



DMA NEWS BULLETIN

FORTNIGHTLY

DELHI MEDICAL ASSOCIATION

VOLUME 51
ISSUE-2

OFFICIAL ORGAN ORGAN OF DELHI STATE BRANCH INDIAN MEDICAL ASSOCIATION

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Dr. Arvind Chopra
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28
PAGES

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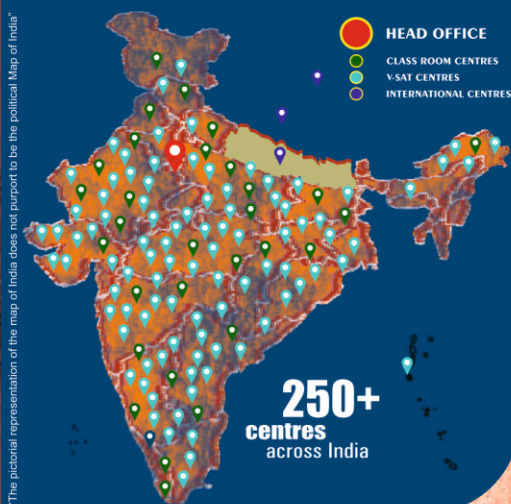
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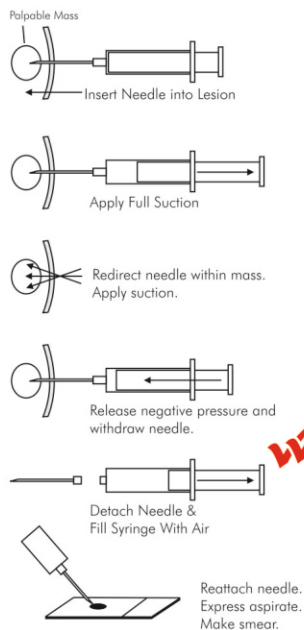
North Delhi Pathology Clinic
27/5, Shakti Nagar, Nangia Park, Delhi-110007



FNAC & Tuberculosis

Confirmation of EPTB using Xpert MTB(CB-NAAT) on Fine Needle Aspirate

Fine Needle Aspiration Cytology is a procedure that involves passing a thin needle through the skin to sample fluid or tissue from a cyst or solid mass. The sample of cellular material is taken during an FNAC. Smears of aspirate is air dried, stained and examined under microscope to judge characters of the cells aspirated. It can be performed on all suspicious superficial lumps such as enlarged **palpable lymph nodes, thyroid nodule, breast lumps or any superficial palpable lump**. This procedure is a relatively non-invasive, less painful and quicker method when compared to other methods of tissue sampling such as surgical biopsy.



FNAC Technique

Procedure:

A fine needle aspiration cytology is a simple and quick procedure. Even local anesthesia is usually not required, as the procedure is usually not painful. The insertion of the needle is similar to the sensation of a blood test. A vacuum or negative pressure is created in the needle and with an in and out motion of the needle, the sample is taken. In some cases, more than one needle insertions may be required to ensure that the sample is adequate. Once the test is completed patient can continue normal activities. There are generally no complications with this procedure.

Results:

The aspirate is examined under microscope and diagnosis is made based on the type of cells that are seen.

Benefits and Limitations:

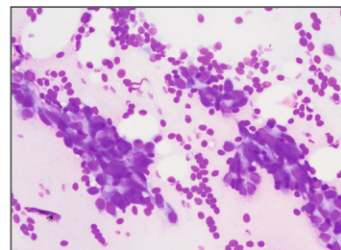
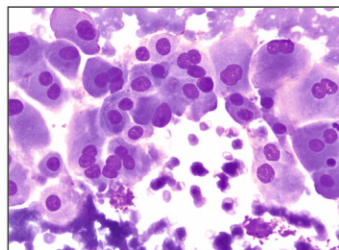
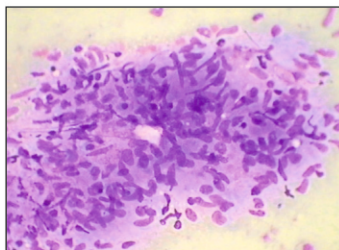
FNAC is a quick and effective test for determining the status of the suspect tissue. Compared to a surgical biopsy, fine needle aspiration cytology involves the little possibility of scarring, infection or pain, and has a significantly shorter recovery time. Because an FNAC can only sample a small number of cells from a mass or lump, there is a risk that any abnormal cells may be missed.

FNAC for Confirmation of MTB-Tuberculosis:

In cases where aspirate from a site-specific specimen is purulent or granulomatous lymphadenitis and Extra Pulmonary Tuberculosis (EPTB) is suspected, Xpert MTB (CBNAAT) testing has an important role in the **confirmation of Tuberculosis**.

Result of Xpert MTB (CBNAAT) test is available the **same day** and confirmation of EPTB along with **Rifampicin resistance** status is possible.

Thus by **combining FNA with Xpert MTB (CBNAAT)** test, it is possible to confirm TB in a significant number of cytomorphologically TB **NEGATIVE** aspirates from a site-specific specimen from Lymph nodes, Breast, Musculoskeletal system, etc..



9873247824, 23841122

8:30 AM to 6:00 PM



ISO 9001:2015 CERTIFIED ORGANISATION

Certificate No. MC-2777



President's Pen...

Great victory for DMA

On 13th April (Saturday) at Annual Convention of NDB where I shared the dais with Sh. Vijay Dev, Chief Secretary Govt. of Delhi along with Dr. K.K. Aggarwal. I raised the issue of institutional FIR in cases of Violence/Assaults at Medical Institutions which was reiterated by Dr. K.K. Aggarwal. Sh. Vijay Dev assured that it will be done. Today Principal Secretary Health has issued a circular in this regard. We are thankful to Chief Secretary Sh. Vijay Dev Ji for his prompt action which will provide congenial atmosphere for working for young doctors. Your doctors will along be indebted to him for this action.

More Transparency required in functioning of DPCC.

Advisory committee meeting for Bio Medical Waste Management was convened on 11th April, 2019 to discuss action plan on BMW management where all the stake holders including Member Secretary CPCB (Central Pollution Control Board), Member Secretary DPCC (Delhi Pollution Control Committee), DGHS GNCT Delhi attended the meeting. From DMA side I along with Dr. Ajay Bedi Secretary DMA NHF and Dr. V.K. Goyal Past Secretary DMA NHF attended that meeting. I raised the issue of poorly functional, not user friendly website of DPCC because of which DMA members are facing difficulty in getting registered with DPCC and it had been intimated to officials of DPCC at various meetings in the past also but problem is still persisting. Some members got their agreements with service providers (Biotic / SMS water grace) but not able to register with DPCC. It was suggested that till the site becomes fully functional the offline application for registration should be accepted. In the said meeting DPCC agreed to the request.

On 15th April, a delegation of DMA met Mr. Imran Hussan Hon'ble Minister of Environment Govt. of Delhi and apprised him about difficulties faced due to website of DPCC and it was decided to organize a camp on 18th April, 2019 for registration with DPCC in his presence. In the said meeting his OSD Mr. Anwar Khan talked to DPCC officials and assured us that team of DPCC will come for registration. DMA members were accordingly intimated.

On 17th When I talked to DPCC officials about offline registration at the camp they told that they require instructions from higher authorities. Then I talked to Principal Secretary Health and reminded him of the meeting chaired by him where a decision to accept offline application was taken and thereafter DMA decided to organize registration camp but persons from DPCC involved with registration are insisting for instructions from Member Secretary DPCC. He told that he will talk to Secretary of Environment and this issue will be resolved. Then to be more safe we talk to OSD to Minister of Environment about all this and he informed to go ahead with offline registration at camp.

But on the camp day i.e. 18th April, 2019 team of DPCC categorically told that they have come only for training and there are no instructions to accept offline applications.

DMA members who came for registration were able to get only agreement with service providers and registration with DPCC not materialized because of their attitude and inspite of accepted it in a meeting chaired by Secretary Health on 11th April, 2019.

Many DMA members are receiving show cause notice from DPCC for non application for authorization under Bio Medical Waste Management Rules. They are not able to register because of faulty website. DMA demand that till the site is fully functional, the offline application should be accepted as decided in the meeting chaired by Secretary Health.

DPCC to requested not take any action against medical practitioners till the system is rectified otherwise we will be compelled to take steps which they will not like.

Also clinics that are not generating Bio Medical Waste should be exempted from registration with DPCC.

It appears that there exists a nexus between service providers and DPCC. List of members for show cause notice is being provided by the service providers only. Only two service providers are there without any competition and they are free to fix the prices in collusion.

Members are requested to intimate DMA through mail or letter if they are facing problems with DPCC website or service provider. So that DMA can approach Delhi Govt. with some authentic documentation.

Those members who are not generating any Bio Medical Waste should intimate DMA so that their case for exemption from registration with DPCC can be discussed.

Very soon we will be sending list of quacks to DPCC to take action against them as DPCC has agreed to take action under BMW rules.

DMA members are warned not to lend their name to be used by quack and thereby helping them in registration with DPCC. Action will be taken against such members.

Long Live DMA

Regards,

Dr. Girish Tyagi
President

ATTENTION !!

All Presidents/Secretaries
of local branches to nominate
two names for
DMA Directory

ATTENTION !!

All Presidents/Secretaries
of local branches to nominate
two names for
Membership Drive

ATTENTION !!

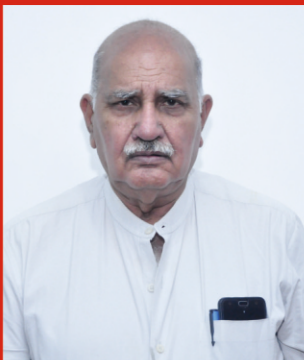
All Presidents/Secretaries
of local branches to nominate
two names for
Anti Quackery

ATTENTION !!

All Presidents/Secretaries
of local branches please ensure to
send your branch news by 3rd &
18th of Every month for publication
in DMA News Bulletin

ATTENTION !!

All Presidents/Secretaries of local branches please ensure to send list
of members from your branch not receiving News Bulletin



Hony. State Secretary's Pen...

Dear all,

At the outset, I will thank Delhi Government especially chief secretary Vijay Kumar Dev at the intervention of Delhi Medical Association (DMA) has resolved a longstanding issue of assault on resident doctors in government hospital's casualties by the disgruntled patients and their families. Time and again the patients have been attacking helpless doctors for the want of facilities provided in the hospitals and attacking them brutally and when it comes to filing an FIR, the poor doctor is confronted with a parallel FIR against him by the relatives alleging counter assault, mishandling or even rape. On the instance, the government has clearly instructed all medical superintendents and administrators of the hospital that in case of assault on any doctor, paramedics and nurse by hostile crowd an institutional FIR shall be registered against the patients and the arrogant relatives.

It is a great issue that the government facilities are severely deficient in reaching the expectations of people at large, the politicians are repeatedly calling hooks that they have improved and made all the facilities available. The lack of ventilators, lack of ICU care, lack of emergency dialysis, neonatal care and in fact all life-saving procedures at the government casualties strongly irk the patients and the outburst is faced by the poor doctor who has got no hand in administration or planning the budget allocation and financing.

We at Medical Association though are satisfied at one hand that the initiative by government to take action against the hooligans saving the dignity of profession yet we strongly desire the casualties and emergencies where sick patients are arriving should always be handled by senior doctors and should be equipped with all life-saving procedure and equipment so as to meet expectation of people at large so that we can have a better relationship with patient and doctors.

It is a matter of deep concern that DMA has repeatedly offered the facilities of 28,000 beds and excellent private services to the government at a very reasonable rate, the lowest possible rates of CGHS. The chief minister, the health minister all other acknowledged that private service is better managed with low cost and better patients satisfaction compared to government hospitals. But very little progress has been made due to stubborn attitude and inconsistent priorities of those who are at the helm of affairs. I think all of us shall realize that the sole aim of government and government sector is to serve and satisfy patient's needs of health, disease and comprehensive health policy is required which can meet requirements on a longer basis rather than immediate to the reactions which are of low outcome yield.

This year we along with my president Dr. Girish Tyagi and some past presidents are planning intelligentsia committee to draft long term future policies and push them right perspective into definitive goals. Your inputs, suggestions shall be valuable. Don't hesitate to communicate me.

Dr. Arvind Chopra

Hony. State Secretary

M.: 9910515062



Hony. Associate Editor's Pen...

Dear all,

The entire medical fraternity, especially those who runs small clinics, consultation rooms, or small nursing homes are feeling badly intimidated and scared of illogical, unscientific and impractical laws on biomedical waste management created by ministry of environment, government of India since 2016.

Ironically the rules have been let loose to the implementing agencies viz. Central pollution control board and Delhi pollution control committee, with all the ambiguities and discretionary weapons creating the scare and nurturing inspector raj and corruption.

The doctors who are not bothered about this are those who work in big government or corporate hospitals and neither have to bear the financial pinch, nor have to face the venom of the draconian act, themselves. Unfortunately there is another category who do not realise the sword hanging on head till it falls and injures. "Ignorance is bliss" for them but such bliss are short term.

Delhi medical association has been consistently approaching all the departments viz, the creators of such impractical and purpose less rules (ministry of environment Government of India), the implementing agencies CPCB n DPCC, and the coordinating agencies like DHS or health department of GNCTD. All three are smart and powerful enough to not to listen any logic and pass the buck on each other to increase our sufferings.

Though with our persistent efforts few welcome changes in most recent gazette on 19th Feb. 2019 (**doing away with the compulsion of maintaining the day to day register and website for non bedded HCF and necessity of STP for less than ,50 bedded smaller hospitals**), have been achieved with support from our well wisher leaders and officials. But still a lot more need be done.

Being personally involved in the above battle at different levels, I feel too low and bit frustrated at this juncture but still we hope to win the final war but only with your full support ..

Dr. Kamal K. Parwal
Associate Editor

KIND ATTENTION!!

Delhi Medical Association is going to publish photo ID Card and New Car Stickers for its members.

The same can be collected from **Delhi Medical Association.**

The Nominal Charges for the same are :

Voter ID Card	Rs. 100/- Only
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Car Sticker	Rs. 20/- Only
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**Delhi Medical Association, DMA House Medical Association
Road, Daryaganj, New Delhi-110002**

Tel. No. 23271726, 23285727



**Delhi Medical Association
&
URDA, INDIA (United Resident Doctors Association, India)**

Organise

**SEMINAR ON
ASSAULT ON DOCTORS &
RESIDENCY SCHEME**

**Sunday 5th May, 2019
from 11.00 am onwards
at
DMA Auditorium, Daryaganj**

All are invited

Dr. Girish Tyagi
President
M: 9868116491

Dr. Arvind Chopra
Hony. State Secretary
M: 9910515062

Dr. Manu Gautam
Chairman
National President, URDA, India
M: 9999770805

Dr. Ashok Aggarwal
Hony. Finance Secretary
M: 9810048230



Dr. Girish Tyagi, President
&
Members of State Executive Committee
Delhi Medical Association
Cordially invite you to

Mother's Day Celebration

on
Sunday, 19th May, 2019
3.00 pm. onwards
at
Hotel Le-Meriden, New Delhi

PROGRAMME HIGHLIGHTS

**Scientific Bonanza | Felicitation of Mothers
Multicultural Dances & Musical Programme
by DMA Family Members**

Dr. Arvind Chopra
Hony. State Secretary
M: 9910515062

Dr. Seema Patni
Chairperson, Mother's Day
M: 9810341225

Dr. Ashok Aggarwal
Hony. Finance Secretary
M: 9810048230

Dr. Ritu Saxena
Co-Convener, Mother's Day

Dr. Savita Puri
Co-Convener, Mother's Day

Dr. Vandita Bansal
Co-Convener, Mother's Day

Shashi Satija
Co-Convener, Mother's Day

Dr. Deepmala Lalchandani
Co-Convener, Mother's Day

Dr. Shama Batra
Co-Convener, Mother's Day

Dr. Sulekha Dalmiya
Co-Convener, Mother's Day

Dr. Sunita Lamba
Co-Convener, Mother's Day

Dr. Rekha Mehra
Co-Convener, Mother's Day

Dr. Amardeep Kaur
Co-Convener, Mother's Day



Delhi Medical Council

308 A, 3rd Floor, Administrative Block, Maulana Azad Medical College
Bahadur Shah Zafar Marg, New Delhi -02 Ph. : 23237962 (4 Lines) Fax : 23234416
Website : delhimedicalcouncil.org E-mail : delhimedicalcouncil@gmail.com

It is, hereby, informed that the following named individuals were found to be practicing modern scientific system of medicine (allopathy) without holding any requisite medical qualification in the NCT of Delhi and DMC has passed the closure orders pertaining to the following named individuals.

It is further informed that police has been requested to register FIR against following named individuals under Section 27 of Delhi medical Council Act, 1997.

November, 2018

S.No	Name	Address
1	Shri Chandrakant Bakshi	Gali No.18, Shiv Mandir, Nazdik Neema Ka Ped, Wazirabad, Delhi-110084
2	Shri Manojit Kumar Ray	Ray Health Care Center, C 1/4, Welcome, Seelampur, Delhi-110053
3	Shri Raman Kumar Biswas	Main Bank Colony Road, Near Vimal Market, Mandoli Chowk, Delhi-110093
4	Shri Naeem Tyagi	Maryam Poly Care Centre, H.No.12, Gali No.22, Old Mustafabad Delhi-110094
5	Shri Mohsin Khan	Madina Hospital, H.No. 2042, Gali No.21-22, Main 25 Foota Road, Nearby Kabristan, Old Mustafabad, Delhi-110094
6	Shri Naushad Ali	Adarsh Health Care Centre, D-49, Gali no.11, Old Mustafabad, Delhi-110094

December, 2018

S.No	Name	Address
1	Shri Shanta Julka	Julka Clinic, 4505, Gali No.5, Ajit Nagar, Gandhi Delhi-110032
2	Shri Manoj Kumar Nath @ Manmotho Kumar Devnath	Bengali Clinic, E-152, Near Murgi Farm House, Madrashi Colony Khyala, Delhi-110018
3	Shri S.K. Biswas/ Shishir Kumar (Bengoli)	Maya Clinic, 28 Feeta Road, D Block, Prem Nagar, Najafgarh Delhi-110043
4	Shri Satpal Tomar	Shop No. 6, Loni Road, Outside RTO Office, Gokulpur Shahdara, Delhi-110035
5	Shri Yogender Kumar Sharma	Shop No. 6, Loni Road, Outside RTO Office, Gokulpur Shahdara, Delhi-110035
6	Shri Praveen Kumar	Shop No. 6, Loni Road, Outside RTO Office, Gokulpur Shahdara, Delhi-110035

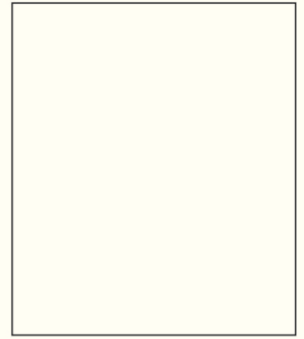
It is, hereby, informed that the following named individuals (DBCP Registered) were found to be practicing modern scientific system of medicine (allopathy) without holding any requisite medical qualification in the NCT of Delhi and DMC has passed the closure orders pertaining to the following named individuals.

S.No	Name	Address
1	Shri Manojit Kumar Ray	Ray Health Care Center, C 1/4, Welcome, Seelampur, Delhi-110053



Dear Members

We are pleased to inform you that Delhi Medical Association is going to publish its DMA Photo Directory 2019. You are requested to fill the directory proforma and send it to DMA office along with your latest photograph.



DELHI MEDICAL ASSOCIATION DIRECTORY PROFORMA 2019

(Surname)

(First Name)

(Middle Name)

Name

LM/CLM Branch No.

IMA No. DMC No.

Date of Birth Marriage Anniversary

Blood Group

Educational Qualification

Name of College(MBBS)

University

Speciality

Year of Joining (MBBS)

Residential Address

.....

Clinic Address

.....

Mobile 1. 2.

Landline Res..... Clinic.....

E Mail

Spouse (Dr./Mr./Ms) Spouse DMA No.

Dr. Girish Tyagi
President
M: 9868116491

Dr. Arvind Chopra
Hony. State Secretary
M: 9910515062

Dr. Ashwini Dalmiya
Chairman, Directory Committee
M: 9811542055

Glimpses of Meeting Held on 18th April, 2019 at DMA Auditorium



Thank you **Shri Vijay Dev**, Chief Secretary, Delhi Government



For helping in issuing of this circular.

Government of National Capital Territory of Delhi

Office of the PR Secretary (Health and Family Welfare)
6th Level A Wing, Delhi Sachivalaya, IP Estate, New Delhi - 2

No. F.342/C-140/H&FW/Vig/2016/prsecyhw/167-216

Date: 16/04/2019

CIRCULAR

All HOD's of Hospitals/Medical Institutions, are hereby directed that in case of any incident involving abuse or violence by the patients or their attendants, an FIR/Complaint is required to be filled by the concerned Hospitals/Institutions immediately. In no case, the individual doctor/para-medical/nursing/administrative staff, etc., should be asked to lodge the FIR/complaints with the Police in such cases.

It will be incumbent on MS/Director of the Institution to ensure that an FIR is lodged in such cases promptly by the hospital or institution concerned rather than insisting on the concerned hospital staff to lodge the FIR.

Non-compliance of foresaid directions will be viewed seriously.

Sanjeev Khirwar

Pr. Secretary (Health & FW)

16/04/2019

TO

All HOD's/MS's/MD's of all Hospitals/Medical Institutions, Govt. of NCT of Delhi & Director, DGHS

Big victory for **Medical Profession** and thanks to **Sh. Vijay Dev Ji**, Chief Secretary Delhi Government for prompt action.



BP measurement is simply not checking BP and charging. It's an art and involves multiple uses and diagnostics, each one of them is ethically billable. Here are some of them.

Instruments:

1. Ambulatory blood pressure monitoring (ABPM)
2. Home BP monitoring: uses a validated, automated oscillometric device that measures blood pressure in the brachial artery and performs measurements in a quiet room after five minutes of rest in the seated position with the back and arm supported and legs uncrossed. At least 12 to 14 measurements are obtained, with both morning and evening measurements taken, over a period of one week.
3. Automated office blood pressure monitoring (AOBP device) that automatically take an average of three measurements.
4. Office-Based Manual BP (requires multiple measurements on different days)

Diagnosis

- ◆ Normal blood pressure – Systolic <120 mmHg and diastolic <80 mmHg
- ◆ Elevated blood pressure – Systolic 120 to 129 mmHg and diastolic <80 mmHg
- ◆ Hypertension: Stage 1 – Systolic 130 to 139 mmHg or diastolic 80 to 89 mmHg/ Stage 2 – Systolic at least 140 mmHg or diastolic at least 90 mmHg. If there is a disparity in the category between the systolic and diastolic pressures, the higher the value determines the stage.
- ◆ Isolated systolic hypertension: BP =130/<80 mmHg
- ◆ Isolated diastolic hypertension: BP <30/=80 mmHg.
- ◆ Mixed systolic/diastolic hypertension: BP =130/=80 mmHg
- ◆ ABPM HT: A 24-hour mean of 125/75 mmHg or above, daytime (awake) mean of 130/80 mmHg or above or night-time (asleep) mean of 110/65 mmHg or above. Daytime (awake) average of =130/=80 mmHg is the most useful of these definitions and it correlates with home BP measurement and also AOBP.
- ◆ White coat hypertension: White coat hypertension is

defined as blood pressure that is consistently elevated by office readings but does not meet diagnostic criteria for hypertension based upon out-of-office readings.

- ◆ Masked hypertension: Masked hypertension is defined as blood pressure that is consistently elevated by out-of-office measurements but does not meet the criteria for hypertension based upon office readings. Diagnosis of hypertension

Spot diagnosis

- A patient who presents with hypertensive urgency or emergency (patients with blood pressure =180/=120).
- A patient who presents with an initial screening blood pressure =160/=100 mmHg and who also has known target end-organ damage (left ventricular hypertension [LVH], hypertensive retinopathy, ischemic cardiovascular disease).

Treat the patient and not the reading

1. Check for the extent of target-organ damage, if any
2. Check for the presence of established cardiovascular or renal disease
3. Check for the presence or absence of other cardiovascular risk factors
4. Check for lifestyle factors that could potentially contribute to hypertension
5. Check for potential interfering substances (chronic use of nonsteroidal anti-inflammatory drugs [NSAIDs], oral contraceptives)

Note:

Measurements obtained by ABPM and home BP monitoring are lower than those obtained by routine office measurement by approximately 5 to 10 mmHg.

Office readings obtained using an AOBP device (in which multiple BP measurements are automatically obtained and averaged with the patient, preferably, alone in a room [unattended measurement]) more closely approximate ABPM and home BP readings than standard office measurement.

Cuff inflation hypertension

A marked rise in blood pressure caused by cuff inflation during self-measurement (cuff inflation hypertension) may

result in some patients from the physical exertion needed to inflate the cuff or from anticipatory anxiety.

Pseudohypertension — Compression of the brachial artery may require a cuff pressure greater than systolic in patients with stiff vessels due to marked arterial calcification. This phenomenon, called pseudo-hypertension, is characterized by systolic and diastolic pressures estimated from the sphygmomanometer that is 10 mmHg or more above the directly measured intraarterial or oscillometric pressure

Leg blood pressure: in suspected coarctation of the aorta in which there is an arm-to-leg gradient or in patients who cannot have BP measured in the arms (eg, due to surgery, indwelling catheters, vascular fistulae, or grafts).

Systolic pressure in the lower extremity is usually higher than that in the brachial artery. In patients with vascular disease, systolic BP at the ankle is often lower than the BP in the arm

Wrist blood pressure: In obese people (when a sufficiently large cuff cannot be obtained, such as when measurement devices are purchased for home monitoring) and in patients with breast cancer who have had axillary lymph node resection.

Finger BP: Devices that measure pressure in the finger are not recommended, including for home monitoring

Billing using BP instrument

1. Office manual blood pressure over one week
2. Office manual blood pressure (three readings)
3. Office automatic blood pressure (three readings)
4. Office automatic blood pressure (over one week)
5. AOBP (automatic mean of three readings)
6. Home monitoring x one week
7. Ambulatory BP monitoring
8. Both arms BP
9. All four limbs BP
10. Wrist BP in obese individuals
11. Postural hypotension evaluation
12. Supine hypertension evaluation
13. BP after and during six minutes walking
14. Ankle Brachial Index
15. FMD endothelial function test using the BP instrument
16. SVT reversal using the BP Valsalva technique
17. Paediatric BP measurement
18. Reduced pulse pressure in dengue fever
19. Penile male organ blood pressure
20. Rule out emergency: Normal AOBP, SPO2, Blood Sugar, PEFR and ECG

BRANCH NEWS

IMA-DNZ

IMA DNZ organized ANNUAL CON on 24th Feb 2019 at 2:00 pm onwards at Hotel THE JEHAN ,Delhi. Attended by more than 250 Doctor's.

15 Lectures were covered,

Guest of Honour was :

DR. ARUN GUPTA
PRESIDENT DMC

DR. G. S. Grewal
Secretary DMA

DR. GIRISH TYAGI
PRESIDENT ELECT DMA

President & Secretary of
IMA Delhi Local branches.



IMA DNZ AGBM organized on 31st March 2019 at Hotel City Park at 9 pm onwards
Attended by more than 150 Doctors.

A Historical Footing!

Founded : Lahore, 1921..... Reinstated : Delhi, 1954



Service to Humanity
with Dedication, Trust,
Excellence &
Nobility for Non Profits...

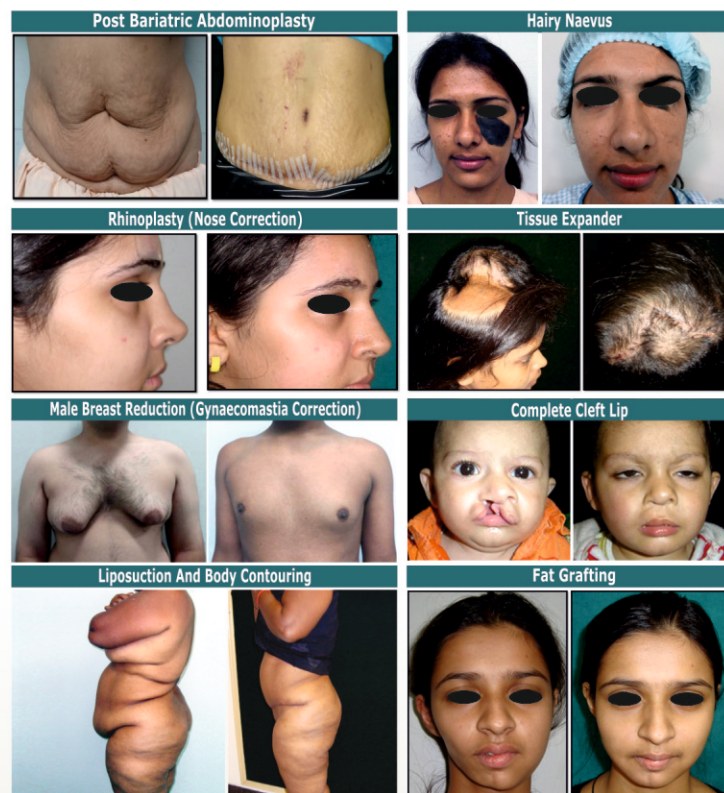


Sir Ganga Ram Hospital



Department of Plastic & Cosmetic Surgery An Overview....

The Department of Plastic and Cosmetic Surgery at Sir Ganga Ram Hospital is recognized nationally and internationally for its state of the art tertiary level care in all disciplines of plastic surgery. About three thousand major surgeries are done every year while emergency services are available round the clock. The Department is among the centres of excellence in microsurgery, aesthetic surgery and hand surgery.



Spectrum of Services :

Aesthetic / Cosmetic Surgery

- ▶ Rhinoplasty (Nose correction)
- ▶ Liposuction and body contouring
- ▶ Male breast reduction (Gynaecomastia correction)
- ▶ Tummy tuck / Abdominoplasty
- ▶ Breast - Augmentation/ Reduction/ Lift (Mastopexy)
- ▶ Hair restoration surgery (Hair transplantation)
- ▶ Eye bag surgery (Blepharoplasty)
- ▶ Fat grafting (Lipo injection)
- ▶ Dimple creation
- ▶ Surgery for facial scars, acne marks/ white patches
- ▶ Lip augmentation /reduction
- ▶ Face lift (Rhytidectomy)
- ▶ Endoscopic aesthetic surgery
- ▶ Gender Affirmation Surgery, FTM & MTF (Sex Change)

Plastic & Reconstructive Surgery

As Sir Ganga Ram Hospital has highest referral for Plastic & Reconstructive Surgery we are attending to patients of all severity in emergency and in planned way.

Emergency

- ▶ Maxillofacial Injuries.
- ▶ Extremity Trauma with Compound and Hand Injuries

Planned

- ▶ Crush Injury Hand, Upper Limb, Lower Limb – Reconstruction.
- ▶ Severe Soft Tissue (Skin, Muscle, Tendon) Injury and Loss – Reconstruction
- ▶ Reimplantation and Revascularization of Digits, Ear, Scalp & External Genitalia.
- ▶ Ear, Nose, Eyelid, Cheek and Lip Reconstruction.
- ▶ Vascular Malformation Treatment.
- ▶ Re-Surfacing for Large Scars, Congenital Pigmented Lesion (Nevus) Burn - Tissue Expanders.
- ▶ All Types of Flap Surgeries.

Reconstructive Microsurgery

Reconstructive Microsurgery is the other area of Plastic Surgery where we have taken long strides. SGRH can boast of being the leading centre in the whole of north India for replantation surgery for finger, hand or limb amputations. Besides this complex reconstruction for major tissue losses either due to trauma or cancer is mostly done by advanced microsurgical techniques.

- ▶ Mandible, tongue, Cheek reconstruction for facial tumour and trauma.
- ▶ Microvascular free tissue transfers (Skin, Muscle, Bone, Composite).
- ▶ Reanimation for facial nerve (Smile Reconstruction) palsy.
- ▶ Vascular Malformation
- ▶ Replantation and Revascularization of digits and limbs.
- ▶ Reconstruction of peripheral nerve and brachial plexus injuries.
- ▶ Recanalisation of vas, fallopian tubes & Vasoepididyma anastomosis



Maxillofacial Surgery

Over 300 operations on children with clefts of lip and palate are conducted every year. Reconstruction of maxillofacial soft tissue and bony injuries is done using advanced bone fixation techniques.

- ▶ Cleft Lip and Palate and Other Facial Clefts and Deformities.
- ▶ Facial Bone Distraction.
- ▶ Severe Facial Soft Tissue Repair.
- ▶ Microtia
- ▶ Anotia
- ▶ TM Joint Surgeries.
- ▶ Orthognathic Surgeries.

Hand Surgery

- ▶ Complex hand injuries
- ▶ Carpal tunnel syndrome
- ▶ Dupuytren's contracture
- ▶ Tendon transfers
- ▶ Toe transfers/ Pollicization
- ▶ Congenital hand anomalies
- ▶ Soft tissue tumors
- ▶ Brachial Plexus injuries
- ▶ Surgery for rheumatoid
- ▶ Syndactyly, Polydactyly

Congenital and Acquired Defects of Trunk and Genitalia

- ▶ Gender Affirmation surgery-FTM & MTF
- ▶ Vaginal Reconstruction
- ▶ Penile Reconstruction
- ▶ Hypospadias and Epispadias
- ▶ Chest and Abdominal Wall Reconstruction
- ▶ Hairy Naevus

Burn Injury

- ▶ Acute Burn Management
- ▶ Fire Cracker Injury
- ▶ Burn Deformity Correction

Academics and Teaching

The Department is the first in a private hospital in India to start DNB training programme in plastic surgery in the year 2001. The curriculum of department aims to make the trainees independent surgeons with basic training and knowledge of plastic surgery. The faculty actively participates in imparting microsurgery training at the Ethicon Institute of Surgical Education.

Research and Publications

Faculty has published many articles and papers in many indexed journals. The faculty is involved actively in the thesis of their DNB trainees.

Workshops and Conferences.

The department routinely organize various international & national conferences and our faculty members are regularly invited at various forums

Community Outreach Activities

Department of Plastic and Cosmetic Surgery is actively involved in social services. It organizes routinely medical camps in remote areas of the country to provide free medical consultation and treatment. We organise camps where needy patients are seen and then treated free of cost at Sir Ganga Ram Hospital.

Smile Train Project

The Department is affiliated with Smile Train Inc. of USA (a non-government charity) and runs the Smile Train SGRH Cleft Project in which poor and needy patients with facial clefts are treated free of cost at Sir Ganga Ram Hospital.



Helpline No.: 011 - 42252081



The Plastic & Cosmetic Surgery Team

Sitting (left to right): Dr. Lalit Choudhary, Dr. Vasundhara Oberoi, Dr. Anubhav Gupta, Dr. S.S. Gambhir, Dr. Mahesh Mangal, Dr. Suresh Gupta, Dr. R.B. Ahuja, Dr. S.S. Saha, Dr. Vivek Kumar, Dr. Bheem Singh Nanda

Standing (left to right): Dr. Nikhil Jhunjunwala, Dr. Pooja Gupta, Dr. Nakul Somani, Mr. Raju, Dr. Himanshu Ranjan, Dr. Chirayu Parwal, Sis. Sobha Thomas, Mr. Kripa Shankar, Dr. Uma Sharma, Dr. Sanjibani Sudha, Dr. Dimpy Sharma, Ms. Shivani Thakur, Mrs. Gunjan Gulati, Ms Dhiraj Arora, Sis. Renju Jacob, Dr. Vivek Gupta, Dr. Gourav Siwas, Mr. Rajesh Jamwal

Message from the Chairman



Dr D S Rana
Chairman
Board of Management

The Department of Plastic and Cosmetic Surgery at Sir Ganga Ram Hospital is amongst the best centers in the country for advanced Cosmetic Surgery, Reconstructive Microsurgery and Craniofacial Surgery.

More than 3000 major plastic surgical procedures are performed every year and patients from across the world come here for these treatments.

We have highly dedicated team of consultants who are known globally for their excellent academic and clinical work.



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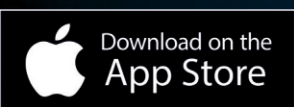
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Migraine in a Nutshell

Dr Debashish Chowdhury

MBBS; DTCD; MD (Medicine); DM (Neurology);
Commonwealth Fellow (Edinburg, UK)
Director – Professor and HOD,
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New Delhi, India

Migraine ranks 6th in terms of prevalence and 2nd in terms of disability amongst all the disorders of the world. It is characterized by moderate to severe head pain, usually accompanied by nausea, vomiting, photophobia, and phonophobia that may be preceded by focal neurologic symptoms, which are called aura. Migraine is the second most common primary headache disorder seen in population but is the most common primary headache seen the clinic. It has the prevalence of 13% in adult population, females being affected more than the males. In India, a recent epidemiological study has shown a very high prevalence of 25%. Migraine is diagnosed by criteria laid down by International Classification of Headache Disorders (ICHD - 3). The criteria include headache duration of 4-72 hours. Typical characteristics of headache are unilateral location, pulsatile quality, moderate to severe intensity, aggravation by routine physical activity and associated with nausea, vomiting, photophobia and phonophobia. Always secondary causes need to be ruled out by history (red flags), thorough examination and investigations if required. Vast majority of patients of migraine do not require imaging. Migraine is co-morbid with many disorders including anxiety, depression, neck pain and somatization disorders. Hence a thorough evaluation of co-morbid conditions is also required for proper treatment of migraine. Increasing evidence suggests a close relationship of migraine with cardiovascular and cerebrovascular disorders. .

For aborting the acute attacks of migraine, recent guidelines include the specific medications like triptans (almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan [oral, nasal spray, injectable, transcutaneous patch], zolmitriptan [oral and nasal spray] and dihydroergotamine (nasal spray, inhaler) [Level A]. Ergotamine and other forms of dihydroergotamine are probably effective (Level B). Nonspecific medications like acetaminophen, nonsteroidal anti-inflammatory drugs (aspirin, diclofenac, ibuprofen, and naproxen), sumatriptan/naproxen, and the combination of acetaminophen/aspirin/caffeine are also useful (Level A). Triptans and ergots are contraindicated in patients with uncontrolled hypertension and coronary artery disease.

When attacks occur weekly or several times (>4) in a month, preventive therapy is indicated. Beta blockers like propranolol and metoprolol, calcium channel blockers like flunarizine, antidepressants like amitriptyline, anticonvulsants like topiramate and divalproex sodium have good evidence base as a preventive agent in episodic migraine (Level A). Physicians need to consider individual contraindications in given patient before choosing a prophylactic agent. For example divalproex should be in child bearing females. Sometimes additional therapeutic opportunities may dictate the choice; for example, topiramate in obese migraine patients. Propranolol is often considered as a 1st line agent in prevention of episodic migraine because of its safety profile and low cost. Preventive medications are titrated gradually. They should be continued for 6-12 months until stabilization of headache occurs. Recently calcitonin gene related peptide (CGRP) or its receptor antagonists in the form of monoclonal antibodies have been introduced which are likely to usher new era in the management of migraine.

OBITUARY

- ◆ DMA regrets to inform the sad and sudden demise of **Mrs. Raghubir Kaur** M/o. Ms. Satinder Kaur DMA Staff on 7th April 2019.
We pray God to rest her soul in peace and give strength to the family to bear this irreparable loss.
- ◆ DMA regrets to inform untimely demise of **Sardar Sohinder Singh Sachdev** F/o Dr. Mahipal S. Sachdev on 14th April, 2019.
We pray to God to rest his soul in peace and give strength to the family to bear this irreparable loss.
- ◆ DMA regrets to inform sad and sudden demise of **Dr. Yogesh Katyal** on 17th April, 2019.
We pray to God to rest his soul in peace and give strength to the family to bear this irreparable loss.

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GUIDELINES FOR DOCTORS ON SEXUAL BOUNDARIES

Version 3.4

Indian Psychiatric Society (IPS) Task Force on Boundary Guidelines

The guidelines for doctors on sexual boundaries was first drafted by **The Bangalore Declaration Group**. **The Indian Psychiatric Society (IPS)** has subsequently worked on this document and publish these guidelines with a view that IPS will hold all members to its ethical standard.

- 1) It is the ethical duty of all doctors to ensure effective care for their patients. This would mean that their own conduct should in no way harm their patient. Sexual relationships between doctors and patients invariably harm both the patient and the doctor. Trust, which is central to an effective doctor patient relationship, is inevitably damaged. In view of the power gradient that invariably exists in the doctor patient relationship, the onus is on the doctor to ensure he or she does not enter into an romantic or sexual relationship with a patient.
- 2) While the laws relating to sexual abuse in India generally pertain to women, these Guidelines aim to be gender neutral and serve as a guide to a code of conduct on doctors of any gender, and to protect patients of all genders too.
- 3) Doctors should ensure that they do not exploit the doctor patient relationship for personal, social, business or sexual gain.
- 4) In view of the power gradient in the doctor patient relationship and possible transference issues, doctors are reminded that even 'consensual' sexual activity between patients and doctors irretrievably changes the therapeutic nature of the doctor patient dynamic. This would be detrimental to the patient (even from the viewpoint of interfering with good medical care). This would mean that even if it is the patient who attempts to initiate the sexual relationship, it would be against good medical practice for a doctor to enter into such a relationship. Besides, it can be said that consent in a power imbalanced relationship is not true consent. While in some situations it may not be considered as 'illegal', these Guidelines would still consider it as a Sexual Boundary Violation (SBV).
- 5) Any non consensual sexual activity would amount to sexual abuse/ molestation/ rape and doctors would be answerable to the law of the land. (Indian Penal Code laws relate to rape, child sexual abuse, sexual molestation, adultery and sexual harassment in the workplace). Sexual activity with a person less than 18 years of age in India amounts to statutory rape (consent immaterial). The Indian Penal Code states that consent for a sexual relationship with a woman of 'unsound mind', is deemed invalid and amounts to rape. The Indian Criminal Law Amendment Act (2013), lists out details of what behaviour is tantamount to sexual harassment and stalking. Section 376C (d) states the punishment for anyone in a position of authority in a hospital, if they misuse their authority by having sexual contact with someone under their care.
- 6) It is obviously important for doctors to take a relevant sexual history and perform appropriate physical examination. This should be done sensitively and documented properly in the notes. If intimate examination is done, gloves should be used, a chaperone present and indication and findings documented in the notes. All this should be communicated properly to patients, to prevent any subsequent misunderstandings. The doctor should not touch a patient inappropriately in the guise of physical examination or sexual therapy, for own sexual gratification. Doctors need to be aware that sexual boundary violations (SBVs) can occur in all gender dyads.
- 7) If treatment that requires the patient to be sedated is used (like electroconvulsive therapy, or any procedure that requires anaesthesia), a nurse should be present during the induction and recovery of anaesthesia. This is good medical practice, not just a deterrent to sexual abuse.
- 8) Doctors are reminded that even a relationship with a *former* patient is discouraged and could be construed as unethical, as the previous professional relationship can influence the current relationship. There are serious

difficulties in defining the time frame that should elapse after the doctor patient relationship is terminated, after which a doctor *may* consider having a sexual relationship with a patient (if existing laws of the Indian Penal Code are not broken). One difficulty is that the ending of 'treatment' does not signify the end of the 'doctor patient relationship' in view of multiple issues involved, including relapse rates of illnesses and individual vulnerabilities of patients.

If, for whatever reason a doctor feels it imperative to have a romantic/ sexual relationship with a patient (and again, if this does not involve the breaking of any laws), then the doctor should ensure the patient's care is 'handed over' properly to another doctor. It is extremely important that the doctor discuss the issue with at least one senior colleague to ensure that the doctor himself/herself is not entering a relationship due to his/her own vulnerabilities which need to be addressed and the former patient is clearly not being exploited. Till evidence suggesting otherwise be obtained, IPS puts the *time frame as 'one year at the very least, after termination of the doctor patient relationship', with the emphasis on 'at the very least'.*

- 9) It is impractical to have a detailed list of do's and don'ts regarding Non Sexual Boundary Violations (NSBVs) as often it is the context which differentiates an acceptable boundary crossing from an unacceptable boundary violation. However, it would be useful to note that sometimes NSBVs can 'slip into' SBVs. It would be important for all doctors to be alert to warning signals in their own (or in their colleague's), as well as patients' behaviour in these situations.
- 10) Doctors are reminded to ensure that they use social media responsibly, as it can inadvertently lead to a blurring of professional boundaries.
- 11) As doctors are to ensure they do not exploit the doctor patient relationship for sexual gain, it would also imply that these Guidelines extend to protect the family members of patients too. (This would extend to family members who are also part of the therapeutic doctor patient/ family dynamic).
- 12) Any failure to follow these Guidelines, if reported to the Indian Psychiatric Society(IPS) will be referred to the Ethics Committee. It is suggested that all allegations of SBV be taken up for initial enquiry by the Ethics Committee of the IPS. If considered appropriate, they will refer the case to the local "Internal Complaints Committee" (as required by the Supreme Court mandated law on Prevention of Sexual Harassment of Women in the Workplace (Prevention, Prohibition and Redressal Act 2013.) Though this law pertains to women at the workplace, many hospitals/ nursing homes have gender neutral policies which extends to patients too.

If any criminal act is reported, then the appropriate process of enquiry by the police should be initiated. Doctors are reminded of their own ethical obligation to report unethical conduct by colleagues. (As listed in Section 1.7 of The Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002). Where children are involved, reporting is mandatory or risks imprisonment (Protection of Children from Sexual Offences Act, POCSO 2012).

- 13) Though these Guidelines pertains primarily to patients, doctors are reminded that similar care should be extended to interactions with students, colleagues and other professionals in the multidisciplinary team- indeed anyone who is in a 'power imbalanced relationship' with the doctor.
- 14) False allegations can occur. It is important for doctors to be alert to warning signals and risk situations. If the doctor finds him/ herself in the midst of an allegation (whether true or false), it would be important to reach out to colleagues for support. Members of the IPS should be available to support a colleague during any enquiry into an allegation. In the event of an allegation, support should not mean 'covering up' the issue. If the allegation proves true on enquiry, the colleague should be supported to the face the consequences of his or her behaviour. Steps should be taken to access help to try and ensure that the behaviour does not recur and patients are protected.
- 15) The Indian Psychiatric Society recognizes that SBVs are not restricted to any particular group of doctors, indeed not restricted to doctors alone, but occurs in all professional groups. In endorsing this Guidelines for Doctors on Sexual Boundaries, the Indian Psychiatric Society takes one step towards effective action against sexual abuse in our society.

Stress urinary incontinence (SUI) is defined as the involuntary leakage of urine, which occurs during efforts that increase the intra-abdominal pressure, such as coughing, sneezing or exercise. It affects the quality of life of a person in terms of social, emotional, sexual and personal aspects. The urine leaks when the intra-vesicle pressure exceeds the urethral pressure. It occurs due to loss of urethral support which is usually a consequence of damage to pelvic structures following child birth. It is the most common form of urinary incontinence in women. It is mainly seen in the reproductive age group and post-menopausal women to the tune of 25%.

Patients should be seen by an urogynaecologist, and a careful history with regards to voiding, urine leakage, frequency, urgency, straining, discomfort, use of drugs and recent surgery should be addressed.

ETIOLOGY

SUI can be mild, moderate or severe. Urethral hypermobility is an important cause of mild to moderate stress incontinence due to the defective pelvic support, arising due to injury to connective tissue during childbirth mainly and due to loss of strength in connective tissue due to postmenopausal hypoestrogenic state. Severe incontinence results from devascularization or denervation of the bladder neck and the proximal urethra in cases of intrinsic sphincter deficiency.

Other contributory factors are:

- Obesity
- Straining at stool or chronic constipation
- Heavy manual labour
- Chronic obstructive pulmonary disease
- Smoking

Management of SUI

HISTORY AND CLINICAL FEATURES

- Passage of urine during coughing, laughing, and sneezing etc
- Nocturia
- Enuresis
- Use of thin to medium-thickness pads.
- History of frequency, urgency, painful or burning micturition, pain with a full bladder to rule out urinary

tract infections (UTIs)

- Concomitant symptoms of faecal incontinence or pelvic organ prolapse
- Coexistent medical problems, obstetrical history, including difficult deliveries, grand multiparity, forceps use, obstetrical lacerations, and large babies.
- Any history of pelvic surgery especially prior incontinence procedures, hysterectomy or pelvic floor reconstructive procedures, urologic procedures, spinal and CNS surgery should be noted.
- History of lifestyle issues, such as smoking, alcohol or caffeine abuse, occupational, recreational and treatment taken if any.

PELVIC EXAMINATION:

- Cough stress test -. It is performed with full bladder. Urine leaks from the urethra at the time of coughing documenting stress urinary incontinence.
- Bonney's test
- Cotton swab test for urethral mobility
- Examination of the external genitalia for birth trauma
- Pelvic floor muscle (Levator ani) strength to be assessed by having the patient perform a pelvic floor muscle contraction "Kegel" exercise
- Pelvic organ prolapse (POP) should be identified and documented if present.

Inspect the vagina for dryness and atrophic changes

INVESTIGATIONS:

URINALYSIS: Urine routine microscopy and culture and sensitivity to exclude urinary tract infections.

POSTVOID RESIDUAL VOLUME- is to be measured by urethral catheterization or ultrasound. It should be assessed within 10 to 20 minutes after voiding to identify urinary retention. A post void residual volume between 50 to 100 ml is considered adequate emptying, while any volume greater than 200 ml is considered inadequate and should be investigated.

Ultrasound Pelvis

TREATMENT

The treatment of urinary incontinence can be nonsurgical or surgical and depends on clinical findings and the degree of discomfort experienced by the patient.

1. LIFESTYLE AND BEHAVIOURAL THERAPY

- Dietary changes - avoidance of caffeine and alcohol
- Fluid restriction- up to two litres per day
- Timed voiding to prevent the bladder from reaching its capacity
- Medication adjustments for possible urinary side effects (diuretics)
- Weight loss (level 1 evidence)
- Smoking cessation
- Postural changes such as crossing the legs during increased intra-abdominal pressure prevents the leakage

2. PHYSICAL THERAPY

Conservative treatment with supervised pelvic floor muscle training (PFMT) is an effective treatment method for stress urinary incontinence. It should be offered to all women as first line management .

PFMT using manual, digital feedback instruction is usually given during office visit, Kegel exercise mostly benefits patients who are under 60 years of age and are most effective if involves at least 24 daily contractions for at least 6 weeks. Vaginal cones of various sizes can also be used.

3. BLADDER TRAINING

It focuses on modifying bladder function by changing voiding habits. It improves voluntary bladder control and involves scheduled toileting.

4. PHARMACOLOGIC THERAPY

There is no currently available FDA approved pharmacological therapy for SUI ;

• Antidepressants

Duloxetine has been approved for the treatment of stress urinary incontinence in Europe. Duloxetine is not US Food and Drug Administration (FDA) approved for stress urinary incontinence.

Duloxetine: 40mg BD (Side effects - nausea, dry mouth)

- Alpha adrenergic Agonist: -Alpha adrenergic receptors are present in both the bladder neck and the proximal urethra, and produce smooth muscle contraction when stimulated. Alpha agonists may help the bladder neck to contract more strongly.
Pseudoephedrine: 60 mg QID or 120 mg BD with the extended-release form
- Estrogen: - The peak prevalence of stress UI coincides with the time that an average woman reaches natural menopause .

Dose: Intravaginal estrogen cream 0.5 g at bedtime two times weekly

5. VAGINAL PESSARY

Pessaries are intravaginal devices that support the pelvic organs. Incontinence pessaries have knobs that sit under the urethra to increase urethral support .These are most commonly used by women who have episodic stress UI (i.e. exercise induced), who are not surgical candidates due to comorbidities, or who have not completed childbearing.

SURGICAL MANAGEMENT

Although more than 100 surgical procedures have been described for the treatment of stress incontinence, gold-standard procedures include Burch colposuspension and Fascial sling (42). Surgery is mostly offered as the primary treatment option for moderate or severe SUI ,if conservative therapy has failed.

- 1). Retropubic suspension (colposuspension, paravaginal repair)
- 2). Sling and tape procedures (including sub-urethral tapes and urethral/bladder neck slings)
- 3). Peri-urethral bulking agent injection
- 4). Artificial urinary sphincter devices

1). RETROPUBIC SUSPENSION (COLPOSUSPENSION)

These procedures are performed via a Pfannenstiel incision with the goal to correct urethral hypermobility. The retropubic space is exposed and permanent sutures are placed in the anterior vaginal wall around the bladder neck and proximal urethra and are sutured to ileopectineal ligament in the case of a Burch colposuspension.

2). SLING AND TAPE PROCEDURES

The earliest reported type of surgery still in use today is the pubo-vaginal sling, and several techniques have been developed using a host of different materials ranging from autologous to cadaveric to biological to synthetic slings.

MID-URETHRAL SLINGS

TVT (Tension free vaginal tape)

TOT(Tension free obturator tape)

The trans-obturator approach is an effective method of placement of a midurethral sling .

3). PERI-URETHRAL BULKING AGENT INJECTION

The injection of bulking agents, sub-mucosally in the female urethra aids in continence via apposition of the urethral wall.

4). ARTIFICIAL URINARY SPHINCTER DEVICES

Artificial urinary sphincter (AUS) insertion dates back to the 1970s, but its use remains controversial due to the risk of complications and common requirement for revision surgery.



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- Utility of EEG in critical care set up
- Recent Updates of Neuro-critical Care Trials
- Status Epilepticus, Refractory Status Epilepticus, and Super-refractory Status Epilepticus
- Cerebral Edema and Elevated Intracranial Pressure
- Intracerebral Hemorrhage
- Management of Stroke in the Neurocritical Care Unit
- Emergency Management in Neuro-critical care
- Critical Care of Neuromuscular Disorders (A+B+C)
- (A) Myasthenic Crisis, (B) AIDP - GBS, (C) CIPN
- Role of NOACs and its reversal in Clinical Neurology
- Expert Panel Discussion - 'Caveats in management of Neuro-critical care patients in our ICUs'

PRE & POST WORKSHOP

Organizing Chairpersons:

Dr. P N Renjen
Dr. Rajesh Chawla
Dr. Sudha Kansal

Organizing Secretaries:

Dr. Dinesh Chaudhari
Dr. Chirag Madaan

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Registration fee @

Rs. 1500/-