• For circulation to Members

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OFFICIAL ORGAN ORGAN OF DELHI STATE BRANCH INDIAN MEDICAL ASSOCIATION

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Rank 1 Dr. Nivedita KH DNB Mid Year 2018
Rank 2 Dr. Shiralle Ranwal NEET PG JAN, 2018
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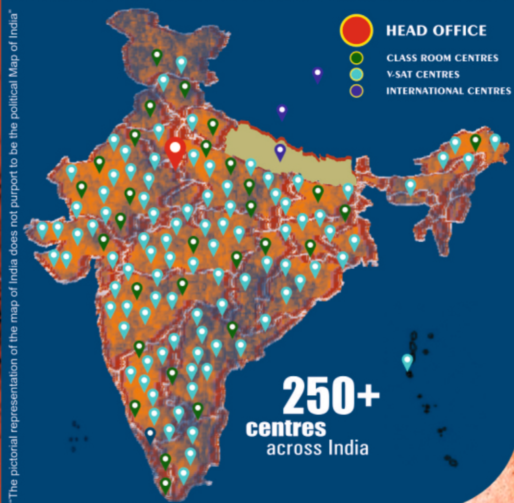

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President's Pen...

Dear friends,

Please accept my heartfelt gratitude for giving me the opportunity to serve you as your representative in Delhi Medical association. It is a moment of pride laden with enormous responsibility. It is an arduous task to shoulder the task of leading an organisation of the most learned strata of society. I have got a committed and dedicated team of office bearers and hope to come upto the expectations of the membership at large.

On the one hand we as a community are highly respected by the society having total faith in our professional knowledge, wisdom and sincerity while dealing with humanity in our efforts to cure them of their physical and mental aberrations from time to time. On the other hand it hardly takes a moment for the patients to turn into a impatient unruly crowd demeaning and disgracing our years of hard work and goodwill.

The assault on doctors is a blot on our civil society and is the result of misunderstanding, mistrust, misinformation between the curer and the cured. There are various reasons for all these but we have to ensure that such incidents are minimised and whosoever is involved in such incident should be taken to task by enforcing available laws and resources. We plan to work in unison with all stakeholders to tackle this.

The government is imposing new obligations and laws on medical fraternity on daily basis. Fire safety norms, biomedical waste disposal rules, issue of minimum wages for staff and high salary for nurses, detrimental amendments in consumer protection act, and promotion of cross-pathy in the name of Indian culture, traditions and in the name of less number of qualified Allopathic doctors.

In addition we have the Corporates, Insurance Agencies and our own medical colleagues who are bent upon trampling the interests of a common doctor or consultants. We have to ensure that members are not being exploited by anyone.

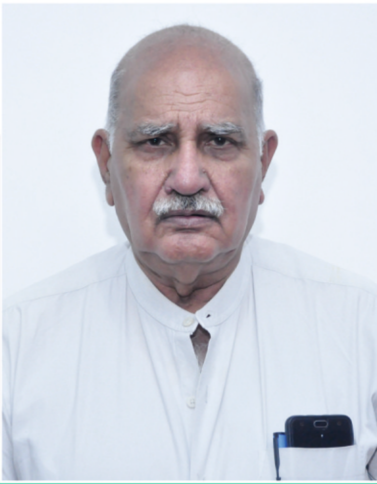
I want to take up the issues pertaining to general practitioners(Family Physician), small and mid size nursing homes. If we don't look after their interests, in the time to come sustainability of these will be difficult and perhaps on the verge of extinction.

All these issues are agitating my mind and I want a wider discussion and dialogue on the ways and means, methods and methodologies to solve and settle these issues. All these issues are unique and have specific solutions. We will be interacting with you on each issue separately to seek your advice and cooperation to address each of your problems.

The myriads of problems affecting and afflicting us cannot be solved by a single person in a tenure of one year. To achieve the solution of even a fraction of existing problems I seek cooperation, contribution and support from each one of you. I assure you that I sincerely want to address any and every issue affecting the membership at large and offer myself with total dedication and complete sincerity to the cause of every member of Delhi Medical Association.

Let everyone be a part of solutions.

Dr. Girish Tyagi
President



SECRETARY PEN...

Dear all,

I am extremely thankful to Dr. Girish Tyagi, President DMA as well as all of you who have reposed faith in me and have elected me unanimously as state secretary of the Delhi Medical Association. While I am extremely conscious of the great responsibility as well as the great expectations from the profession in this hour of crisis. The enormous negativity around the profession among the society, government and media is suffocating the professional working and independent thinking.

This year I promise to dedicate myself towards solving the actual problems such as repeated assaults among medical professionals working in the causalities and emergencies. The motivated litigations are breaking down the confidence of individual practitioners which needs to be strengthened through the association of doctors working to solve the issue.

I believe, as a medical professional each one of us is the .leader of the community and carries a strength to influence the mind of the people living in the society, Somehow the time has come when we have to prove the strength of the profession as an opinion leader.

In the coming general elections of the country it is our duty as well as opportunity to prove the strength of the profession, The same can be proved when each of us take the responsibility that we participate in the coming general elections whole heartedly and shall lead in the front and create positive influence in the society aiming to help people take correct political decision.

Kindly pursue Election Voting with an intensity that your strength is felt in the community and every leader is conscious of the collective strength of the profession. You should be seen, leading the community to the Booth.

Kindly ensure that you contact every voter of your polling booth and ensure that the definite impact is created.

Dr. Arvind Chopra
Hony. State Secretary
M: 9910515062

Hony. Associate Editor

Dear Colleagues,

It is indeed a proud privilege to communicate to you all through this prestigious column. This has been made possible by total faith in me reposed by the entire state executive of Delhi Medical Association , which elected me unanimously on this coveted post for the ensuing year 2019-2020.

The regular news bulletin is the soul of any organization and it is not only the organ for connecting all the members to association activities but it also keeps them informed about all the new rules and guidelines issued by various regulatory authorities pertaining to our day to day practice.

Though in the electronic era the importance of print media is questioned by many but I sincerely believe that the print format of this bulletin is still essential as the news papers are rather more relied and relished by readers at large inspite of massive flooding by round the clock news channels.

Nevertheless, it is an unfortunate fact that every good thing looses it's sheen over the years, particularly when it is marred by monotony in content, presentation and design.

I will do my best to break this monotony and make the bulletin keenly awaited by all, twice a month and real delight to read.

One of the unsolved challange in past few years has been the the non availability of bulletin to many (or most)of the members, needless to say such situation arouses a lot of suspicions in members mind about transparency in printing and distributing channels,. I am well aware of it and working hard to resolve the issue. Preliminary it seems that the it is the callous and insincere attitude of our postal department which is responsible for this mess.

We, at DMA led by President Dr. Girish Tyagi, a veteran fratetnity leader, have already resolved to keep this issue highest on agenda and planning to meet senior authorities in post and communication departments to ensure unhindered flow of this communication life line which connects the members to their only and lonely association.

Certainly a lot of ideas must be crossing your mind for all round improvement in this most important aspect of DMA activities. Please trap those ideas, share with me and become part of much needed facelift of our glorious communication life line.

Available at your service all the day @ 9811112714, 8800635155 drkamalparwal@gmail.com

Dr. Kamal K. Parwal
Associate Editor

Glimpses of Meeting with Past Presidents of DMA

Held on 6th April, 2019 at DMA Auditorium

DELHI MEDICAL ASSOCIATION

OFFICE BEARERS 2019-2020

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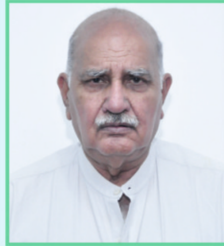
Dr. Girish Tyagi
M: 9868116491



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Associate Editor, DMA N/B.
Dr. Kamal Parwal
M: 9811112714

Glimpses of Annual General Body Meeting Held on 31st March, 2019

At DMA Auditorium, Daryaganj, New Delhi

LANDMARK CASE THAT DEFINED THE MEDICAL NEGLIGENCE

Delhi Medical Council

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DR. ARUN GUPTA
President, DMC

DR. GIRISH TYAGI
Secretary, DMC

In absence of proper laws and acts passed by legislature, the judgments of the Apex court assume significance, as they become the law. In this backdrop we, doctors must be fully aware of landmark judgments passed by the apex courts as they are guiding principles in deciding medico- legal cases.

One of such landmark cases is the KUSUM SHARMA VS. BATRA HOSPITAL CASE. While delivering the judgment in this case, the honorable Supreme Court issued guidelines to settle Medico-legal cases. A thorough knowledge of these guidelines can act as the best defense for a doctor in case of medical negligence suit.

Very brief summary of the case.

Patient developed blood pressure. He was referred and admitted in Batra Hospital. An ultrasound of abdomen and a CT scan of abdomen was done and it was found that there was a smooth surface mass in the left adrenal. Diagnosis of well-encapsulated benign tumorwas made. On test, the tumor was found to be malignant. The treatment for malignancy by way of administering Mitotane could not be given, as it was known to have side effects. So surgery was planned .

During the surgery, the body of the pancreas was damaged which was treated and a drain was fixed. According to the appellants, considerable pain, inconvenience and anxiety were caused to the deceased and the appellants, as the flow of fluids did not stop. After another expert consultation a second surgery was carried out.

The deceased was discharged, with an advice to follow up and for change of the dressing. On 9-10-1990, Shri Sharma vomited at home and arrangements for shifting him to the Batra Hospital were made by Dr. Mani. Shri Sharma died in the hospital of `pyogenic meningitis.

The appellants filed a complaint before the National Commission attributing deficiency in services and medical negligence.

The appellants alleged that

- The informed consent was not taken.
- The only tests done before operation to establish the nature of tumor were ultrasound and C.T. scan which clearly showed a well capsulated tumor in the left adrenal.
- There was nothing on record to conclusively establish malignancy of the tumor before the operation was undertaken.
- They were not told about the possible complications of the operation.
- They were told that it was a small and specific surgery, whereas, the operation lasted for six hours.
- The pancreatic abscess was evident as a result of pancreatic injury during surgery.
- There was nothing on record to show that doctor possessed any kind of experience and skill required to undertake.

Defense and arguments

Shri Sharma's death was attributable to the serious

disease with which he was suffering from. It is also mentioned that the conduct of the deceased himself was negligent when he was discharged. The doctors specifically advised him "Regular Medical Follow Up" which the deceased failed to attend. The Fitness Certificate issued to the deceased also bore the endorsement "he would need prolonged and regular follow up". However, the deceased did not make any effort and was totally negligent.

The risk involved in the operation was explained to the petitioner, her husband and their relative and they agreed after due consultation with their family doctor." During surgery the tail of the pancreas was traumatized during retraction, as patient was extremely obese. The damage to the pancreas was repaired immediately. The fact was recorded in the discharge summary.

It is denied that the patient and the appellants were assured that fluid discharge would stop within 2 or 3 days time or that it was normal complication after any surgery.

The histopathology report recorded the tumor being malignant. Since cases of adrenal Cancer have a very poor prognosis six slides were sent to Sri Ganga Ram Hospital for confirmation. The histopathology report from Sri Ganga Ram Hospital also indicated cancer.

In the discharge summary prepared initially it was recorded specifically that the adrenal mass was malignant and that the patient should be started on Mitotane at the earliest after the period of recovery. However, the appellants had requested to delete all references about cancer from the discharge slip, as her husband was likely to read the same. She apprehended that in such an event her husband would become mentally disturbed. Having regard to the apprehension expressed by the appellant, respondent prepared a fresh discharge summary, which did not contain any reference to cancer. The diagnosis of cancer was not an afterthought. The diagnosis of cancer was a considered one after two histopathological reports.

Outcome

On scrutiny of the leading cases of medical negligence both in our country and other countries especially United Kingdom, some basic principles emerge. While deciding whether the medical professional is guilty of medical negligence following well known principles must be kept in view:-

I. Negligence is the breach of a duty exercised by omission to do something, which a reasonable man, guided by those considerations, which ordinarily regulate the conduct of human affairs, would do, or doing something, which a prudent and reasonable man would not do.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

IV. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

V. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VI. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable

skill and competence acceptable to the medical profession.

VII. It would not be conducive to the efficiency of the medical profession if no Doctor could administer medicine without a halter round his neck.

VIII. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.

IX. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

X. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind.

While delivering the judgment the apex court made reference to relevant points in judgments of following landmark cases.PoonamVerma v. Ashwin Patel &Ors.,Jacob Mathew's case,The Indian panel code specially sections 88, 92 and 370

The appeal being devoid of any merit is dismissed.

QUACK SENTENCED SIX MONTHS RIGOROUS IMPRISONMENT

Soumen Mukhopadhyay who was practicing at Nand Nagri without possessing requisite medical qualifications. In 2007 his clinic was inspected by CDMO North East district team and found him to be practicing Allopathic system of medicine while claiming to have MD (AM) in Ayurvedic system of medicine and Electrohomeopathy.

He was served a show cause notice to appear before Antiquackery committee of DMC on 11th October 2007.

He appeared before the committee and admitted to be practicing allopathy.

On 24/10/07 a Closure order was issued wherein he was directed to stop practicing allopathy and close down the clinic. The copy of the said order was also sent to CDMO (NE) and SHO Nand Nagri for compliance.

When his clinic was again inspected by CDMO (NE) team, it was found to be functioning.

Thereafter Case was filed in the court and FIR 114/10 was registered at PS Nand Nagri.

On 5th April Honorable court of Pankaj Arora MM passed order on sentence where Soumen Mukhopadhyay was sentenced rigorous imprisonment for 6 months for offence U/s 27 DMC act and to pay compensation amount of Rs 40,000/- to DMC. In default of payment of compensation the convict shall undergo further simple imprisonment for 3months.

DR. ARUN GUPTA
President, DMC

DR. GIRISH TYAGI
Secretary, DMC

DIRECTORATE OF FAMILY WELFARE

MATERNAL HEALTH DIVISION

7th Floor, Vikas Bhawan-II, Civil Lines, Delhi

Ethical Consideration in Obstetrics, curbing unnecessary Primary Sections

1 Recommendations		Grade of recommendations
First stage of labor		
1	A prolonged latent phase (eg. Greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women) should not be an indication for caesarean delivery.	1B (strong recommendations, moderate quality evidence)
2	Slow but progressive labor in the first stage of labor should not be an indication for caesaren delivery	1B (strong recommendations, moderate quality evidence)
3	Cervical Dilation of 6 cm should be considered the threshold for the active phase of most women in labor. Thus, before 6 cm of dilation is achieved, standards of active phase progress should not be applied.	1B (strong recommendations, moderate quality evidence)
4	Caesarean delivery for active phase arrest in the first stage of labor should be reserved for women at or beyond 6cm with ruptured membranes who fail to progress despite 4 hours of adquate uterine activity or at least 6 hours of oxytocin administration with inadequate uterine activity and necervical change.	1B (strong recommendations, moderate quality evidence)
Second Stage of Labour		
1	A specific absolute maximum Length of time spent in the second stage of labor beyond which all women should undergo operative delivery has not been identified.	1C (strong recommendations, low quality evidence)
2	Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for the followng; At least 2 hours of pushing in multiparous women At least 3 hours of pushing in nulliparous women Longer durations may be appropriate on an individual basis (eg. With the use of epidural analgesia or with fetal malposition) as long as progress is being documented.	1B (strong recommendations, moderate quality evidence)
3	Operative vaginal delivery in the second stage of labor by experience and well trained physicians should be considered safe, acceptable alternative to caesarean delivery. Training in, and ongoing maintenance of practical skills related to operative vaginal delivery should be encouraged.	1B (strong recommendations, moderate quality evidence)
4	Manual rotation of the fetal occiiput in the setting of fetal malposition in the second stage of labor is a reasonable intervention to consider before moving to operative vaginal deliverry or caesarean delivery. In order to sagely prevent caesarean deliveries in the setting of malpositon, it is important to assess the fetal position in the second stage of labor, particulary in the setting of abnormal fetal descent.	1B (strong recommendations, moderate quality evidence)
Induction of labor		
1	Before 41 0/7 weeks of gestation, inductionof labor generally should be performed based on maternal and fetal medical indications. Inductions at 41 0/7 weeks of gestation and beyond should be performed to reduce the risk of cesarean delivery and the risk of perinatal morbidity and mortality.	1A (strong recommendations, high quality evidence)
2	Cervical ripening method should be used when labor is induced in women with an unfavourable cervix.	1B (strong recommendations, moderate quality evidence)
3	If the maternal and fetal status allow, caesarean deliveries for failed induction of labor in the latent phase can be avoided allowing longer durations of the latent phase (up to 24 hours of longer) and requiring that oxytocin be administered for at least 12-18 hours after membrane rupture before deeming the induction a failure. Twin gestation	1B (strong recommendations, moderate quality evidence)
1	Perinatal outcomes for twin gestations in which the first twin is in cephalic presentation are not improved by caesarean delivery. Thus women with either cephalic / cephalic - presenting twins or cephalic / noncephalic presenting twins should be counseled to attempt vaginal delivery.	1B (strong recommendations, moderate quality evidence)

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Dr. Deepak Chaudhary
Director

ARTHROSCOPY AND SPORTS MEDICINE CENTER
BLK SUPER SPECIALITY HOSPITAL

Dr. Shiv Chouksey
Associate Consultant

The term arthroscopy is derived from two words, "arthro" meaning joint and "skopein" meaning to see. It is a surgical procedure will allows the surgeon to look inside a joint via small incisions- about the size of a button hole. The view inside the joint is transmitted to a high definition video monitor through fibre optic cables. The procedure is used to diagnose and treat problems inside a joint.

Treatment of sport injuries begin with a thorough history, examination and investigations such as X-rays and MRI. However, final diagnosis of an intra-articular pathology is made through the arthroscope which allows direct visualization of the structures inside the joint, namely synovium, cartilage, ligaments and sometimes tendons. The joints most commonly affected by sports injuries include the knee, shoulder, hip, ankle, elbow and wrist.

Knee joint is undoubtedly the most common joint affected by injuries. Arthroscopic procedures such as ACL reconstruction, menisectomy and synovectomy are commonly performed procedures. With better and modern instrumentations, procedures such as meniscal repair which allows the surgeon to preserve the torn meniscus, OATS (OsteochondralAutogenous Transfer System) and ACI (Autolougous Chondrocyte Implantation) which help to restore the native cartilage have become a possibility. These procedure are technically demanding but have excellent outcomes. They also reduce the morbidity associated with menisectomies and cartlage loss.

Shoulder, the most mobile joint of our body is prone to injuries owing to this virtue of mobility. Arthroscopic Bankart Repair is the gold standard in most cases of recurrent shoulder dislocations. Suture anchors are drilled in the glenoid bone and labrum is reattached to its original position, all this done through three small 1cm incisions. Rotator cuff lesions are the most common cause of traumatic shoulder disfunction in the elderly. Being misdiagnosed as frozen shoulder at occasions, this condition tends to worsen over time owing to capsular adhesions and muscle atrophy. Arthroscopic rotator cuff repair allows the patient to perform all activities without any restrictions. Procedures for acromio-clavicular joint dislocations, sub-acromial impingements, loose body removal can be done via arthroscopy.

With development of better instrumentations and surgical techniques, arthroscopy of smaller joints such as the ankle, elbow and wrist have become a possibility.

Ankle sprain is the most common sporting injury for any joint. Though majority of cases with not require any surgical intervention, some ankle sprains are more complicated. Cartilage injury in the ankle joint(mainly talus) following a severe ankle injury can be unforgiving causing recurrent pain, swelling and early osteoarthritis of ankle joint. Arthroscopy can be used to debride such lesions or even perform OATS or ACI as described for knee cartilage injuries. Arthroscopic assisted reconstruction of ankle ligaments has been described ad encouraged. Loose body formation in the elbow is common overuse injury in throwing athletes and cricket fast bowlers. A simple debridement of the elbow provides not only pain relief but excellent functional improvement of the athletes.

Even Hip pathologies are now being addressed arthroscopically , with lot of good beneficial results . Hip labralrepairs ,femoro-acetabular impingement or even mere hip joint debridement provide immidiete relief to the patient symptomatically as well as when the issues are addressed on time without delay can prevent lot of adversities to the joint.

The arthroscopic surgery requires the similar anesthetics as an open surgery depending upon the joint being operated. Two button sized portals are created, one is the viewing portal and the other is the working portal. Sometimes additional portals may be required to visualize different parts of the joint or insert other instruments. The surgery starts by doing a full diagnostic rounds wherein all structures are visualized and final decisions made. At times, lesions not so apparent on MRIs or other imaging are seen under direct visualization (and vice versa). For example, MRI showing a meniscal tear, may be seen to be a healing tear that doesn't require any intervention or a missed cartilage lesion on the MRI may need addressing during the surgery. The patient should be prognosticated and the final decision be made by the surgeon during the procedure.

Advantages of arthroscopic surgery include early mobilization of the patient, shorter surgical time, minimal intra operative bleeding, better cosmesis and a shorter recovery time among others. Although uncommon, complications might occur with arthrocopy surgeries as well. Infections, post operative swelling, damage to blood vessels can occur, however, incidence has been less than 0.6% cases.

Recovery in terms of puncture wound healing takes a few days. Patients are mobilized early, however it also depends on the type of procedure performed. It is not uncommon for patients to go back to work in matter of a few days. Return to sports require a strict rehabilitation protocol which should be goal based and not solely dependent on time. The sports medicine physicians, physiotherapists, sports psychologists, coaches play a paramount role during recovery and return to play. It is vital to understand, that each person is different and recovery time will reflect that individuality.

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SMASHING RECORDS BY DAMSONIANS IN 2018-19

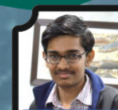
NEET PG TOPPERS JAN 2019

4 Rank – Dr. Aishwarya S. Durgad.

5 Rank – Dr. Rajath R. G.

10 Rank – Dr. Sree Vandana

11 Rank – Dr. Suyash Niranjan A.


12 Rank – Dr. Anuj Ban

14 Rank – Dr. Bhavishya Shetty

AIIMS TOPPERS NOV 2018

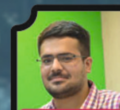
1 Rank – Dr. Umang Arora

2 Rank – Dr. Aayush Goyal

3 Rank – Dr. Rahul Neema

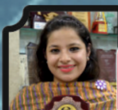
3 Rank (Cat). – Dr. Lokesh

4 Rank – Dr. Sarvesh Goyal


5 Rank – Dr. Pawan Gabra

PGI TOPPERS NOV 2018

1 Rank – Dr. Sarthak Wadhera


1 Rank (Inst). – Dr. Namrata Das

2 Rank – Dr. Pawan Gabra

3 Rank – Dr. Shivam Bansal

4 Rank – Dr. Nikhil Singhania

5 Rank – Dr. Mayank Saini

JIPMER TOPPERS NOV. 2018

1 Rank – Dr. Amiya Ranjan Nayak

2 Rank – Dr. Niveditha K.H

3 Rank – Dr. Ragunath K.

4 Rank (Inst). – Dr. Vineet Aggarwal

5 Rank – Dr. Malini M.

6 Rank – Dr. Aatish Rengan

DNB TOPPERS MID YEAR 2018

1 Rank – Dr. Nivedita Kh

2 Rank – Dr. Debayan Chakraborty

3 Rank – Dr. Sumit Aggarwal

6 Rank – Dr. Siladitya Mahanty

7 Rank – Dr. Athira

8 Rank – Dr. Deep Mehta

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SGRH Department of Pathology

Histopathology Division *Background....*

The 'Department of Histopathology' has been an important component of Sir Ganga Ram Hospital from its inception for the crucial role it plays in patient care. The focus has always been on delivering efficient and quality service. It has a team of well qualified faculty members with long experience and wide recognition. The department is accredited by NABL for all its investigations.

Automated microtomes for cutting sections

Fully automated IHC stainer

Fully automated tissue processor

Overview & Strengths....

- **Faculty staff** are well trained, experienced and have areas of special expertise involving non-neoplastic conditions and all forms of cancer and other tumors related to different organs/systems of body. The expertise of consultants attracts a number of referrals for difficult and controversial cases from outside
- Dedicated & well trained **technical staff**
- **Latest and advanced equipment and automated technologies** are used in the procedures for prompt & accurate diagnosis
- The focus is on delivering an **early report** without compromising quality
- **Prompt and quality service** and accurate, dependable, diagnosis
- Facilities are present to issue **urgent report,** when clinicians so require, in patient's interest
- All processed material on which diagnosis are given, all written reports (hard and soft copies) are **stored for reference and review,** when needed

Spectrum of services & activities :

Diagnostics

- **Surgical Resection and Biopsy :** Over 22,000 samples are reported annually

Special tests

- **Frozen Section :** Intraoperative report on tissues is given within minutes to help the surgeon take critical decision regarding patient management
- **Microwave processing for urgent biopsies :** If a critical treatment decision is to be made on small biopsy diagnosis, a report can be given within 24 hrs.
- **Immunohistochemistry :** Extensive panel of more than hundred antibodies are available to facilitate tumor differentiation and categorization
- **Immunofluorescence :** Immunologic diseases are diagnosed by using a panel of antibodies including IgG, IgA, IgM, C3, C1q, fibrin, Kappa & Lambda light chains in all kidney biopsies and some skin biopsies Auto-antibodies like ANA, ASMA, AMA, ALKMA, ANCA, PLA 2R, dsDNA done by IF

Teaching and Research

- Active in-service residency training programme for DNB in Pathology
- Faculty staff have long experience in undergraduate and postgraduate teaching
- Several intra and interdepartmental conferences conducted by the department faculty

All the postgraduates and staff are involved in research projects and have published these in indexed journals. Several of the faculty members act as advisors and committee members / chairman for research in institutional and national bodies.

Histopathology Team

Sitting L to R : Dr. Pallav Gupta, Dr. Sunila Jain, Dr. Prem Chopra, Dr. Sunita Bhalla, Dr. Shashi Dhawan, Dr. Seema Rao
Standing L to R : Dr. Sankar. K, Dr. Arupparna Sen Gupta, Dr. Anisha Manocha, Dr. Md. Ali Osama, Dr. Kanchan Shrivastav, Dr. Shreya Bramhe, Dr. Saurabh Garg

Contact Us : Histopathology Division

Tels. : +91-11-42252130, +91-11-42252137
All working days 9:00 - 5:00 PM Monday through Saturday.
Email : pathology@sgrh.com, pathologysgrh@gmail.com

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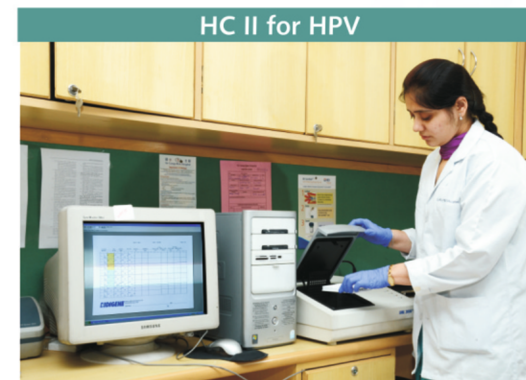

Cytopathology Team

L to R: Dr. Pooja Bakshi, Dr. Kusum Verma, Dr. Sweety Kalantri

Cytopathology Division *Background*

- Established as independent laboratory with State of the Art facilities in 2005- comparable to any international cytopathology laboratory
- Laboratory manned by experienced, well trained and dedicated cytopathologists
- Has trained cytotechnicians for preparatory work
- NABL certified lab since inception

Strengths

- One of the few laboratories in India offering Liquid Based Cytology (LBC) for Gynecologic and non-gynec specimens
- High risk HPV-DNA in cervical samples
- LBC and HPV – comprehensive service for Cancer Cervix detection
- Offering Immunohistochemistry (IHC) on cell block preparations of FNAC and body fluids
- Interpretation of EUS and EBUS guided FNAs from abdominal and thoracic organs

Spectrum of Services

- Comprehensive cytology service- diagnosis of neoplastic & infectious disorders
- Cervical / vaginal smears
- HPV-DNA (high risk)
- Fluids (pleural / pericardial / peritoneal / CSF)
- Urine, Synovial fluid
- Respiratory – Sputum, Bronchial, BAL
- Brushings
- FNAC- Palpable and Nonpalpable masses – Ultrasound, CT, EUS and EBUS guided

Teaching & Research

Consultants-involved in training DNB, publishing papers, delivering guest lectures, editorial board members.

Contact Us : Cytopathology Division

Tels. : +91-11-42252145
All working days 9:00 - 5:00 PM Monday through Saturday.
Email : cytopathologysgrh@gmail.com

Message from the Chairman

Dr D S Rana
Chairman
Board of Management

Laboratory services at Sir Ganga Ram Hospital are the backbone for all the departments in providing prompt and reliable diagnosis for proper patient care and management. The Department of Pathology has been a centre of excellence and a role model for other institutes.

It has earned a great reputation in terms of work ethics, quality of work and promptness of diagnosis. It has a team of dependable and experienced faculty members of repute. It runs a successful DNB prgramme and conducts many academic activities.

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E-mail: gangaram@sgrh.com Visit us at www.sgrh.com

Gazette Notification on

TUBERCULOSIS

Ques. What is the Gazette Notification on Tuberculosis about ?

Ans. The latest gazette notification dated 19th March, 2018 by Ministry of Health & Family Welfare, Govt of India is to ensure proper tuberculosis diagnosis and its management in patients and their contacts and to reduce tuberculosis transmission and further to address the problems of emergence and spread of drug resistant-Tuberculosis.

Ques. What does the said notification want from Doctors ?

Ans. Through the notification, the govt of India wants to collect complete information of all tuberculosis patients from Doctors and Chemists.

Ques. To whom is it applicable / who has to notify a case of Tuberculosis ?

Ans. Every clinical establishment as defined under the Clinical Establishment Act, 2010 (C.E.A.). In short, every Doctor of any pathy of medicine (allopathy/AYUSH), Laboratory and Chemist running a Pharmacy.

Ques. Is the notification applicable to the entire country / all States ?

Ans. Yes.

Ques. Which type of patients have to be notified ?

Ans. All patients who are diagnosed to be suffering from Tuberculosis or initiated on anti-tubercular drugs, whether by clinical, microbiological or radiological diagnosis.

Ques. Do I have to notify all cases of Tuberculosis- whether diagnosed by me or by anyone else ?

Do I have to notify all cases of Tuberculosis- whether on treatment from me or on treatment by anyone else?

Do I have to notify cases of Tuberculosis who are already on treatment ?

Ans. Yes.

Ques. Do I have to notify cases of Tuberculosis who have fully completed their treatment and are in consultation with me for other medical issues ?

Ans. The notification is silent on this aspect. A careful reading of the notification leads to a logical conclusion that it needs to be reported. Although, a clarification is needed from the MOH&FW regarding the issue that whether cases of past history of tuberculosis need to be reported or not.

Ques. Can a patient self-notify ?

Ans. Yes. The patients are encouraged to self-notify themselves as well as the details of their treating physicians to the govt of India.

Ques. How and where do I notify ?

Ans. Can be reported electronically at the website- https://nikshay.gov.in through Annexure-II for Doctors. (Annexure-I is for medical laboratories, Annexure-III is for Chemists) Or, by hard copy to District Health Officer or Chief Medical Officer of a District and Municipal Health Officer of urban local bodies.

You should receive a SMS on completing the process of online reporting.

You need a govt-issued I.D. of the patient (mandatory) for the reporting process.

Ques. What happens if I fail to notify ?

Ans. One could be liable for committing an offence under Section 269 and Section 270 of the Indian Penal Code.

Section 269 IPC- Negligent act likely to spread infection of disease dangerous to life- Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.

Section 270 IPC- Malignant act likely to spread infection of disease dangerous to life- Whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

Ques. What happens after such notification to the government ?

Ans. The information on tuberculosis notification received by Public Health Staff, shall be used only for extending the care and support, take appropriate public health action; including financial and non-financial incentives to patients, like free drugs and diagnostics, screening for co-morbidities, drug susceptibility testing, information technology based treatment adherence support system for improving quality care, etc., and providing feedback to the respective treating medical practitioner: provided that the confidentiality of the individual identity of the tuberculosis patient shall be maintained.

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Celiac Disease

Laboratory Diagnosis

Signs and Symptoms

1. Diarrhea
2. Bloating
3. Gas
4. Fatigue
5. Weight Loss
6. Constipation
7. Depression
8. Itchy Rash
9. Iron-Deficiency Anemia

Usually, initial CELIAC DISEASE testing involves the detection of SPECIFIC AUTOANTIBODIES, followed by a BIOPSY to confirm a diagnosis of celiac disease. Autoantibodies may also be used to screen blood relations of patients who are confirmed cases of the disease.

Suggested Laboratory Approach:

Screening

1. **tTG IgA Abs,** Serum
2. **IgA,** Serum

Further:

1. **DGP IgG Abs,** Serum
2. **Endomysial Abs,** Serum

Confirmation

1. **Biopsy**
2. **Genetic** Tests HLA DQ2 & DQ8

General Assessment

1. Complete blood count (CBC) with ESR
2. C-Reactive protein (CRP)
3. Comprehensive metabolic panel (CMP)
4. Vitamin D, Vitamin B12 and Folate
5. Iron,TIBC, Transferrin & Ferritin

Significance of various tests for diagnosis of Celiac disease:

Category	No.	Test
Screening Tests	1.	**tTG-IgA Abs** (Anti-tissue Transglutaminase IgA), Serum: This is the most sensitive and specific blood test for celiac disease.
	2.	**Total IgA** (Total Immunoglobulin A), Serum: This test is may be ordered in conjunction with an anti-tTG – IgA to detect IgA deficiency.
Further Tests	1.	**DGP-IgG Abs** (Deamidated Gliadin Peptide antibodies IgG), Serum: This test is positive in some patients specially children suffering from celiac disease but are negative for anti-tTG.
	2.	**Endomysial Abs- EMA** (Anti-Endomysial Antibodies, IgA), Serum: Less common antibody may provide additional information if the primary test result is not clear.
Confirmatory Tests	1.	**Biopsy, Small Intestine:** To confirm a diagnosis of celiac disease, a **biopsy** of the small intestine is examined to detect damage to the intestinal villi.
	2.	**Genetic tests** Human Leukocyte Antigen (HLA) markers **DQ2 & DQ8:** HLA markers DQ2 and DQ8 are strongly associated with celiac disease and are now available but not routinely ordered. They are most useful only in patients whose other diagnostic test results are inconclusive.
General Assessment		**Other tests** may be ordered to assess the severity of the disease
	1.	**Complete blood count (CBC)** to look for anemia,
	2.	**Erythrocyte sedimentation rate (ESR)** to detect inflammation,
	3.	**C-Reactive protein (CRP)**, a more sensitive measure of inflammation,
	4.	**Comprehensive metabolic panel (CMP)** to determine electrolyte, protein, and calcium levels and to evaluate the health of the kidneys and liver,
	5.	**Vitamin D, Vitamin B12 and Folate** to detect vitamin deficiencies,
	6.	**Iron, Iron binding capacity, Transferrin,** and **Ferritin** to detect iron deficiency.

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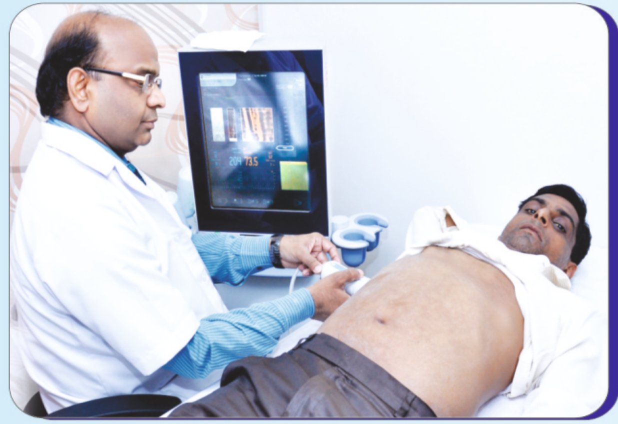

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HOW GOOD IS OUR GUT IN THE SUMMER SEASON?

DR. RAJESH UPADHYAY

DR. ANUPAM PRAKASH

We all have heard the adage that "winters are a healthy soon". So what is it in summers that actually makes it a worse season healthwise? And how do summers adversely affect the intestines and the liver. This is what we shall discuss briefly in the ensuing discussion.

The summers are known for their heat and the Indian summers are nasty because o the intense heat conditions with maximum temperatures ranging between 40-48 0C and the minimum temperatures ranging from 25-35 0C. Apart from the sheer heat, there are intense windy conditions, a typical heat wave called 'loo' blows which literally saps the human body, even taking the moisture away from the skin and worsening dehydration.

Rising temperatures are known to increase gastrointestinal motility. In summers, even under normal healthy circumstances, the frequency of motions rises and the fluidity of motions also increases. Therefore, loose stools may not always indicate disease. However, it is noteworthy that patients suffering from heat exhaustion develop severe abdominal cramps and also loose motions. Heat waves are also associated with alterations in gut flora, which can result in loose stools (without infection), and at times can result in greater propensity to develop gut infections too.

However, it is important to note that water scarcityis known to increase cases of infectious gastroenteritis. Gastroenteritis manifests as diarrhea and/or vomiting. The causative organisms can be parasites like Entamoeba and Giardia, or bacteria like Salmonella or viruses causing gastroenteritis/diarrhea. The intense high temperatures in addition predispose to the chances of early occurrence of dehydration and increase the propensity to develop severe dehydration.

Amoebic dysentery or amoebic colitis is known to occur in India in summers when the water is scarce. It can manifest as loose motions mixed with blood and mucus, pain abdomen and tenesmus.

According to the US Department of Agriculture, Food poisoning is also more common in summers. Foodborne illnesses are two times more common during the summer months than during other parts of the year in USA. However, in India because of higher temperatures we all witness that the food becomes stale much earlier in summers, and therefore, food poisoning is much more common in the summers. The bacteria that cause food poisoning are known to grow fastest in hot and humid weather.

Recently, it has been reported that heat waves are associated with flares of Inflammatory bowel disease (IBD). Inflammatory bowel disease could be classically ulcerative colitis or Crohn's disease. Typical features of inflammatory bowel disease are pain abdomen, loose motions and bloody diarrhea. Heat waves, defined as temperatures lasting above normal for 6days or more, have been reported to be associated with acute flare-ups of IBD.

Hepatotropic viruses, which spread by the water-borne route, also find an increased transmission in the summers. Hepatitis A virus and hepatitis E virus can cause acute infectious hepatitis manifesting as jaundice. These infections can occur in both sporadic and epidemic forms. There could be isolated cases of jaundice occurring in the community, with some cases occurring in the community and getting treated without seeking medical attention. However, most cases develop jaundice, some cases need admission and occasional cases can be fatal too. Fatality can be up to 50% if these infections occur in pregnant females. Patients develop fever, which may be short-lived but other symptoms like jaundice (yellow eyes, yellow urine and yellow skin) and loss of appetite, and feeling of ill-being can persist for a variable duration from 3-4 weeks to up to 8-12 weeks. There is no definitive treatment for acute infectious hepatitis caused by hepatitis A and hepatitis E viruses, but supportive management which includes bed rest, and proper diet helps tide over the illness period, while the virus is cleared by the body on its own. In fulminant cases, liver support systems may need to be used in hospital intensive care settings.

Patients of irritable bowel syndrome (IBS), specially suffering from diarrhea-predominant variant, do find difficulties in summers. IBS has a strong psychological component and summer heat in India can be draining and contribute to physical stress, which is known to worsen the symptoms of diarrhea predominant IBS, and the physiological increase in gut motility with rising temperatures may also contribute to aggravation of the symptoms of diarrhea.

The summer heat in itself causes decrease in appetite and the long days increase fatigue. High temperatures during the night also result in decreased sleep and decreased rest at night promotes body fatigue, resulting in negative effects on the overall health. It is imperative in the summers to take adequate water, and the water should be clean and free from infective organisms. Adequate water supply is required to maintain proper body hygiene which can prevent transmission by the oro-faecal route. Carbohydrate rich cool drinks and adequate nutrition is required to maintain good health during the summers. Not spending a lot of time in the direct sunshine and limiting activities outdoors in the afternoon can help prevent effects of heat on the body and the gut and also prevent dehydration from occurring. Regular consumption of fruits (like watermelon, melon) and vegetables like cucumber (kheera and kakdi) are also very helpful in providing hydration and additionally consumption of probiotic rich food items like yogurt/curd and lassi, can replenish gut flora.

Happy Summers!

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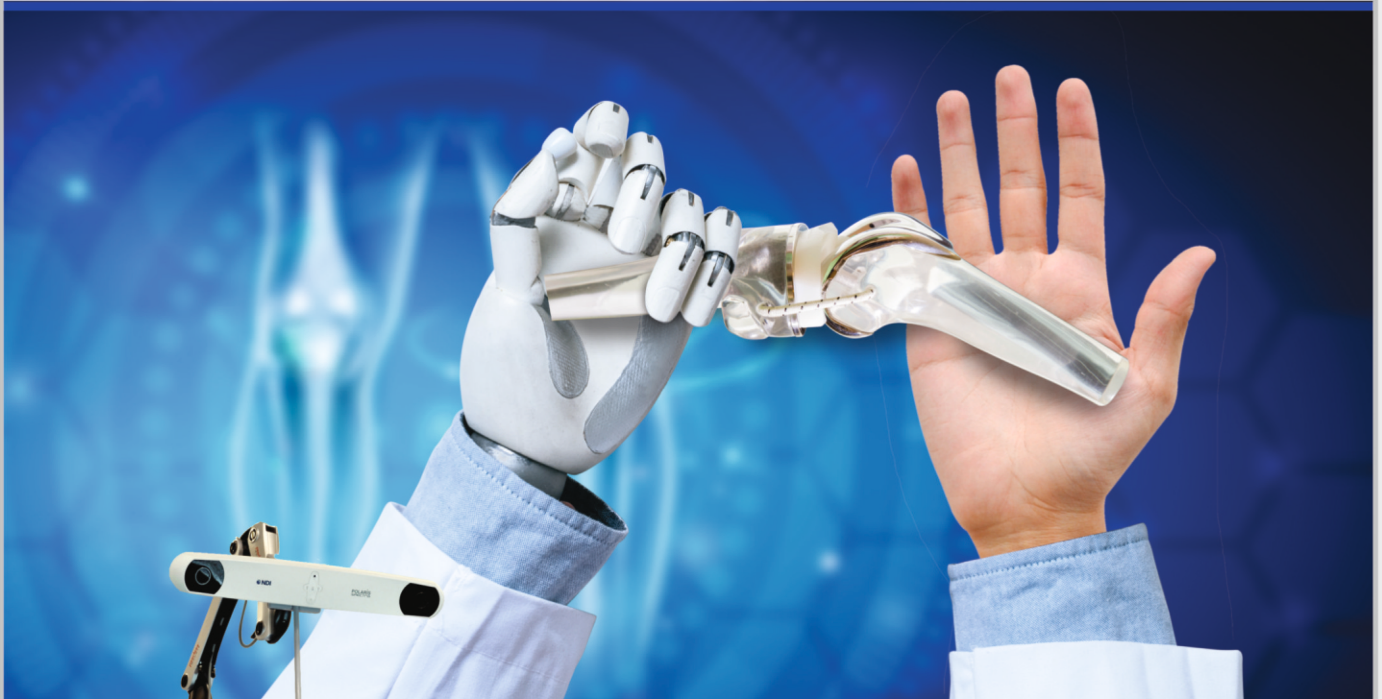

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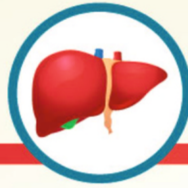
LIVER  MATTERS

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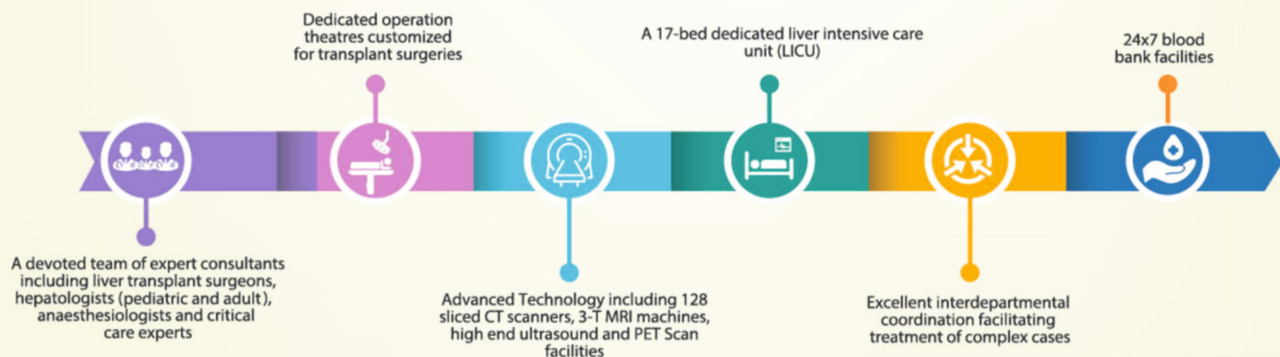

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