• For circulation to Members

DMA NEWS BULLETIN

FORTNIGHTLY

VOLUME 51
ISSUE-15

DELHI MEDICAL ASSOCIATION

OFFICIAL ORGAN OF DELHI STATE BRANCH INDIAN MEDICAL ASSOCIATION

President
Dr. Girish Tyagi
M: 9868116491

Hony. State Secretary
Dr. Arvind Chopra
M: 9910515062

Hony. Finance Secretary
Dr. Ashok Aggarwal
M: 9810048230

Hony. Associate Editor
Dr. Kamal Parwal
M: 9811112714

24 PAGES

10th November, 2019 | Email: delhimedicalassociation@gmail.com | Web: www.delhimedicalassociation.com | Price Rs. 5.00

DMA House, Medical Association Road, Daryaganj, New Delhi-110002 | Tel : 011-23271726, 23285727

Dr. B. M. Makkar
MD, FIAMS, FRCP (Glasg), FACP (USA)
Diabetes & Obesity Specialist
Sr. Consultant - Sri Balaji Action Medical Institute

unite for diabetes

Facilities Available

- Specialist Consultations for Diabetes and Obesity
- Diet/Nutritional Planning and Counselling
- Annual Health Check Packages
- Customized Diabetes Management Packages
- Customized Weight Management Packages
- Complete Laboratory Services by Quest Diagnostics India Pvt. Ltd.
- Spot HbA1C Testing, Spot Lipid Profile Testing
- CGMS (Continuous Glucose Monitoring)
- Testing for Peripheral Neuropathy
- Testing for Cardiac Autonomics Neuropathy
- Testing for Blood Circulation Status in Lower Limbs (Peripheral Arterial Disease)
- Computerized Electrocardiography
- Eye/Fundus Imaging
- Body Composition Analysis
- Sleep Study

Inspiring a
healthier life

Dr. Makkar's
DIABETES & OBESITY CENTRE
"caring for diabetes... for life"

Diabetes and Obesity Centre
A – 5B/122, Paschim Vihar, New Delhi-110063
Tel. +91-11-2526 7671, 2528 0150 **Mob.** +91-9811077419 **Email** mail@drbmmakkar.com
www.diabetesobesitycentre.com, www.drbmmakkar.com

THE MUCH TALK ABOUT UNITY

The medical profession has repeatedly heard slogans from its leaders asking for unity in the profession. We have also witnessed, with transient concerns, attacks on the medical profession by various strata of society: patients and their relatives; police; politicians, etc. etc.

The attacks vary from deplorable physical assaults (on doctors and their establishments) to statutory attacks of impractical legislative and administrative requirements thrust on the medical profession without taking the stake holders viewpoint or with little application of mind.

In my nearly two decades of voluntary working for the welfare of the medical profession, I have seen innumerable such situations where the profession (or some segments of the profession) have been confronted with challenges and attacks in one or the other form where you look upon those leading the profession to take up genuine issues and hardships of the profession. We look upon "our leaders" to confront these challenges with conviction, dedication and a killer instinct to achieve what should be ideal results. I must honestly admit that more often than not we have failed. Failed to get our genuine demands met; failed to convince the authorities that be of the relevance and genuineness of our demands. Of course to fan our own egos we come up with bloated statements like: 'massive success'; 'unprecedented agitation'; 'never before response', etc. etc. The membership at large, frustrated and dismayed by all the tamasha keeps losing faith in the professional leadership.

Delhi recently witnessed an agitation by lawyers triggered by an alleged attack on one of their professional colleagues. I must make it clear that I am not opining on or getting into the merits of the case (now subjudice to an enquiry). All I am looking into is the "UNITY" shown by the lawyers profession and how that unity had its impact all over. Broadly viewed the lawyers profession has many similarities to the medical profession. It also has its associations. It also has association politics and elections. It also has professional rivalries. It also probably has few black sheep's. But when it comes to professional unity they leave all this behind and stand together as a rock. All differences put aside for the moment.

I was only wondering if our association leadership could take pro-active steps to foster this long talked about unity: at least in an hour when the profession's dignity and safety are at stake.

I don't want to end with the usual slogan (Long Live Doctors Unity) but want to initiate this frank and bold thought provocation amongst all colleagues to see that how we can march towards this much talked about doctors unity...in true sense!

आज सड़को पे लिखे, सैकड़ों नारे न देख,
पर अन्धेरा देख, तू आकाश के तारे न देख।
एक दरिया है यहाँ पर दूर तक फैला हुआ,
आज अपने बाजुओं को देख, पतवारें न देख।।

Dr. Ashwini Dalmiya
Vice President

Hony. Associate Editor's Pen...

With the passage of national medical commission bill in parliament and presidential accent to it with rather supersonic speed the government of the day has made its intentions of implementing the cherished reforms in the medical regulatory body on the ground very clear.

Since the NMC is now the law of land, we all should recognise it's existence in our day to day life despite few apprehension raised earlier by many of us across the nation.

Let us move ahead of it, and hope that the NMC is constituted quickly and allays our all apprehension by making just rules, good enough for conducting itself totally free of personal or selfish interests of few individuals, but for the benefit of health care system of our nation.

Our present health ministry has been moving swiftly in this direction and the larger medical advisory council has already been formed which shall truly represent every state and union territory with one appointee from each state or UT government.

Apart from it, this is the only forum where a ground level representative from the, "elected" members of each state council is elected.

The Delhi Medical Council has elected one of our former president and a fraternity leader, par excellence for many decades, Dr Harish Gupta by overwhelming majority, for this coveted post.

It can be safely presumed that the membership of DMA at large shall have its voice in the new regulatory body in form of Dr Harish Gupta.

I believe in full sincerety that Dr Harish will not only act as DMA representative in NMC to raise our concerns time to time but also act as NMC representative in DMA to constantly make note of ground level assessment and acceptance of every move, the NMC makes concerning us.

Through these lines let me raise our first fear, that NMC might be controlled more by the top level , state paid, beaurocrates and medical academicians , who are historically either unaware of problems of basic health care professionals or are arrogant enough to trivialise our existence in the health delivery system of the nation.

We all know the commitment of Dr Harish Gupta along with his fighting spirits and acumen for the cause of masses. He has to make best use of his aggressive oratory with prolific organizational skills to create a substantial group in the new forum, of like minded people and ensure that our voice is never dampened in the apex body of medical regulation.

It is a challenging role Dr Harish, for you to establish the credibility of NMC in us and at the same time, to express the strength of our beloved DMA in national medical commission.

Hope you will do it for all of us dear Harish.

Dr. Kamal Parwal
Hony. Associate Editor

Hony. State Secretary's Pen...

Dear Colleagues,

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.

After the guidelines issued by Delhi government Health Department about the rate lists . It is now very difficult to run a hospital while the hospital expenses of the nursing homes/hospitals are increasing day by day , on the other hand the state and central government are decreasing the rates.

In the last few years, there is -

- Increasing electricity rates (commercial)
- Increasing Govt licensing fees
- Increasing expenditure on DPCC and STP
- Heavy Impact of GST and other Taxes.
- Increasing salary of all manpower
- Increasing rate of water supply

There all is going to compel the private hospitals for deprive of latest technology management, hospital development and ultimately closeting the hospitals.

CGHS rates although fixed through tender 3 years back but it is too low that a private nursing home can afford. As many procedures charges are too low after looking at expenditure.

The rates proposed by CGHS can only be honoured by either compromising the patient safety. But the nursing homes/hospitals taking CGHS empanelment because the govt departments/local bodies/public undertaking/universities are only gives panels to those who are empanelled with CGHS.

The New DAK rate list is killing as it is 40% less than the CGHS Rate. It is difficult to survive and run the establishments in such a low rates. There are no increment in rates paid by any panel since 90s. Inspite of these, all the hospitals are servicing the community with great devotion and dedication and following with all policies of Delhi govt, arranging camps, Polio camps and other community services for the welfare of general public.

And now 31 general insurance companies and 26 TPA (Third Party Administration) have come together to fix rates of common surgical procedures such as cataract, hernia, appendicitis removal , kidney transplants and angioplasty without taking us in the confidence i.e. medical association .

We have met with the various officials from Health Department of Delhi Government to discuss the following points-

a) Increase in rate of DGHS atleast 2 folds
b) Bring new DAK rate to latest DGHS rates
c) There should be annually increase in new DAK rate list

On behalf of Delhi Medical Association we request all the members that we should unite ourselves and at least boycott the present rated offered by DGHS, TPS and insurance companies.

We shall united- We will win

Dr. Arvind Chopra
Hony. State Secretary

KAROL BAGH BRANCH

IMA KBB organised CME on Recent Advances in Gastroenterology on 31 st October 2019 at Delhi Eye Centre where Dr Naresh Bansal, Consultant Gastroenterologist,SGRH delivered his talk.This was followed by talk on Partial Knee Replacement by Dr Pradeep Bageja.The session ended with Dr Jyotsna Lal regaling all with some beautiful songs .

IMA WESTOWN BRANCH

IMA Westown organised a cleanliness drive on 2nd October 2019 at Rajouri Garden area. A good number of members undertook the PLOGGING activity and also pledged to undertake the activity at personal level as well.

Chronic Kidney Disease
What a physician should know?

Dr. N.P. Singh
Sr. Director-Medicine & Allied Speciality
& Medical Avisor, Max Super Speciality, Vaishali

Introduction

The burden of chronic kidney disease (CKD) is on the rise. Owing to better life expectancy, increase in prevalence of diabetes mellitus, hypertension and urinary stone disease, more and more people are being diagnosed with this malady. Despite the rising prevalence, CKD finds no mention in the national programme dealing with non communicable diseases. The global burden of kidney disease, which has been rising consistently, poses a major challenge to the primary care physician–who is the firs tcontact for most

patients with CKD. Chronic Kidney Disease (CKD) is a key determinant of adverse health out comes and is regarded as an independent risk factor for CVD events. The global burden of CKD is considerable and has risen dramatically over the past 20 years. GBD 2016 report documented that CKD had rapidly moved up the ranks of causes of global deaths and is currently positioned at 11th on the list. [2] The estimated global crude prevalence of CKD was 147.6 million in 1990 which increased to 275.9 million cases in 2016. In the last two decades, crude mortality also doubled from 0.59 to 1.2 million. Pre dominant traditional risk factors such as

diabetes followed by hypertension were the leading drivers of CKD globally and contributed 50.6% and 23.3% respectively. Recently, a form of CKD among rural agricultural communities not attributable to traditional causes (such as diabetes, hypertension, primary glomerular disease, or obstructive nephropathy) has been reported from larger studies in Central America, Southern Asia, North and West Africa and Egypt. These have been collectively termed as CKD of unknown origin or "CKD of non traditional cause," or "kidney disease of unknown etiology in agricultural area". In a recent report of CKDu from rural population of Uddanam, Andhra Pradesh, India, Tatapudi R Retal18 reported 18.23% prevalence of CKD which is 4 to 18 times higher than other reported studies. Known traditional risk factors such as persistent hypertension, diabetes and significant proteinuria were absent in 73% of patients with CKD, identified as CKD u. The lack of community based screening programs has led to patients being detected with CKD at an advanced stage. We propose a simplified approach in dealing with CKD.

Chronic kidney disease : Definition

CKD is defined as abnormalities of kidney structure or function, present for> 3 months, with implications for health. Criteria for CKD (either of the following present for> 3 months) is as following:

Markers of kidney damage (one or more)

- Albuminuria (AER> 30mg/24 hours; ACR> 30mg/g [>3mg/mmol])
- Urine sediment abnormalities
- Electrolyte and other abnormalities due to tubular disorders
- Abnormalities detected by histology
- Structural abnormalities detected by imaging
- History of kidney transplantation
- Decreased GFR<60ml/min/1.73m2

Risk factors for development of CKD

- Diabetes
- Hypertension

Genetics and family history of stage 5 CKD or hereditary kidney disease-ADPKD.

History of acute kidney injury and exposure to nephrotoxins (NSAIDs abuse, contrast).

Cardio vascular disease (ischaemic heart disease, chronic heart failure, peripheral vascular disease and cerebral vascular disease)

Multisystem diseases with potential kidney involvement–SLE, auto immune disease.

Opportunistic detection of haematuria or proteinuria.

Table1. Risk factors associated with Chronic kidney disease of unknown origin.

- Water source or intake - (Ground well, tube well, tap)- Arsenic, cadmium
- Dehydration
- Extreme physical exertion
- Heat stress
- Agrochemical exposure
- Nephrotoxic drugs and traditional remedies (Aristolochic acid)
- Smoking and Alcohol
- Infections
- Snake bite
- Family history of CKD - presence of 1 degree relative with CKD
- Neighbor with CKD - atleast 1 neighbor with CKD

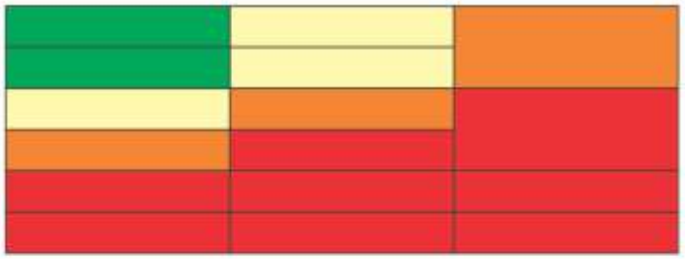
Classification

CKD is classified based on ***Cause, GFR category, and Albuminuria category (CGA):***

Assign cause of CKD based on presence or absence of systemic disease and the location with in the kidney of observed or presumed pathologic-anatomic findings. Assign GFR and albuminuria categories as follows in figure.

GFR Categories (ml/min/1.73m2) Description and range			
	G1	Normal or high	≥90
	G2	Mildly decreased	60-89
	G3a	Mildly to Moderately decreased	45-59
	G3b	Moderately to severely decreased	30-44
	G4	Severely decreased	15-29
	G5	Kidney Failure	<15

Persistent albuminuria categories Description and range		
A1 Normal to mildly Increased	**A2** Moderately Increased	**A3** Severely Increased
<30mg/g <3mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol



Green: low risk (if no other markers of kidney disease, no CKD); Yellow: moderately increased risk; Orange: high risk; Red: very high risk

Formula for calculation of eGFR

A number of formulae have been derived to estimate GFR or C_{cr} values on th e basis of serum creatinine levels are as following:

CG/BSA formula

Creatinine clearance (ml/min/1.73m2) = [(140-age) * (weight) / (serum creatinine*72)] * (0.85iffemale)

Modification of Diet in Renal Disease (MDRD) equation

We also used abbreviated fourvariables Modification of Diet in Renal Disease(MDRD)equation to estimate GFR.

MDRD-GFR (ml/min/1.73m2)=186* (serum creatinine)-1.154* (age)-0.203* (0.742iffem

Figure1. Mobile based application for eGFR calculator

Clinical manifestations of CKD

- Deranged RAAS axis-hypertension
- Water and salt imbalance-oedema, dehydration, CHF, hypertension, hypo/hypernatremia
- Dyslipidemia
- Potassium homeostasis - Vhypo/hypercalemia
- Acid base disturbance - metabolic acidosis
- Bonecalcium, phosphorous metabolism - renal bone disease, vascular calcification
- Erythropoeitin deficiency - Vanemia
- Insulin metabolism - hypo/hyperglycemia
- Other endocrinopathies - Thyroidhormones, growth hormones
- Malnutrition
- Amenorrhoea, sterility, growth failure.
- Psychological manifestation.

Investigation for CKD

- CBC, KFT
- Urinalysis, Urineprotein/creatinine ratio.
- Renal ultrasound, DMSA, DTPA.
- HbA1C, lipid profile, thyroid profile
- Auto immune work-up, serum and urine protein electrophoresis
- Renal biopsies
- Cardiac evaluation - VECG, 2DECHO
- Anemia work-up - Ironprofile
- Calcium, phosphorous, vitamin D, PTH levels
- Viral markers-Hepatitis B and C, human immunodeficiency virus (HIV).

Manifestations of uremia in end-stage renal disease (ESRD)

- Pericarditis (complicated by cardiac tamponade resulting in death)
- Encephalopathy: progress to coma and death
- Peripheral neuropathy
- Restless leg syndrome
- Gastrointestinal symptoms: Anorexia, nausea, vomiting, diarrhea
- Skin manifestations: Dryskin, pruritus, ecchymosis
- Fatigue, increased somnolence, failure to thrive
- Malnutrition
- Erectile dysfunction, decreased libido, amenorrhea
- Platelet dysfunction with tendency to bleed

Prevention of progression of CKD

There should be health promotion at individual and community levels for early screening of risk factors and timely management. It is important to strengthen the health service networks for a better quality of life and patient safety as well as adequate financing. The main goal is to delay the progression of the disease to ward end-stage kidney failure and dialysis. This can be attained by:

- Prevent risk factors of CKD
- Prevent cardiovascular events - Treat cardiovascular risk, especially with smokers and hypercholesterolemia
- Blood pressure/ Blood Glucose Control
- Encourage labs to report estimated eGFR and urine albumin/creatinineratios
- Dietary recommendation in the form of restriction of proteins, salt, fluid, potassium and phosphorous.
- Early patients education regarding natural disease progression, different dialytic modalities, renal transplantation should be imparted with timely placement of permanent vascular access-AV fistula, CAPD.

Strategies for Delaying progression to next stage of CK	Goal
ACE inhibitoror ARB or both	Proteinuria <0.5 g/day and GFR decline < 2 ml/min/year
Additional antihypertensive as needed	BP <130/80 if proteinuria<1g/day & BP<125/75 if proteinuria>1g/day
Dietaryproteinrestriction	0.6 to 0.8g/kg/day (caution in vegetarians
Glycaemic control	HbA 1c<7%
Cholesterol lowering therapy	LDL<100mg/d
Anaemia correction	Target Hb10 to 12g/d
Dietary salt restriction Smoking cessation,Weigh tcontrol Avoid nephrotoxic drug Reduce elevated Ca, Po4	3 to 5g/da

Different modality of renal replacement therapy and its longterm complications?

By replacing some of the lost functions of the kidney, dialysis has permitted hundreds of thousands of patients to live and function. Of the two modalities of dialysis, hemodialysis (HD) and peritoneal dialysis (PD), the former is by far more popular.

Indications for renal replacement therapy include the following: Severe metabolic acidosis, Hyperkalemia, Pericarditis, Encephalopathy, volume overload, Failure to thrive and malnutrition, Intractable gastrointestinal symptoms.

Hemodialysis

Hemodialysis is a method that isused to achieve the extra corporeal removal of waste products such as creatinine and urea and free water from the blood when the kidneys are in a state of renal failure. Fistula, graft and catheter are the hemodialysis as sesssite in which fistula should be considered the first choice. Long term risk of hemodialysis includes neuromuscular complications (muscle cramps, restless legs syndrome, seizures, headache), hematological complication (dialysis associated neutropenia, intradialytic hemolysis, hemorrhage, thrombocytopenia), cardiovascular complication (intradialytic hypo/hypertension, cardiac arrhythmias, pericarditis) and pulmonary complications (Hypoxema).

Peritoneal dialysis

With peritoneal dialysis, a catheter is put into the abdomen. Dialysate consists of asterile, lactate based solution inserted through aperitoneal catheter into the abdominal cavity. Diffusion occurs from the blood perfusing the peritoneum to the fluid in the abdominal cavity a cross the peritoneum. Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) are form of peritoneal dialysis. The most common problem with peritonial dialysisis peritonitis, a serious abdominal infection. Other complications include, encapsulating peritoneal sclerosis, catheter malfunction, fluid leak, pain, bleeding and malnutrition.

Contra indication to dialysis modalities

There are few situations in which Hemodialysis and peritoneal dialysis are contraindicated as following:

Peritoneal dialysis:

- Loss of peritoneal function
- Producing in adequate clearance
- Adhesions blocking dialysate flow
- Abdominal wall stoma
- Diapharagmatic fluid leak
- In ability to perform exchanges in absence of suitable assistant.

Hemodialysis

- No vascular access possible
- cardiac failure
- Coagulopathy

Kidney transplantation in India

Renal transplantation has become the treatment of choice for most patients with end stage renal disease (ESRD). Statistics suggests that about 150,000 people in India are waiting for renal transplantation. Only 1 out of 30 people who need a kidney receives one. There are two types of kidney transplants : living transplant those that come from living donors and cadaver transplant those that come from unrelated donors who have died (non-living donors). A living donor may be some one in your family. The overall deceased donation rate in India was 0.8 per million population in 2019. Currently only 13 of the 36 states and union territories have so far done deceased donation. Of these only about 5 to 6 do it regularly and have a proper system for organ donation and allocation.

When to refer Nephrologist?

- Referral to specialist kidney care services is recommended if:
  - GFR<30ml/min/1.73m2
  - ACR>300mg/g(.30mg/mmol)
- Other referral circumstances to consider:
- AKI or abrupt sustained fall in GFR
- Progression of CKD
- Urinary red cell casts, RBC>20 per hpf
- CKD and hypertension refractory to treatment with 4 or more anti hypertensive agents
- Persistent abnormalities of serum potassium
- Recurrent or extensive nephrolithiasis
- Hereditary kidney disease

Recommended reading

KDIGO.2013. KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of the Chronic Kidney Disease. Kidney international supplements. Vol3; issue1.

Singh NP, Kumar A. Kidney transplant in India: Challenges and futurere commendation. MAMCJ Med Sci2016;2:12-7.

Under Construction Hospital is available for SALE / JOINT VENTURE / LEASE Size of Plot- 1200 Sq Yards (10800 sq ft) Proposed Facilities - 1 Modular operation theater, 1 Gynae Operation theater along with separate labor room, I.C.U ., Dialysis, Pathology lab , Radiology - C.T Scan, M.R.I, Ultrasound, X-Ray, I.P.D , O.P.D rooms, Casualty , General ward, Private and semi Private wards etc. The project is located near Delhi in The N.C.R region in T.D.I City, Kundli, Currently The project has basement, ground, First and second floor of the building structure completed .

Golden Opportunity to Own a 50 Bedded Hospital In the Heart Of Delhi- NCR region at price of a residential plot in Delhi.
Contact – Dr. Rishi Modi - 9599946450 , 9899677880 for further details.

Congratulations

DR. RAJIV GUPTA

Senior Consultant and
Head, Department of Anaesthesiology
and Interventional Pain Management
Maharaja Agrasen Hospital
for
being elected as a
Governing Council member of
Indian Society of Anaesthesiologists.

Dr. Girish Tyagi
President

Dr. Arvind Chopra
Hony. State Secretary

MENT OF CARDIOLOGY

When it comes to the Heart, Trust....

Dharma Vira Heart Centre

ne before.

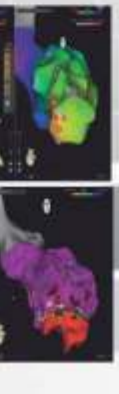
Message from the Chairman : Cardiology

Dr J P S Sawhney
Chairman
Department of Cardiology

At Dharma Vira Heart Center, it's our desire to provide the society with the highest standard of healthcare services. We ensure delivery of quality care with highest level of expertise from medical experts backed by well trained support staff, robust infrastructure and latest technology. We are committed to provide world-class healthcare services to every cardiac patient at an affordable cost.

vancements

ng &
of
ex
c
nia
T



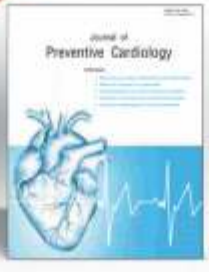
This Centre is doing Trans Catheter Aortic Valve Replacement (TAVR) with good result at an affordable price

COMPREHENSIVE CARDIAC CARE UNDER ONE ROOF

ACCUMULATING TRUST MORE THAN 60 YEARS
60 yr's TRUST

Key Highlights

- ★ A model of successful group practice of Cardiology.
- ★ One of the largest series of Primary Angioplasty in the Country.
- ★ Performing all Pediatric Cardiology procedure & surgeries
- ★ Robust Heart Failure programme including patient care, devices & Heart Transplant with good post-transplant outcome.
- ★ Very successful Cardiac Rehabilitation and Secondary Prevention Program
- ★ A Centre for excellence for cardiac surgeries. All major surgeries including septal myectomy for HOCM & thrombectomy for CTEP performed at the centre.
- ★ All Non-Invasive & Nuclear Cardiology under one roof.
- ★ Robust academic programme of super speciality (DNB) teaching.
- ★ Major centre for clinical research. Various major trials have been done at centre which have changed the clinical practices.
- ★ We are publishing Journal of Preventive Cardiology to spread message to fellow physician.



Indian Medical Association

Central Delhi Branch

organises

CLINICON | 2019

at

DMA Auditorium, Daryaganj, New Delhi

on

Sunday, 1st December, 2019

9.00am - 5.00pm

FACULTY


Dr. Sanjay Tyagi


Dr. Sanjiv Malik


Dr. K.K. Aggarwal


Dr. Girish Tyagi


Dr. Arvind Chopra


Dr. Anupam Sibal


Dr. Yash Gulati


Dr. J.C Passy


Dr. Harish Gupta


Dr. Tapaswini Pradhan


Dr. Amit Vij


Dr. Vishal Aggarwal


Dr. Anil Aggarwal


Dr. Rahul Bhargawa


Dr. Rajiv Anand


Dr. N.P. Singh


Ms. Meghna Aggarwal

CLINICON | 2019

Sunday, 1st December, 2019 | 9.00am - 5.00pm

THEME:
PEARLS OF CLINICAL PRACTICE

Approach to Diagnosis & Management of a Patient with

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

ECG Workshop : Dr. Prem Aggarwal

CEA : Dr. Harish Gupta

Doctor - Patient Relationship :
Panelists : Dr. Vinod Dua, Dr. Sanjiv Malik, Dr, Girish Tyagi, Dr. Arvind Chopra

Moderator : Ms. Meghna Aggarwal

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

SMS Reg@9811542055

Dr. Prem Aggarwal
Dr. Ashwini Dalmiya

Prior Registration Must

Send your Registration at :
E-mail: **imacentraldelhibranch@gmail.com**

Dr. Prem Aggarwal
Conference Chairman &
President, IMA CDB
Mob. 9810203358

Dr. Vinod K. Goel
Hony. Fin. Secretary
Mob. 9868525757

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

DRUG AND KIDNEY

Narinder Pal Singh, Anish Kumar Gupta
Department of Medicine
Max Super Specilaity Hospital, Ghaziabad

Correspondence

Dr (Prof.) Narinder Pal Singh
Medical Director & Senior Director, Medicine
Max Super Speciality Hospital, Vaishali
Ghaziabad, UP-201012, India.

Introduction

The incidence of drug induced nephrotoxicity has been increasing with increasing number of drugs and with easy availability of over-the-counter medication. Antibiotics, NSAIDs, ACEI and contrast agents are the major culprit drugs contributory to kidney damage. Some studies suggest there is an increased risk of CKD in individuals who are using proton pump inhibitor (PPI). Drug-induced AKI accounted for 20% of all AKI in an Indian study of which aminoglycosides accounted for 40% of total cases.Globally, there is a separate category for drugs that can be sold over the counter, but India does not have any such demarcation of OTC drugs. The true incidence of drug induced renal disease is difficult to ascertain because of the diagnostic inaccuracies in detecting the non-specific structural and functional abnormalities. Disposition of a number of drugs is affected by the kidney function and their doses need to be modified in states of altered renal function.

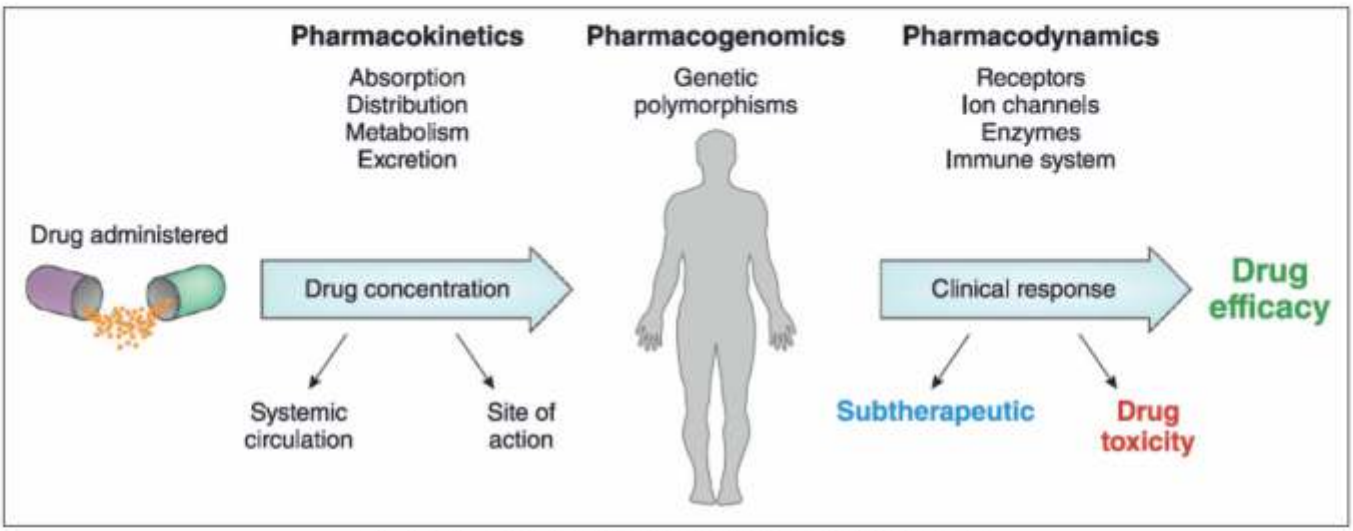


Figure 1. Factors affecting clinical pharmacology

Factor affecting renal vulnerability to toxic insults

- High renal blood flow
- High metabolic activity of the renal tubular cells
- Counter current mechanisms raise local drug concentration in renal medulla to levels higher than elsewhere in the body, increasing toxic exposure.
- Concentrated urine increases the solute concentration in the tubule fluid, there by exposing the epithelium to high toxic concentration.
- Changes in the urine pH affect the solubility of a variety of excreted drugs, causing damage by intra tubular precipitation.
- Kidney has the largest endothelial cell surface area by weight, thereby increasing the potential of damage by vasoactive drugs or immune complexes

Figure 1. Risk factors for nephrotoxicity

Patient-related factors	Drug-related factors
Age, sex, race	Inherent nephrotoxic potential
Pre-existent renal disease	Repeated exposure
Specific disease (diabetes mellitus, multiple myelome, proteinuric patients, lupus)	Dose, Duration, frequency and form of administration
Sodium-retaining states (cirrhosis, heart failure, nephrosis)	**Drug interactions**
Dehydration and volume depletion	Combined or closely associated use of diagnostic or therapeutic with added or synergistic nephrotoxic potential (eg. Radiocontrast agents, aminoglycosides NSAIDs, cisplatin, ACEI)
Acidosis, potassium and magnesium depletion	
Hyperuricemia, hyperuricosuria	
Sepsis, shock	
Renal transplantation	

Effects of drugs on the kidneys

- Pre-renal effects
  - eg, water and electrolyte loss, increased catabolism, vascular occlusion, altered renal haemodynamics
- Obstructive uropathy
- Allergic or immunological damage
  - eg, hypersensitivity reactions resulting in vasculitis, interstitial nephritis, glomerulonephritis
- Direct nephrotoxicity
  - giving rise to acute tubular or interstitial damage and renal papillary necrosis

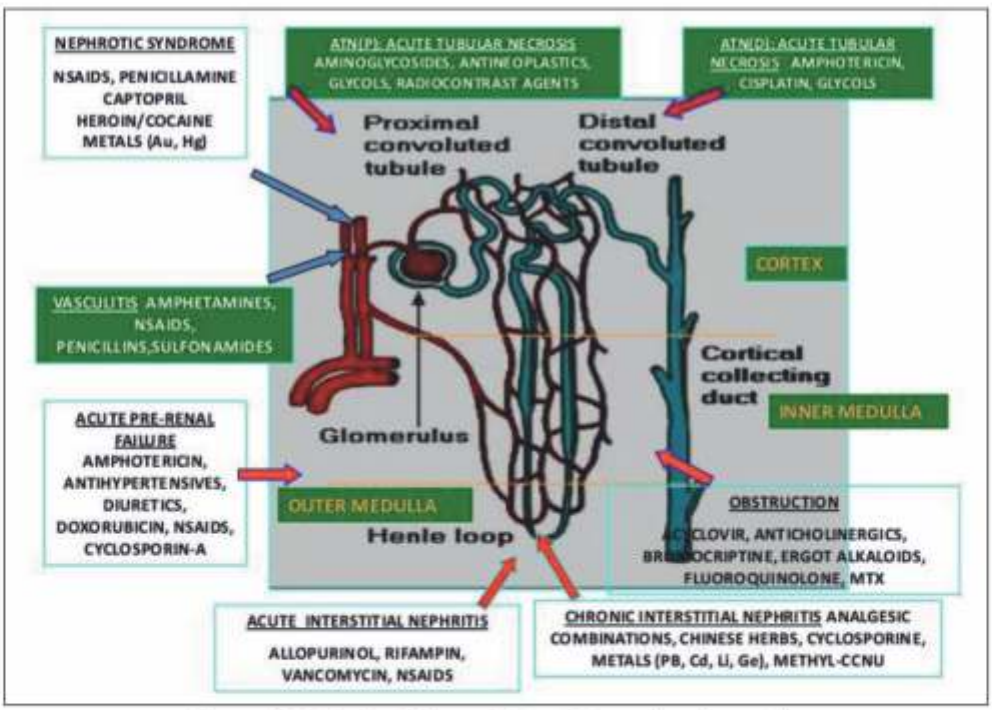


Figure 1. Pathophysiology of drug-induced nephropathy

Syndromes of drug-induced nephropathies

Syndrome	Drugs
Pre-renal failure/ functional renal failure	NSAIDs, ACE-inhibitors, amphotericin-B, cyclosporine, diuretics
Acute tubular necrosis	AMG, cephalosporins, Am-B, rifampicin, pentamidine, NSAIDs, contrast media, cyclosporine, cisplatin
Acute interstitial nephritis	Methicillin, ampicillins, rifampicin, NSAIDs, allopurinol
Drug induced crystalluria	Sulfadiazine, methotrexate, methoxyflurane, acyclovir, indinavir
Hypersensitivity angiitis	Penicillin G, ampicillin, sulfonamides, thiazides, Metolazone
TMA/HUS	Mitomycin-C, cyclosporine, contraceptives, OKT3, 5-FU, quinine, cocaine
Isolated proteinuria with nephrotic syndrome	Gold, heroine, captopril, NSAIDs, IFN- alpha, D- penicillamine
Chronic tubulointerstitial disease	NSAIDs, Thiazides, Lithium, Chinese herb nephropathy, germanium
Retroperitoneal fibrosis	Methysergide, hydralazine, methyldopa

Prevention

- Identifying high risk patients and quick recognition of drug induced injury-related syndrome with prompt cessation of the offending drug are the key to managing such a case before the injury causes permanent damage to the renal tissue.
- Special risk groups include - Age (elderly), volume-depleted state, concomitant use of other nephrotoxic drugs, Pre-existing renal disease.
- Patients need be monitored for - Symptoms, blood pressure, urine volume, urine microscopy, serum electrolytes (Na+ and K+), serum levels of certain drugs.
- Routine monitoring of SCr daily with calculation of dose on basis of eGFR/creatinne clearance especially in elderly.
- In patients on ACEI/ARBs, transient deterioration in SCr may be seen on the 3rd day in most patients but derangement persisting beyond the 7th day of therapy needs active intervention to rule out sub-clinical renal stenosis. If SCr > 1.5 mg/dl stop the drug and consider alternate therapy.

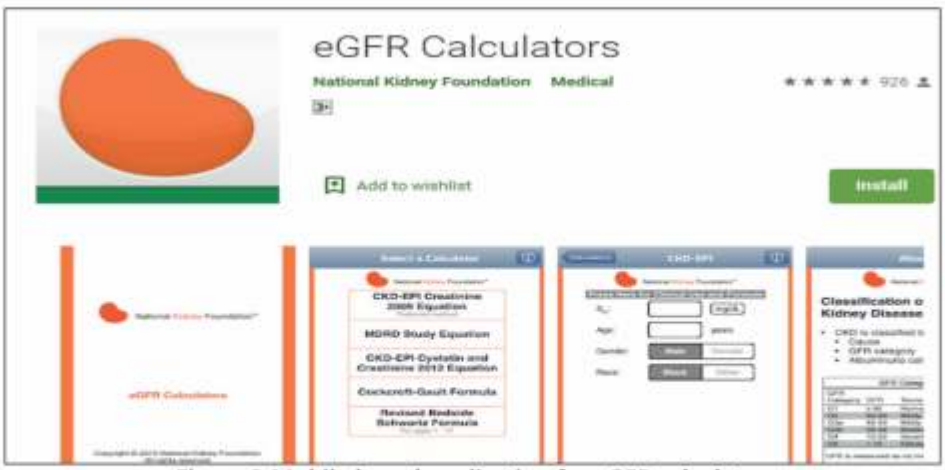


Figure 2.Mobile based application for eGFR calculator.

NO CRIMINAL CASE AGAINST DOCTORS WITHOUT INDEPENDENT MEDICAL OPINION FROM EXPERT IN SAME FIELD

Compiled by - **Dr. Arvind Chopra**
Hony. State Secretary, DMA

The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion, reiterated the Supreme Court while responding to a medical negligence case.

The SC bench stated that this medical opinion should be taken preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying Bolam's test to the facts collected in the investigation.

The same pronouncement by the SC was given earlier in 2005 where the apex court had laid down guidelines governing the prosecution of doctors for the offence of criminal negligence, punishable under Section 304A of IPC. That time, the SC had held :

1. *A private complaint may not be entertained unless the complainant produces prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge.*
2. *The investigating officer should before proceeding against the doctor accused of negligence, obtain an independent and competent medical opinion, preferably from a doctor in government service qualified in that branch of medical practice.*
3. *A doctor accused of negligence should not be arrested in a routine manner unless, his arrest is necessary for furthering the investigation or unless there is a flight risk.*

''The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain of criminal law under Section 304-A of IPC. The criminal process once initiated subject the medical professional to serious embarrassment and sometimes harassment,'' the then bench had reasoned.

This time, the SC was hearing an appeal against an order of the Nagpur bench of the Bombay high court that had set aside an order of the sessions court that discharged a woman along with another from charges under causing death by negligence.

The matter relates to administering medicine of Lariago. The Trial Court framed the charged the charges after examining the witnesses. On revision being field, the revision was allowed by the Sessions Court. The order had been questioned before the High Court. The High Court has set aside the order of the Sessions Court and restored the order of the Magistrate.

The petitioners then approached SP and maintained that the HC order was passed without taking the SC pronouncement into account.

The court noticed that the Trial Court had framed charges after examining the witnesses. However, revision of the said order was allowed by the sessions Court which went on to discharge the Appellants. This order of discharge was subsequently questioned before the high, which set aside the order of discharge and restored the order of the Magistrate.

Nothing that the courts below had not proceed in conformity with the above said Supreme Court ruling and had not obtained any expert opinion, bench of justice Arun Mishra, Vineet Saran and S. Ravindra Bhatt said,

''Ad admittedly, no medical expert has been examined in this case, we set aside the impugned orders passed by the courts below and remand the case to the trial court to examine the witnesses and to take the view of the medical expert on behalf of the complaint and only thereafter, to form an opinion whether any charge is made out in the case or not. Obviously, the trial court shall not be influenced by any of the observations made by this Court or in the impunged order passed by the High Court. The matter to be decided strictly in accordance with law on the basis of the evidence and after hearing both the sides.''

ARE YOU READY FOR THE FUTURE OF HEALTHCARE ?

Join the American Academy of Anti Aging Medicine at the first ever Smart-A4M India Conference. Planned by renowned clinicians and researchers, the conference defines why Integrative Medicine is the future of healthcare with outcome focused treatments and satisfied patients .

18-19, JANUARY 2020
HYATT REGENCY, NEW DELHI

Optimise your treatment method with a new form of medicine that is

PREVENTIVE | PERSONALISED | PREDICTIVE | PARTICIPATORY

LECTURES BY

Tribhuvan Gulati MD,MACP	**Andrew Heyman** MD, MHSA	**Pamela Smith** MD, MPH, MS	**Biren Banerjee** PHD
Introduction to Anti aging	Leaky gut & the gut brain axis	Improve memory and focus at any age	Genes, Life & beyond
Shabnam D Kar MBBS,MD	**Kalpana Shekhawat** MBBS,MD	**BS Rajput** MBBS, D.Ortho, M.Ch Ortho	**Anoop Bhagat** MBBS,MD, ABARM,FNMN
Autoimmune Thyroid	Impact of Intermittent fasting on cardiovascular health	Stem Cells as new age medicine	Mitochondria Disease & Endocrine Dysfunction

AND SEVERAL OTHER MEDICAL PHYSICIANS FROM INDIA & OVERSEAS

Early bird registrations valid till 30 November 2019

visit : www.smartmetabolicaging.com/event-registration/admin@smartmetabolicaging.com | +91-93159 02303

Technology, Expertise & Precision

Robot assisted partial & total knee replacement surgery

Delhi's first Robotic Knee Replacement Centre

Dr. Aashish Chaudhry
Sr. Consultant - Orthopaedics & Joint Replacement
M.S. Ortho, M.Ch (Ortho),
MRCS, FACS, FICA, DipSICOT

Promising consistent & accurate results

Salient features of robotic assisted knee replacement

- ✓ Precision in mapping the joints
- ✓ Minimal pain and blood loss
- ✓ Minimally invasive and less scars
- ✓ Speedy recovery and reduced hospital stay
- ✓ Enhances life of implant

Aakash Healthcare
Super Speciality Hospital
We care, He cures

88000 15950 011-280 888 88

Hospital Plot, Road No. 201, Sector-3, Dwarka, New Delhi - 110 075.

www.aakashhealthcare.com | reachus@aakashhealthcare.com | Follow us on:

Regd. with Registrar of Newspaper under No. 17462/1968
Date of Publication 7-8 and 22nd & 23rd of the same month

Regd. No. DL (c)-05/1286/2018-20
Licence to Post without Prepayment No. U (C)-106/2018-20
Date of Posting 10-11 & 25-26 of Same Month at Delhi RMS

Glimpses of **Diwali Celebration** on 26th November, 2019 at DMA House















Published, Printed and Edited by Dr. Arvind Chopra, Hony. State Secretary & Editor on befalf of Delhi Medical Association
Published from Delhi Medical Association, DMA House, Ansari Road, Daryaganj, New Delhi 110002
Printed at Chaar Dishyen Printers (P) Ltd. G-39 & 40, Sector-3, Noida