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DELHI MEDICAL ASSOCIATION

OFFICIAL ORGAN OF DELHI STATE BRANCH INDIAN MEDICAL ASSOCIATION

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Stop all cashless, it is a matter of dignity

Indian private hospitals and healthcare providers are in agony. Cashless services have become an albatross around our neck and now it looks prudent to get rid of it.

Everyone wants services from healthcare providers on deferred payments, that also on highly negotiated prices without being accountable and answerable in any way. This has turned into one sided abusive and exploitative relationship. Government agencies and insurers think that getting services on deferred payments from healthcare providers is their prerogative and our compulsion.

Now it has become a matter of dignity for medical profession that we assert ourselves and demand changes in whole system of hospitals empanelment, pricing of services, payments mechanism and redressal of our grievances. We need a just system which allow us to serve society in a dignified way. We want that we should be considered an equal stake holder and acknowledged for our role.

Already many centres have voluntarily consented to join the big movement to, "Say no to Cashless" This movement is taking up the shape of a mass movement and spreading all over India.

Providing cashless services in current format is untenable as:

1. Insurance companies, third party administrators and reimbursing government agencies don't clear dues timely
2. Many insurers don't even respect preauthorisation given by them
3. They blackmail & threaten centres to sign arbitrary packages without any rationale and costing principles
4. Payments keep pending for months and years, which have become a big financial burden on hospitals and Nursing homes. Medical establishments are facing severe financial crisis
5. Our repeated attempts to approach insurance companies and IRDA India has fallen on deaf years
6. They blackmail small centres without any negotiating powers to sign very low packages and then use them as market standards
7. Empanelment process is not transparent and inclusive. All registered centres are not offered empanelment. It remains highly restricted with less than 10% hospitals on Preferred Providers Network.
8. Insurance companies are not widening provider base to increase options for patients. IRDA is not taking any action to widen providers network
9. There is no grievance redressal mechanism for hospitals in this whole affair
10. Despite cooperation from hospitals in providing cashless services, these insurance companies and TPAs keep defaming hospital industry in Media.
11. Method of deciding pricing through bidding by CGHS is irrational and without following any costing principles

We are not venture capitalists, finance companies or bankers, who will be able to provide cashless services on credit basis. Government or insurance companies are not providing us any financial guarantee or security to handle cashless business. Government agencies and insurance companies should come out with innovative products to provide cashless healthcare services. Burden of deferred payments shouldn't be put on hospitals. Current situation is one sided and against the growth and survival of hospital sector in India.

We find it untenable to provide cashless services under current circumstances. Insurance companies and government agencies have started thinking that we are fragmented and providing them services on credit has become a compulsion for us. Now, it is a matter of dignity for us that we are also treated as stake holders and fair dialogue takes place to resolve pending issue.

It is high time that medical profession decides to get liberated from this maze of empanelment, pricing and payments and focus on providing healthcare, which they know best. It is high time that we stop giving credit facilities to everyone, whether they are insurance companies or government agencies.

Dr. Girish Tyagi
President

Dr. C.P. Khandelwal

HONY. ASSOCIATE EDITOR'S PEN

Say no to health care on enforced rates

India is a welfare state and ensures the right of life as a fundamental right, enshrined in article 21 of constitution of India. The government of India and all state governments has though consistently put efforts in this direction by trying to achieve the cherished goal of 'health for all' as envisaged by WHO from time to time but the deadline seems to be shifting ahead all the time.

Our nation is a 7th largest economy of the world in terms of GDP and the rank goes still higher to third in the globe, if we compare GDP with purchase power parity or PPP, but because of our terribly big population we go down to rank 120th in world when it comes to per capita GDP.

According to lancet studies we rank at 145th in world when it comes to health care access and quality index (HAQ) and stand behind our neighbors like China, Srilanka, Bhutan and Bangladesh. Needless to say the major cause of such dismal performance in this important sector is minimum state spending on health which is less than 1.5% of GDP as against over 15% in USA. The total per capita health care expenditure in USA goes few thousand times higher than us given their per capita GDP.

Fortunately, our sovereign has started thinking seriously in this direction in past few years and the Aaushmaan Bharat or PMJAY is a big leap forward dreaming to provide quality health care to most downtrodden population of the country with roughly 50



crores beneficiaries. Health being a state subject largely (though on concurrent list too) Delhi govt. has come up with its own model through mohalla clinics and delhi aarogya kosh i.e. DAK.

DAK, though is a real welfare scheme but bound to run in rough whether because of the remarkably poor rates offered to private sector, which is the back bone of NCT health care delivery system. These rates are much lower than even CGHS and GIPSA rates which

are totally not feasible, even with reasonable compromise in quality of care, if honored with honesty. This has happened because our private sector players are running behind empanelment on all the poor rates, may be, in the hopes of employing all the fraudulent or quality compromising means to make it overall profitable.

Since we are continuously being exploited by all the managed health care agencies because of totally unhealthy competition within us, we are bound to suffer more, unless we really unite together to say an absolute NO to enter in any such contract with DAK and challenge the compulsions, put by the oppressive regime (if any), in court of law.

Let us say NO to DAK rates and then follow the same approach for PMJAY, GIPSA, CGHS et al

Dr. Kamal Parwal
Hony. Associate Editor

BRANCH NEWS

IMA DNZ BRANCH

Indian Medical Association - Delhi North Zone organised Midterm conference, on 10th November 9:00 AM to 5:00 PM at Crowne Plaza, Rohini. Topics for discussion, were chosen from all specialities, Cardiology, Diabetes, Eye, oncology, Family Medicine, Nephrology, Robotic surgery etc.

Leading consultants spoke to more than 200 delegates and shared their knowledge and practical experience. President Dr. N N Jha, emphasized the significance of CMEs for learning the latest in the field of Medicine. Earlier the Inauguration ceremony was attended by Chief Guest Dr. Ashok Rana, DGHS, Delhi, Guests of Honour Dr. Arun Gupta, President, DMC, Dr. Sunil Gupta, MS, Safdarjung Hospital, Dr. B.B. Wadhwa, President Elect, DMA, Dr. Naresh Chawla, Master of Inauguration ceremony, emphasized the unity among cadres of DMA,

and regular exchange between Branches of DMA, will bring unity in ranks of DMA.

Dr N N Jha, President, Dr Abhishek Kumar, Hon. Secy, Dr H N Gangwal, Finance Sec. and many members of State Executive, Central council and Branch Executive committee & Past presidents took great interest & worked hard to make it, grand success. Many dignitaries from other branches, including Dr. G. S. Grawal, Dr. Alok Bhandari, Dr. Sangeeta Mutneja, Dr. Mutneja, Dr. Vikas Sharma, Dr. Sameer graced the occasion and were honoured by a Doshsla.

Dr. N N Jha, President. Dr. Abhishek Kumar, Hony secy, Dr HN Gangwal, Hony Finance Secy





The air quality in Delhi, the capital territory of India, according to a WHO survey of 1650 world cities, is the worst of any major city in the world. Air pollution in India is estimated to kill about 1.5 million people every year; it is the fifth largest killer in India. India has the world's highest death rate from chronic respiratory diseases and asthma, according to the WHO. In Delhi, poor quality air irreversibly damages the lungs of 2.2 million or 50 percent of all children.

Air quality index of Delhi is generally Moderate (101-200) level between January to September, and then it drastically deteriorates to Very Poor (301-400), Severe (401-500) or Hazardous (500+) levels in three months between October to December, due to various factors including stubble burning, road dust, vehicle pollution and cold weather. In November 2017, in an event known as the Great smog of Delhi, the air pollution spiked far beyond acceptable levels. Levels of PM2.5 and PM 10 particulate matter hit 999 micrograms per cubic meter, while the safe limits for those pollutants are 60 and 100 respectively.

A public health emergency has been declared in Delhi on last few days after the air quality in the national capital further dipped to the hazardous "severe plus" category. The skies of Delhi-NCR, which has been covered in a thick blanket of grey smoke turned thicker in the morning, sending alarm bells ringing.

The National Disaster Management Authority (NDMA) has announced a list of guidelines for residents of Delhi to follow to deal with the smog.

1. Avoid strenuous activities and hard labour as this forces one to inhale more and thus take in more harmful particles from the air.
2. If you have to exercise and do physical activities, try to do it indoors instead of going out. Also, physical activities should be left for the evening.
3. Drink more water to flush out toxins and harmful particles from the body.
4. Start wearing masks to protect yourself from the harmful effluents floating in the air. Do not use surgical masks and comfort masks as they do not qualify to protect you from the hazardous particles. Buy the right masks with respirators.
5. Start carpooling with friends and colleagues or people travelling on the same route to reduce the number of vehicles plying on the road.
6. Get some air-purifying plants like tulsi and money plant for your home and office to keep the air as clean as possible.

THINGS TO AVOID

1. Avoid using the bigger roads with more traffic. Pollution is significantly less on smaller roads and bylanes that are off the main road.
2. Do not burn garbage, plastics and other discarded items in the outdoors. Stop neighbours from burning any such items either.
3. Avoid outdoor activity as much as possible. Mornings should be avoided even more as the smog cover is the most severe early in the morning.
4. Do not burn any firecrackers. Authorities have already put a ban on all cracker burning this winter.

HEALTH HAZARDS TO WATCH OUT FOR

Hospitals in Delhi have seen a sudden spike in the number of patients reporting with respiratory and breathing complications.

- The severe air pollution can cause eye burning, eye watering.
- Breathing and respiratory difficulty, asthma problems and allergy.
- Chronic obstructive pulmonary diseases.
- Besides affecting lungs, high levels of pollutants in the atmosphere cause inflammation in blood vessels and may lead to hardening of arteries which can act as a trigger for stroke or heart attack in persons, already at risk of the disease.

Dr. Arvind Chopra

Hony. State Secretary

Most people don't think about self-esteem. It's not usually on their radar. But what a role it plays in our lives. We wear low self-esteem on us like a garment that everybody can see. I think it's time we pay attention to it. So let's start now. This does take a bit of practice, but once you implement these strategies, you will instantly begin to notice changes in your life.

- **Accept thoughts, emotions, and sensations as they are**

Do not judge them. They are neutral and do not define who we are. They rise up within us and can be released through the body and mind. They are fleeting in nature and can also be changed.

- **Eliminate “should” from your vocabulary**

“Should” comes from a place of judgement. Examine your beliefs, especially around your “shoulds.” Question them. What happens when you turn your “shoulds” into “coulds?” Does it open up other options or encourage less judgement?

- **Do not rely on other people to provide you your sense of worth**

They will inevitably disappoint. We have to internalize our power and make ourselves the only wielder of it. No label, position, or relationship can give us worth. Those are external factors. We have to ensure that if something or someone is removed from our lives, our esteem will remain intact.

- **Forgive**

We need to forgive ourselves for our past wrongdoings. Shame, regret, and guilt sabotage our self-esteem and self-worth. We often find it easier to forgive others, but we must apply this compassion to ourselves as well.

- **Take stock of your talents**

Everybody has a gift or calling in this world. In fact, each of us have many different abilities that help others. We must identify these. If we are unsure of what these abilities are, start small. What small things are we good at? Enjoy? In what ways do we make other people's lives better? Celebrate these; they are the very things that make us feel worthy.

These five strategies are simple; however, following them will take mindfulness and perseverance. I assure you, all the effort will be worth it when you start to live with inner calm and contentment on a daily basis. This newfound self-worth will show up in your relationships, career, and fresh opportunities and people that you will attract. Remember, like attracts like.

A healthy and secure you will attract other healthy and confident individuals.



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- Dr. V. Mohan - Padma Shree Awardee, Diabetologist, Chennai
- Dr. Anil Bhan - Sr. Cardio-Thoracic Surgeon, Medanta Gurugram
- Dr. Ashok Seth - Sr. Cardiologist and Chairman of Fortis-Escorts Heart Institute
- Dr. K. Narasimhan - Director, Sri Sathya Sai Mobile Medical Hospital, Puttaparthi
- Prof. Dr. P. Venugopal - Ex. Cardiac Surgeon, AIIMS
- Dr. Shekhar Rao - Director, Sri Sathya Sai Hospital, Whitefield, Bangalore
- Prof. Dr. P.S. Saharia - HOD ENT Deptt., Max Hospitals, Medical Coordinator SSSSO, Delhi-NCR
- Dr. Ganesh Mani - Padma Shree Awardee, HOD CTVS Dept., Max Healthcare, Saket
- Dr. Ram Manohar Rao All India Medical Coordinator, SSSSO, India
- Dr. Vipin Kumar Singhal - Paediatrician, Medical Convener, SSSSO Delhi - NCR

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There are many diseases which are life threatening and need your immediate attention. But non-life threatening diseases due to their continuous pain, discomfort & mental agony catch up your attention much more. Pilonidal Sinus is one such disease. In Latin Pilo means hair & Nidal means nest.

The disease was discovered in 1867, was thought to be congenital at that time because of its location in midline. It took 57 years for medical science to understand that it was acquired.

Points in favour of it being acquired are:

1. It is uncommonly found in axilla and inter digital space (barbers).
2. Hair in the track is dead and there are no hair follicles in wall.
3. Recurrence is present.

Since then medical science has toiled to find a cure.

Thanks to the hard work of countless surgeons around the globe, sharing their experiences and learning together from their mistakes that it is now possible to cure Pilonidal Sinus completely.

Clinical features:

1. It is characterized by an infected sinus containing dead hair with single or multiple openings. Single opening is always found in midline usually at last piece of coccyx. Multiple openings up to 6 can also be seen.
2. Small tuft of hair projects.
3. Blood stained foul smelling discharge is present.
4. No constitutional symptoms are there even at peak of local symptoms.
5. Abscess formed bursts into a primary midline opening or a secondary opening away from midline.

Pathogenesis:

1. Broken hair from as high as nape of neck and upper back collect at post anal dimple and nearby area. Broken infected peri anal hair is also present in this area. Shearing action due to sitting on hard surface, vibration of vehicle and moisture lead to the penetration of hair in an active sweat gland and broken skin. If dermatitis is present it facilitates hair entry and sinus is formed.
2. Once a sinus is formed it sucks hair due to intermittent negative pressure. Inflammation, infection and purulent discharge follow.

Epidemiology:

1. Age & sex: Mostly men 20 to 30 years of age, hairy. Male to female ratio is 4:1. Beyond 30 years of age in extremely

hairy and obese. Obesity & deep buttocks add to the chances of Pilonidal Sinus.

2. Professionally: People sitting for long hours like call centre executives, drivers, are most susceptible to this disease.

Long sitting hours, hard sitting surfaces, vehicular vibration of seats & tight clothes create negative pressure which facilitates the sinus to suck broken hairs and create nest of hairs.

So common was Pilonidal Sinus among JEEP DRIVERS in World War II that it came to be called as JEEP BOTTOM.

3. By habit: People who use toilet paper are more prone as infected hair get entangled in tissue paper which sticks the peri anal area.
4. By race: Never in blonds as hair are soft.

Treatment:

1. Conservative: In early stages conservative treatment like cleaning the track, removing hair and antiseptic wash is enough to cure the disease. Treatment for acute abscess is simple IND with small incision & broad spectrum antibiotics cure the disease. But due to absence of constitutional symptoms the patient comes late and surgery is the only choice for cure.
2. Surgical: This is achieved by excision of sinus without primary closure option 1 or with primary closure option 2. In the first option healing is by secondary intention. It's usually successful but healing time is 4-6 weeks with heavy dose of antibiotics & NSAIDS. Due to long recovery time patients loose on job & day to day normalcy. In the second option there are various procedures described for primary closure like Bascom's, Karyadaki's, advancement flaps, etc. But the failure rate is as high as 50%.
3. Advanced treatment: Micro Endoscopic Cryo Surgery has answered the limitation of conventional treatment. First we have to determine the extent of the disease. We inject dye into the sinus & visualise the complete track of the sinus. With help of micro endoscope from the primary opening we clean the track till the last. As there is no incision recovery is fast, no heavy dose of antibiotics, and NSAIDS is required. The patient can attend to his professional duties and personal life from the same day. The miracle combination of skill & technique has been bringing big smile to the millions of ailing patients who have suffered recurrence and failures.

Prevention: People with excess sweat and obesity must wear loose clothes, keep area dry, remove of hair regularly and undergo weight loss.

Recurrence: Most common cause is primary closure and the lack of preventive measures as described above.



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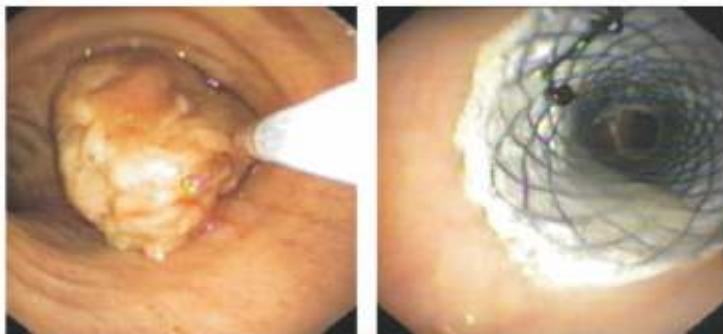


The Chest Medicine Team

Sitting left to right:
Dr. Ujjwal Parakh, Dr. Bobby Bhalotra,
Dr. Neeraj Jain, Dr. Arup Basu,
Dr. Amit Dhamija, Dr. Abhinav Guliani,

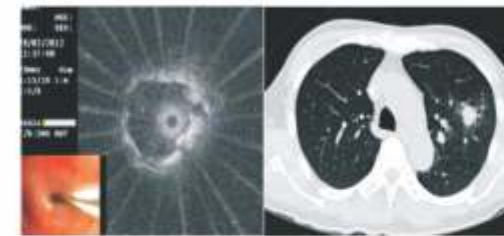
Standing left to right:
Mr. Mahesh, Dr. Shuvranu, Mr. Nain,
Mrs. Kamal, Mrs. Princi,

Helpline : + 91 11 42252082



An Overview....

- The Department of Chest Medicine has been functional at **Sir Ganga Ram Hospital** since 1993. It provides all that is necessary for high quality care of patients with state-of-the-art equipment required for diagnosis and treatment of respiratory diseases, a humane approach combined with total dedication and academic activities to always remain abreast with the latest developments in the field of respiratory medicine.
- The Department is well equipped to deal with preventive, diagnostic, therapeutic, emergency and rehabilitative aspects of Chest Medicine to provide quality and comprehensive care for patients that is comparable to best in the world.
- One of the **major highlights** is our foray in recent years into **Interventional Pulmonology**, which is likely to become a super speciality in the coming future. We are proud of our setup of **Endobronchial Ultrasound (EBUS)**, which is the **first of its kind in the country** and offers both **linear and radial EBUS** facilities. We have **performed more than 10,000 EBUS procedures** in the last 9 years, which is by far the **highest by any centre in the country**. We are also the National Training Centre for Olympus.
- Ours is the only centre performing over **2000 bronchoscopies** every year.
- We were the first centre in North India to start **Bronchial Thermoplasty for severe asthma** patients
- Another highlight of the department is the **dedicated Respiratory High Dependency Unit (HDU)** fully equipped with invasive and non-invasive ventilators and hemodynamic monitoring.
- The Department has an organized academic program for both theoretical and practical training for National Board postgraduates, with two intakes yearly.



Services Offered

- 24hrs emergency services
- Respiratory High Dependency Unit (RHDU)
- Non Invasive Ventilation
- Pulmonary Function Testing
- Spirometry with diffusion & lung volume studies with Body Box
- Pleural aspiration under ultrasound guidance
- Chest Tube / Intercostal Drain
- Allergy testing
- Pulmonary Rehabilitation

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- State of the art Bronchoscopy tools for diagnostic and therapeutic bronchoscopy
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- Bronchial Thermoplasty for severe asthma (first in North India)
- Rigid Bronchoscopy
- Hot biopsy forceps
- Foreign Body Removal
- Facility for Endobronchial Stent placement
- Electrocautery / Argon Plasma Coagulation
- Tumor removal / de-bulking
- Fluoroscopy guidance
- Endobronchial glue insertion
- Endobronchial Spigot insertion for broncho-pleural fistula
- Medical Thoracoscopy / Pleuroscopy
- Hot biopsy forceps / Balloon Dilatation



Future Plan

- Ready to initiate Lung Transplant Program in coordination with the Department of Thoracic Surgery

Message from the Chairman



Dr. D S Rana
Chairman
Board of Management

The Department of Chest Medicine at Sir Ganga Ram Hospital is fully equipped with modern, state of the art equipment, complemented by leaders in the specialty. The department has been a pioneer in introducing Endobronchial Ultrasound bringing thrust in the field of Interventional Pulmonology. With a robust academic programme, it has been imparting training to young medical specialists. With a dedicated Respiratory HDU, it is fully equipped in providing acute respiratory care.

With a robust academic programme, the department has been imparting training to young medical specialists and it has been actively participating in the charitable endeavors of the hospital.



Sir Ganga Ram Hospital Mang, Rajinder Nagar, New Delhi - 110060, 24 Hour Helpline : 25750000, 42254000, Fax: +91-11-25861002, E-mail: gangaram@sgrh.com Visit us at www.sgrh.com



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SMASHING RECORDS BY DAMSONIANS IN 2018-19

NEET PG TOPPERS JAN 2019

 Dr. Aishwarya S. Durgad 4 Rank	 Dr. Rajath R. G. 5 Rank	 Dr. Sree Vandana 10 Rank	 Dr. Suyash Niranjan A. 11 Rank	 Dr. Anuj Ban 12 Rank	 Dr. Bhavishya Shetty 14 Rank
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AIIMS TOPPERS MAY 2019

 Dr. BHAVESH M. 1 Rank	 Dr. RANJAN KUMAR SAHOO 2 Rank	 Dr. ASHOK DHUDWAL 3 Rank	 Dr. RAGHUNANDAN DIXIT 4 Rank	 Dr. HEMANT AMARDEEP 5 Rank	 Dr. PPRNA GARG 6 Rank
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PGI TOPPERS MAY 2019

 Dr. BHAVESH M. 1 Rank	 Dr. SHIVAM GOAL 2 Rank	 Dr. HEMANT AMARDEEP 3 Rank	 Dr. DEEPAK GARG 4 Rank	 Dr. IFTIKHAR KHAN 6 Rank	 Dr. PPRNA GARG 7 Rank
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JIPMER TOPPERS MAY 2019

 Dr. Praveen Kumar 1 Rank	 Dr. Darshan Patel (CBT Student) 2 Rank	 Dr. NIKHIL VOHRA 3 Rank	 Dr. Mohamed Ilyas R. 4 Rank (Inst.)	 Dr. BHAVESH M. 5 Rank	 Dr. SHIVAM GOAL 6 Rank
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DNB TOPPERS MID YEAR 2018

 Dr. Nivedita Kh. 1 Rank	 Dr. Debayan Chakraborty 2 Rank	 Dr. Sumit Aggarwal 3 Rank	 Dr. Siladitya Mahanty 6 Rank	 Dr. Athira 7 Rank	 Dr. Deep Mehta 8 Rank
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Indian Medical Association
Central Delhi Branch

organises

CLINICON | 2019

at

DMA Auditorium, Daryaganj, New Delhi

on

Sunday, 1st December, 2019

9.00am - 5.00pm

FACULTY



Dr. Sanjay Tyagi



Dr. Sanjiv Malik



Dr. K.K. Aggarwal



Dr. Girish Tyagi



Dr. Arvind Chopra



Dr. Anupam Sibal



Dr. Yesh Gulati



Dr. J.C Passy



Dr. Harish Gupta



Dr. Tapaswini Pradhan



Dr. Amit Vij



Dr. Vishal Aggarwal



Dr. Anil Aggarwal



Dr. Rahul Bhargawa



Dr. Rajiv Anand



Dr. N.P. Singh



Ms. Meghna Aggarwal

THEME:
PEARLS OF CLINICAL PRACTICE

Approach to Diagnosis & Management of a Patient with

- | | |
|-------------------------|-------------------------|
| 1. Chest Pain | - Prof. Sanjay Tyagi |
| 2. Jaundice | - Dr. Anupam Sibal |
| 3. Deafness | - Prof. JC Passy |
| 4. Pain Abdomen | - Prof. Anil Aggarwal |
| 5. Oedema | - Prof. NP Singh |
| 6. Common Skin Diseases | - Dr. Amit Vij |
| 7. Anaemia | - Dr. Rahul Bhargav |
| 8. Joints Pain | - Dr. Vishal Aggarwal |
| 9. Cancer | - Dr. Tapaswini Pradhan |
| 10. Headache | - Dr. Rajiv Anand |

ECG Workshop : Dr. Prem Aggarwal

CEA : Dr. Harish Gupta

Doctor - Patient Relationship :

Panelists : Dr. Vinod Dua, Dr. Sanjiv Malik, Dr. Girish Tyagi, Dr. Arvind Chopra

Moderator : Ms. Meghna Aggarwal

Yoga, Medical Check up, ECG, HbA1C, Lipid Profile of delegates in morning at CLINICON on 1.12.2019 at DMA.

SMS Reg@9811542055

Dr. Prem Aggarwal
Dr. Ashwini Dalmiya

Prior Registration Must

Send your Registration at :

E-mail: imacentraldelhibranch@gmail.com



Dr. Prem Aggarwal
Conference Chairman &
President, IMA CDB
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Dr. Vinod K. Goel
Hony. Fin. Secretary
Mob. 9868525757



Dr. Ashwini Dalmiya
Organising Secretary
Secretary, IMA CDB
Mob. 9811542055

CLINICAL APPROACH TO ACUTE SKIN PROBLEMS

DR. AMIT VIJ
M.D. (DERMATOLOGY)
CONSULTANT DERMATOLOGIST
DELHI

INTRODUCTION

- **Dermatology** is the branch of medicine concerned with the skin, hair, and nails, as well as the conditions associated with them.
- Basic knowledge of dermatology is essential for every physician.
- Skin lesions may be primary or secondary.
Primary lesions (e.g., macules or papules) appear as a direct result of a disease process.
Secondary lesions such as scales or ulcers may develop from primary lesions or result from external trauma (e.g., infections, scratching).
- Dermatological conditions can often be diagnosed based on patient history and physical examination but may require laboratory testing or biopsy to confirm the diagnosis.

Stevens Johnson Syndrome (SJS)



MACULE /PATCH

flat lesions defined by an area of changed color



PAPULES

raised, solid lesions <5 mm in diameter



PUSTULES

raised lesions containing purulent exudate



BLISTERS

Vesicles (<5 mm) and Bullae (>5 mm) circumscribed, elevated lesions containing fluid



PLAQUES

lesions >5 mm in diameter with a flat, plateau-like surface



NODULES

lesions >5 mm in diameter with a more rounded configuration



WHEALS (urticaria, hives)

papules or plaques that are pale pink and may appear annular (ring like) as they enlarge;
classic (nonvasculitic) wheals are transient, lasting only 24 h in any defined area.



Nonpalpable purpura

flat lesion that is due to bleeding into the skin.
Petechiae --- <3 mm in diameter
Ecchymosis--- >3 mm in diameter



Palpable purpura

visible non-blanching hemorrhages, are raised and able to be touched or felt upon palpation



ULCER

defect in the skin extending at least into the upper layer of the dermis



ESCHAR

necrotic lesion covered with a black crust



COMMON ACUTE SKIN CONDITIONS

The most common ACUTE skin conditions in daily clinical practice are-

- FEVER & RASH
- CUTANEOUS DRUG REACTIONS

FEVER & RASH

Acutely ill patient with fever and rash -- a diagnostic challenge for physicians.

FEVER is temporary ↑ in the body's temperature in response to disease or illness

RASH is a change of the skin which affects its colour, appearance or texture.

It may occur because of-

- Multiplication of infective organism in the skin.
- Toxins produced by organisms acting on skin structure
- Autoimmune destruction of skin due to inflammatory response against the infecting microbes.
- Vascular involvement.

History taking for Rash

appeared before or after fever ?	site of onset	medications taken within the recent period
recent exposure to ill individuals	exposure to domestic pets and other animals	direction and rate of spread
immune status	specific travel history	

PHYSICAL EXAMINATION

Distribution pattern	Morphology	Configuration
Symmetrical	Monomorphic	Linear
Asymmetrical	Pleomorphic	Annular
		Grouped

Rash pattern and the most frequent associated diseases

Rash Characteristics	Disorders
Central distributed maculopapular eruption	Exanthematous drug-induced eruption, LE, viral fever, dengue, measles, rubella



Rash pattern and the most frequent associated diseases

Rash Characteristics	Disorders
Urticarial Eruptions	Urticaria, Angioedema, Papular urticaria(insect bite)



Rash pattern and the most frequent associated diseases

Rash Characteristics	Disorders
Nodular Eruptions	Erythema nodosum, panniculitis



Rash pattern and the most frequent associated diseases

Rash Characteristics	Disorders
Purpuric Eruptions	meningococemia, encephal meningitis, sepsis, Viral infections that cause hemorrhagic rash include coxsackievirus A9, echovirus 9, EBV, cytomegalo virus (CMV), measles virus



Rash pattern and the most frequent associated diseases

Rash Characteristics	Disorders
Vesicular rashes	Varicella, herpes simplex, herpes zoster, Hand-foot-mouth disease,



TREATMENT APPROACH FOR RASH WITH FEVER

- The disorders responsible for fever and rash are numerous, and their manifestations protean; therefore, multiple specialists are frequently involved on the diagnostic approach.
- Cause of fever is to be determined as its treatment will help in controlling the rash.
- Topical moisturizing lotion will help in reducing the irritation levels.
- Mild topical steroids can be used for pruritis for localized areas.
- Oral anti histamines can be given continuously depending on the severity of rash and itching.
- Oral steroids should be used cautiously depending on the blood parameters.

CUTANEOUS DRUG ERUPTION

- In everyday clinical practice, almost all physicians come across many instances of suspected adverse cutaneous drug reactions (ACDR) in different forms.
- Although many a times, presentation is too trivial and benign, the early identification of the condition and identifying the culprit drug and omit it at earliest holds the keystone in management and prevention of a more severe drug rash.
- It is most challenging and practically difficult when patient is on multiple medicines.
- Therefore, in practice, the diagnosis of ACDR is purely based on clinical judgment.

To be continued...



6th Annual MLAG Conference 2020

(Hosted by Medicos Legal Action Group & Delhi Medical Association)

Venue: India Islamic Cultural Centre, Delhi, India

Date: 02nd February, 2020



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• PROGRAMME HIGHLIGHTS

PCPNDT Act: Amendments we never had

The ever evolving Consent

Bridge courses: The legal Infirmities

Euthanasia: Are the legal requirements being circumvented

Doctors Unity: Beyond the rhetoric

Unborn and the law

Acts done in good faith: Are you legally protected

Doctors Encounters with the police: Dichotomy in theory and practice

Culpability of resident doctors

Future shock: Unsustainably low standard of medical care staring at us

Judgements per incuriam and their effect on medical practice

Violence against doctors: Are reasons financial, political or social

Thinking out of the box: Decoupling medical liability

Debate: Doctors as judges in Medico legal cases

Words of wisdom: Advice of a judge

Differing monetary value of life: Vagaries of compensation calculation in different accidents.

Special Session on pre invited questions from registered delegates

The Newer Acts: Are they shaping or distorting the healthcare scene in India



6th ANNUAL MLAG CONFERENCE 2020

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MLAG Member/Resident Doctor/PG Student	INR 2,000/-	INR 2,500/-	INR 3,000/-
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