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IMA DOMBIVLI

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FROM THE PRESIDENT'S DESK

Hello friends,

It gives me a great feeling and a thrill to address all the members of IMA Dombivli from President's desk. At the same time it gives a tremendous sense of pride and responsibility to head such a prestigious organization.

I am the 46th president and 4th lady president of our IMA. I seek the blessings of all stalwarts of presidents before me and intend to set an example for my following presidents to come. Friends we have always had a rising graph and I intend to continue the same tradition.

The theme of this year is “TIME TESTED TO,,,,,,,,UNEXPLORED”..Lets walk together this much time tested road to explore the yet unexplored roads together. I seek company of each and every member of our family in this journey with our hands held tight together.When we are united we will fight the oppressive atmosphere in which our noble profession is being dragged in.Together we will march on and emerge victorious,as it is our responsibility to our next generations of doctors to provide them with a healthy working atmosphere.

I can assure you all that our organization is in safe hands because my hands are strengthened by the hands of a very capable executive team. We all are bound by sense of greatest responsibility towards our IMA branch.There will be a equal mixture of academic feast for everybody along with a generous dash of fun and frolic.We have planned various activities in upcoming year…… cmes, cultural events, picnic, theme parties, grand family functions, hands on training workshops, community programmes, camps………so on and so forth. But it all will be successful when each and every member participates in it . Friends we ask for your physical presence for all our events, as it takes a lot of planning to organise any event. Your presence boosts the morale of the organising team.

We will give our best for success of our branch and keep its name like a shining star in Central and State IMA. Action is the foundational key to success and we promise an action packed year.

At the end I quote,”Knowing is not enough, we must apply. Willing is not enough, we must do it.” The secret of getting ahead is getting started. So here begins our journey together……forward……..

THANKING YOU WITH A BOW

DR. NITI UPASANI

PRESIDENT IMA DOMBIVLI

EDITORIAL

On behalf of the DIALOGUE Editorial team, I thank Pres Dr Niti Upasani for giving us the opportunity to interact with each one of you through our quarterly magazine.

We are striving to present before you a bouquet of various articles which will be of academic interests, some which will be entertaining and some which will be food for your thoughts. We are also starting a new column TRAVELOGUE which I am sure you will enjoy.

The cover page of the Dialogue is aligned with this year's theme of Bhagyalaxmi and Anandi projects which deal with Girl child and education. The colours of the Umbrella depict the various roles that a girl/woman plays in her lifetime.

A woman is a Breadwinner, whether it is significant or not, she steps in and make sure there's a roof over the head.

As a Nurturer, she looks after the kids physically, emotionally, mentally and spiritually. At work, she innovates on even the most menial tasks bringing new ideas to implement something fresh and when she gets home, she's whipping up a new recipe… because she is an Innovator

As a Role model, she sets the standard for her children and as a Teacher she makes sure that the child follows those standards and principles. She is her family's biggest fan and is a professional booster & personal Cheerleader. She cheers everyone's big and small successes becoming a great Motivator.

She helps others reach their fullest potential as a Mentor, to stay inspired and keep their goals and dreams in focus by showing them through her lifestyle and work ethic. Woman, thy other name is Multitasking. She juggles effortlessly between her daily duties of cooking, cleaning and doing all odd jobs for the family with love and responsibility while climbing the professional ladder.

It is because of these very important roles of a woman that she is very capable of taking up leadership at all levels with the right dose of commitment, passion, power, and precision.

Today as we have a woman president, it is very apt that she has focused on girl child.

Let us all participate in the Beti Bachao, Beti Padhao project.

Dr Leena Lokras

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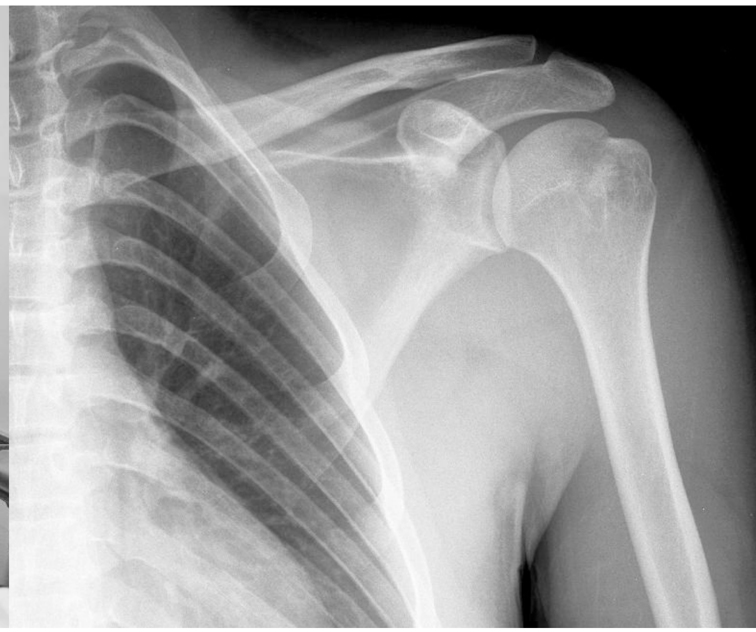

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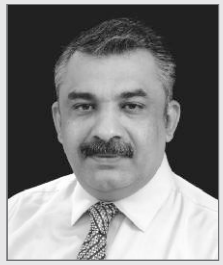

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Dr Alka Gadgil
Dr Anita Karnik

COMMON REGIONAL NERVE BLOCKS FOR SURGERIES

Dr. Kala Eswaran
Practising Anaesthesiologist

Kala Eswaran, M.D (Anaesthesiology)

- *M.B.B.S., M.D. from University of Mumbai, Topiwalla National Medical College and B.Y.L.Nair Charitable Hospital,*
- *Life member of AMC Mumbai, ISA, ISPA, IMA Dombivli , NSSA, AORA*
- *MMC accredited speaker.*
- *Expertise in Paravertebral blocks, Epidural, Labour analgesia, Nerve blocks for orthopedic procedures.*
- *On board SMILE TRAIN as an anesthetist for cleft lip/palate surgeries*
- *Trained in contemporary and folk dance and currently pursuing Bharat Natyam*
- *Received KOP's best paper award under "Private Practitioners Award", at ISACON 2016 for oral presentation on "PARAVERTEBRAL BLOCK FOR MODIFIED RADICAL MASTECTOMY : My Experience".*
- *Poster accepted and presented at NYSORA International Conference in Dubai in March 2017, with the title - PARAVERTEBRAL BLOCK FOR MODIFIED RADICAL MASTECTOMY – MY EXPERIENCE OF 100 CASES.*
- *Recipient of Hall of Fame award from GARC Coimbatore*

Since many decades general anaesthesia (where patients are made to lose consciousness which is reversible) and spinal anaesthesia (where an injection is given to the lower back to make your limbs and abdomen numb) have been considered as gold standard practices throughout the world. Nevertheless, last decade has seen the rise of nerve blocks since it has many unique advantages over decades of standard practices. Ultrasound guided (USG) helps to visualize and block nerves under direct vision by using real time images.

The advantages of Nerve Blocks include no compromise of the cardio respiratory system, selectively anaesthetize the part to be operated, excellent pain relief which also extends for many hours after operation, minimal nausea and vomiting, resumption of normal diet after couple of hours after operation, avoids all the complications of general anaesthesia and spinal anaesthesia. (including awareness during surgery), very suitable for daycare surgery, high comfort levels achieved with USG, while the block is being performed and a high success rate.

What exactly is Ultrasound guided Nerve block (UGNB)?

It is an alternative to general anesthesia / spinal anaesthesia, where the anaesthesiologist blocks the peripheral nerves under direct vision by using real time image seen on ultrasound machine. It is a relatively new technique which is becoming popular for its obvious advantages. Earlier it used to be a blind technique to block the nerves by assuming the landmarks on skin surface. For example: if you need an operation on your hand, a small needle is passed underneath the skin at around shoulder area to block the nerves supplying the hand.

Is it painful while block is being performed?

It is equal to any other simple injections you might have experienced before. Moreover the injection is being performed after administering some opioids and benzodiazepines (both of which make you a little sleepy and comfortable)

Is it a safe procedure?

Yes it is a safe procedure. Earlier the blocks were performed as a blind technique, with multiple pricks and some discomfort. Now with the advancement in technology, arrival of new medicines with higher safety of margin, and overall greater understanding of nerve blocks, the technique has become safer.

What happens after block is given?

Once the nerve block is performed, the affected part becomes numb, and you gradually lose control over that part in 10 – 20 minutes.

Will I be fully awake during the operation?

Yes, you will be awake during the operation. But many patients will be given tranquillizers so that they are asleep and do not remember the events during operation.

What if the block given to me fails?

The success rate using this new technique (ultrasound guided nerve blocks) is as high as 100%. But having said that failures can still happen in a very few cases. In such case you will be given general anaesthesia as a backup plan.

Is this a new technique in anaesthesia practice?

Well yes this is a new technique though introduced a couple of decades ago. This is widely practiced in United Kingdom and many parts of Europe as a fundamental tool for pain management in major operations. In our country this has started to gain popularity in last 5 years or so.

In which kind of patients nerve blocks are given as first choice?

In last 5 years we have been using this technique frequently as a soul anaesthetic and as well as for pain management after major operations. It has made a huge difference in management of very critical and sick patients coming for operation. It also has a major role in some deserving patients like for example: patients with heart ailments, very elderly patients (> 70 years), patients with respiratory problems (asthma, smokers), very fat patients with OSA, in emergency situations and in patients with obstructive sleep apnea (OSA)

Nursing Considerations:

It is very important to protect the affected area from harm. Patients will have minimal or no sensation to the blocked area. If a catheter is placed, a more dilute medication will be used than the concentrated solution used for placement of the block. Some numbness/tingling as well as decreased motor function is still common. If a lower extremity block is performed, use extreme caution when am bulating the patient until the nerve block has worn off and/or the nerve catheter has been removed**.**

Medications

A variety of local anesthetics may be used for the nerve block. The most common include lidocaine, ropivacaine, bupivacaine, and mepivacaine. The type of medication used, the concentration, the volume administered, and the location of the block will affect the onset and duration. Some patients may still experience shorter or longer durations than those listed. Occasionally epinephrine may be added to a nerve block. Epinephrine causes vasoconstriction of the blood vessels near the injection site. This causes decreased uptake of local anesthetic into the vasculature, allowing the block to work for a longer duration. Opioids are rarely used in a nerve block.

It is possible for a patient to develop **local anesthetic toxicity** from a nerve block or a nerve catheter. It may be caused by accidental injection directly into a blood vessel, or vascular reabsorption from around the injection site. Common symptoms of local anesthetic toxicity include numbness and tingling around the mouth, a metallic taste, or ringing in the ears. If it progresses, it may lead to seizures, arrhythmias, and even cardiac arrest.

Methods of Locating Nerve for Nerve Blocks

- Landmark technique using anatomy
- Paresthesia – subjective technique and requires patients compliance
- Nerve stimulation – attaches to needle and causes spasms of associated muscles near the nerve.
- Ultrasound – Friend in the nerve block world. Ultrasound allows you to see your needle at all times and also see the spread of the local anaesthetic drug solution

Types of Nerve Blocks

Upper Extremity nerve blocks: These can be classified further into:

- Intra-scalene nerve block
- Supraclavicular nerve block
- Infraclavicular nerve block
- Axillary nerve block
- Radial nerve block
- Ulnar nerve block
- Median nerve block
- Digital nerve block
- Wrist nerve block

Lower Extremity nerve blocks: These can be classified further into:

- Sciatic nerve block
- Femoral nerve block
- Adductor canal block
- Fascia iliaca nerve block
- Lumbar plexus nerve block
- Popliteal nerve block
- Ankle nerve block – sapheneous, post-tibial, sural, superficial peroneal and deep peroneal

Chest and Abdominal nerve blocks: These are helpful in providing post-operative pain relief and as a sole anaesthesia technique in extremely high risk medical condition. These can be classified further into:

- Thoracic and lumbar epidural blocks
- Thoracic and lumbar paravertebral nerve blocks
- Transverses abdominal plane blocks
- Rectus sheath blocks
- Ilio-inguinal nerve blocks
- Iliohypogastric nerve blocks
- Quadratus lumborum blocks
- Pec I block
- Pec II block
- Serratus anterior block
- Latissiumus dorsal block

•••

25 YEARS OF MY PRACTICE

It gives me immense pleasure that I have completed my 25 years of practice in Dombivali.Its a good gesture that IMA felicitates doctors

Who have completed 25 years of their practice on doctors day

I am from Hyderabad an IT city rather a metropolitan city .studied at Gandhi Medical college .Ipassed out in the year. 1978 though I got a seat in MD pathology I opted to remain MBBS and practice as family physician as here you deal with people I came down to Dombivali in the year 1982 after getting married to Dr.G.V.Kulkarni a paediatrician I call Dombivali a glorified village

It took 10 long years for me to open my own ANKUR CLINIC as both of us were busy in setting up ANKUR HOSPITAL .a 10bedded nursing home .The funnniest part of my practice is I Practice paediatrics in the morning and I am a GP in the evening .It becomes easier for me to practice that way

90% of people in Dombivali are educated so it's easy to practice here .The area where I practice Tilaknagar is mini Pune !of Dombivali .people are really smart here

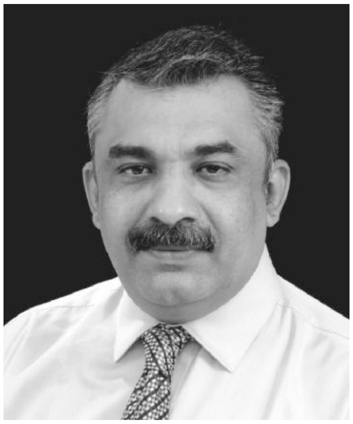
IMA Dombivali is an active branch and both of us are associated with it for the past 35 years we do take part in all it's activities and thoroughly enjoy it

I finally thank president Dr Niti and her team as they have honoured me .I liked the momento too.

•••

HBI & ACCREDITATION

DR MANGESH PATE
M.D. [PEDIATRICS]



PEDIATRICIAN & NEONATOLOGIST
NATIONAL TREASURER, IMA-HBI
MAHARASHTRA STATE TREASURER, IMA-HBI
PAST PRESIDENT, IMA DOMBIVLI
NATIONAL COORDINATOR FOR IMA-HBI HEALTHCARE ACCREDITATION

The Indian Medical Association (IMA) launched its wing the ‘Hospital Board of India’ aimed at giving the doctor community & the institutes run by them a say in formulation of major policies in the health sector.

Since the government consulted organisations unrelated to healthcare and some chosen corporates while framing the healthcare policies, IMA felt the need for such a board.

Our Hospitals, our institutes are ‘sanctum Sanctorum’ for us. We live our lives within the four walls of our hospitals.., our workplace. While we are captain of our own institute, we deal with many routine or complex issues & problems. We deal with these issues at local level on our own. While doing so, we always look for shortcuts to get the work done. Many times the issues grow & become unmanageable. IMA - HBI is the only solution to work out in such difficult situations. The representation through the mother organisation has shown its impact many times. So it is always wise & right that the issues should always be directed through the organisation.

‘Hospital Board of India’ helps the hospitals and doctors in preparing the medical standards and also providing uniform treatment guidelines. HBI also deals with various problems of our institutes. It would also help the hospitals in bargaining in procurement of machinery and equipments and in protocols, patient and hospital safety issues.

IMA constituted the Hospital Board India – (IMA-HBI) with the objective of helping the hospitals in preparing the medical standards, providing uniform treatment, addressing Human capital related issues pertaining to the Healthcare Industry and improvement of public Health and Medical Education in India.

Accreditation of healthcare is an important tool for improving and regulating the quality of care.

“Cluster Based Technical Assistance for NABH Pre-Accreditation Entry Level Certification Programme” by IMA Maharashtra State & State Chapter of IMA Hospital Board of India is efforts by IMA-HBI to facilitate accreditation for small & medium size hospitals.

This initiative is by IMA , IMA-Hospital Board of India. IMA Life Membership & HBI membership is compulsory.

This initiative is a part of the leadership role that IMA played in championing the cause for a more liberal accreditation programme that suits the realities of the tens of thousands of small and medium medical professionals owned hospitals which are the true back bone of the health care delivery across our country.

The IMA has an exclusive agreement with NABH to promote this programme across the country and a successful pilot has been working in South India over last 2 years with considerable participation.

The key reason for IMA to develop this cluster based technical support programme enabling the hospitals to achieve the entry level NABH accreditation was the prevalent scenario where several private agencies are offering so called consultancy support at inflated prices and without sufficient technical knowhow.

There have been several instances over the last few years of our hospitals being swindled by such fly by night operators and agencies.

The technical assistance programme designed and offered by IMA HBI is implemented Nationally and has been pilot tested and modified to the needs of small and mid-sized hospitals.

This works on the principle of collaboration between the participants hospital under the IMA umbrella and offers trustworthy and sound technical assistance validated and constantly monitored by the IMA team.

Any short comings in the support programme shall be immediately addressed through a monitoring committee of IMA and corrective actions ensured on receiving any grievances from our participant hospitals.

IMA-HBI- NABH initiative is transparent on the cost sharing to be borne by each category of hospitals (classified according to bed strength) and the services that will be provided by the technical assistance team.

What is NABH?

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India (QCI), set up to establish and operate accreditation programme for healthcare organizations. The board while being supported by all stakeholders including industry, consumers, government, have full functional autonomy in its operation.

What is Accreditation?

A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

What NABH accreditation means?

Commitment to create a culture of quality, patient safety, efficiency and accountability towards patient care.

Establishment of protocols and policies as per National/International Standards for patient care, medication management, consent process, patient safety, clinical outcomes, medical records, infection control and staffing. Patients are treated with respect, dignity and courtesy at all times. Patients are involved in care planning and decision making. Patients are treated by qualified and trained staff. Feedback from patients is sought and complaints (if any) are addressed. Transparency in billing and availability of tariff list.

Continuous monitoring of its services for improvement. Commitment to prevent adverse events that may occur.

What are the benefits of Accreditation?

Accreditation benefits everyone. Patients are the biggest beneficiaries. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.

Accreditation to a Hospital stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.

The Staff in an accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing.

Accreditation provides an objective system of empanelment by insurance and other Third Parties. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

Continuous monitoring the progress in meeting the standards, such as through a mini-evaluation of each chapter at regular intervals.

I am sure that our professional community would recognize the importance of this key initiative and value the credibility factor embedded in this joint endeavor; as in case of many other programmes and causes IMA has championed on behalf of our fraternity.

• • •

REPORT ON CME

Dr Oak Medha Oak & Dr. Meena Parthi

Keeping the theme "Time tested to unexplored "

We are trying to conduct multispeciality CME for our IMA members aiming to brush up our knowledge & go to the basics, irrespective of our speciality .

1st CME on ILD and lung cancers .Speakers were dr Mehul Thakkar and Dr Pritam Kalaskar .

Spoke in detail about diagnosis , management of ILD and NHL and how we can help patients in this morbid condition. Next was anaesthetist based management of cardiac arrythmias, hear failure on 22 nd april with anchor as Dr Prassana Mahajan .

CME on 21 st was to enlighten us on GERD ulcerative colitis and Crohns disease by eminent speakers Dr Bodas and Dr Bhushan Pandit. Diagnosis important so we can initiate early treagment was the message .

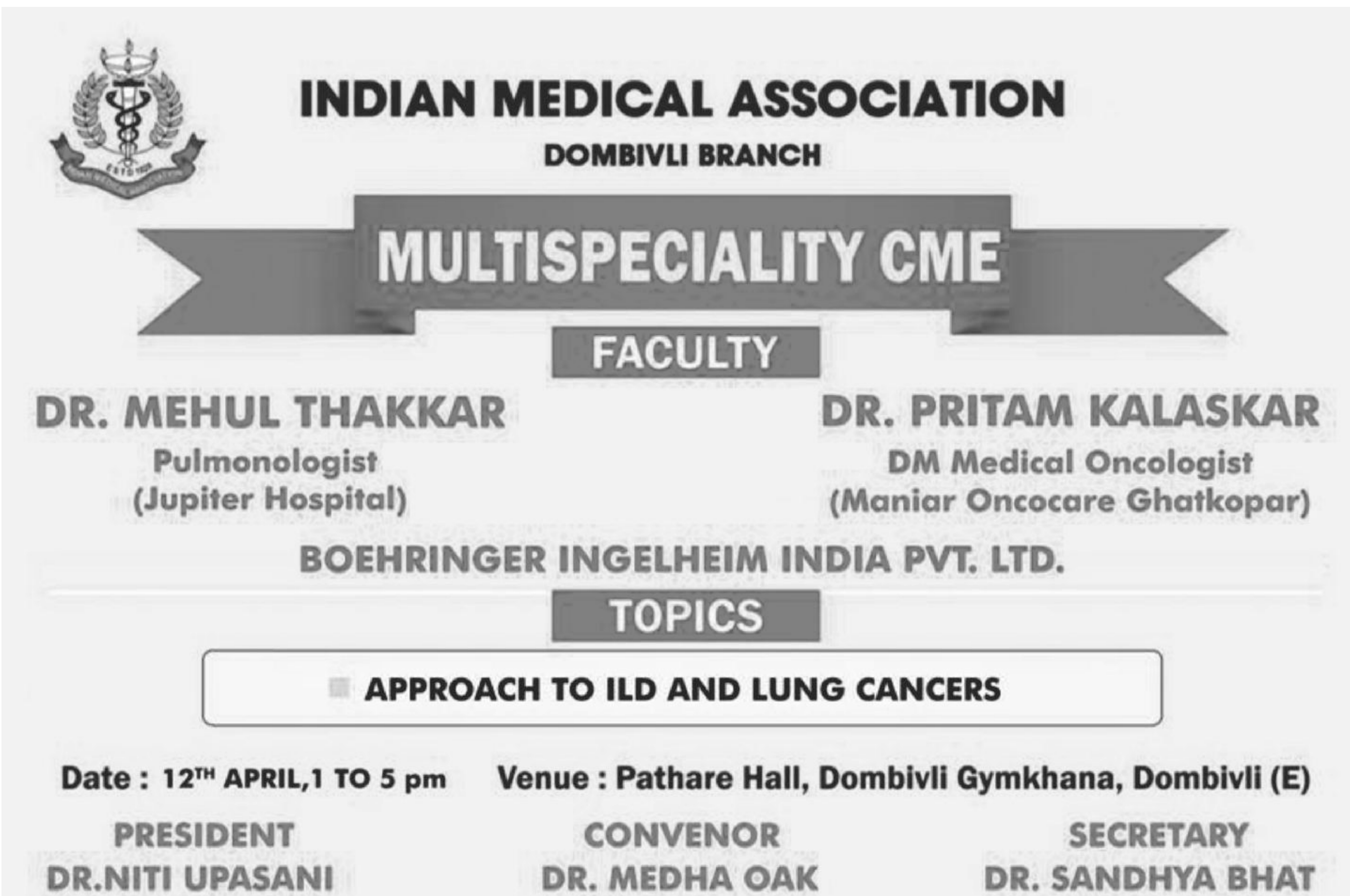
Upcoming CME on 19 th july is on thyroid illness management in pregnancy and peripoerative period by Dr Vedas Nimkar and Dr Padma Menon .

Thanks

Regards

•••

CME CONDUCTED SINCE APRIL 2017



THE RISING BURDEN OF DIABETES

Dr Abhay Mutha
Consulting Diabetologist
Ruby Hall Clinic, Pune

The prevalence of Diabetes is steadily increasing worldwide. particularly in the developing countries. Type-2 Diabetes is by far the most common form of Diabetes on a global scale, amounting for almost 95% of all cases. During the past few decades, it has reached epidemic proportions in many parts of the world: the increase is closely associated with the development of Obesity.

The W.H.O. has predicted that the global prevalence of Type-2 Diabetes will be more than double from 135 million in 1995 to 300 million in 2025, and this increase will affect both industrialized and developing countries. The impact on less-developed countries will be disproportionately high.

DIABETES IN INDIA

The prevalence of typo-2 Diabetes in India has been steadily increasing in Urban as well as Rural areas too. It was 2-1% in 1970 to a whooping rise of 11.6% in 1996 and more than 13% by 2000 in adult Indian population. Moreover, there is an equally large pool of persons with IGT.

Countries with highest number of Adults with diabetes:

COUNTRY	1995	2025
INDIA	19.4 Millions	57.2 millions
CHINA	16.0 millions	37.6 millions
USA	13.0 millions	21.9 millions
PAKISTAN	04.3 millions	14.5 millions
RUSSIA	08.9 millions	12.2 millions
JAPAN	06.3 millions	08.5 millions
WORLDWIDE	135.3 millions	300.0 millions

W.H.O. estimates that there were 19.5 million Diabetics in 1995 in India, and this number is likely to be 57.2 million in 2025.

How does Indian Diabetes differ from Western World?

1. Seen at least a decade earlier, compared to the Western world;
2. Tendency increasing to affect younger generation.
3. Less obese population too.
4. Delayed diagnosis and diagnosis with some complication in almost 50% of patients (ECG abnormalities, Hypertension, PVD, Retinopathy etc.)
5. Out of diagnosed about 30 million patients today, only 25-30% received proper pharmacological treatment.

WHY SUDDEN INCREASE IN TYPE-2 DIABETES:

This form of Diabetes is considered a life style disease. We Indians are genetically predisposed to Diabetes, and this genetic predisposition is getting unmasked in the presence of the right (wrong) environmental factors, such as. sedentary lifestyle, change in traditional food habits from coarse simple meals to higher refined calorie dense food, and stress of urban living.

The rapid increase in population, increased longevity and high ethnic susceptibility to diabetes. coupled with rapid urbanization and changes from traditional life styles, will continue to trigger a diabetes epidemic.

CAN WE PREVENT OR DELAY THE TYPE-2 DIABETES :

Lot of work is going on to try and prevent or delay onset of Diabetes. People at risk should be screened regularly to prevent Diabetes.

Change in life-style and dietary habits along with increricd physical activity can certainly help in reducing burden of the Type-2 diabetes. Lot of work is going on in this area by adopting healthy lifestyle and use of drugs like : Glitazones, Acarbose, Metfonnin and Acc inhibitor, etc. in people at risk for Diabetes.

To fight the epidemic of diabetes, a special team efforts are required (Diabetologists, Social Organisations, Nutritionists, Community and Government).

Latest Diagnostic Criteria For Diabetes Mellitus

Recent estimates indicate that there were 171 million people in the world with diabetes in the year 2000 and this is projected to increase to 366 million by 2030. ADA estimated the national costs of diabetes in the USA for 2002 to be US$ 132 billion, increasing to US$ 192 billion by 2020. The clinical diagnosis of diabetes is often prompted by symptoms such as increased thirst and urine volume, recurrent infections, unexplained weight loss, and in severe cases, drowsiness and coma and hrgh levels of glycosuria are usually present.

The latest criteria for diagnosis of diabetes as per ADA 2016 are as follows:

l. FPG > 26 mg/dL {7.0 mmol/L}; fasting is defined as no caloric intake for at least 8 h.

   or

2. 2'h PG > 200 mg/dL (1 1.1 mmol/L) during an 0GTT. The test should be performed as described by the WH0, using a glucose load containing the equivalent of 75-gmarhydrous glucose dissolved in water.

   or

3. HbAlc > 6.5%(48mmol/mol).The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.

   or

4. In a patient with classica lsymptoms of hyperglycaemia or hyperglycaemiccrisis a random plasma glucose > 200mg/dL {11.1mmol/L).

Screening for type 1 diabetes mettitus (T1DM)

'Blood gfucose is preferred over acute HbAl c to diagnose onset of TI DM with symptoms of hyperglycaemia

Screening children for T2DM and prediabetes

Consider screening for T2DM and prediabetes for alf children who are overweight and have two or more of the folf owing risk factors:

- Famiry history of T2DM diabetes in a first- or second_deg ree relative
- Native American, African American, Latino, Asian American or pacific lslander descent
- signs of insuf in resistance or conditions associated with insulin resistance
- Maternar history of diabetes or GDM during the child's gestation
- Test every 3 years using HbAlc beginning at the age of 10 or onsbt of puberty

Whom to screen?

People with the foliovriing features should be included for screening: ..,-'.,-

Sedentary lifestyle

Fi rst-deg ree retative(s) With diabeteS

High-risk race or ethnicity

Women who delivers a baby weighing > g lb or who has previously been diagnosed with GDM

HDL-C < 35 mg/dl and/ortriglycerides > 250 mg/dL

HbAl c) 5.7o/o, tGT or IFG

Hypertension (> 140/g}mmHg oron treatment)

History of cardiovascular disease conditions associated with insufin resistance such as severe obesity, acanthosis nigricans, pCOS

African-American, Latino, Native American, Asian American, pacific lslander origin,u

How to screen ?

There are two simple tests used in diabetes screening:

1 'FPG test invorves checking the rever of grucose in blood while the person is fasting. if his/her blood glucose level is higher than 1 25 mg/dL, he/she will need to be retested at another time to confirm the

Diagnosis

2. OGTT involves drinking sugary solution two hours before drawing the blood. lf the test results are 200 mg/dl or higher, the person will need to have a repeat test to confirm the diagnosis.

Screening in India

India faces several challenges in managing diabetes, including rising prevalence in urban and ruralareas, rack of awareness, suboptimar grycaemic contror, increasing prevalence of diabetic complications and limited economic and human resources. In India, screening for diabetes is mostly recommended in community health schemes by way of opportunistic or selective testing. The Indian Council of Medical Research (ICMR) has taid down important guidelines for healthcare providers on screening individuals for diabetes based on their risk profile."

Annual re-screening is suggested for those testing normal or with impaired glucose regulation. The ICMR recommends screening for hypertension and dyslipidaemia for those with established diabetes. In the year 2010, the government of India had set up National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke. This programme aims to control non-communicable diseases by early diagnosis of chronic diseases using opportunistic screening of people aged > 30 years at the point of primary contact with any healthcare facility, be it the village, community health centres (CHC), district hospital, tertiary care hospital, etc. The programme has built-in components of mass awareness creation, self-screening and training of healthcare providers. screening involves simple critical examination comprising of relevant questions (such as history of tobacco use) and easily conductable measurements (such as blood pressure) to identify those individuals who are at a high-risk of developing diabetes and cardiovascular disease and thus warrant furthe investigation or action.

Diabetes clinics are also established at CHC and district hospitals wherein comprehensive examination of patients referred by lower health facility/health workers is conducted to rule out complications or advanced stages of diabetes. "More recently, HbAl c was introduced to reduce time and avoid inconvenience of multiple testing in screening participants for preventlon trials. Screening procedures for prevention trials include the use of a risk assessment questionnaire, anthropometric measurements, blood pressure and biochemlcal tests. Individuals diagnosed with diabetes are referred to their physicians for further management.

The decision about which test to used to assess a specific patient for Diabetes should be at the discretion of the health care professional, taking into account the availability and practicality of testing an individual patient or groups of patients.

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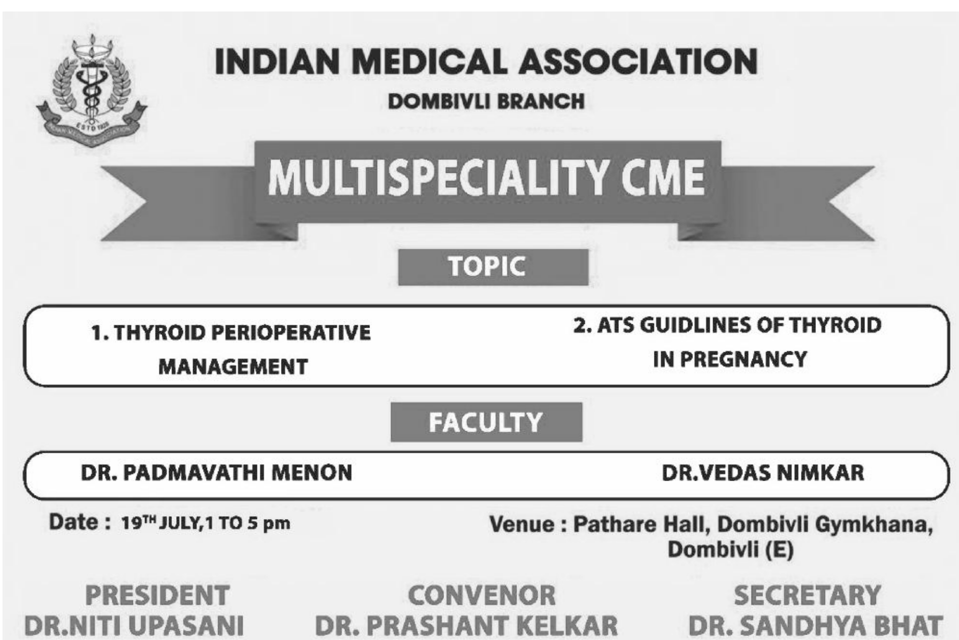


UTERINE TRANSPLANTATION: POTENTIAL CHALLENGES & CONTROVERSIES

Dr S Krishnakumar, Consultant JK Women Hospital
Dr Kiran Thorat, Fellow, IVF & ART, JK Women Hospital

Introduction

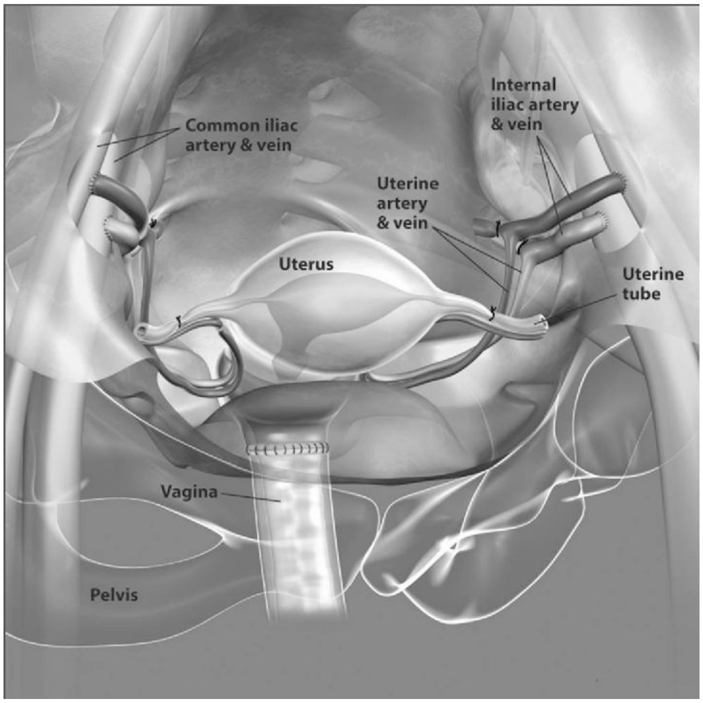
Despite the tremendous advancements made, in the field of infertility, absolute uterine factor infertility (absence of the uterus or the presence of a non functional uterus) is one of the few spheres where still there is a lot of scope for research and growth. Present options for women with absolute uterine factor infertility are either gestational surrogacy or adoption. With stringent rules of surrogacy involving ethical, legal, and religious constraints in various parts of the world including India and adoption being a long, tedious, and emotionally challenging option, the need was felt to think out of the box and provide these patients with a ray of hope. The uterine transplant was brought out as one such option.

A womb transplant – involving only women – is thus the only "gender transplant" performed to date

History

Uterine transplant is a type of nonvital/quality of life enhancing/ ephemeral transplant. Initial research on the subject was done in animals and later on extended to humans. Womb transplants were performed in animals as long ago as the 1960s .The first uterine transplant was performed on April 6, 2000.

This was followed by 12 (1 in Turkey and 11 in Sweeden) unsuccessful efforts to transplant and sustain a uterus in humans until the humungous success by Brännström et al. of Sahlgrenska University Hospital (Gothenburg, Sweden) in 2013. A 35-year-old lady with Rokitansky syndrome category was chosen. A functional neovagina was created by mechanical self-dilatation. IVF of the recipient and her partner was done prior to the transplant, and 11 embryos were cryopreserved after collection over three cycles. The donor was a 61-year-old menopausal para 2 lady. She was treated for 3 months prior to transplant with a sequential combined oral contraceptive pills. Post the transplant, the recipient's first menstruation occurred 43 days, with cycles at regular intervals of between 26 and 36 days. One year after transplantation, the recipient underwent single frozen embryo transfer in a natural cycle, which resulted in pregnancy. Triple immunosuppression (tacrolimus, azathioprine, and



corticosteroids) continued throughout pregnancy. Three episodes of mild rejection were observed but they were all reversed by corticosteroid treatment. Fetal growth parameters and blood flows of the uterine arteries and umbilical cord were normal throughout pregnancy. She underwent a preterm delivery at 32 weeks due to preeclampsia and gave birth to a male baby with a normal birthweight for gestational age (1775 g) and with APGAR scores 9, 9, 10.

Recently A team at Galaxy Care Laparoscopy Institute (GCLI), Pune successfully completed the highly complex and delicate procedure of India's first uterine transplant on a woman from Solapur district on 18 th may 2017 with MRKH syndrome and another womb transplant on next day on 19th may 2017 on a 24-year-old woman from Baroda who suffers from Asherman's Syndrome, who received her mother's womb. Both patient were discharged from hospital after 1 month in healthy condition. The surgery at Galaxy was the first of its kind in the world where the uterus from the donor was retrieved laparoscopically.

INDICATIONS

Uterine transplant can be considered in the following situations:

Congenital

- Mullerian agenesis.
- Other mullerian anomalies not amenable to surgical correction or failed correction.

Acquired

- Intrauterine adhesions, not amenable to or failed hysteroscopic surgical procedures.
- Hysterectomy (peripartum) and for acquired indications

Uterus Donors

The uterine transplant donors can either be live or deceased (brain dead, beating heart)

Disadvantages of a deceased donor

- Organ availability is less.
- Brain death induces major systemic inflammatory changes which may negatively affect graft survival.
- Fibroids, endometrial polyps, hyperplasia, and cervical dysplasia that need to be ruled out prior to the procedure are not possible in case of a deceased donor.

PREOPERATIVE EVALUATION AND COUNSELING

Just like any tissue transplant, the uterine transplant too is a major surgery both for the donor and the recipient. The procedure should encompass a thorough evaluation to select the donor recipient, match them and then counsel them duly to address any emotional and psychological issues. In general, the live donor has to be in good health to minimize the surgical risk at hysterectomy. Imaging is done to rule out uterine pathologies, vascular anomalies, or atherosclerosis of uterine vessels. Blood grouping and Rh typing are done and matched between the donor and recipient The recipient is informed that she would need an IVF procedure in an ART laboratory to fertilize her oocytes obtained after controlled ovarian stimulation and ovum pickup (OPU) followed by embryo transfer once the transplanted tissue has been successfully tolerated by the body. IVF after surgery is not recommended as it is technically more difficult due to abnormal uterine vascular pedicles and anastomosis sites that increase the risk of bleeding at OPU and also due to the associated increased risk of infections in immunosuppressed patients. Pregnancy termination would be possible by a cesarean section. Surgical removal of the transplanted uterus could later be recommended for medical reasons, owing to rejection, surgical complications at cesarean section, or side effects of immunosuppression.

Immunosuppression

The most important aspect of any transplant is the postoperative immunosuppression. Immunosuppressive therapy is continued until birth, when a cesarean section is performed and the allograft uterus is removed. For that reason, the complications that this therapy may cause for fetal development must be clarified. The only information on the safety of new drugs during pregnancy and lactation is from experimental and preclinical animal studies because experimental trials on pregnant or lactating mothers are prohibited. In the absence of controlled studies, negative reports have predominantly stemmed from pharmacovigilance, case reports and small case series .

RISKS ASSOCIATED WITH UTERINE TRANSPLANT

- Surgical risks.
- Risk of immunosuppressants to the mother and baby.

  Rejection of graft. Surgical risks The surgery involves a long intraoperative time: More than 10 h for the donor and almost 5 h for the recipient which is associated with increased risks of anesthesia and prolonged immobilisation. The surgery is extensive and intricate involving many small vascular anastomosis in a particularly difficult and inaccessible part of the body. Transplant surgeries are associated with increased rejection risks, and long-term immunosuppression is needed.

Obstetric risks

Following are the associated obstetric risks associated with uterine transplant:

- Spontaneous abortion.
- Premature births.
- Intrauterine growth restriction.
- Preeclampsia.
- Delivery by elective lower segment caesarean section.
- Azathioprine and tacrolimus in high doses are associated with congenital malformations in the baby.

ETHICAL CONSIDERATIONS

Despite the latest advances and progress made in this field, there are certain unanswered questions involving technical, legal, and social aspects of uterine transplantation.

Technical

- Does it make sense to try to control the immune system's response with potent drugs that can cause life-threatening infections and cancers just for a few years and to hope for the recovery of that system through withdrawal of the medications and (presumably) the uterus?
- Will the immune system recover back to baseline? Are experiences with failed kidney transplantation an appropriate model?
- Are there long-term consequences for the patient?

Social

- Are there really enough resources available to support widespread use of a therapy that is not required and may indeed be harmful?
- If not, and it will only be available to wealthy individuals, how will they find a uterus?

Legal

- Is it reasonable to intentionally expose a helpless fetus to development while receiving immunosuppressants? To the unknown impact of growth within a transplanted uterus? Who should consent for that fetus? With the current scenario in the Indian set up where the government is trying to make stricter laws for surrogacy to check the malpractice menace, the introduction of the uterine transplant for uterine factor infertility would not be easy as there is a scope of unethical practices related to organ retrieval and sale as in any other organ transplantation service.

At the present time, uterus transplant requires more research and fine-tuning. If uterus transplants achieve the medical status of other solid organ transplants, it may provide an opportunity for women who otherwise would be unable to have a child of their own. If only it were not so complicated and expensive.

Conclusion

In ethical and clinical terms, it is the opinion that in the current state of knowledge womb transplants are still a highly experimental procedure and should be subject to all the risk/benefit assessments normally applied in similar circumstances. It should also be recalled that this is not a life-saving procedure and that the womb should in any case be removed after any pregnancy in order to permit the interruption of immunosuppressive therapy: the risk/benefit assessment should be performed in this light. In brief, in ethical terms womb transplants from a deceased donor, in specific, carefully controlled and clinically assessed circumstances and bearing in mind that such procedures are currently highly experimental, could be acceptable, while the removal and transplantation of a womb from a living donor presents for now such major issues and contra-indications as to render it unacceptable.

But as with every invention in medicine controversies and debate always result, and time only will tell what prospects it holds for the future.

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Dombivli

24/7 FULLY EQUIPPED CARDIAC AMBULANCE

Laxmidarshan, Off.Manpada Road, Shrikhand

BETI BACHAO BETI PADHAO (BBBP)

- DR. SUCHITRA P. KAMATH

(FIRST WOMAN EDITOR OF IMA-MOUTHPIOECE DIALOGUE; CO-CHAIRMAN OF BETI BACHAO BETI PADHAO SUB COMMITTEE – IMA DOMBIVILI)

Beti Bachao Beti Padhao was started by our honorable Prime minister Shri.Narendra Modi ji with the objectives of preventing sex selective abortions,ensuring survival and protection of girl child and the education of girl child.

IMA started this subcommitte this year with Dr.Jyothi Chidgupkar as the Incharge of BBBP at state level and Dr.Vijaylakshmi Shinde as the Chairperson.

Dr.Niti Upsani started the BBBP subcommittee this year .The projects of BBBP will be conducted with these objectives in mind.

PROJECT: SELFIE WITH DAUGTHER

‘A Daugther is someone whom you laugh,dream and love with all your heart’.

The Selfie with daugther contest was held withis aim. The contest was open to IMA dombivili doctors and their Spouses.

Photos with catchy,inspirational tagline were judged by experts in the field. Dr. Rahul Bhirud judged the photos while Dr. Kanvinde selected the best tagline.

The winners were

- Selfie with Daugther Photos -

  1st - Prize - Dr.Swati Petkar

  2nd- Prize - Dr.Sayali Chaudhary

  3rd Prize - Mrs Sheetal Dhadas

- Tagline winners -

  1st Prize - Dr.Vandana Dhaktode

  2nd Prize - Mrs Sheetal Dhadas.

  3rd Prize - Dr.Ashwini Acharya with Dr. Sandeep Dave.

- Consolation prizes were shared by Dr. Neelima Date, Mrs Geeta Joshi and Mrs.Vidula Dixit.

Project ANANDI ;

Project Anandi is named after first woman doctor Dr. Anandibai Joshi. It is aimed at helping the needy girl child with financial aid for education, health or marriage.

Once again IMA Dombivili members have come in a great way in supporting this noble cause.

Dr. Somnath Babale, Dr. Kala Eshwaran, Dr. Seema Shanbhag and our President Dr. Niti Upsani have made significant contribution toward this project.

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BIOMEDICAL WASTE MANAGEMENT : A CHALLENGE

Dr Vijayalaxmi Sushil Shinde, Dr Sushil K Shinde, Eva Womens Clinic and Lab, Dombivli

BACKGROUND AND IMPORTANCE

- According to Biomedical Waste (Management and Handling) Rules, 1998 of India "Any waste which is mainly engineering functions, such as collection, transportation, operation or treatment of processing systems, and disposal of wastes.
- World Health Organization states that 85% of hospital wastes are actually non-hazardous, whereas 10% are infectious and 5% are noninfectious but they are included in hazardous wastes.
- About 15% to 35% generated during the diagnosis, treatment or immunization of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals.
- The Government of India (notification, 1998) specifies that Hospital Waste Management is a part of hospital hygiene and maintenance activities.

Need of biomedical waste management in hospitals

- Injuries from sharps leading to infection to all categories of hospital personnel and waste handler.
- Nosocomial infections poor waste management.
- Risk of infection outside hospital for waste handlers and scavengers and at time general public living in the vicinity of hospitals.
- Risk associated with hazardous chemicals, drugs to persons handling wastes at all levels.
- "Disposable" being repacked and sold by unscrupulous elements without even being washed.
- Drugs which have been disposed of, being repacked and sold off to unsuspecting buyers.
- Risk of air, water and soil pollution directly due to waste, or due to defective incineration emissions and ash3.

Problem With Waste Disposal

- Bio-Waste regulation is unsatisfactory as some hospitals are disposing of waste in a haphazard, improper and indiscriminate manner.

- Lack of segregation practices, mixing of hospital wastes with general waste making the whole waste hazardous.
- Inappropriate segregation ultimately results in an incorrect method of waste disposal.
- Inadequate Bio-Medical waste management thus will cause environmental pollution,smell, growth and multiplication of vectors like insects, rodents and worms and may lead to the transmission of diseases like typhoid, cholera, hepatitis and AIDS through injuries from syringes and needles contaminated with human.

BMW RULES ARE APPLICABLE TO

- All who generate, collect, receive, store, transport, treat, dispose, or handle BMW in any form
- Hospitals, nursing homes, clinics, dispensaries,
- veterinary institutions, animal houses,
- pathological laboratories, blood banks,
- ayush hospitals,
- health camps,
- blood donation camps, vaccination camps, first aid rooms of schools, forensic and research labs

BMW RULES ARE NOT APPLICABLE TO:

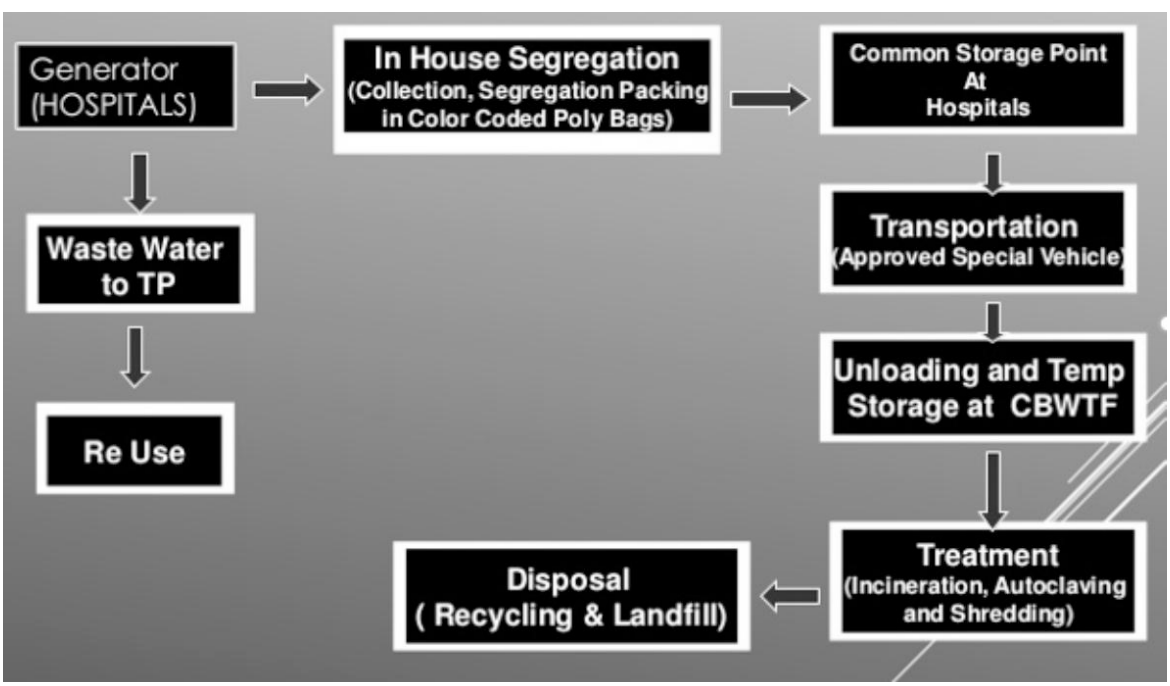
- Radioactive waste, Hazardous chemicals, Municipal solid waste, Lead acid batteries, Hazardous waste, Hazardous microorganisms

Biomedical Waste Management Process

- Waste collection, Segregation, Transportation and storage
- Treatment & Disposal, Transport to final disposal site
- Final disposal

SCHEDULE I

- BMW Categories and their segregation, collection, treatment, processing and disposal options



Category	Type of Waste	Type of Bag or Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
Yellow	**(a) Human Anatomical Waste:** Human tissues, organs, body parts and fetus below the viability period (as per the Medical Termination of Pregnancy Act 1971, amended from time to time).	Yellow coloured non-chlorinated plastic bags	Incineration or Plasma Pyrolysis or deep burial*
	(b)Animal Anatomical Waste : Experimental animal carcasses, body parts, organs, tissues, including the waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses.		
	(c) Soiled Waste: Items contaminated with blood, body fluids like dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.		Incineration or Plasma Pyrolysis or deep burial* In absence of above facilities, autoclaving or micro-waving/ hydroclaving followed by shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery.
	(d) Expired or Discarded Medicines: Pharmaceutical waste like antibiotics, cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc.	Yellow coloured non-chlorinated plastic bags or containers	Expired `cytotoxic drugs and items contaminated with cytotoxic drugs to be returned back to the manufacturer or supplier for incineration at temperature >1200 ^{0}C or to common bio-medical waste treatment facility or hazardous waste treatment, storage and disposal facility for incineration at >1200^{0}C Or Encapsulation or Plasma Pyrolysis at >1200^{0}C. All other discarded medicines shall be either sent back to manufacturer or disposed by incineration.
	(e) Chemical Waste: Chemicals used in production of biological and used or discarded disinfectants.	Yellow coloured containers or non-chlorinated plastic bags	Disposed of by incineration or Plasma Pyrolysis or Encapsulation in hazardous waste treatment, storage and disposal facility.

	(f) Chemical Liquid Waste : Liquid waste generated due to use of chemicals in production of biological and used or discarded disinfectants, Silver X-ray film developing liquid, discarded Formalin, infected secretions, aspirated body fluids, liquid from laboratories and floor washings, cleaning, house-keeping and disinfecting activities etc.	Separate collection system leading to effluent treatment system	After resource recovery, the chemical liquid waste shall be pre-treated before mixing with other wastewater. The combined discharge shall conform to the discharge norms given in Schedule-III.
	(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.	Non-chlorinated yellow plastic bags or suitable packing material	Non- chlorinated chemical disinfection followed by incineration or Plazma Pyrolysis or for energy recovery. In absence of above facilities, shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery or incineration or Plazma Pyrolysis.
	(h) Microbiology, Biotechnology and other clinical laboratory waste: Blood bags, Laboratory cultures, stocks or specimens of micro-organisms, live or attenuated vaccines, human and animal cell cultures used in research, industrial laboratories, production of biological, residual toxins, dishes and devices used for cultures.	Autoclave safe plastic bags or containers	Pre-treat to sterilize with non-chlorinated chemicals on-site as per National AIDS Control Organisation or World Health Organisation guidelines thereafter for Incineration.

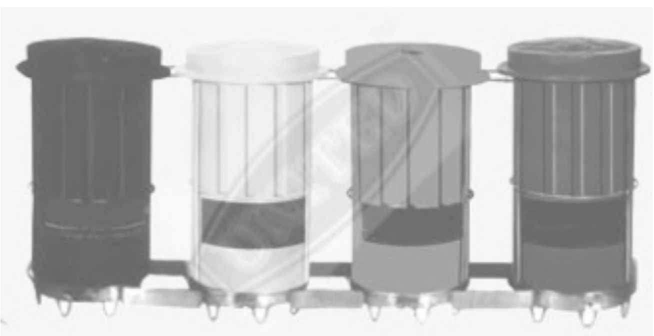
Category	Type of waste	Type of Bag/ Container	Treatment and Disposal options
Red 	**Contaminated Waste (Recyclable) - Disposable items like tubings, bottles, I/v sets, catheters, urine bags, syringes (without needles), vacutainers (with needles cut), gloves**	**Red coloured non-chlorinated plastic bags or containers**	**Autoclaving or micro-waving/ hydroclaving followed by shredding or mutilation or combination of sterilisation and shredding**

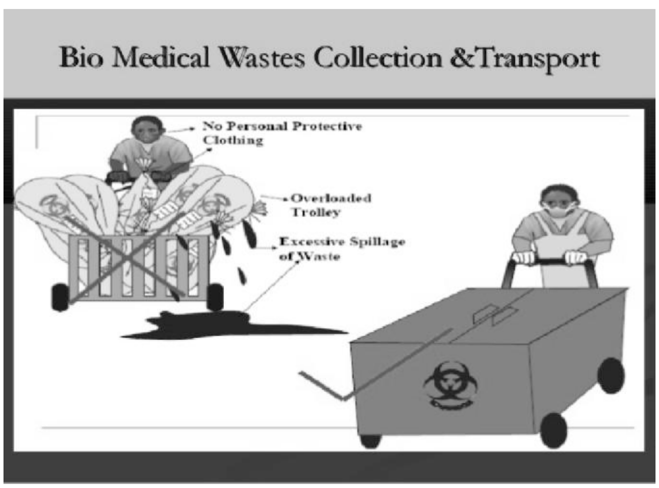
Category	Type of waste	Type of Bag/ Container	Treatment and Disposal options
White (Translucent) 	Waste sharps including Metals - Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades	Puncture proof, leak proof, tamper proof containers	Autoclaving followed by shredding or mutilation or encapsulation Combination of shredding cum autoclaving Final disposal to iron foundries/ sanitary landfill/ concrete waste sharp pit

Category	Type of waste	Type of Bag / Container	Treatment and Disposal options
Blue	**(a) Glassware** **Broken/ discarded and contaminated glass (medicine vials, ampoules) except cytotoxic wastes** **(b) Metallic body implants**	**Cardboard boxes with blue coloured marking**	**Disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium Hypochlorite treatment) or through autoclaving or microwaving or hydroclaving and then sent for recycling.**

SEGREGATION, PACKAGING, TRANSPORTATION AND STORAGE

- Segregation at point of generation.Containers or Bags shall be labelled as specified in Schedule IV
- Bar coding and GPS shall be added by the occupier and operator of CBMWTF within one year time.Transport vehicle details
- Untreated human anatomical waste, animal anatomical waste, soiled waste and biotechnology waste shall not be stored beyond 48 hours
- Clinical lab waste shall be pre-treated by sterilisation to Log 6 or disinfection to Log 4 as per WHO guidelines





SEGREGATION, PACKAGING, TRANSPORTATION AND STORAGE

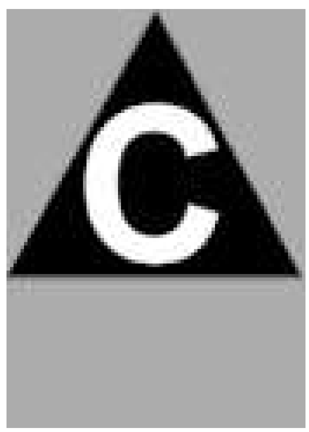
LABEL FOR TRANSPORTING BIO-MEDICAL WASTE BAGS OR CONTAINERS

Day ....Month ....
Year ....
Date of generation ....

Waste category Number ....
Waste quantity...........
Sender's Name and Address
Phone Number ....
Fax Number...............
Contact Person ....

Receiver's Name and Address:
Phone Number ....
Fax Number ....
Contact Person ....

In case of emergency please contact :
Name and Address :
Phone No.
Note :Label shall be non-washable and prominently visible.



SUMMARY

- The segregation of waste at source is the key step and reduction, reuse and recycling should be considered in proper perspectives.
- Categories are colour codes: Yellow, Red, White, Blue
- BAR code, GPS shall be implemented soon. Waste labelling must.
- LEGAL LIABILITY: Occupier/ operator of CBMWTF liable for damages to environment/ public due to improper handling of BMW .Liable for action

under section 5 and section 15 of the Act, in case of any violation

- Safety ,health check ups,PPE, vaccination of Staff handling waste should be done.
- Major accidents should be reported
- Maintenance of records and Annual report should be submitted.
- The challenge : scientifically manage growing quantities of biomedical waste .If we want to protect our environment and health of community we must sensitize our selves to this important issue not only in the interest of health managers but also in the interest of community.

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माझ्या कविता

डॉ. सतीश अ. कानविंदे

प्रिय रसिक वाचक,

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

येशिल ! येशिल ! येशिल !!!

येशिल ! येशिल ! येशिल ! मित्रा कधी रे घरी तू येशिल ?
होताला धरुन, आधार देऊन, अड्ड्यावर मला तू नेशिल ?

कोरडी पडली जीभ रे माझी, पाजेना कुणीही दारु
भूकही लागेना, थकवा जाईना, हाक कशी मी मारु ?
ठरल्या वेळेच्या आधीच येऊन दारावर थाप तू देशील ?
येशिल ! येशिल ! येशिल !

सूर्य मावळेल, काळोख होईल, बायका-पोरही येतिल
रोजच ढोसतो म्हणून मला ते सारेच फैलावर घेतिल
ओरड त्याची मी ऐकून, न ऐकून हळूच बाहेर नेशिल ?
येशिल ! येशिल ! येशिल !

झिंगून येईन, शिव्या मी देईन, ओकून करीन घाण
थप्पड खाऊन पडता वाटेल आत्ताच जाईल प्राण
उद्या येण्याचे कबूल करुन हळूच निघून जाशिल ?
येशिल ! येशिल ! येशिल !

आला श्रावण आला

कोंबडीसमोर उभा राहून
बोकड लागला नाचू
म्हणाला 'आषाढ संपला श्रावण लागला
आता महिनाभर तरी वाचू'

कोंबडी म्हणाला बोकडा
तुला माहित नाही वाटतं !
हल्ली श्रावणात सुद्धा लोकांना
मटणच जास्त लागतं!

समजू नकोस महिन्याभराने
आयुष्य तुझे वाढेल
तुझ्यासाठी खाटीक कधीही
सुरा बाहेर काढेल

मांसाहार करणाऱ्यांची संख्या
खूपच आता वाढलीय
श्रावण पाळणाऱ्यांची संख्या मात्र
बघ रोडावत चाललीय

तरी आनंदाने चाख तू
या श्रावणाची गोडी
वास्तवाची जाण तुला मी
करुन दिली थोडी

कोंबडीच्या बोलण्याने
बोकड नाराज झाला
दुःख विसरण्यासाठी
तो बारमध्ये आला

तिकडे एक बोकडीण
त्याला एक बाराबाला भेटली
ती तर बोकडाच्या
अंगालाच खेटली

बोकडसुद्धा कमी नव्हता
त्याने खूप धमाल केली
म्हणाला 'आता मेलो तरी बेहत्तर
आजवरची सगळी जिंदगी तेल लावत गेली.फ

•••

FOOLS

Khushi Barnwal

People, are fools. We, are fools. I, am a fool.
Why do I bother to write,
to express my emotions through a combo of parchment and ink ,
Or to augment the world's notes with my personal tinge,
Or to nourish the paraphernalia of written text?
At times, all of them and at times, none of them!

The empathetic surge through my mind,
The adrenaline rush through my body,
The longing of the veins to feel the connection,
The throbbing of heart to not suppress my feelings,
The excitement for delivery of my thoughts
Because it is only then that ecstasy is perceived,
Only then is truly tranquility received.

The general populace struggles and slaves and wretches for endless hours,
No sooner does that session end than another one commences .
The slogging, the misery and the gloom
It is so not appealing that we wish, to end----
Our monotony, our routine, our jobs and even our lives.
And yet we push our bodies,
Yet we force our mind,
To bear and not resist ,
To promise but not fulfill,
To survive and not live.

What keeps ME going? Such a mystery!
The mystical pleasure of absorbing the depths of poetry,
To believe that there exists another universe---- where talking is through antennas, where magic is not a wonder.
Be it fairy tales or novels or write-ups or essays
Bingo! There's a repertoire of sentiments right there.
Which by the way we are missing out on in our definition of reality,
And is waiting to be embraced with an honest mind, with an open soul.
Doesn't polytony stand synonymous to impossible?
'I'm possible,' they say but is it ever?
It's just a lame excuse which cowards accept.
What's wrong with that? Several mortals may ask.
I say it is only one version, an interpretation of the truth which will only take your hopes so far.
It will encourage you for sure. No dilemma there.
But did Leonardo paint Mona Lisa merely by hoping?
Did the Wright brothers bring the flying device to practicality simply by dreaming?

Buckle up. Gear up. Pull up your socks.
To ride your bright and shining whatever.
We are engaged in doing what we almost loathe.
Envisioning that one fine moment onwards
We might actually fall in love ,
With what we do instead of what we should have been doing.
And the fun fact-----there's no hypocrisy involved.
Because that abstract quality isn't looked down upon when everyone's a part of it
And not apart from it!
And now see the wonder that is wordplay,
'Gateway' becomes 'get away'.
However, is that just what it is?
As, while we are trying to go through and make it through,
We are in fact trying to get away.
And even though we realise that, we keep going that way, with those ideals, with those morals and with those vendettas.
Isn't a simple explanation needed?
People, are fools. We, are fools. I, am a fool.

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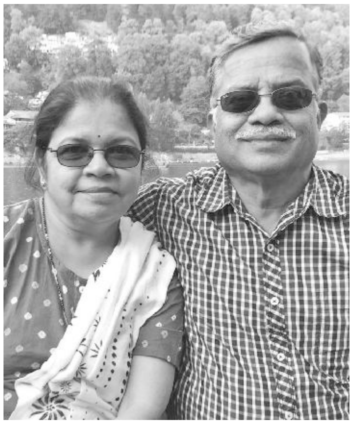
MY LIFE JOURNEY IN DOMBIVLI

Dr Arvind and Dr Janhavi Bengeri



APRIL 1979 FINISHED MY INERNSHIP AT BELGAUM CIVIL HOSPITAL .

NEXT DAY TOOK A BUS TO MUMBAI WITH MBBS DEGREE AND MEDICAL COUNCIL REG CERTIFICATES IN HAND DREAMING TO DO POST GRADUATION MD MED/PAED.

WHY MUMBAI ?

MY MATERNAL UNCLE DR B S RAICHUR WAS PROF OF PATHOLOGY AT GRANT MEDICAL COLLEGE,WHO CALLED ME TO MUMBAI.

ALONG WITH ME THREE OF CLASSMATES ALSO CAME, DR KISHOR,DR BASHIR, DR SHETTY UNKNOWN PLACE LITTLE MONEY IN POCKET ALL WENT TO MY AUNT'S PLACE IN VILE PARLE.

ALTHOUGH IT WAS A SMALL HOUSE OF ONE ROOM KITCHEN MY AUNT HAD A BIG HEART IN ACCOMODATING ALL OF US FOR 15 DAYS. FROM NEXT DAY ALL OF US STARTED SEARCHING FOR A HOUSE POST IN BMC HOSPITALS.

AFTER 15 DAYS ALL OF US GOT HOUSE POSTS IN DIFFERENT HOSPITALS. I GOT A POST IN GHATKOPAR MUNCIPAL HOSPITAL IN PAEDIATRICS.

AS ALL OF YOU KNOW IT WAS A HEAVY DUTY OF 24 HRS HARDLY GETTING TIME TO EAT AND SLEEP.

I BECAME A BETTER DOCTOR GAINING CONFIDENCE BECAUSE AFTER INTERNSHIP I WAS STILL RAW AND UNPOLISHED.

AFTER 6 MONTHS I GOT HOUSEPOST IN MEDICINE IN KASTURBA HOSPITAL NEAR SAAT RASTA OPP JAIL. I WAS LUCKY TO WORK UNDER A GREAT TEACHER FAMOUS DIABETOLOGIST DR V S AJAGAONKAR SIR, A GEM OF PERSON VERY KIND HEARTED.

HERE HE TAUGHT US LOT OF BED SIDE BASICS, LIKE SIMPLE TECHNIQUE OF HOW TO GIVE INJECTIONS ETC.

AFTER THIS I WAS LOOKING FOR A RAGISTRAR'S POST IN MED/ PAED.I WAS UNLUCKY /INSTEAD GOT MEDICAL OFFCER POST IN BMC DURING KASTURBA POSTING I HAD APPLIED FOR MEDICAL OFFICER POST IN BMC AND GOT A CALL FROM THEM.

THOSE DAYS VERY FEW PEOPLE FROM MUMBAI USED TO APPLY FOR MO POST. ACCEPTED THE MO JOB BUT NO ACCOMADATION, WHERE TO STAY? MY OTHER FRIENDS CAME TO MY RESCUE ,ALLOWED ME STAY WITH THEM, WE WERE CALLED AS PARASITES.

MO JOB 9 TO 4 EVENINGS WERE FREE. MAIN REASON FOR ACCEPTING JOB WAS MY FATHER HAD JUST RETIRED FROM JOB OURS WAS A BIG FAMILY LOWER MIDDLE CLASS SO SITUATION MADE ME TO ACCEPT THE JOB FOR A STARTING SALARY OF RS 1000/-.

MY FIRST JOB FOR SIX MONTHS WAS MO IN MOBILE DISPENSARY DAILY GOING TO DIFFERENT SLUM AREAS IN WHOLE 0F MUMBAI.

AFTER SIX MONTHS I CAME TO KNOW EVERY NOOK AND CORNER OF MUMBAI. HERE I SAW THE REAL MUMBAI AND PAIN OF POOR PEOPLE. THEN I WAS POSTED AT B WARD OPP JJ CASUALTY AS MO. WHEN I GOT MY PAY ON FIRST , STOOD AT BUS STOP OPP JJ TO GO TO CHUNABHATTI. WHILE ENTERING THE DOUBLE DEKKER BUS SOME BODY PICK POCKETED MY PURSE, AND I LOST ALL MY PAY. THIS MADE ME LIKE CRYING. NEXT DAY ANOTHER DOCTOR COLLEAGUE OF ME GAVE AN ADVISE,ON FIRST DAY AFTER GETTING PAY ALWAYS GO HOME IN A TAXI FEELING LIKE A KING.

TO GAIN SOME EXPERIENCE STARTED WORKING AS ASSISTANT WITH ANOTHER GREAT TEACHER AND PAEDIATRICIAN DR V B ATHAVALE SIR [HOD SION HOSPITAL /COLLEGE] IN HIS PRIVATE CLINIC. BOTH THESE TEACHERS DR VSA AND DR VBA TAUGHT ME LOT ABOUT HOW ONE SHOULD BEHAVE WITH PATIENTS AND BE A GOOD DOCTOR WHICH I WILL NOT FORGET.

AFTER FEW MONTHS WE THREE CLASSMATES TOOK A HOUSE FOR RENT IN CHUNABHATTI. THE FAMOUS MARATHI ACTRESS ASHWINI BHAVE FAMILY WERE OUR NEIGHBOURS, THAT TIME SHE WAS STILL IN SCHOOL AND VERY NICE FAMILY. EVENINGS WE USED TO COOK RICE DAL BREAD BHAJI FRENCH TOASTS PULAV AS WE WERE FED UP EATING DAILY OUTSIDE FOOD.

ASHWINI BHAVE AND HER BROTHER ATUL WERE OUR GUESTS TO EAT FRENCH TOASTS WHICH THEY LOVED VERY MUCH .

AS THE DAYS PASSED BY I STARTED GETTING GP LOCUM OFFERS FOR 10-15 DAYS AT SION KOLIWADA BANDRA ETC.

THIS MADE ME TO THINK OF STARTING MY OWN GP,BUT NOT MUCH MONEY IN POCKET STARTING PRACTICE IN MUMBAI WAS OUT OF REACH. ONE OF MY NON MEDICAL FRIEND WAS STAYING IN DOMBIVLI AND HE SUGGESTED IT IS AFFORDABLE.

SAW A SHOP ON OLD AYARE ROAD FOR A DEPOSIT OF RS 20000/- RS 90/- RENT .I HAD ONLY RS. 5000/- WITH ME AS SAVINGS ,SO MY FATHER GAVE ME ANOTHER RS 7000/-. RS 8000/- SHORT, REQUESTED THE OWNER FOR INSTALMENT FECILITY FOR 6 MONTHS.

THUS SANJEEVANI CLINIC WAS STARTED ON 26 TH JAN 1981.MY ANOTHER RELATIVE IN DOMBIVLI HELPED TO DO CLINIC POOJA BY PROVIDING PUROHIT AND ALL THE HELP. AS I KNEW FEW PEOPLE, I DISTRBUTED CLINIC INAUGURATION CARDS TO ALL AYARE ROAD PEOPLE, WHICH HELPED ME A LOT; GOT 10 PATIENTS ON 1 ST DAY ONLY.

MY UNCLE ASKED ME TO MEET SOME OF HIS DOCTOR STUDENTS WHO WERE PRACTICING IN DOMBIVLI . THEY ARE DR U P RAO , DR R M BHAT AND DR JAGDISH UPASANI THREE GREAT DOCTORS OF DOMBIVLI . WENT AND MET THEM TOOK THEIR BLESSINGS.

BEFORE STARTING PRACTICE TOOK BLESSINGS OF DR VS AJAGAONKAR SIR AND DR V B ATHAVALE SIR. THEY JUST GAVE ME A SIMPLE ADVISE; DO SINCERE AND STRAIGHT FORWARD PRACTICE NEVER TAKE SHORT CUTS DO NOT GO AFTER MONEY EARN A NAME AND MONEY WILL COME AUTOMATICALLY. WHICH IS REALLY TRUE .

MY PRACTICE WAS PART TIME ONLY IN THE EVENINGS, MORNING BMC MO DUTY. GRADUALY PRACTICE STARTED PICKING UP STARTED MORNING OPD AFTER 2-3 YRS. ALTHOUGH SEEING MANY PATIENTS COLLECTION WAS LESS BECAUSE THE RATES WERE VERY LESS RS 5/- FOR 2 DAYS MEDICINES [DUE TO COMPETITION WITH OTHER PATHIES WAS FORCED TO CHARGE LESS].

SHIFTED TO DOMBIVLI IN 1983 SHARING ACCOMADATION WITH NON MEDICAL FRIENDS. AS BOTH TIME OPD PLUS BMC JOB 14 HOURS TOTAL DUTY NO TIME SLEEP ,USED TO SLEEP IN TRAIN. BOOKED A HOUSE IN 1984 CALLED MY PARENTS BROTHER AND SISTER FROM NATIVE PLACE TO STAY WITH ME . LEFT THE JOB IN 1984.

GOT MARRIED TO DR JANHAVI IN 1984, WHICH TOOK PLACE IN DOMIVLI ONLY. I AM VERY LUCKY TO MARRY JANHAVI, A BEAUTIFUL WIFE, A NICE AND GREAT MOTHER TO OUR ONLY SON ASHISH.

SHE STARTED SEPARATE PRACTICE IN 1984 NEXT TO DR SUNIL KAMATH ON MANAPADA ROAD. LANGUAGE WAS A BIG PROBLEM FOR

HER AS SHE DID NOT KNOW MARATHI BEING FROM SOUTH.

STILL SHE PICKED UP THE MARATHI LANGUAGE EXCELLENTLY LEARNING FROM PATIENTS AND TEACHING ASHISH AT HOME . SHE HAD ROARING PRACTICE , BUT AFTER 5 YRS HAD TO CLOSE HER SEPARATE CLINIC AND STARTED SIITING WITH ME PART TIME . THE REASON WAS ASHISH STARTED GOING TO SCHOOL AND NECESSITY TO LOOK AFTER HIM AND HIS UP BRINGING. I SALUTE JANHAVI FOR THIS BIG SACRIFICE .MOTHER IS MOST IMPORTANT PERSON IN THE FAMILY AS UPBRINGING OF CHIDREN IS MOST DIFFICULT JOB.

LATER CAME TO KNOW DR YOGESH ACHARYA DR JUVLE DR JAMBHEKAR DR DIXIT DR KOLHATKAR DR GADGIL DR DB JOSHI AND MANY MORE. JOINED IMA IN 1989. THEN BECAME FRIENDS WITH ALL OF YOU DOCTORS. REALLY ENJOYED WORKING IN VARIOUS POSTS IN IMA FROM COMMITTEE MEMBER TO VICE PRESIDENT.

I LEARNT A LOT IN IMA,ESPECIALLY CLINICAL MEETINGS WHICH I ATTENDED AND PRESENTED CASES F0R 25 YRS FROM 1989 TO 2014. IT HELPED ME VERY MUCH IN MY PRACTICE. I REQUEST IMA OFFICE BEARERS TO RESTART THE CLINICAL MEETINGS. STARTED FREE DIABETES DETECTION CAMPS IN 2000,AS I THOUGHT OF GIVING BACK SOMETHING TO THE SOCIETY. DID 17 CAMPS TRIED TO EDUCATE THOUSANDS OF THEM ABOUT DIABETES.

THANKS TO BRAHMAN SABHA FOR GIVING ME BHEESHAKVARRYA AWARD IN 2009. THANKS TO IMA FOR GIVING ME LIFE TIME ACHIEVEMENT AWARD IN 2016 .

ENJOYED WORKING WITH ALL THE DOCTORS I STILL REGRET FOR NOT BECOMING IMA PRESIDENT WHICH WAS DUE TO SOME PERSONAL REASONS . ANOTHER REGRET IS NOT DOING POST GRADUATION. AT THE SAME TIME HAPPY TO SERVE DOMBIVLIKARS, AND IMA.

IMA DOMBIVLI HAS GROWN TREMENDOUSLY IN RECENT TIMES. WISH ALL THE BEST TO EACH AND EVERY ONE AND TO IMA AND ALL THE OFFICE BEARERS .

PLEASE PARDON ME IF I HAVE HURT ANY ONE UNKNOWINGLY. GOING TO MY JANMABHOOMI FROM DOMBIVLI THE KARMABHOOMI WILL BE IN TOUCH WITH ALL OF YOU, WILL KEEP COMING TO DOMBIVLI OFTEN

THANK YOU ALL

GOODBYE

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भावपूर्ण श्रद्धांजली

आम्हा डॉक्टरमित्रांना व असंख्य रुग्णांना आपल्यातीलच आहेत असे वाटणारे डॉ. शरद सागडे ह्यांचे शुक्रवार दि. २६ मे रोजी दुःखद निधन झाले. सहा महिन्यांपूर्वीच स्वादुपिंडाचा कर्करोग आहे व यकृतात पसरलेला आहे असे निदान झाले. त्यांच्या कुटुंबियांना व आम्हा मित्रांना मोठा आघात होता. ऑपरेशन शक्य नसल्यामुळे केमोथेरपी चालू झाली. काही काळ चांगला गेला व नंतर आजार पुन्हा बळावला व प्रकृती खालावली. वयाच्या ६३व्या वर्षी अकाली निधन झाले.

माझी ओळख १९७३ साली झाली. एम.बी.बी.एस.ला ग्रँट मेडिकल कॉलेजमध्ये ॲडमिशन घेतल्यानंतर झाली. एम.बी.बी.एस.ला आमची विशेष ओळख नव्हती. शरदची हुषार विद्यार्थ्यांमध्ये गणना व्हायची. शरद पहिल्यापासून हुषार, शांत व अभ्यासू. एम.बी.बी.एस.ला फर्स्ट क्लास मिळाल्यानंतर आवडत्या सर्जरी शाखेत प्रवेश घेतला. पोस्ट ग्रॅज्युएट करताना आमचा परिचय वाढला. शरद दिवसाचे १६ ते २० तास वॉर्डमध्येच असायचा व केवळ झोपण्यापुरताच खोलीवर जायचा. बासरी वादन हा त्याचा छंद होता.

शरद सतत वॉर्डमध्येच असल्यामुळे त्याच्या युनिट मधल्या व इतरही युनिट मधल्या सहकारी डॉक्टरांचा फायदा झाला तो आपणहूनच म्हणायचा, ‘तुम्हाला बाहेर जायचे असेल तर जाऊन या, मी पेशंटकडे बघतो, काळजी करु नका. सावकाश या.’ डॉक्टरांप्रमाणे रुग्णांमध्ये लोकप्रिय असल्यामुळे त्याच्या ओ.पी.डी. मध्ये सतत गर्दी असायची. १९८१ मध्ये एम.एस. झाला व १९८३ मध्ये एम.सी.एच. (युरोलॉजी) झाला. एम.सी.एच. झाल्यानंतर सुप्रसिद्ध यूरोलॉजिस्ट डॉ. फडके यांच्याकडे २ वर्षे काम केले. त्याचे काम बघून १९८५ मध्ये हिंदूजा हॉस्पिटल मध्ये कन्सलटंट युरोलॉजिस्ट म्हणून त्यांची नेमणूक झाली. तेव्हापासून ते शेवटपर्यंत तो हिंदूजा हॉस्पिटलमध्ये कार्यरत होता. १९८३ ते २००५ पर्यंत डोंबिवली येथे वास्तव्य होते. २००६ साली विक्रोळी येथे रहाण्यास गेला.

हिंदूजा हॉस्पिटलमध्ये जे.जे.त रेसिडेंट असल्यासारखा काम करायचा. ऑपरेशन झाल्यानंतर पेशंट बरा होईपर्यंत स्वतः काळजी घ्यायचा. पेशंट की केमोथेरपी पाच दिवसानंतर चालू करु. मी ३-४ पेशंटना ऑपरेशनच्या तारखा दिल्या आहेत. ऑपरेशन झाल्यावर केमो चालू करु. हे ऐकल्यावर शीतल व डॉक्टर अवाक् झाले. पहिल्या केमो ट्रिटमेंटने बरा झाल्यावर घरी न बसता हिंदूजा मध्ये रुग्णसेवा चालू केली, परंतू काही दिवसानंतर कॅन्सरने डोके वर काढले. दुसरी केमो चालू झाली. पण प्रकृती खालावली. पण या महान माणसाने असे सांगितले की ‘मी सिरीयस झाल्यावर जास्त दिवस आय.सी.यू. मध्ये व व्हेंटिलेटर वर ठेवू नका. मला घरी न्या व शांतपणे देवाकडे जाऊ द्या.’ त्याच प्रमाणे त्याची इच्छा पूर्ण करण्यात आली. त्याच्या अकाली निधनाने आम्हा डोंबिवली डॉक्टरांचा व असंख्य पेशंट्सचा आधार गेला आहे. असा या महान, साध्या अजातशत्रू व मितभाषी देवासमान व्यक्तिमत्त्वाला आम्हा डोंबिवलीकरांची भावपूर्ण श्रद्धांजली.

‘दिव्यत्वाची जेथ प्रचिती
तेथे कर माझे जुळती’

डोळ्यात पाणी आजला ।
गेलास सोडून साथ ।।
प्रेमळ तुझा स्वभाव ।
रुग्णसेवेचा मनी भाव ।।
धन्वंतरी मनी शरद सागडे तू ।
सदैव आम्हा स्मरणीय तू ।।

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MY JOURNEY TO PORTUGAL

Dr Sharad Dhaktode
MS

A General Surgeon.

Studied MBBS and MS at prestigious SETH GS MEDICAL COLLEGE and KEM HOSPITAL.

An Avid collector of Silver coins , Stamps , Currencies and Single Malt Scotch Whisky from all over the world.

True nature lover.

Portugal

It is one of the best holiday destination in Europe.

Portugal has been blessed with a glorious climate and stunning natural scenery, and this includes the beautiful sandy coastlines.

As a people, the Portuguese are welcoming and hospitable.

The melancholic trill of the Fado Guitar followed us from Portugal's Manueline Lisbon to Baroque Oporto and the sun-soaked beaches of Vilamoura. We Wandered through the medieval cities of Obidos, Évora and Guimarães, and visited the religious landmarks of Fatima, Batalha and the dramatic Hieronymite Monastery, enjoyed a delicious 'pasteis de nata' or two along the way.

LISBON

We saw Lisbon's landmarks including the Monument to the Discoveries, the suspension bridge spanning the River Tagus, the Belém Tower and the quaint Alfama district. We Visited the UNESCO World Heritage site of the Hieronymite Monastery during our sightseeing tour with a Local Specialist. Later we went to the historic towns of Cascais and Queluz.

We enjoyed Portuguese Fado Evening Of Music & Song With Dinner

We savoured a typical meal with local aperitifs and wines and hear beautiful, traditional Fado singing.

The Golden Triangle: Sintra, Cascais & The Estoril Coast

We visited the impressive Royal Palace of Sintra before passing through the fashionable resort of Estoril. Then, we explored the picturesque fishing village of Cascais, with its beautiful array of mansions and exclusive residences.

LISBON – ALGARVE REGION

We Crossed the River Tagus and drive south towards the Serra de Arrabida Mountains. Enjoyed a Be My Guest lunch at a traditional Stud Ranch where Lusitano horses are reared before arriving on the Algarve coast.

Algarve Dinner

An authentic local dinner, where we tasted delicious dishes cooked in a traditional 'Cataplana', along with other specialities.

ALGARVE EXCURSION

This morning we enjoyed a scenic coastal drive to the Sagres Peninsula. Admired spectacular views across Baleeira Beach before continuing our journey along the coast to Cape St. Vincent for beautiful sea views from the south-western most point of Portugal. Visited the resort of Lagos, where Henry the Navigator lived.

Faro And Almansil Excursion

With a Local Specialist we headed to Faro, the historical capital of the Algarve, to visit the old walled town and to have some time for souvenir shopping. Then, on to Almansil and the Chapel of St. Lawrence - one of the Algarve's best kept secrets.

ALGARVE REGION – ÉVORA

This morning we travelled across the Serra de Caldeirao to Evora. Joined a Local Specialist and visit ed the elaborate cathedral, Roman temple and the Chapel of Bones. Evora is one of Portugal's most beautifully preserved medieval towns. Spend time this afternoon seeing the 14th century walls, winding lanes and other enchanting sights at your own pace or joined an Excursion to the village of Monsaraz.

Monsaraz And The Deep Alentejo Drive

We with a Local Specialist drove through the vineyards and groves of cork oaks to charming Monsaraz, one of the most famous and beautiful 'white villages' of the Alentejo, inhabited since prehistory. We admired the castle which overlooks Spain and saw views of the largest artificial lake in Europe, before tasting typical local refreshments.

ÉVORA – CASTELO DE VIDE – BELMONTE – VISEU

Continuing north to Castelo de Vide and wandering through narrow alleys and the town's Jewish quarter, we Crossed the valley of the River Tagus towards the Serra de Estrela mountains. Saw the Roman tower in Belmonte. Arrived later at Viseu, a bustling town with historical buildings, set high on a plateau near the famous Dão vineyards.

Ínsua Manor - Food And Wine Pairing Experience

Situated in the heart of the famous wine region, we went on a short drive to the spectacular Ínsua Manor, an 18th century manor house and estate, where we enjoyed a gourmet experience matching local food with different local wines.

VISEU – MATEUS – GUIMARÃES – OPORTO

Travelling through the beautiful Douro Valley where port wine is produced we Explored the magnificent gardens at the Palacio de Mateus, depicted on the label of the distinctive Mateus wine bottles, Continuing via Guimarães for views of the impressive castle. Tonight enjoyed a Regional Meal on the waterside of Oporto.

OPORTO SIGHTSEEING

Our Local Specialist took us on a sightseeing tour of Oporto. Saw the remarkable bridges across the Douro River and the Baroque Church of St. Francis. Visited the Stock Exchange Palace with its splendid Arabian Hall and then experienced a Cultural Insight into the traditions of the local wine produced at a tasting in a port cellar. Spent the afternoon relaxing or shopping for souvenirs.

Douro Cruise And Dinner

Enjoyed a relaxing and leisurely cruise along the Douro River. We had a chance to see two medieval "world heritage" cities plus five impressive bridges, one of them the famous UNESCO-listed Eiffel bridge. Afterwards, savoured a typical meal in the Medieval Ribeira Quarter

OPORTO – COIMBRA – TOMAR – FÁTIMA

In Coimbra saw ancient streets and squares and visit the old university. In Tomar visited the UNESCO World Heritage site of the Convent of Christ, originally built as a Templar stronghold in the 12th century. Arrived later in the city of Fátima.

FÁTIMA – BATALHA – NAZARÉ – OBIDOS – LISBON

Visited the shrine where three young shepherds famously saw the apparition of the Virgin at the pilgrimage site of Fatima. Visited the monastery at Batalha - a UNESCO World Heritage site, it is the best example of late Gothic architecture in Portugal. Stopped at the fishing village of Nazaré on the coast and visited the medieval city of Obidos.

Tonight in Lisbon celebrated with our companions and Travel Director a Farewell Dinner with wine.

DEPARTED LISBON

With a fond farewell to OUR fellow travellers at the end of a spectacular Portuguese Holiday.

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Disha Kidney Care

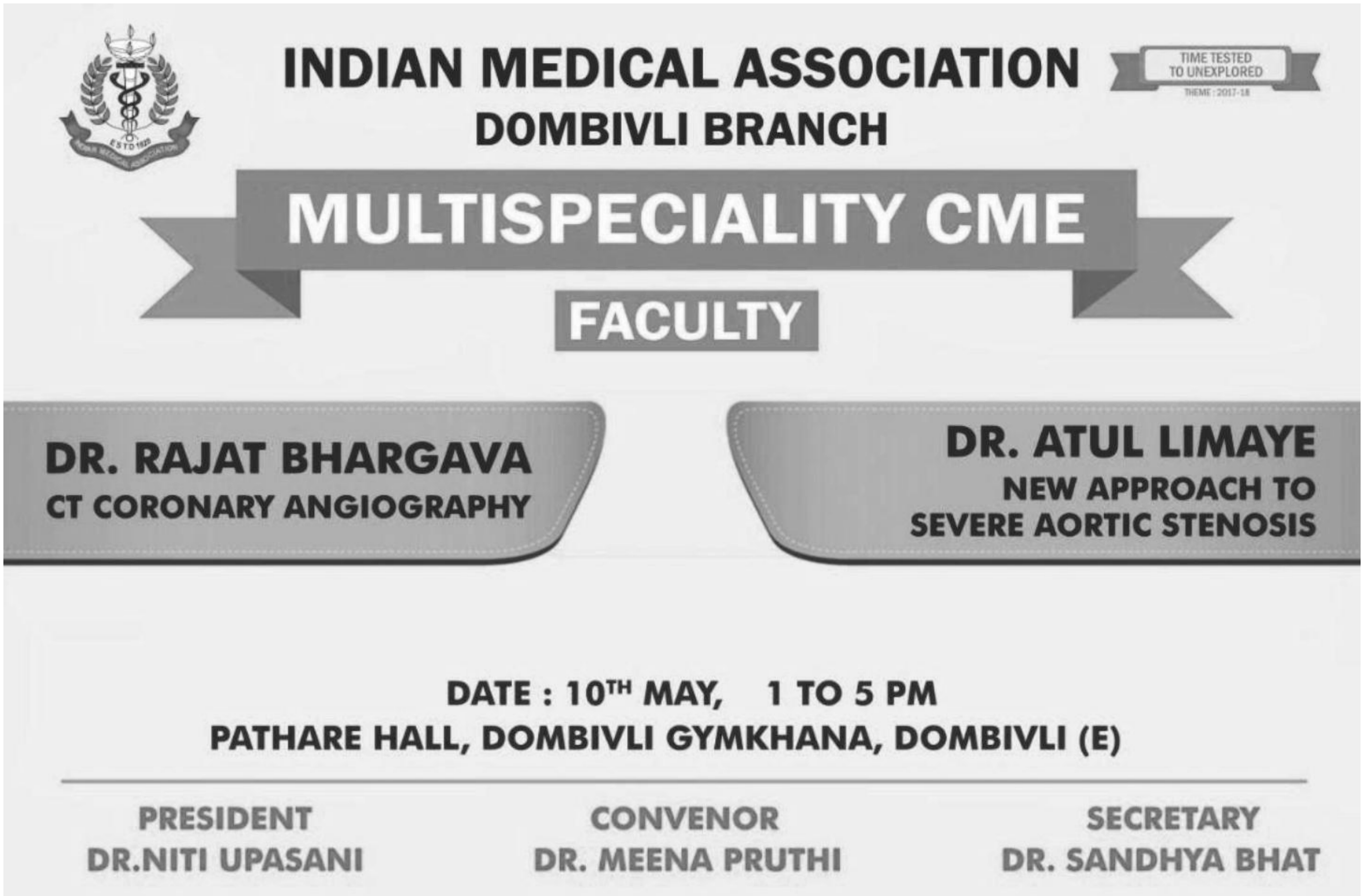
Path To Quality Care

Dr. DINESH P. MAHAJAN

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

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

THE 2ND MULTI SPECIALITY CME ORGANISED BY IMA DOMBIVALI FOCUSED ON THE CURRENT TRENDS IN CARDIOLOGY DIAGNOSIS AND MANAGEMENT.



The 2nd Multi speciality CME organised by IMA Dombivli focused on the Current Trends in Cardiology Diagnosis and Management.

Dr. Atul Limaye, a Consultant Cardiologist at Fortis Hospital Mulund spoke about TAVI -Trans-catheter Aortic Valve Replacement for the treatment of patients with Severe Aortic Stenosis who are at a high risk for Valve Replacement Surgery.

Dr. Rajat Bhargava, a Consultant Radiologist from Mulund Fortis gave us a picturesque insight into the Indications and Pitfalls of CT Coronary Angiography.

The sessions were moderated by eminent Consultants & IMA members;

Dr. Anil Dixit & Dr. Rajesh Mulay.

The Speakers and Moderators were felicitated with floral bouquets & token of appreciation by IMA President Dr. Niti Upasani

It was a highly interactive session with Clear Take Home Messages and well appreciated by the IMA audience of about 80 attendees.