doctor would be a disservice to the society.

The purpose of holding a professional liable for his act or omission, if negligent, is to make the life safer and to eliminate the possibility of recurrence of negligence in future. Human body and medical science both are too complex to be easily understood. To hold in favour of existence of negligence, associated with the action or inaction of a medical professional, requires an in-depth understanding of the working of a professional as also the nature of the job and of errors committed by chance, which do not necessarily involve the element of culpability.

Accident during the course of medical or surgical treatment has a wider meaning. Ordinarily, an accident means an unintended and unforeseen injurious occurrence; something that does not occur in the usual course of events or that could not be reasonably anticipated (See, Black's Law Dictionary, 7th Edition). Care has to be taken to see that the result of an accident which is exculpatory may not persuade the human mind to confuse it with the consequence of negligence.

Medical Professionals in Criminal Law

The criminal law has invariably placed the medical professionals on a pedestal different from ordinary mortals. The Indian Penal Code enacted as far back as in the year 1860 sets out a few vocal examples. Section 88 in the Chapter on General Exceptions provides exemption for acts not intended to cause death, done by consent in good faith for person's benefit. Section 92 provides for exemption for acts done in good faith for the benefit of a person without his consent though the acts cause harm to a person and that person has not consented to suffer such harm. There are four exceptions listed in the Section which is not necessary in this context to deal

with. Section 93 saves from criminality certain communications made in good faith. To these provisions are appended the following illustrations:-

Section 88: A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under a painful complaint, but not intending to cause Z's death and intending in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence.

Section 92: Z is thrown from his horse, and is insensible. A, a surgeon, finds that Z requires to be trepanned. A, not intending Z's death, but in good faith, for Z's benefit, performs the trepan before Z recovers his power of judging for himself. A has committed no offence.

A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is no time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child's benefit. A has committed no offence.

Section 93: A, a surgeon, in good faith, communicates to a patient his opinion that he cannot live. The patient dies in consequence of the shock. A has committed no offence, though he knew it to be likely that the communication might cause the patient's death.

Indiscriminate prosecution of medical professionals for criminal negligence is counter-productive and does no service or good to the society.

The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

The word 'gross' has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304A of the IPC has to be read as qualified by the word 'grossly'.

To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

Res ipsa loquitur is only a rule of evidence and operates in the domain of civil law specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. Res ipsa loquitur has, if at all, a limited application in trial on a charge of criminal negligence.

Guidelines :

The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain of criminal law under Section 304-A of IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered in his reputation cannot be compensated by any standards.

A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying Bolam's test to the facts collected in the

investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld."

Medical professionals need to remove fear of civil and criminal prosecution from their mind and should accept this as part of professional responsibility. There is need to keep the lines of communication open with patient/relatives as they are customers and future brand ambassadors. In most of the cases root cause of the problem is communication gap. Treating the patient medically or otherwise should be exactly the way we ourselves expect to get treated by other doctor / professional.

The Judges are not experts in medical profession and are humans too. At times emotions and personal experience with doctors play important role while deciding quantum of compensation/punishment. The cost of the things at the time of judgments is on the top of the subconscious mind and sometimes it takes 5- 10 years from the date of incidence to pronouncement of judgment. In view of this professional and hospital indemnity amount should be substantial.

It is time to transform the image of Doctor from Soft to Tough target. And why doctor should feel guilty about earning money unlike other professionals?

Refrences:

1. IPC
2. Consumer Protection Act,1986
3. Bolam v Friern Hospital Management Committee [1957] 2 All ER 118
4. Jacob Mathew vs State Of Punjab & Anr (2005) 6 SCC1

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डॉ. अनघा हेरुर

Consulting Ophthalmic surgeon having own practice at Anil Eye Hospital, Dombivli, Since 1997.

Bright academic career from schooling till post graduation.

Has won many gold and silver medals and awards including "Doctor of Year Award 2012" conferred by Brahman sabha dombivali.

खुद को कर बुलंद इतना

ये क्या कम है हमने आज किस्मत को हराया है,
खुदा की है इनायत हमने ये दीदार पाया है ।।

हमारी सोच ही अब मीत बन जाती तो क्या होता,
मगर इन्सान ने खुद को ही अब दुश्मन बनाया है ।।

ये माना हर डगर तनहा है, आगे हर कदम मुश्किल
जमाने ने तेरी राहों को काँटो से सजाया है ।।

कभी तनहाईयों में जिंदगी से दिल ने ये पूछा,
तेरी दुश्वार राहों ने हमें क्यों आजमाया है ?

जहाँ हर मोड पर मर मर के हमने पल गुजारे थे,
उसी दुनिया ने हमको आज जीना भी सिखाया है ।।

जरा कुछ कर गुजरने की जो हमने ठान ली जबसे,
तभीसे खुदबखुद ही मुश्किलों ने सर झुकाया है ।

डॉ. अनघा हेरुर

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ये जो है जिंदगी

ना बदला कुदरत का जलवा
न बदली ये दिन और रातें
बदलें तो बस अपने दिल हैं
और बदले हैं रिश्ते नाते ।

क्या इसी परिवर्तन का नाम जिंदगी है ?

सहर तो होकर ढलती रातें,
बदते वक्त की माया है
कब रुककर ये हमने सोचा
क्या खोया, काय पाया है ?

क्या इसी कालचक्र का नाम जिंदगी है ?

हो न हो अपने संग दुनिया
कदम कदम बस बढना है
जंग छिडी जो हर पल अब
इस दिल को तनहा लडना है ।

क्या इसी तनहाई का नाम जिंदगी है ?

हार, दर्द या मौत ही सही
नाहक उनसे डरते हैं,
यूँ चिंता में जीकर क्यों हम
पलपल डरकर मरते हैं ?

क्या इसी खौफ का नाम जिंदगी है ।

सुख कैसे पहचाने अब ?
जीवन की मंजिल है कहाँ
सुन धडकनों की पुकार..
इस दिल का साहिल है कहाँ ?

शायद इन्हीं सवालों का नाम जिंदगी है ।

डॉ. अनघा हेरुर

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SKIN DONATION : AN EASIEST WAY TO ACT NOBLE

Dr. Sunil Keswani

Skin is the largest organ of the body and acts as a shield to protect the body from environmental changes, harmful chemicals and infections. Normally our skin repairs itself from daily wear and tear. But when the skin is badly burnt or damaged it is unable to repair itself without external help.

When a person has more than 40 to 50% burns, he is vulnerable to infections, severe fluid loss and sometimes even death if body doesn't get protective cover immediately. 80% of such patients can be saved if there is enough skin in the skin bank.

We doctors can effectively spread this message in the society. It is a very simple task for all of us.

Since the concept of skin donation is relatively new, let us know about it through this article so that we can propagate the concept to the community.

In a developing country like India, where the social inequalities among the genders are high about 7 million people suffer from burn injury every year. Out of this 80% are women and children. Rest 20% is men at factories and other work places. Most of the cases of burns in women and children are homicidal or suicidal due to dowry and other domestic violence.

However there is no National Burns Registry so the above statistics is based on reports collected by police and fire brigade. But the matter of fact is because of the medico legal issue associated with any burn cases, most of the burns cases are not reported to police in rural areas. So the actual number of burns cases may be more than 7 million.

According to a Lancet study, an estimated 1.63 lakhs deaths were caused by fire in India in 2001, out of which 68000 urban and 95000 were rural fire related deaths. the ratio of young women to young men was 3:1 with fifty seven percent of women between 15 and 34 years of age. The common causes of burn injuries are dowry deaths, stove burning, self immolation, domestic violence, and professional hazards and kitchen accidents

Why Skin Donation?

When burns occur, the skin is lost which leads to infection, fluid loss and ultimately death. In case of smaller percentage of burns (total body surface area), skin from the un-burnt area of the patient is taken out and put on the burnt wound to cover it and to reduce the chances of infection but when burns percentage is more than 50% then the patient doesn't have his own skin to cover the burn wound. In that scenario we need some skin substitutes. There are a number of skin substitutes commercially available but of very high cost. Contradictorily the economic status of most of the burns patients doesn't permit them to go for such treatments.

The whole problem can be solved if people donate their skin after death. This cadaver skin is processed and can be used as a skin substitute which is regarded as the gold standard till today.

The cost of cadaver skin is very low as compared to commercially available synthetic skin substitutes.

Skin Donation Procedure:

1. Skin harvesting is done within 6 hours from the time of death.
2. A very thin layer (1/8 th layer of the entire skin) is harvested.
3. The skin is harvested from both the legs, thighs and the back.
4. There is no bleeding or oozing from the site of donation.
5. There is no disfigurement to the body.
6. The harvested part is properly bandaged and the body is given back to the family.

Contraindications for Skin Donation:

1. HIV, Hepatitis B, Hepatitis C.

2. STDs.
3. Generalized infections, septicemia (Pneumonia, Tb, etc).
4. Any kind of skin infection.
5. Evidence of skin cancer.

Advantages of Cadaver Skin

1. Donated Skin covers the burn wound and acts as a barrier of infection
2. No blood matching, no skin type matching, no color matching, no age matching required.
3. There is no pain
4. It helps to heal faster, so period of hospitalization is reduced.
5. The cost of treatment is reduced to a great extent.
6. India has a huge population and a lot of skin can be donated.
7. The cost of cadaver skin is very low.
8. The Cadaveric Skin is stored in 85% Glycerol at a temperature between 4-8 degrees Celsius. This skin can be preserved for 5 years.

In the city of Mumbai about 1000 people die of Burns every year. The majority are women.50% of these could have survived if we had enough skin in the Skin Bank. Each burn patient requires about two donations so roughly the requirement is 2000 donation per year. It is not that people do not want to donate but because people are NOT AWARE OF SKIN DONATION CONCEPT. India having a huge population will have no dearth of Skin and lot of burns victims can be saved if people come forward to pledge their skin after death to save many lives.

The details of Skin Banks being set-up under the guidance of NBC are given below :

SL. NO.	SKIN BANK	LOCAL HOSPITAL	PLACE
1	RCBN Skin Bank	National Burns Centre	Airoli, Navi Mumbai
2	Surya Hospital Skin Bank	Surya Hospital	Pune, Maharashtra
3	Orange City Hospital Skin bank	Orange City Hospital	Nagpur
4	Ganga Hospital Skin Bank	Ganga Hospital	Coimbatore
5	Victoria Hospital	Victoria Hospital	Bangalore

SKIN DONATION HELPLINE NO: 27793333

IMA Dombivli: World Health Day Celebration Shubh Mangal Hall 7th April 2016

नन्याच्या नानाची

डॉ. प्रमोद बेजकर
एम्.बी.बी.एस्.

जनरल प्रॅक्टिशनर म्हणून गेले २० वर्ष डोंबिवलीत प्रॅक्टिस. कविता आणि लेख लिहिणं हा माझा आवडता छंद. मनाला ताजेतवाने करण्यासाठी हलकं-फुलकं लिहिणं आणि वाचणं हा उत्तम उपाय आहे अशी माझी धारणा आहे. त्यामुळेच हा लेखन प्रपंच.

नन्याला आम्ही मित्र चक्रम नन्या म्हणत असलो तरी मला तो बुद्धिबळातल्या उंटासारखा वाटतो. त्याची विचार करायची पद्धत एकदम उंटासारखी तिरकी, त्यामुळे वागण्यात, बोलण्यात कायम तिरकसपणा.

शाळेत या महाशयांचा एकदा गृहपाठ करायचा राहिला आणि त्या विषयाचे मास्तर खवीस म्हणून प्रसिद्ध. त्यांचा सकाळचा पहिला क्लास. या नन्याने सकाळी जाऊन त्यांच्या मागच्या पुढच्या दारांना मस्तपैकी कुलूप लावलं. मास्तरांना ते समजून, आरडाओरडा करुन शेजाऱ्यांना बोलवून कुलूप तोडेपर्यंत, आणि ते शाळेत येईपर्यंत त्यांच्या क्लासची वेळ टळून गेलेली. हा त्याचा वात्रटपणा अम्हालाच माहित होता. तेव्हा पासून चक्रम ही उपाधी त्याला मिळालेली. तिरकसपणा ही त्याची नंतरची कमाई. या नन्याच्या आजोबांची एक गाय होती, असायची ती गोठ्यात, पण आम्हाला कुठेही गाय दिसली की आमच्यातला एकजण ओरडायचा नन्याच्या नानाची, की सर्वजण एकसुरात टेंबलायचे गाय. वय वाढलं तरी आमचा पोरकटपणा आणि नन्याचा उंटपणा काही कमी झाला नाही.

परवाचीच गोष्ट. सोसायटीतला वॉचमन मध्यरात्री खुर्चीत झोप काढत होता, म्हणून नन्याने त्याला दणकावला आणि कामावरुन काढून टाकायची धमकी दिली. तेव्हा अखिल गरीब माणसांचा जाहीर कळवळा असणाऱ्या सोसायटीतल्या एक बाई नन्याशी भांडायला लागल्या. नन्याने विषय न वाढवता गुरख्याची माफी मागितली. रात्री त्या गुरख्याला झोपायला वळकटी आणून त्याने बाजूला बोर्ड लावला, सोसायटीत रात्री येणास चोरांना मज्जाव आहे.

नन्याला कशाचं म्हणजे कशाचं कौतुक वाटत नाही. एका धाडसी पाठलागानंतर चोराला पकडणाऱ्या पोलीस अधिकाऱ्याचं पेपरात चाललेलं कौतुक वाचून नन्या म्हणाला ''पोलीस चोर नाही तर एक उंदीर पकडायला असतात ? आणि पळणारा चोर पकडला तर काय एवढं? हे काय चोर बेशुद्ध पडायची वाट बघणार काय ?'' त्यामुळेच त्याला सचिन काय नि आता विराट काय यांचं काडीइतकं कौतुक नाही. ''त्यांना रन काढायला नाहीतर काय लवकर आऊट व्हायला टीममध्ये घेतात ? आऊटच व्हायचं असेल तर मी त्यांच्यापेक्षा लवकर आणि कमी पैशात आऊट होईन की.'' एकदा सचिन लागोपाठ लवकर बाद व्हायला लागला, तर प्रतिस्पर्धी संघापेक्षा नन्यालाच जास्त आनंद. बघ पठ्ठ्या किती ग्रेट आहे. घेतलाय कशासाठी आणि करतोय काय, अगदी रत्न आहे रत्न.

मी कविता करतो म्हणून मी त्याचं नेहमीचं गिऱ्हाईक. नेहमी ऐकवी, तो कवी, असं म्हणून तो मला ऐकवी या नावानेच हाक मारतो. कवी म्हणजे शब्दाला शब्द जोडणारा प्लंबर हे त्याचं लाडकं मत. यावर तू कविता करुन दाखव की असं मी आव्हान दिलं तर, मी कुठे प्लंबर आहे असं म्हणायला तो मोकळा.

त्याच त्या मराठी भावगीतांच्या झेरॉक्स ऐकणाऱ्या एका कार्यक्रमाला मी नन्याबरोबर गेलो होतो. कार्यक्रम संपल्यावर नन्या म्हणाला. ''नाट्यगृह म्हणजे ओसाडगावाची वस्ती होती! ''सगळीकडे रिकाम्या खुर्च्या ?'' मध्यंतरात नन्या नाटकाच्या व्यवस्थापकाला सांगून आलाच, उद्यापासून ''कृपया फ्री पासेस मागा'', असं जाहिरातीत लिहा.

नन्या वाढदिवस साजरा करत नाही. तो सूर्य म्याडसारखा चकरा मारतोय, म्हणून आपलं वय

वाढतंय, नाहीतर आपलं त्यात काय कर्तृत्व, हे त्याचं म्हणणं. वय वाढलं की अक्कल वाढते असं म्हणून घरात वादंग होतात, हे त्याचं मत.

एक मोठ्या डॉक्टरकडे तो जाऊन आला. **I treat, He cures** असं अगदी ठळक छापलेलं होतं. मला नन्या म्हणाला, आकाशातला बाप म्हणे मला बरं करणार. पण त्या बापाचं हे लेकरु फुकटचे बरेच पैसे घेतयं की रे. एकूणच नन्याचं आणि देवाचं काही जमायचं नाही. देवकृपेने अपघातातून वाचलो असं कुणी म्हटलं तर, देवानं आधी तुला खड्ड्यात कशाला घातलं असा नन्याचा प्रश्न. देव म्हणजे माणसाच्या डोक्यातलं खूळ असं म्हणणारा नन्या एकदम पूजा वगैरे करायला लागलाय हे ऐकून त्यामुळेच मला जाम आश्चर्य वाटलं. काय रे तुला काय साक्षात्कार झालाय की काय, असं मी विचारल्यावर नन्या महणाला, ''अरे पुजा करण्यातली गंमत तुला कळायची नाही. पूजा करताना देव कसे आपल्या आदनेत असतात. कुठला देव पहिल्यांदा ताम्हणात घ्यायचा, कुणाला फुल वाह्यचं की वहायचच नाही, सारं आपल्या हातात. नैवेद्य पण कधी दिला, कधी नाही दिला! मी आज पुजा करीन का नाही या संभ्रमात मी देवांना रोज ठेवतो. दुधात पण साखर नाही बरं का, माझ्या डायबेटीसची परतफेड म्हणून. देव सारं काही करतात ना ? पूजा करताना मला तर देवांचा देव झाल्यासारखं वाटतं.'' यावर मी देवभोळा काय बोलणार.

क्रिकेट हा साथीचा रोग आहे, ज्याला झाला त्याची बुब्बुळं टीव्हाला चिकटतात, साऱ्याच शहरांना स्मार्ट सिटी म्हणा, म्हणजे सगळ्या बावळटांना स्मार्ट झाल्यासारखं वाटेल, आपल्याला इतिहास घडवता येत नसला तरी बिघडवता छान येतो...नन्याची किती मुक्ताफळ वेचायची ?

माझं कुठे काही किडुक मिडुक छापून आलं तर नन्या म्हणणार, अरे पेपरातलं आजचं उद्याची रद्दी. पेपर मोठा तितकी जास्त रद्दी. आता मी नन्याबद्दल लिहिलेलं परत वाचत होतो, तर ते वाचून स्वतःलाच म्हणालो, इतके दिवस तू लिहिलेलं रद्दी व्हायला दुसरा दिवस उजाडायला लागालचा. तू तर आजच सारी रद्दी केलीस. आणि मी दचकलोच. वाटायला लागलं की मीच आता नन्या होत चाललोय की काय ?

•••

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IMA'S ACADEMIC ENDEAVOR : CGP AND AMS

Dr. Niti Upasani

Dr. Niti Upasani is a Gynaecologist practising at her 'Indira Nursing Home'. She is associated with IMA Dombivli since many years. Currently she is the 'President Elect' and Chairperson of IMA CGP subchapter, Dombivli branch. She is also an Organising Secretary for forthcoming Annual Conference of IMA and Women's Wing, 'EVECON'. She is also state representative of Dombivali IMA.

Indian Medical Association of General Practitioners (IMA CGP) is the academic wing of Indian Medical Association catering to the academic needs of Family Physicians of India and Asia.

IMA CGP conducts Conferences such as International Congress of Family Physicians (ICON). Annual General Practitioners Conference (GPCON) and Zonal Conferences at various states with the best International faculties gracing the event.

IMA CGP organizes an All India Young Doctor Convention every year with the objective to advocate young doctors to pursue Family Medicine Practice as their choice and not by chance.

An International Study Tour every year not only refreshes the members but also provides them with first hand information of the Family Doctor concept in other countries.

Started in the year 1963 by Dr. P. C. Balla, IMACCIP was aimed at providing knowledge to General Practitioners awarding Fellowship of the College of General Practitioners with definite syllabus and curriculum approved by the College of General Practitioners. Changing time and the need for international exposure and recognition has made IMA CGP collaborate with other Universities, nationally and internationally.

Following are the courses offered by The College of General Practitioners:

A. CONTACT PROGRAMME COURSES:

1. Post Draduate Diploma In Emergency Medicine (PGDEM) in collaboration with George Washington University (USA) and IIEMS (USA)
2. International Post Graduate Paediatric Certificate Course (IPPC) jointly co-awarded by Sydney Children's Hospitals Network and Sydney Medical School of the University of Sydney in conjunction with IMA CGP
3. MRCGP (international) in INDIA in collaboration with Royal College of General Practitioners
4. FFM (Fellowship in Family Medicine)
5. Diploma In Family medicine (DFM) with Martin Luther Christian University, Shillong
6. Fellowship certificate in Primary care cardiology with Martin Luther Christian University, Shillong
7. Fellowship certificate in primary care Echocardiography with Martin Luther Christian University, Shillong

8. Fellowship Certificate In Diabetes and Non Communicable Disease with Martin Luther Christian University, Shillong
9. Fellowship in Reproductive Medicine with Martin Luther Christian University, Shillong
10. Fellowship Certificate In Sexual Medicine with Martin Luther Christian University, Shillong
11. Fellowship Certificate In Emergency Medicine with Martin Luther Christian University
12. Fellowship Certificate in Ultrasonography
13. Fellowship Certificate in Cancer Palliative Care Medicine with Martin Luther Christian University, Shillong
14. Fellowship Certificate in Sports Medicine and Rehabilitation with Martin Luther Christian University, Shillong

15. Honorary FCGP B.IMA E varsity or Online Courses:

IMA E-varsity Programme

Following are the online courses offered:

1.	Diploma in Family Medicine	2 Years
2.	Fellowship in Family Medicine	1 Year
3.	Fellowship in Diabetes Mellitus	1 Year
4.	Certificate in Primary Care Radiology	6 Months
5.	Certificate in Genetic Counselling	24 Weeks
6.	Fellowship in primary care cardiology	1year
7.	Fellowship in primary care paediatrics	1year

IMAAMS:

The Academy of Medical Specialities was formed in the year 1979 by the visionaries of Indian Medical Association with the intention of providing a forum for Specialists of all branches of medicine to discuss academic matters of multidisciplinary interest. The main objective of IMA AMS is to update the recent advances in all Specialities for better clinical judgment in their practice. It will also motivate specialists to actively participate in all the activities of the Indian Medical Association. The Headquarters office of the IMA Academy of Medical Specialities functioning in the IMA House, New Delhi, has been shifted permanently to Hyderabad with effect from 1st April 2008 and is located in the IMA Building at Hyderabad.

The membership of Academy of Medical Specialities is open to all the Life Members of IMA who have Speciality qualification in any discipline of medicine. The Fellows of College of General Practitioner who have passed the FCGP examination are also eligible to become members of Academy of Medical Specialities as they have specialised in the field of family medicine. The Academy of Medical Specialities also awards Fellowship to the senior members of the profession.

The Academy proposes to organize training programmes in different fields of medicine and also conduct AMS Certification Courses.

Currently there are 16 State Chapters and 128 Branch Chapters with 9061 Life Members. The Academy organises scientific programmes in all parts of the country through its State and Branch Chapters. The National body of IMA AMS organises an Annual Academic Conference and also regional Conferences in different zones of the Country. The membership of Academy of Medical Specilaities is open to all the Life Members of IMA who have Speciality qualification in any discipline of medicine. The Fellows of College of General Practitioner who have passed the FCGP examination are also eligible to become members of Academy of Medical Specialities as they have spelialised in the field of family medicine.

Friends our Dombivali IMA branch has recently been honoured to receive CGP sub chapter. Let's enrol in large numbers. Knowledge and proficiency are the keywords to success in our profession. We have to keep ourselves always abreast with newer advances and techniques. Our own IMA is helping us to do that. So let us all take advantage of this. I request you all to come forward and join our academic program in large numbers. I hope you all will respond positively.

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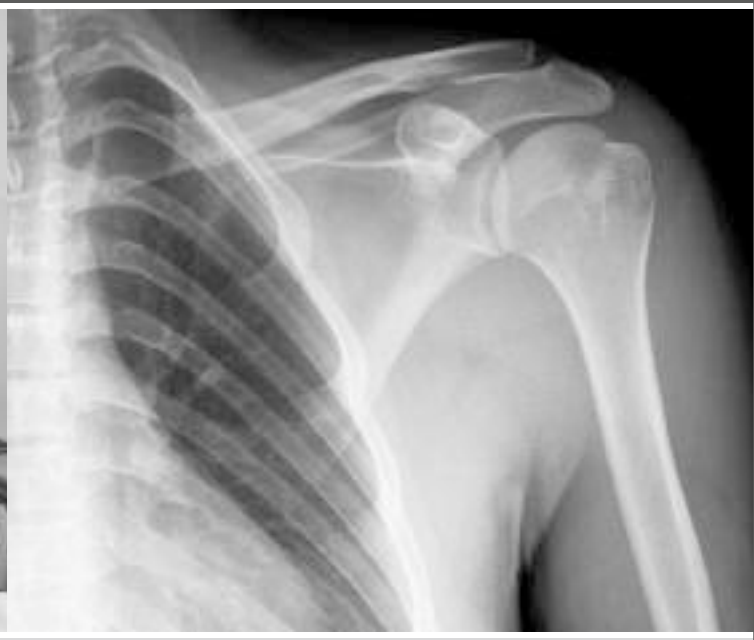

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M.D. Radiology
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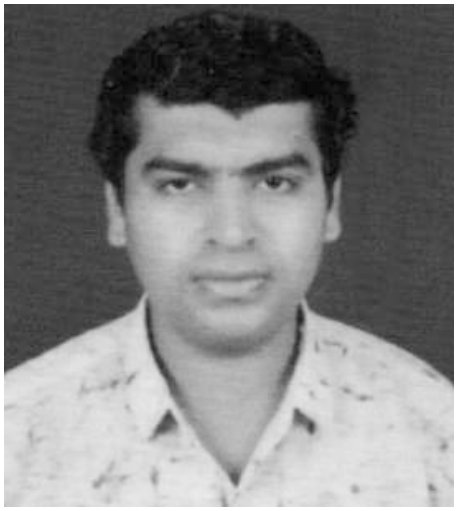
OUR CGP EXPERIENCE - FUN AND LEARN

Dr. Rajan Mane



Dr. Rajan Mane has been very active in IMA since many years and has held various posts in IMA Executive Committee. Currently he is the President of IMA Kalyan and also chairs the CGP Subchapter of IMA Kalyan branch, He is the first batch of IMA CGP degree holders of Kalyan and is felicitate at ICON currently held at Juhu IMA Hall.

The germ of a idea of setting up of IMA CGP Kalyan subfaculty was conceptualised in MASTACON Dec 2014 organised by IMA Pune at Four Points Hotel and Pune Boat Club. Since I was the secretary at the time I had taken upon myself to attend all the IMA executive meets and MASTACON functions throughout Maharashtra. this was unique way of getting to know office bearers and other Doctors from IMA Maharashtra from close quarters. Dr. Sangle Pradipkumar who happens to be IMA Kalyan State representative accompanied me in Pune MASTACON meet.

We chanced to meet Dr Ravindra Kute Surgeon from Shreerampur and then Jt. Secretary of IMA CGP Maharashtra State who enlightened us on setting up of IMA CGP Kalyan subfaculty.

As per the guidance of Dr Kute about 27 members from IMA Kalyan applied for registeration of CGP life membership with ima CGP Maharashtra state by paying a sum of Rs1000/- through IMA Kalyan bank account.

The same was notified to Dr. Raja Rajeshwar, Honorary Secretary of IMA CGP HQ in Chennai, who issued the life certificate prerequisites for enrolling as life members requires one to be IMA life member. Alternatively if a Doctor is practising for more than 20 yrs he or she is eligible for honorary membership and degree of FCGP. (Fellow of College of General Practitioners) by paying a sum of Rs. 10000/- which might have been raised now. Others had to pay Rs. 4000/- as examination fees and appear for theory and practical examination before acquiring FCGP degree. 25 candidates applied for the exam and in return received comprehensive textbook on family medicine and art of family practice compiled by Dr. Ahrul Raj and Dr. Jayalal comprising of 800 pages. apart from this candidates also received a journal to be completed with different topics and case studies of the student in the previous years.

Under the auspices of IMA Kalyan we initially formed the body of IMA CGP Kalyan subfaculty with office bearers as Assistant Director Assistant Secretary and Treasurer by mutual consent of members.

Dr. Pravin Bhujbal, M.D. (General Physician), Mr. Mangesh Kasle, M.D., Pediatrics, Dr. Nitin Chitnis, Anaesthesiologist, Dr. Vijay Thakur, M.S. (E.N.T.) and Dr. Satpute all are IMA CGP life members in spite of being speciality doctors.

IMA CGP Maharashtra State issued a letter to this effect and a bank account was opened for financial transactions.

Monthly clinics on various topics were organised sometimes with pharma companies assistance and many times in hospitals and dispensaries of members on various medical issues. The record and documentation of the same was kept to be presented to the state authorities.

We received orientation regarding FCGP exams from Dr. Kute and also from Dr Jayesh Lele and Dr Pachanekar and Dr Sujatunissa who was director IMA CGP Maharashtra state at that time. the theory examination Paper was

arranged by office 2016 bearers of Kalyan in Jan 2016. and Dr Kute came to supervise the exams which were conducted in a local school in Kalyan Lokgram. It was a three hours paper.

The practical and viva exams were originally planned to be held in KDMC hospital, in Kalyan but because of technical difficulty and consent problem were conducted in AIMS hospital. These were supervised by. Dr. Jayalal who came all the way from Chennai for the same practicals and viva were performed on 19 Feb. which started at 10 am and concluded at 2.30 pm and were well co ordinated by AIMS hospital.

All the candidates passed with good performance.

We all 25 members enjoyed this FCGP course thoroughly. The syllabus is clinically oriented, especially the book on Family Practice is quite informative quoting contemporary developments and medicines. We can treat the patients much better with all this knowledge. Even the specialist doctors opted for this course and they found it useful for comprehensive clinical practice.

FCGP degrees on 25 candidates is proposed to be held on 25 June in icon 2016 conference in IMA Juhu Hall Mumbai west branch and all the Chennai HQ officials along with IMA Mah State officials will be present for the same about 80 IMA Kyn members are expected to attend the ICON conference to witness the convocation ceremony of their colleagues in the future we hope to continue the tradition with new batches of CGP kalyan and new office bearers by consent or by election.

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INSTALLATION CEREMONY
Pathare Hall, Dombivli Gymkhana
3rd April 2016

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डॉ. अमर पोवार
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व्यवसायाने मी भूलतज्ञ. वैद्यकीय व्यवसाय म्हणजे रोजच नवीन आव्हाने पेलणे. एकंदरीतच आयुष्य म्हणजे नवीन आव्हानांचा सामना रोज करणे असे माझे मत. कलासाधना हा मनावरील ताण दूर करणारा हमखास उपाय आहे. त्यामुळे कथा, कविता आणि साहित्यात रमणे मला आवडते.

त्यातलाच हा एक प्रयत्न तुमच्यासमोर मांडला आहे.

छोट्या छोट्या चांदण्या लावलेली भली मोठी निळसर पर्स सांभाळत अरुणिमा परळ स्टेशनला पोहोलची, तेव्हा साडेसात वाजून गेले होते.

सात सेहेचाळीसची अंबरनाथ पकडून रिक्षाने साडेनवापर्यंत घरी पोचली तरी कोणी काही बोलणार नव्हतं तिला.

घरी होतच कोण ? आजारी बाबा आणि छोटा भाऊ अनिमिष.

घरचं सगळ तीच बघायची, सकाळी सहाला उठून सगळा स्वयंपाक करुन अनिला तयार करुन शाळेत सोडायचं आणि सव्वासातची फास्ट लोकल पकडायची असं तिचं गेल्या सहा वर्षांचं रुटीन झालं होतं. परतताना कधी अनिसाठी खाऊ तर कधी क्रिकेट बॅट सोबत असायची.

गेल्या काही दिवसात अनि जरा नाराजच झाला होता, त्याला गेम काही आणू शकत नव्हती ना अरु ताई...

तिने इंडिकेटर वर नजर टाकली. गर्दी यथातथाच होती, पण मुंबईची गर्दी ती. दोनच मिनिटात अख्खं स्टेशन भरुन जाईल हे तिला चांगलंच माहिती होतं. त्यामुळे पर्स ओढणी नीट सावरुन ती उभी राहिली. पहिल्या लेडीज डब्याच्या खूण केलेल्या ठिकाणावर. अजून सहा मिनिटं लोकल यायला.

डावीकडून एक तृतीयपंथी येतोय हे तिच्या चाणाक्ष नजनेरं टिपलं. तो तिच्याकडे पाहून हसला. तिला किळस आली. अरुणिमानं तोंड फिरवलं तोच तिच्या दंडाला त्याचा निसटता स्पर्श झाला.

आग ओकणाऱ्या डोळ्यांनी तिनं वळून पाहिलं. समोर भडक मेकप केलेला चेहरा. भुवया कोरलेल्या आणि लालमिट्ट लिपस्टिक. खोल गेलेले पण भोवती कोल लावून आणखी विद्रुप केलेले डोळे. कुठेतरी तिला ओळखीची खूण जाणवली पण पटकन सवयीनं हात पर्सकडे गेला. हाताला लागली ती पहिली नोट तिनं त्या खरखरीत होतात कोंबली. अन् पुन्हा चरफडली. ती पन्नासची नोट होती. तिच्या कानशीलांवरुन हलकी अलाबला काढून तो हिजडा पुढे गेला.

रेटारेटी करत अरुनं आज कशीबशी मधली सीट पटकावली आणि थोडी शांत झाली. खिडकीतून येणारा थोडाफार थंड वारा तिला सुखावून गेला, आणि...

तिला ओळख पटली. तो तृतीयपंथी तिच्या ऑफीसशेजारच्या बोगेसमोर बूटपॉलिश करणारा मुलगा होता ! संतोष त्याचं नाव.

एटीएम् कितीतरी वेळा त्याच्याकडे थाबूंन पॉलिश करुन घ्यायचा, हे दोघे फिरायला जायचे तव्हा. आता संतोषची संतोषी कधी झाली ते काही हिला कळलं नाही. आत्मारामला हे कधीच आवडलं नसतं.

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आत्माराम

नुसत्या आठवणीनंच अरुणिमाचं मन पुलकित झालं.

बदलापूरला राहणारा. गरीब पण स्वाभिमानी, मिशाळ पण हनुवटीवर ती गोड खळी असणारा, भरभरुन बोलणारा अटूट. त्याचं ए टी एम् हे नाव तिनंच ठवलं होतं आणि आता तर त्याचे मित्रही त्याच नावाने हाक मारायचे त्याला !!

त्या कॉमन गेटवरच्या भेटी, स्टेशनवर तासनतास गप्पा मारत बसणं, फोनवरच्या त्या निरर्थक रात्र रात्र चालणाऱ्या गोष्टी...

एखादा चुकार स्पर्श आणि नंतर नंतर जाणवत गेलेली त्या स्पर्शातली उब.

कित्येकदा वेळ आणि संधी असूनही न ओलांडलेली सीमारेषा... आश्वासक, फुलपंखी दिवस !

त्याला आवडते म्हणून केलेली निळसर रंगाची उधळण...निळी साडी निळा ब्लाउज आणि निळे हेउर क्लिप्स. निळीच पर्स. चांदण्या लावलेली.

अरुनं पर्स चाचपून पाहिली. किंचित हलकी लागत होती. आतलं काही पडलं का ? उघडून पाहिलं तर छोटंसं वॉलेट गायब.

अरुला हुंदकाच आला.

अटूटनं दिलेला छोटासा गणपती त्या वॉलेटमध्ये ठेवला तिनं. आणि ते वॉलेटही अटूटचीच आठवण होतं.

अर्थात शेवटची...

अरुच्या गालावरुन अश्रू ओघळू लागले.

स्फुंदत स्फुंदत ती पर्स पुनःपुन्हा उलटी पालटी करु लागली.

अरे ए टी एम्, मला अशी पाहून तुला दया कशी येत नाही ? कुठे जाऊन बसलायस ??

समोर एक परिचित भडक साडी उभी राहिली. अरुने वर पाहिलं, तर संतोष.

'ये छोटा पर्स आपका है ना ? चढते टाइम मुझे डोअर में मिला. आपको यहाँ चढते देखा तो समझ गयी आपका है.

झडप घेऊन तिनं वॉलेट उघडलं.

गणपती तिच्याकडे पाहून हसत होता !

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HEMOPHILIA

Dr. Sandeep Bartakke
MD., MRCPCH
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MD.

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He has done his MD and DCH from Mumbai and acquired a degree of MRCPCH from London. He has done his fellowship in Hemato Oncology from Toronto. He has more than 10 publications in National and International Science Journals.

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INTRODUCTION

Hemophilia is an X-linked congenital bleeding disorder caused by a deficiency of coagulation factor VIII(in hemophilia A) or factor IX (in hemophilia B).

In India, the incidence is 1 per 10,000 births and our country harbours the second highest number of global patients with haemophilia A.

INHERITANCE PATTERN

It is an X- linked recessive disorder. A family history of bleeding is obtained in about two-thirds of patients, and as many as 1/3 of cases are the result of spontaneous mutation .

When should we suspect Hemophilia?

Hemophilia should be suspected in patients presenting with a history of

1. Easy bruising in early childhood
2. "Spontaneous" bleeding, particularly into the joints, muscles, and soft tissues
3. Excessive bleeding following trauma or surgery

Bleeding manifestations

The characteristic phenotype in hemophilia is the bleeding tendency. Some children with severe hemophilia may not have bleeding symptoms until later when they begin walking or running. Most bleeding occurs internally, into the joints or muscles. The severity of bleeding in hemophilia is generally correlated with the clotting factor level

How to establish the diagnosis of haemophilia?

Screening tests (Platelet count, PT, APTT, bleeding time) will show isolated prolongation of APTT.

Correction or mixing studies using pooled normal plasma will help to define whether prolonged APTT is due to inhibitors of factor deficiency.

A definitive diagnosis depends on factor assay to demonstrate deficiency of FVIII or FIX.

PRINCIPLES OF CARE IN HEMOPHILIA

1)Prevention of bleeding and joint damage

Drugs that affect platelet function, particularly acetylsalicylic acid and non-steroidal anti-inflammatory drugs NSAIDs, except certain COX-2 inhibitors should be avoided.

- Good oral hygiene is essential to prevent periodontal disease and dental caries, which predispose to gum bleeding
- Physical activity should be encouraged to promote physical fitness and

normal neuromuscular development, with attention paid to muscle strengthening

PROPHYLAXIS FOR HEMOPHILIA

Regular prophylaxis with 2 to 3 times per week factor infusion can prevent recurrent joint bleeding and joint deformities.

2) Prompt management of bleeding

- Acute bleeds should be treated as quickly as possible, preferably within two hours.
- In severe bleeding episodes that are potentially life-threatening, especially in the head, neck, chest, and gastrointestinal tract, treatment with factor should be initiated immediately, even before diagnostic assessment is completed.

First aid measures:

In addition to increasing factor level with clotting factor concentrates (or desmopressin in mild hemophilia A), protection (splint), rest, ice, compression, and elevation **(**PRICE**)** may be used as adjunctive management for bleeding in muscles and joints.

Pain management (Pain caused by joint or muscle bleeding)

1. Cold packs, immobilization, splints, and crutches
2. Initially, intravenous morphine or other narcotic analgesics can be given, followed by an oral opioid such as tramadol, codeine. When pain is decreasing, paracetamol/acetaminophen may be used.

HEMOSTATIC AGENTS FOR HEMOPHILIA

It is strongly recommended to use viral-inactivated plasma-derived or recombinant concentrates in preference to cryoprecipitate or fresh frozen plasma for the treatment of hemophilia and other inherited bleeding disorders.

Dosage/administration :

In the absence of an inhibitor, each unit of FVIII per kilogram of body weight will raise the plasma FVIII level by 2 IU/dl and each unit of FIX per kilogram of body weight will raise the plasma FIX level by 1 IU/dl.

The dose **of FVIII** is calculated by multiplying the patient's weight in kilograms by the factor level in IU/dl desired, multiplied by 0.5.

The dose **of FIX** is calculated by multiplying the patient's weight in kilograms by the factor level in IU/dl desired

Factors should be infused by slow IV injection at a rate not to exceed 3 ml per minute in adults and 100 units per minute in young children

OTHER PLASMA PRODUCTS

FRESH FROZEN PLASMA

Dosage/administration

- One ml of fresh frozen plasma contains 1 unit of factor activity.
- It is generally difficult to achieve FVIII levels higher than 30 IU/dl with FFP alone.
- FIX levels above 25 IU/dl are difficult to achieve. **An acceptable starting dose is 15−20 ml/kg**

CRYOPRECIPITATE

- **It is preferable to FFP for the treatment of hemophilia A**
- Cryoprecipitate contains significant quantities of FVIII (about 3-5 IU/ml), VWF, fibrinogen, and FXIII but not FIX or FXI and hence it cannot be used for hemophilia B

Dosage/administration

- A bag of cryoprecipitate made from one unit of FFP (200-250ml) may contain 70–80 units of FVIII in a volume of 30–40 ml.

Other pharmacological options

Desmopressin (DDAVP)

- DDAVP may be the treatment of choice for patients with mild or moderate hemophilia A .
- Desmopressin does not affect FIX levels and is of no value in hemophilia B
- A single dose of 0.3 µg / kg body weight, either by intravenous or subcutaneous route, increases the level of FVIII three- to six-fold

Tranexamic acid

- Tranexamic acid is an antifibrinolytic agent that competitively inhibits the activation of plasminogen to plasmin.

Epsilon aminocaproic acid

- Similar to tranexamic acid but is less widely used as it has a shorter plasma half-life, is less potent, and is more toxic

3) **Management of complications including: joint and muscle damage and other sequelae of bleeding**

4) **Management of inhibitor development & viral infections transmitted through blood products**

Genetic testing/counselling and prenatal diagnosis

Where available and possible, genetic testing for carrier status should be offered to at-risk female family members of people with hemophilia to facilitate genetic counselling, and if desired by the family, prenatal diagnosis.

Vaccinations

1. **Persons with bleeding disorders should preferably receive the vaccine subcutaneously rather than intramuscularly or intradermally.**
2. If intramuscular injection is to be given, it is best done soon after a dose of factor replacement therapy.
3. An ice pack can be applied to the injection area for five minutes before injection, the smallest gauge needle (usually 25-27 gauge) should be used and pressure should be applied to the injection site for at least five minutes

Newer advances

1. Gene therapy trials have shown promising results.
2. Better factor concentrates e.g. 4th generation Recombinant, Human cell culture, Long-acting factor concentrates.

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IMA Dombivli: 2nd CME
Pathare Hall, 15th June 2016

NEW FRONTIERS IN EPILEPSY MANAGEMENT

SPARSH

Multispeciality Hospital & I.C.C.U.

ISO 9001:2008 CERTIFIED

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

1st Floor, Sudama Arcade,
Dr. R. P. Road, Tilak Nagar,
Dombivli (E) 421 201
Tel.: 0251 - 2445044, 2448044
Email : sparshhospital12@gmail.com

FACILITIES

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

MEDICLAIM FACILITIES CASHLESS

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

Dr. Hemant S. Wahane

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

Dr. Amol U. Sonawane

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

Dr. Charusheela H. Wahane

D.A.
Anaesthesiologist

Dr. Shalaka A. Sonawane (Mungekar)

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

HON. SECRETARY'S REPORT

Dr. Utkarsha Bhingare

It is a great honour to be elected as the secretary of the esteemed IMA Dombivli branch and I accept the position with full responsibility. I am aware of the duties that come with the position and I am positive that I will be able to discharge them well. I extend my whole hearted support to President Dr Hemraj Ingale. Our aim over this year is to make IMA more transparent, efficient and stronger in each and every avenue.

Under the able leadership and guidance of Dr Hemraj Ingale and the executive committee we had our new membership enrolment drive in month of May. We had record breaking new membership this year. we installed 20 single life and 14 couple life members.

Under the **"Aao Gaon Chale"** thrust area of president, 2 camps were conducted at Mamnoli. In first camp 127 patients benefitted while in 2nd camp 259 patients were examined.

2 CMEs were conducted with one credit point each.

It was a Proud moment for IMA Dombivli when our branch got CGP subchapter during the prestigious Annual CGP conference at Juhu on 25th June 2016.

I thank you all for your support and seek your co-operation in all our future programs and projects.

Complete Cancer care

10 YEARS OF SUCCESS

Radiation

Radiation Therapy: It's a painless treatment to kill cancer cells either as a part of comprehensive treatment including surgery and chemotherapy or radiation alone. Here we have state of the art machine that delivers the highest technique of treatment – IMRT, IGRT, ARC, SRS, SRT with precision to the mark. We love to see the patients go back smiling with the minimal side effects as a result of accurate treatment given by our highly skilled and experienced radiation oncology team.

Surgery

Surgery: The surgical oncology team at AIMS is that of highly skilled cancer surgeons and plastic surgeons. They execute complicated surgeries and reconstruction in state of the art modular operation theatre. The hospital also boasts of well equipped and staffed recovery rooms and ICU. They have expertise to perform surgeries of all body parts.

Chemotherapy

Chemotherapy: Chemotherapy are agents that act on cancer cells all over the body when injected into the body. At AIMS, all agents of chemotherapy are delivered under the supervision of well trained and experienced medical oncologist. The team ensures appropriate administration of chemotherapy accompanied by complete supportive care of patients.

AIMS
WE ARE THERE

Asian Institute of Medical Sciences

Super-Specialty Hospital

Dombivli

Tel :- 0251-2475000, www.aimshospital.co.in

Helpline No : - 9930227687

सैराट : एक चिंतन

डॉ. अद्वैत पाध्ये
एम्.डी.डी.पी.एम्.

व्यवसायाने मानसोपचार तज्ञ. टिळकनगर विद्यामंदिर येथे शालेय व जी.एस्. मेडिकल कॉलेज व के.ई.एम्. हॉस्पिटल, मुंबई येथून वेद्यकीय शिक्षण. सर्व शिक्षणात चमकदार कामगिरी. व्यवसायाबरोबरच अनेक सामाजिक उपक्रमही राबवतात. व्यक्तिला तणावाच्या 'distress level' मधून 'disorder level' मध्ये म्हणजे 'मनोरुग्ण' पातळीपर्यंत जाऊ न देणे हे मुख्य ध्येय. अनेक वृत्त पत्रांमधून मनोविश्लेषण व लेखन.

साधारण दोनेक महिन्यांपूर्वीची गोष्ट. सैराट या शब्दाने smart media वर धुमाकूळ घातला होता. रोजच्या रोज record break !! आज ३० कोटींचा गल्ला, उद्या ४० परवा ८०, तेरवा रिंकू राजगुरुला राष्ट्रीय पुरस्कार. टोकाची स्तुती आणि टोकाची टिका. स्तुती असो वा निंदा परिणाम एकच. प्रसिद्धी आणि प्रसिद्धी. इतका वलयांकित झालेला चित्रपट पाहण्याची अतोनात इच्छा नाही झाली तरच नवल. शेवटी परवा तो योग आला.

थिएटर मध्ये गेलो. पहिला धक्का. एवढ्या आठवड्यानंतरही house full !!! दुसरा धक्का नव तरुणाई पासून ते मध्यमवयीन वयस्क आणि अतिवयस्क सर्वांचीच गर्दी. म्हणजे सगळ्या वयोगटा पर्यंत पोचलाय सिनेमा मी तर्क केला.

सिनेमा सुरु होताच त्याचे स्वागत शिट्ट्यांनी झाले. पण मला सिनेमा सुरु झाल्यावर त्यातली भाषा कळायला मात्र दोनचार मिनीटांचा वेळ लागला. पूर्ण ग्रामीण ढंगातली भाषा रोज ऐकायची सवय नसल्यामुळे असे झाले, पण मग भाषेची, संवादांची पकड बसली ! सिनेमातली ग्रामीण पार्श्वभूमी आणि तिथलेच साध्या चेहेऱ्यांचे मुख्य व सगळेच नवे कलाकार, उत्कृष्ट कथा, पटकथा, संवाद, सर्वात मुख्य म्हणजे अजय अतुलचे बदहारदार, जनसामान्यांची नस ओळखून बांधलेले संगीत, कलाकारांचा नवीन असुनही जमलेला सहज अभिनय. या सिनेमाच्या जमेच्या बाजू. फक्त थोडा गतिमान असता तर बरे असे फक्त वाटले. सिनेमातील गीते पण कथेच्या ओघात येतात. अर्थपूर्ण आहेत. त्यामुळेच प्रभावी ठरली आहेत.

आता चित्रपटाच्या आशयाविषयी ! सिनेमाचा पहिला अर्धा व दुसरा अर्धा असे भाग करुन मग विचार करु या. आमच्या शेजारी बसलेल्या एका नवतरुणाच्या मते तर मध्यंतरालाच सिनेमा संपतो! म्हणजे, सगळी गाणी, मस्ती, मजा एका पहिल्या भागात दाखवल्यावर दुसऱ्या भागात सिनेमा एकदम गांभीऱ्याकडे वळतो त्यामुळे ते सामान्यांना पटत नाही किंवा पचत नाही. असो. सिनेमात परश्या नावाचा कॉलेज तरुण आर्ची या त्याच्याच कॉलेजमधल्या मुलीच्या प्रेमात पडतो (याडं लागलं). त्याला ती आवडत असते. तो तिच्या मागे असतो. त्यावेळेस त्याच्या मनात तिची आर्थिक स्थिती, उच्च जात वगैरे काहीच नसते. तो फक्त तिच्या प्रेमात असतो आणि त्यासाठी तो, त्याचे मित्र तिच्यावर इंप्रेशन पाडायचा प्रयत्न करत असतात. पण जेव्हा वर्गात त्याचे मार्क्स कळतात, तो कविता वग२रे करतो हे कळते तेव्हाच त्याचे स्थान आर्चीच्या मनात बळकट होते, म्हणजेच आजच्या ही काळात किंवा त्या वयातसुदेधा मुलीला मुलाचे त्या वयातील कर्तृत्व किंवा चांगले कामच आवडत असते. हे अधोलिखित होते. त्यापुढे मात्र आर्चीच पुढाकार घेते. आजच्या मुलीसुद्धा जास्त बोल्ड झाल्या आहेत. त्या स्वतःला व्यक्त करतात हे दिसते किंवा आर्ची सारख्या उच्च वर्गातल्या मुली असे करु शकतात. सत्तेमुळे असेही असु शकेल! आणि अडनीड्या वयामुळे त्यांच्यात शारिरीक आकर्षण येते (झिंगाट) व त्यात ते वहावत जातात (सैराट झालं जी), ज्यामुळे त्यांना विरोधाला सामोरं जावं लागतं व शेवटी एकमेकांबद्दलच्या अप्रीव ओढीला मियंत्रित करु न शकल्याने ..... बेभान (प्रेमात) होऊन पळून जातात.

मग समोर येतं ते खरं वास्तव. कायद्याचा करावा लागलेला सामना, मारहाण, मग पळून

गेल्यावर मागे लागलेले गुंड, झोपडपट्टीत रहावे लागणे, तिथली घाण, दारिद्र्य, काम करावे लागणे यामुळे उच्चवर्गातल्या आर्चीला एकटे वाटणे, कुठे निघून आलो, चुक केली असे वाटणे, आईची आठवण येणे वगैरे वास्तव अतिशय छान दाखविले आहे. त्याचबरोबर त्याचा तिच्याबद्दलचा पझेसिव्हनेस, त्यातून संशयी वृत्ती व मग भांडण. मग आधीच भावनिक झालेल्या आर्चीचे रागावून निघून जाणे व परत येणे हे देखील खुप/सैराट प्रेमात पडलेल्यांबद्दल एक वास्तव छान दाखवले आहे. फक्त परश्याला आपल्या घरच्यांची, मित्रांची आठवण पण येत नाही हा भाग खटकतो.

आणि मग सगळे छान होऊ लागलेले असतानाच, ते आयुष्यात स्थिरावत असतानाच पुन्हा जातीय अस्मिता व राजकीय नुकसानामुळे बेभान झालेले आर्चीच्या घरचे लोक स्वैराचारी (सैराट) होतात. स्वतःच्याच बहिणीचा व परश्याचा जीव घेतात व त्या छोट्याला अनाथ करतात हे देखील भयानक असे सामाजिक वास्तव दाखवत दिग्दर्शक आपल्याला म्हटलं तर सुन्नं करतो, म्हटलं तर जागं करतो !

म्हणजे एकीकडे टीन एज मधला परशा, आर्चीचा स्वैराचार त्यांना एका भयानक वास्तवाला सामोरे नेतो. त्यामुळेच त्यांचे शिक्षण वगैरे सर्व बाजूला पडते, प्रत्येकालाच त्या बाई/काकूंसारखी मदत करणारी व्यक्ती भेटेलच असे नाही. त्यामुळे प्रेम करताना वा प्रेमात पडले तरी आपल्या भावनांवरचा आपला लगाम घट्ट ठेवायलाच हवा, डोके शांत ठेवून, सर्वांना आपले प्रेम पटवून देऊन तसेच करिअरचे / शिक्षणाचे भान ठेवून प्रेम करा हा संदेश जणू हा सिनेमा सर्व वास्तवातील परश्या व आर्चींना देतोय ! टीनएजर्ससाठी लैंगिक शिक्षणासाठी हे महत्त्वाचे योगदान सिनेमा देतो !

त्याचबरोबर जातींचे आपल्या समाजात घट्ट पाळेमुळे रोवून बसणे हे भयानक वास्तव समोर येते. त्यामुळे परश्याचे कुटुंब देशोधडीला लागते. त्यांची जात पंचायत पण त्यांना बहिष्कृत करते. हे वास्तव आजही महाराष्ट्रात, देशात आहे हे किती विचार करायला लावणारे वास्तव्य आहे ! जाता जात नाही मनातून, त्यामुळे वागण्यातून पण तिला घालवायला पाहिजे, निदान या जात पंचायती तरी बंद केल्या पाहिजेत. यासाठी अनिस जो संघर्ष करते आहे त्याचे महत्त्व अधोरेखित करते.

सर्वात महत्त्वाचे म्हणजे उस, साखर, पैसा त्यातून राजकारण म्हणजे सर्वांवर गुंडगिरी करत सैराट–स्वैराचारी वागणे व कोणत्याही टोकाला जाणे. राजकारणासाठी जात जाती पैशांशी सौयरीक किती महत्त्वाची आहे हे विदारक सत्य हा सिनेमा अधोरेखित करतो.

पण नुसतेच विचार करुन उपयोग नाही. या तीनही बाबतीत कृतीही तेवढीच आवश्यक आहे, नाहीतर सैराट होतच राहतील यात शंका नाही !

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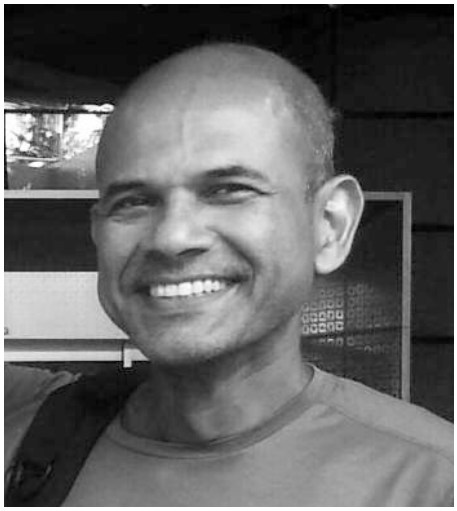

Dr. Ajit Oak ...The Champion ...

Dr. Ajit Jambhekar who interviewed Dr. Oak on his great achievement

Friends,

Dr. Ajit Oak is just back after completing his 89-27 km ultramarathon run from Pertermaritzberg to Durban in South Africa on 29-05- 2016. This extremely gruelling run takes a severe toll on your mind & body. You need great grit, determination and efforts to complete the marathon. Here are some views he shared with us.

Q.1 When did you take up running and what prompted you to do so ?

Ans. I was a recreational runner since 1978, when I was in 8 th standard. I used to do 6 to 7 rounds of Shivaji Park every day early in the morning (1 round = 1 km.) When I started my practice in Dombivli in 1991, I was 72 kg. and with load of practice and irregularities in sleep – eat – work schedule……, I put on weight, exponentially. By the time it was 2003, I was 107 kg. I Started getting sleep apnoea, headache and at this point I started dieting and serious running.

Q. 2 Which was the first significant run under taken by you ?

Ans. In 2004, SCMM edition I did my 1 st dream run which was 7 or 9 km. I took 45 min. The same year, my friend's wife Dr. Mrs. Parekh from Ghatkopar ran 21 km. and this ticked me and the very next year i.e. 2005 SCMM I did my 21 km half marathon And in the same year in December 2005 I ran my 1 st full marathon.

Q. 3 Your 1 st "Comrade" Marathon (87 km.) was completed in 2011, where else did you participate ? What is so unique about "Comrade" Marathon?

Ans. SCMM in Jan. every year since 2006

Pune International every year since 2005

Thane Varsha Marathon Since 2010

Berlin Marathon 2007

Sydney Marathon 2007

Honkong Marathon 2008

Singapore Marathon 2013

Bengaluru Ultra Marathon 2010 75 Km, 100km in 2011 and 2012.

Kaveri Trail Marathon

Aurovil Marathon

Satara hill Marathon

Hydrabad Marathon

1 Comrade is mother of all races. It is a drutal race run in hilly area between Durban and Petermaritzberg.

2 On even years it is from Petermaritzberg to Durban. It is Down run,89.25 Km. On odd years it is from Durban to Petermaritzberg, up run 87 km.

3 One has to complete the race within 12 hours.

4 Gun time is the start time.

5 Participant has to qualify for the race by completing full marathon within 5 hours.

6 Participants are seeded, depending on their FM timings, from A to H, the fastet in A & slowest in H pen.

7 This slowest runners in H pen lose almost 10 minutes before they actually start the race i.e. when they cross the start point.

8 There are cut off points at various distances.

Distance	Cut of time
31 km.	3 hrs. 10 min.
45 km.	6 hrs. 10 min.
58 km.	8 hrs. 30 min
69 km.	10 hrs.
82 km.	11 hrs. 20 min.
89 km.	12 hrs.

One has to cover the distance within the cut off time, failing which the runner is not allowed to run ahead of that point. He is bailed at that time.

1 It has 5 named hills i.e. Cowies hill, Fields hill, Bothas Hill, Polyshort, Inchangia and 17 other unnamed hills.

2 The Course is hilly and passes through valley of 1000 hills.

3 Down run has net elevation open of 1200 meters & up run has net gain of 1800 meters

4 Comrades was born in 1922, when Vic Clapham, a grocery shop-owner from Petermaritzberg organised 1 st race between 2 cities with a view that, if the soldiers participate, they would be strong army men.

Q. 4 How do you train yourself for this race ?

Ans. It requires good foundation. The training starts in December and ends in April. Typically one has to do minimum of 5 days training per week, to cover 1200 km. in 5 months. Each week includes time trial, speed trails, hill repeats, long run, temporun. One has to do 3 marathon (42 miles) 3 more runs each of 50 km. 56 km & 66 km during this period. This has to be tapered off in the last month for legs to freshen up for the final race important is to stay injury free ! I train myself at the monstrous Matheran hills. It has total 6.7 km. distance from bottom to top with elevation of 700 meters.

Q. 5 Does the training & sports gym create a hole in your pocket ?

Ans. Yes ! Training requires you to sacrifice lot of things : Time, Energy & money ! & your family time of course which can not be counted in money.

Q. 6 Almost 12 hours of running & no Official time out, how do you replenish your calories & fluids? Are leg cramps very frequent & painful ?

Ans. One has to calculate the calories, water, electrolyte loss during running activity. One needs 1 st Class proteins, like whey proteins all green leafy vegetables, beetroot products, sweet potatoes, Before the race one has to load with proteins carbohydrade to replenish glycogen stores. On race day 250 ml. water & electral every 2 km. with dates & energy bars. Body cooling with ice cold water is essential. Salt sugar solution magnesium supplement every 10 km. All these measures prevent lactic acid accumulation in muscles. If the muscles are over fatigued or are faced to work at a pace faster than training pace, muscles start firing or contracting erratically and the cramps sets in and once it sets in is very difficult to come out of it.

Q. 7 What is the Bus system in comrades Marathon?

Ans. Bus is nothing but a herd of runners with a leader or Bus driver who is trained to run the race distance within 12 hrs. or 11 hrs. or 10 hrs. The bus driver paces the group and brings the bus within the time limit of the bus.

Q. 8 Have you suffered any major injuries while running ?

Ans. While running comrades 2012, 2013, 2014, 2015 all these 4 years I suffered from severe cramps in both calves, limiting my pace

Q. 9 Running is surely a healthy sport, but does too much of it affect your knees ?

Ans. Any sport activity will produce some damage to the body. But with proper training, strengthening,

stretching those injuries can be minimised, whether it is knee or spine .

Q. 10 A large number of Marathon runners have been reformed addicts. With that in view, will you expect the youngsters to take up to running to stay focused in life ? Will you coach them for running

Ans. In western population many top atheletes are reformed addicts fortunately scenario is not same in India. Most of the talented runners are from villages, rural areas. Due to lack of proper training guidance and financial constraints they fail to surface on the competitive event.

Young generation should be encouraged to participate any of the sport activity easily available for them and should be practical for their geographic area.

I would love to coach them for running.

Q. 11 What started as a hobby turned into a passion and now it is almost a part of life with you, did anyone discourage you?

Ans. Nobody discouraged me from this activity but always advised me to take proper rest and recover after the event and not to tax the body with burden. Running activity should not be exertion but should be exercise & relaxation.

Q. 12 After such splendid achievement would you take up to audiovisual motivational facts for school & college students. ?

Ans. School & college youth forms budding sport stars & scientists, I would love giving motivational talks to them.

Finally before I conclude, I think I would attribute a lions share of my success to Medha, Bageshree and my entire family for their unstinted rock solid support for this achievement.

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INSTALLATION CEREMONY
PathareHall, Dombivli Gymkhana
3rd April 2016

TO LIVE HAPPILY EVER AFTER: MARRIAGE IS A MARK SHEET

Harish Shetty
(Reprint with permission. Form blog)

If anyone bombastically roars in a party that 'they are happily married', then remember that it is a lie. There are no happy marriages. Peaceful marriages are a realistic goal where happiness is a byproduct. Happiness can never be chased nor avoided. Pleasures can be gone after and that is not the same as happiness. And when some couples share that they never had a crisis in their conjugal life then there never is and was any love. Crisis is a sign of affection and love. Irrevocable crisis is a sign of love on the death bed or the postmortem room……It may be a sign of hostility and vengeance too.

Marriages like any institution are in an exciting flux colored by the issues, idiosyncrasies and innovations of our era. As women are asking for more and the sea of humanity wanting to live centuries in a decade, the emotions sprinkle and at times burst causing pain, joy, change and also harm. Following are some scenarios one sees in day to day life…….

Time is Gold

Couples remind themselves that they are married by watching the cozy photograph stored on the cell phones. As long working hours sap the energy and provide very little time to connect, touch, time and talk are the casualties. The soul and the skin both remain undernourished. Irritability and anger are the consequences. Lack of sleep also adds fuel to the fire. When time is scarce, emotional contact time replenishes emotional energy. The Mehtas would come home and argue over who will pay the bills, help the kids with tuitions and son and so forth. After a few sessions the couple simply began by resting their heads on each other's lap and sharing feelings ….in my words the LAP TOP MANTRA. Everything changed. Energy was back and bonding better and tasks completed in record time. Rediscovering soft touch and small talk improves relationships. Emotional contact time and family contact time even brief, short but intense neutralizes the toxins caused by rapid pace of life.

Changing power equations

As the empowerment of women is a slow and sure, reality power equations are changing. The wife wants a separate bank account and the liberty to take important decisions. This when understood and accepted by the husband helps build relationships and reduces burden on one spouse. But when this change is resisted conflicts are visible. The Cherians are in deep distress. Though the husband insisted on a working wife they had serious objections to her phone calls, dressing sense and late hours at office. They wanted her salary cheque to be deposited in the husband's account. She objected. The man wanted me to convince his wife. I led the man to get in touch with his fears. 'She will leave me and go, my mother always obeyed my father.' As the fears were laid bare on the table we explored the positive change the wife had brought to the family. 'She is chirpy, happy and has added glow in all our hearts'. The issue was clinched. The irrational beliefs were demolished slowly. Freedom to sleep, spend and splurge is a must for the new age woman.

New Definitions

Marriage has many definitions as perceived by people. In my opinion it is 'mind to mind, lip to lip, heart to heart and hip to hip'…where every aspect is important. Many suffer from a syndrome of 'anticipating worry' all the time. In a couple when one partner anticipates worry there is a conflict. There are negative statements made all the time by the spouse leading to reactions from the other. For e.g. a husband once said that 'his wife is happy-go-lucky and is irresponsible'. This was because she had planned a picnic inspite of the fact that their child scored less in a school test. The husband did not have a positive demeanor of anticipating joy. The wife wanted to unwind and the husband would not listen. In another couple the wife actually suffered from the syndrome of, 'capture, copy and file'. She would recall all negative incidents and share it all the time. She had little memory for the positive ones. Anticipating joy and recalling positive experiences in life helps marriages rock. Physical intimacy is important and spelling out each other's needs adds zing to a marriage.

Distance and boredom

Many couples do not understand that seeing each other under the roof of a restaurant is not similar to living under the same roof. Things change. A lady complained that her husband was better when her husband was a boyfriend. Men have similar complaints. Love is not about roses,

gifts and about a long kiss. Love is also about the pains, tribulations and struggle. It needs maintenance just like a car. It needs engine oil and coolants. Many fail to understand this. Living together would mean parents, uncles and relatives in contact with all their needs, egos, sermons and quirks. When the man believes that his in laws are 'mother in love' and 'father in love 'the marriage remains well oiled. Yet in some families there may be conflicts and the couple may do well with each other but not with their families. Here the maxim of 'minimum contact and minimum conflicts' works.

When the vows break

Cultures do not meet any more but bang into each other. Work places are about long intensive activity where hearts and minds engage each other. Love is never restricted to numbers whereas romance has to be restricted to one. Many convert their 'likes' into 'love' and fall in love with another. Globalization and its pace is also a cause. When societies do not meet naturally, it mates unnaturally. Love marriages also face the risk of being challenged and at times the split is wide open. Many feel that love marriage is a guarantee for lifelong union and that is not true. Love marriage is heart to the hip, whereas arranged marriage is from the hip to the heart.' Living together fosters love which is why arranged marriages also succeed. Both need hard work to thrive. Love has birth, growth and death and at times rebirth. If it dies and does not revive it is better to seek a separation rather than simply exist. A peaceful separation helps children to accept the same and remain free from trauma. If a society celebrates birth and death, marriage and divorce, the society will be healthier and enjoy more peace. Divorce parties are as important as marriage parties.

Emotional arbitration

Any relationship in life can go sour be it a marriage, a business partnership or a friendship. In a conflict one is blind and deaf. The fight vitiates the narrative and exaggerates personal perceptions. There is amnesia of the positives and exaggeration of the negatives. Here the arbitration of friends, family or a counselor may help. There are several institutions of arbitration in communities. Marriage counseling may take weeks, months and years too. Both the partners need to invest so much time in the same.

Depression can cheat

When the Iyers were quarreling every day and were on the brink of a divorce they visited a counselor. It all began with simple irritable behavior that led to confrontations on various issues. The din of the fights submerged the origins of the conflict and the blame game began. When the counselor slowly dissected the problem, he saw the origins in the illness of depression which the husband suffered. Treatment of this man resolved everything. Depression may hit any one and may not have a trigger. Identifying it early and rectifying it is a must. Shoving it under the carpet can destroy a marriage. Such fractures of the grey cells are easily treatable. When it is mild, exercise can be an antidepressant. Yoga, Vippassana and other forms of meditation helps marriages. Yet one needs to understand that these practices are not a substitute for healthy communication.

New scripts

The script of day-to-day life has changed. Couples may be thrown in different cities, may choose not to have kids and may be married to their work where the conjugal partner may be the second spouse. So a million variations may exist and as long as they find balance, life moves peacefully at a different pace during different times. Marriage is no longer the goal of women and many men too, and that is all right. Being alone is better than being lonely inside a marriage some share. Gay marriages will be soon a reality and living together without the sanction of the establishment are seen .Here the same rules apply as in sanctified marriages.

Marriage is a mark sheet where a spouse may not score good marks in all subjects, but the average score is the key. One may try to increase the score as far as one can in a lifetime. Adjustment may have cost Manmohan Singh his job but marriages do succeed with a little give and take.

The secret is working towards peaceful coexistence!

[Dr Harish is a Psychiatrist and a Counselor. He can be reached at mindmoodsandmagic.blogspot.in. All the names in the article have been changed to protect identities]

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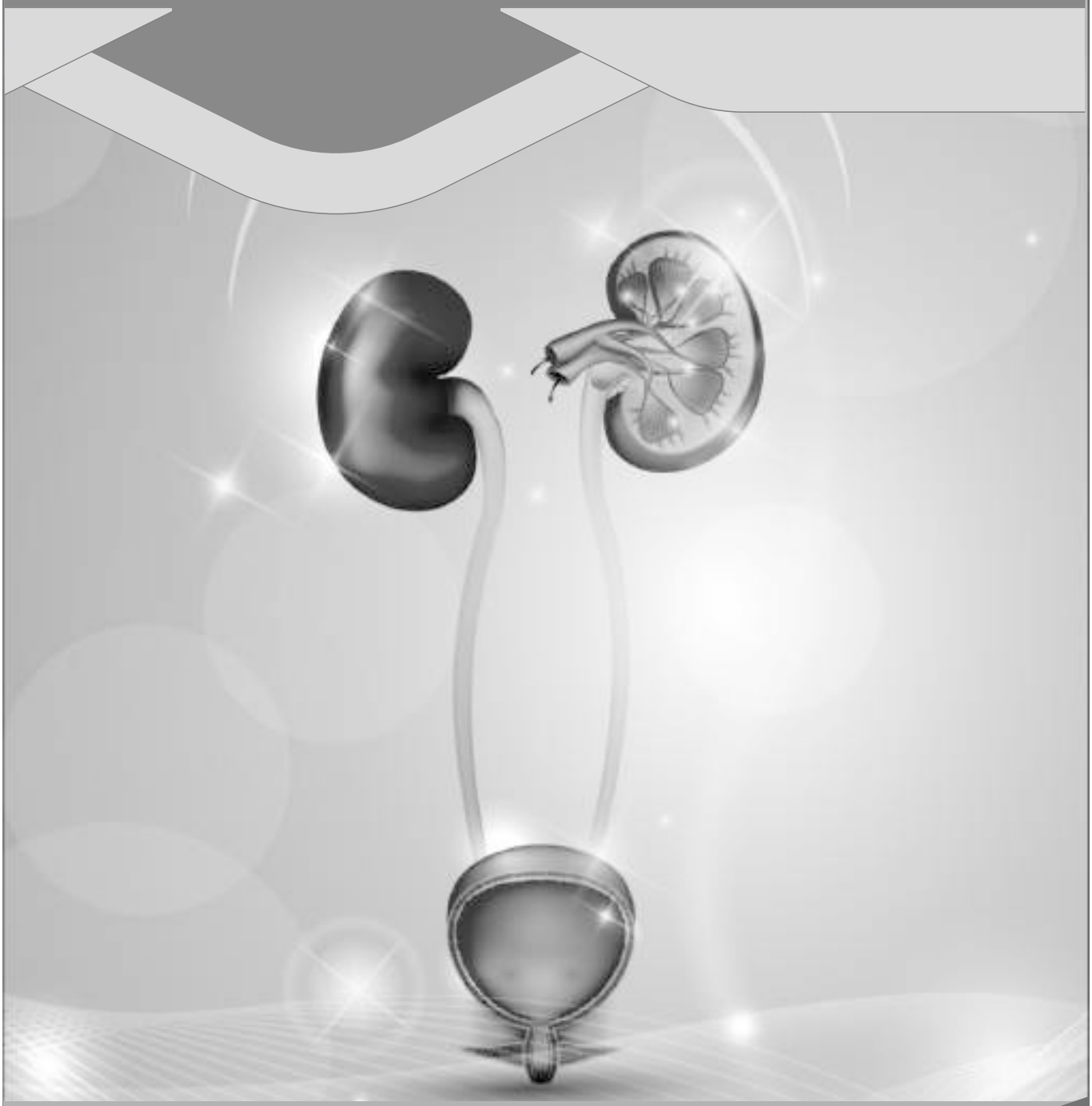

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