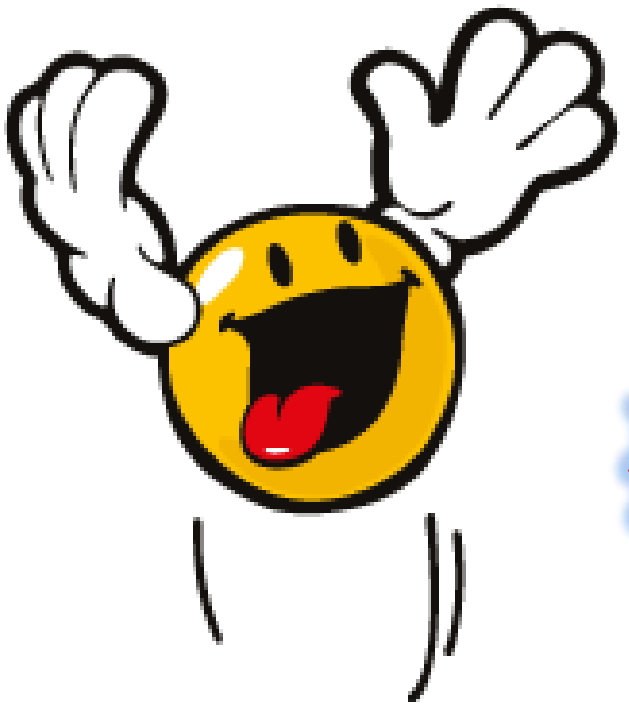
What's Up?
@St John's Hospital

Issue 8, October 3rd, 2018

Canopy of Trees next to our library looks so blissful – probably an ideal place for meditation

PC: Dr. Rakesh

St John's National Academy of Health Sciences
St John's Medical College Hospital, Bengaluru



HOORAY!!!

HAVE YOU TRIED THE INTERACTIVE ELECTRONIC VERSION OF THE MAGAZINE?

	03-10-2018 Whatsup? @ St.John's Hospital	086 Total views	3 min Avg time spent	66% Avg completion	25 glanced 16 quick read 45 deep read
	29-09-2018 Whatsup? @ St.John's Hospital	104 Total views	2 min Avg time spent	50% Avg completion	47 glanced 14 quick read 43 deep read

MESSAGE FROM THE EDITORIAL TEAM

Hola a todos!

"Whatsup? @ St John's Hospital" magazine's eight issue is out today. We are very happy to announce, that our team has grown further. We welcome Dr. Nivedita Kamath, Dr. Archana S, Dr. Pratiksha Rao, Dr. Deepak Kamath, Dr. Sanjukta Rao, Dr. Ruchi Kanhere to our team. We are also thankful to Mr. Bharat Gera and Mr. Bhavyank from the department of IT for all the technical help and for being a part of the team.

We hope all of you are enjoying the issues published till date. We have a new emotional section called "**Survivor's Corner**" from this issue. We hope all of you enjoy reading it.

Also Since we mark the world hospice day this 13th October, we hereby present a short history and the importance of palliative care. We sincerely thank Dr. Subhash Tarey (Professor and Head, Department of Pain Palliative care) for providing the contents and write up.

Any accomplishments, interesting cases, happenings and announcements can be published in this magazine. Feel free to contact us anytime, for publishing your content.

Regards

Editorial Team

WORLD HOSPICE DAY
13TH OCTOBER 2019

World Hospice and Palliative Care Day is organized by a committee of the Worldwide Hospice Palliative Care Alliance, a network of hospice and palliative care national and regional organizations that support the development of hospice and palliative care worldwide.

To share our vision to increase the availability of hospice and palliative care throughout the world by creating opportunities to speak out about the issues

To raise awareness and understanding of the needs – medical, social, practical, spiritual – of people living with a life limiting illness and their families

To raise funds to support and develop hospice and palliative care services around the world.

This year is the centenary of ***Dame Cicely Saunders***, founder of the modern hospice movement. So it is fitting that this year's World Hospice and Palliative Care Day theme draws its wording from her iconic quote: 'You matter because you are you and you matter until the end of your life'.

THEME FOR WORLD HOSPICE DAY 2018

#BecauseIMatter

WORLD HOSPICE DAY

DAME CICELY SAUNDERS

Mother of Hospice Movement

Cicely Saunders founded the first modern hospice and, more than anybody else, was responsible for establishing the discipline and the culture of palliative care.

She introduced effective pain management and insisted that dying people needed dignity, compassion, and respect, as well as rigorous scientific methodology in the testing of treatments. She abolished the prevailing ethic that patients should be cured, that those who could not be cured were a sign of failure, and that it was acceptable and even desirable to lie to them about their prognosis.

Cicely Saunders became, and perhaps always was, a grande dame and natural leader, and established a reputation in the national consciousness almost on a par with that of Florence Nightingale. In 1967 she founded St Christopher's Hospice in south west London.

Saunders introduced the idea of "total pain," which included the physical, emotional, social, and spiritual dimensions of distress. She regarded each person, whether patient or staff, as an individual to the end.

Cicely Mary Strode Saunders, medical director St Christopher's Hospice 1967-85. She died on 14th July 1985 in the Hospice that she built.

WORLD HOSPICE DAY

HOSPICE MOVEMENT IN INDIA

HOSPICES IN ANCIENT INDIA

If we go back in the history of Mauryas in ancient India, There is evidence that Palliative care and hospice concept was promoted by King Ashoka. It has been found in some "*shilalekhas*' that he built *"Punya Shalas"* for the benefit of pilgrims who could not continue with the pilgrimage due to sickness. They were looked after by court appointed *'Vaidya'* and *'Paricharika'*. On the other hand he built resting places for tired pilgrims called *"Dharma Shalas"* where pilgrims could rest and continue with their pilgrimage.

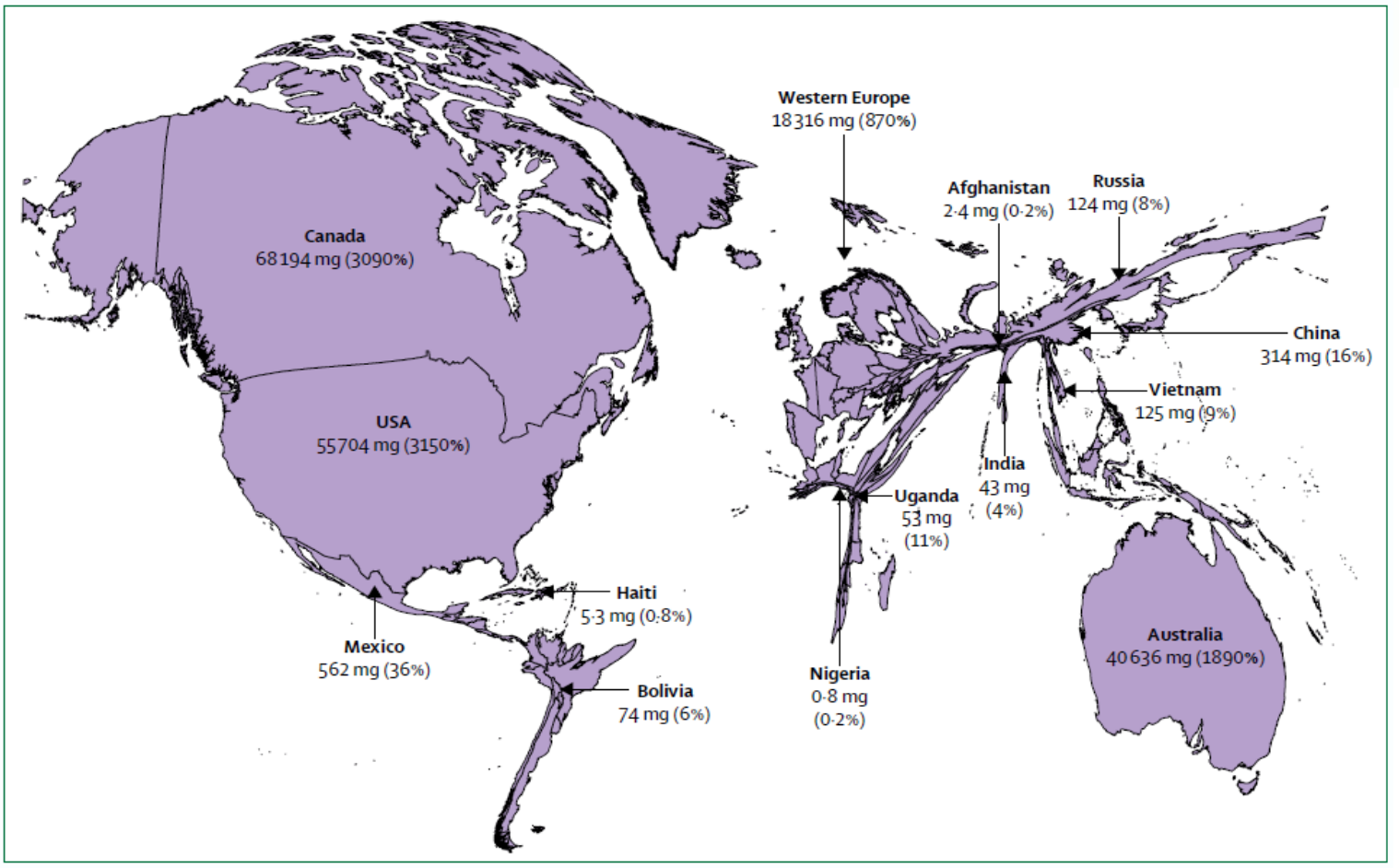
HOSPICES IN MODERN INDIA

"Shanti Avedana", the first hospice in India was built in 1986 by Dr. L.J. de Souza, a surgical oncologist with Tata Memorial Hospital. It is managed by a trust and offers free care. It has since opened branches in New Delhi and Goa.

Karunashraya: The Bangalore Hospice Trust (BHT)- Karunashraya, meaning an 'Abode of compassion,' was formed as a registered charitable trust by the Indian Cancer Society (Karnataka Chapter) and the Rotary Club of Bangalore Indiranagar to provide free professional palliative care for advanced stage cancer patients who are beyond cure. Its inpatient facility started working since May, 1997. It has helped establishment of many Hospices in South India. Karnataka has Hospices in Shivamogga, Udipi, Puttur and Mangalore.

Snehadaan: St John's Medical College is associated with "Snehadaan", a palliative care center set up by Camillians, an International Faith based organization involved in healthcare. It is a hospice primarily set up to provide care to patients afflicted with HIV/AIDS. It has expanded its scope to serve patients with Palliative care needs.

WORLD HOSPICE DAY



Distributed Opioid Morphine-equivalent (Morphine in mg/patient in need of palliative care, average 2010-2013), and estimated percentage of need that is met for the health conditions most associated with serious health related suffering.

REF: International Narcotics Control Board and WHO Global Health Estimates 2015.

IG NOBEL 😂

1994

W. Brian Sweeney, Brian Krafte-Jacobs, Jeffrey W. Britton, and Wayne Hansen

CONSTIPATION IN SERVICEMEN

©www.supraclinics.com

For their breakthrough study, "The Constipated Serviceman: Prevalence Among Deployed US Troops," and especially for their numerical analysis of bowel movement frequency.

Results were obtained from a bowel function questionnaire issued to 500 deployed marines and sailors. When constipation is defined as no bowel movement for greater than 3 days, 3.9% of the Marine/sailor personnel are constipated when in their home environment as compared to 6.0% when they are aboard ship and 30.2% while in the field.

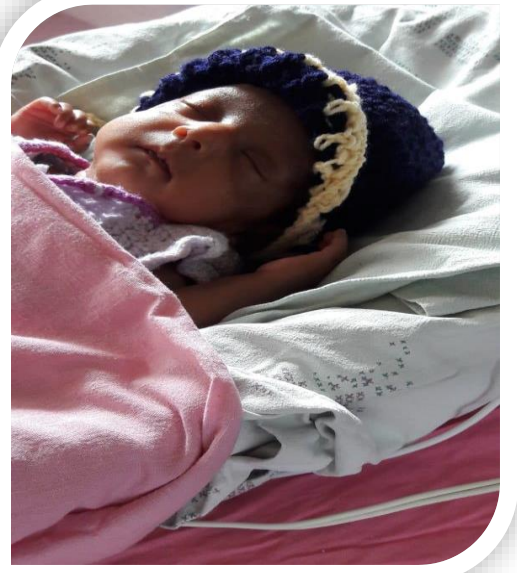
Alternatively, when constipation is defined as the presence of certain anorectal complaints (hard stools, straining, painful defecation, and bleeding with defecation), the incidence is 7.2% when at home as compared to 10.4% aboard ship and 34.1% in the field.

"Military Medicine," vol. 158, August, 1993, pp. 346-348.

REF: https://www.improbable.com/ig/winners/

SURVIVOR's CORNER

At 1.2 kg and 50 days of life



Now at 2 kg and 2 and 1/2 months

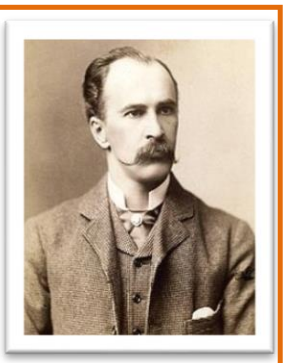
Liya (gift from God) was born at 27 weeks weighing just 740 g. Her parents did not want to take care of such a tiny child and wanted to take her DAMA. They have decided to give her up at the CWC. We currently have custody of little Liya. She had RDS, required surfactant and respiratory support for a few weeks, then had GNB sepsis, got a blood transfusion and now has retinopathy of prematurity. She has had one laser treatment for her eyes but is otherwise well and is waiting for discharge.

Liya is now 3 months old – although she has just reached her corrected date of birth – i.e., the date she should have been born on. A number of people have helped her in the last 92 days of her life. The nurses who take "special" care of her, the mothers in the NICU who gave her breast milk at a time when it was crucial for her survival, families who have donated money for her, volunteers who do kangaroo mother care and the Ethiopian observers who named her, have all been instrumental in her survival.

We hope to discharge her soon to an orphanage after which she will be put up for adoption.

CONGRATULATIONS NICU TEAM

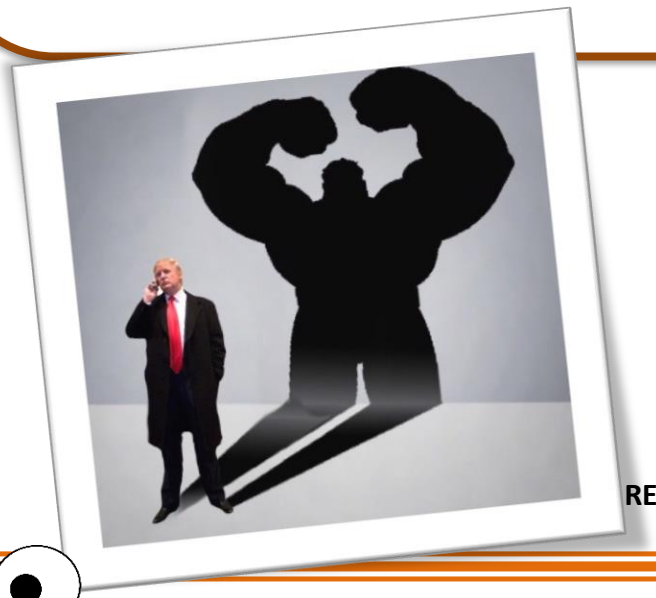
THE QUOTABLE OSLER



SIR WILLIAM OSLER

Self-satisfactions is comparable to a delusion of Grandeur:

Self-satisfaction, a frame of mind widely diffused, is manifest often in greatest intensity where it should be least encouraged, and in individuals and communities is sometimes so active on such slender grounds that the condition is comparable to the delusions of grandeur in the insane.



Ignorance increases dogmatism:

The greater the ignorance the greater the dogmatism.

03rd October 2018

REF: The Quotable OSLER: Edited by Mark E Silverman, T. Jock Murray, Charles. S Bryan

MEDICINE DIS WEEK

A Bird's Eye View.....

Use of Esomeprazole and Aspirin in Barrett's Oesophagus.

Oesophageal Adenocarcinoma is the sixth most common cause of cancer death worldwide and Barrett's Oesophagus is biggest risk factor. A 2X2 factorial designed RCT called AspECT trial recruited 2557 patients, randomised them 1:1:1:1 to receive high-dose (40mg BD) or low-dose (20mg OD) PPI, with r without aspirin (300mg – 325mg OD) for 8 years. High dose PPI were significantly better than low dose PPI. If the patients using NSAIDs were censored at the time of first use, aspirin was significantly better than no aspirin. High dose PPI and aspirin chemoprevention therapy, especially in combination, significantly and safely improved outcomes in patients with Barrett's Oesophagus.

- Jankowski JAZ et al, Lancet 2018; 392: 400–08.

Does Oral Steroids help in resolution of Otitis media with Effusion in Children?

A randomised study called OSTRICH trial aimed to investigate whether a short course of oral steroids would achieve acceptable hearing in children with persistent otitis medial with effusion and hearing loss. OSTRICH randomised 389 children to receive oral prednisolone versus a placebo. Acceptable hearing was observed in 40% children in oral steroid group as opposed to 33% in placebo. 1 in 14 children might achieve improved hearing but not quality of life.

-Francis NA et al., Lancet 2018; 392: 557–68.

Esomeprazole and aspirin in Barrett's oesophagus (AspECT): a randomised factorial trial

Janusz A Z Jankowski, John de Caestecker, Sharon B Love, Gavin Reilly, Peter Watson, Scott Sanders, Yeng Ang, Danielle Morris, Pradeep Bhandari, Stephen Attwood, Krish Ragunath, Bashir Rameh, Grant Fullarton, Art Tucker, Ian Penman, Colin Rodgers, James Neale, Claire Brooks, Adelyn Wise, Stephen Jones, Nicholas Church, Michael Gibbons, David Johnston, Kishor Vaidya, Mark Anderson, Sherzad Balata, Gareth Davies, William Dickey, Andrew Goddard, Cathryn Edwards, Stephen Gore, Chris Haigh, Timothy Harding, Peter Isaacs, Lucina Jackson, Thomas Lee, Peik Loon Lim, Christopher Macdonald, Philip Mairs, James McLoughlin, David Monk, Andrew Murdock, Iain Murray, Sean Preston, Stirling Pugh, Howard Smart, Ashraf Soliman, John Todd, Graham Turner, Joy Worthington, Rebecca Harrison, Hugh Barr, Paul Moayyedi

Lancet 2018; 392: 400–08

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Summary

Background Oesophageal adenocarcinoma is the sixth most common cause of cancer death worldwide and Barrett's oesophagus is the biggest risk factor. We aimed to evaluate the efficacy of high-dose esomeprazole proton-pump inhibitor (PPI) and aspirin for improving outcomes in patients with Barrett's oesophagus.

Methods The Aspirin and Esomeprazole Chemoprevention in Barrett's metaplasia Trial had a 2×2 factorial design and was done at 84 centres in the UK and one in Canada. Patients with Barrett's oesophagus of 1 cm or more were randomised 1:1:1:1 using a computer-generated schedule held in a central trials unit to receive high-dose (40 mg twice-daily) or low-dose (20 mg once-daily) PPI, with or without aspirin (300 mg per day in the UK, 325 mg per day in Canada) for at least 8 years, in an unblinded manner. Reporting pathologists were masked to treatment allocation. The primary composite endpoint was time to all-cause mortality, oesophageal adenocarcinoma, or high-grade dysplasia, which was analysed with accelerated failure time modelling adjusted for minimisation factors (age, Barrett's oesophagus length, intestinal metaplasia) in all patients in the intention-to-treat population. This trial is registered with EudraCT, number 2004-003836-77.

Findings Between March 10, 2005, and March 1, 2009, 2557 patients were recruited. 705 patients were assigned to low-dose PPI and no aspirin, 704 to high-dose PPI and no aspirin, 571 to low-dose PPI and aspirin, and 577 to high-dose PPI and aspirin. Median follow-up and treatment duration was 8·9 years (IQR 8·2–9·8), and we collected 20 095 follow-up years and 99·9% of planned data. 313 primary events occurred. High-dose PPI (139 events in 1270 patients) was superior to low-dose PPI (174 events in 1265 patients; time ratio [TR] 1·27, 95% CI 1·01–1·58, p=0·038). Aspirin (127 events in 1138 patients) was not significantly better than no aspirin (154 events in 1142 patients; TR 1·24, 0·98–1·57, p=0·068). If patients using non-steroidal anti-inflammatory drugs were censored at the time of first use, aspirin was significantly better than no aspirin (TR 1·29, 1·01–1·66, p=0·043; n=2236). Combining high-dose PPI with aspirin had the strongest effect compared with low-dose PPI without aspirin (TR 1·59, 1·14–2·23, p=0·0068). The numbers needed to treat were 34 for PPI and 43 for aspirin. Only 28 (1%) participants reported study-treatment-related serious adverse events.

Interpretation High-dose PPI and aspirin chemoprevention therapy, especially in combination, significantly and safely improved outcomes in patients with Barrett's oesophagus.

Funding Cancer Research UK, AstraZeneca, Wellcome Trust, and Health Technology Assessment.

Introduction

The incidence of oesophageal adenocarcinoma has increased substantially in North America and Europe over the past 40 years.[1] Although incidence might be plateauing, areas such as Hawaii are still seeing annual increases of 8%.[1] There are over 52 000 cases of oesophageal adenocarcinoma worldwide each year and 5-year survival is less than 10% when detected through symptoms. Increasing incidence of oesophageal adenocarcinoma is probably related to the rise in gastro-oesophageal reflux disease in high-income countries, especially in populations of European descent.[2–5]

Gastro-oesophageal reflux is one of the main risk factors for Barrett's oesophagus, in which a portion of the oesophagus that is usually lined with squamous epithelium undergoes metaplastic change to become columnar mucosa. Barrett's oesophagus is a complex, genetically predisposed, premalignant condition[6] that affects 2% of the adult population in western countries and can progress to adenocarcinoma, following the sequence oesophagitis-metaplasia-dysplasia-adenocarcinoma.[7,8] Surveillance of Barrett's oesophagus to detect early stage cancer has been associated with only a modest improvement in the outlook of oesophageal

Oral steroids for resolution of otitis media with effusion in children (OSTRICH): a double-blinded, placebo-controlled randomised trial

Nick A Francis, Rebecca Cannings-John, Cherry-Ann Waldron, Emma Thomas-Jones, Tom Winfield, Victoria Shepherd, Debbie Harris, Kerenza Hood, Deborah Fitzsimmons, Amanda Roberts, Colin Powell, Micaela Gal, Christopher C Butler

Summary

Background Children with persistent hearing loss due to otitis media with effusion are commonly managed by surgical intervention. A safe, cheap, and effective medical treatment would enhance treatment options. Underpowered, poor-quality trials have found short-term benefit from oral steroids. We aimed to investigate whether a short course of oral steroids would achieve acceptable hearing in children with persistent otitis media with effusion and hearing loss.

Methods In this individually randomised, parallel, double-blinded, placebo-controlled trial we recruited children aged 2–8 years with symptoms attributable to otitis media with effusion for at least 3 months and with confirmed bilateral hearing loss. Participants were recruited from 20 ear, nose, and throat (ENT), paediatric audiology, and audiovestibular medicine outpatient departments in England and Wales. Participants were randomly allocated (1:1) to sequentially numbered identical prednisolone (oral steroid) or placebo packs by use of computer-generated random permuted block sizes stratified by site and child's age. The primary outcome was audiometry-confirmed acceptable hearing at 5 weeks. All analyses were by intention to treat. This trial is registered with the ISRCTN Registry, number ISRCTN49798431.

Findings Between March 20, 2014, and April 5, 2016, 1018 children were screened, of whom 389 were randomised. 200 were assigned to receive oral steroids and 189 to receive placebo. Hearing at 5 weeks was assessed in 183 children in the oral steroid group and in 180 in the placebo group. Acceptable hearing was observed in 73 (40%) children in the oral steroid group and in 59 (33%) in the placebo group (absolute difference 7% [95% CI –3 to 17], number needed to treat 14; adjusted odds ratio 1·36 [95% CI 0·88–2·11]; p=0·16). There was no evidence of any significant differences in adverse events or quality-of-life measures between the groups.

Interpretation Otitis media with effusion in children with documented hearing loss and attributable symptoms for at least 3 months has a high rate of spontaneous resolution. A short course of oral prednisolone is not an effective treatment for most children aged 2–8 years with persistent otitis media with effusion, but is well tolerated. One in 14 children might achieve improved hearing but not quality of life. Discussions about watchful waiting and other interventions will be supported by this evidence.

Funding National Institute for Health Research (NIHR) Health Technology Assessment programme.

Lancet 2018; 392: 557–68

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Division of Population Medicine, School of Medicine (N A Francis PhD, M Gal DPhil), **and Centre for Trials Research, College of Biomedical & Life Sciences** (R Cannings-John PhD, C-A Waldron PhD, E Thomas-Jones PhD, V Shepherd MA, D Harris PhD, K Hood PhD), **Cardiff University, Neuadd Meirionnydd, Heath Park, Cardiff, UK; Swansea Centre for Health Economics, College of Human Health Sciences, Swansea University, Singleton Park, Swansea, UK** (T Winfield PhD, D Fitzsimmons PhD); **Cardiff and Vale University Health Board, Child Health Directorate, St David's Children Centre, Cowbridge Road East, Cardiff, UK** (A Roberts MD); **Department of General Paediatrics, Children's Hospital for Wales, Heath Park, Cardiff, UK** (C Powell MD); **and Nuffield Department of Primary Care Health Sciences, University of Oxford, Radcliffe Observatory Quarter, Oxford, UK** (C C Butler FMedSci)

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Introduction

Otitis media with effusion is estimated to affect 50–80% of children by the age of 5 years and costs the National Health Service (NHS) up to £90 million per year.[1] Antibiotics, topical intranasal steroids, decongestants, antihistamines, and mucolytics are ineffective treatments for this condition.[2–4] Intervention options are largely limited to watchful waiting, hearing aids, or surgical insertion of ventilation tubes through the tympanic membrane (with or without adenoidectomy or tonsillectomy). Use of an autoinflation device resulted in a modest benefit for some children aged 4–11 years.[5] However, 80% of children are affected by otitis media with effusion before the age of 4 years, a time when language development is most rapid, hearing loss has its greatest effect on language development, and when children are generally unable to use an autoinflation device.[6] Hearing aids are an effective treatment, but children often find them uncomfortable, might feel self-conscious, and can become a target for bullying.[7] Both hearing aids and surgery require referral to secondary care, with major cost implications.[8] A safe, cheap, and effective medical treatment, especially if implementable in primary care, would enhance treatment options.

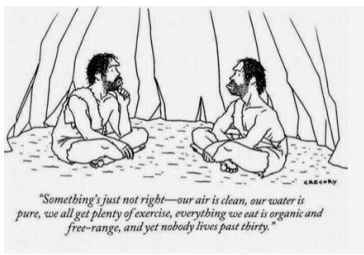
Our Cochrane review of oral or topical steroids for otitis media with effusion found a significant benefit with oral steroids plus antibiotics versus with antibiotics alone, and a significant point estimate suggesting benefit for oral steroids versus control.[3] Studies were generally small, of poor quality, and short term. The only study to

THE STORY OF MEDICINE

It's story TiME

PRE-HISTORIC HEALTH
A STRUGGLE FOR SURVIVAL

Becoming human was a distinct advantage, over other animals, to prehistoric ancestors. Human beings were occasionally able to live beyond their reproductive years — a very unusual occurrence in animals and this lengthening of life proved a human adaptive change of major importance. The short lifespans was mainly because of hard nomadic life, the climate and warfare.



From the evidence, it seems unlikely that diseases unknown today affected these early societies. However, some illnesses that are now quite mild may have been extremely virulent. By about 5000 BC, many wandering nomads had settled into communities. Initially, this promoted health and longevity, especially among women, as the stresses of migration were reduced, and it was far easier to care for the sick.

As settlements became more densely populated after 2000 BC, epidemics of childhood diseases became possible. Living cheek by jowl also undoubtedly led to personality clashes and depression - the first signs of modern stress.

PEARLS OF WISDOM

WORLD HOSPICE DAY SPECIAL

"People will forget what said, people will forget what you did; but people will never forget how you made them feel"- ***Maya Angelou***

“In the end these things matter most. How well did you love? How fully did you live? How deeply did you let go? - ***Gautam Buddha***

“Too often we underestimate the power of touch, a smile, a kind word, or the smallest act of caring, all of which have a potential to turn a life around.” -***Leo Buscaglia***

“The worst thing we can do is abandon someone who is hurting. Attitudes which promote death rather than affirm life are the ultimate abandonment” ***– Cicely Saunders***

“Pain is inevitable. Suffering is optional.” - ***Gautam Buddha***

“We cannot change the outcome, but we can affect the journey” – ***Ann Richardson***

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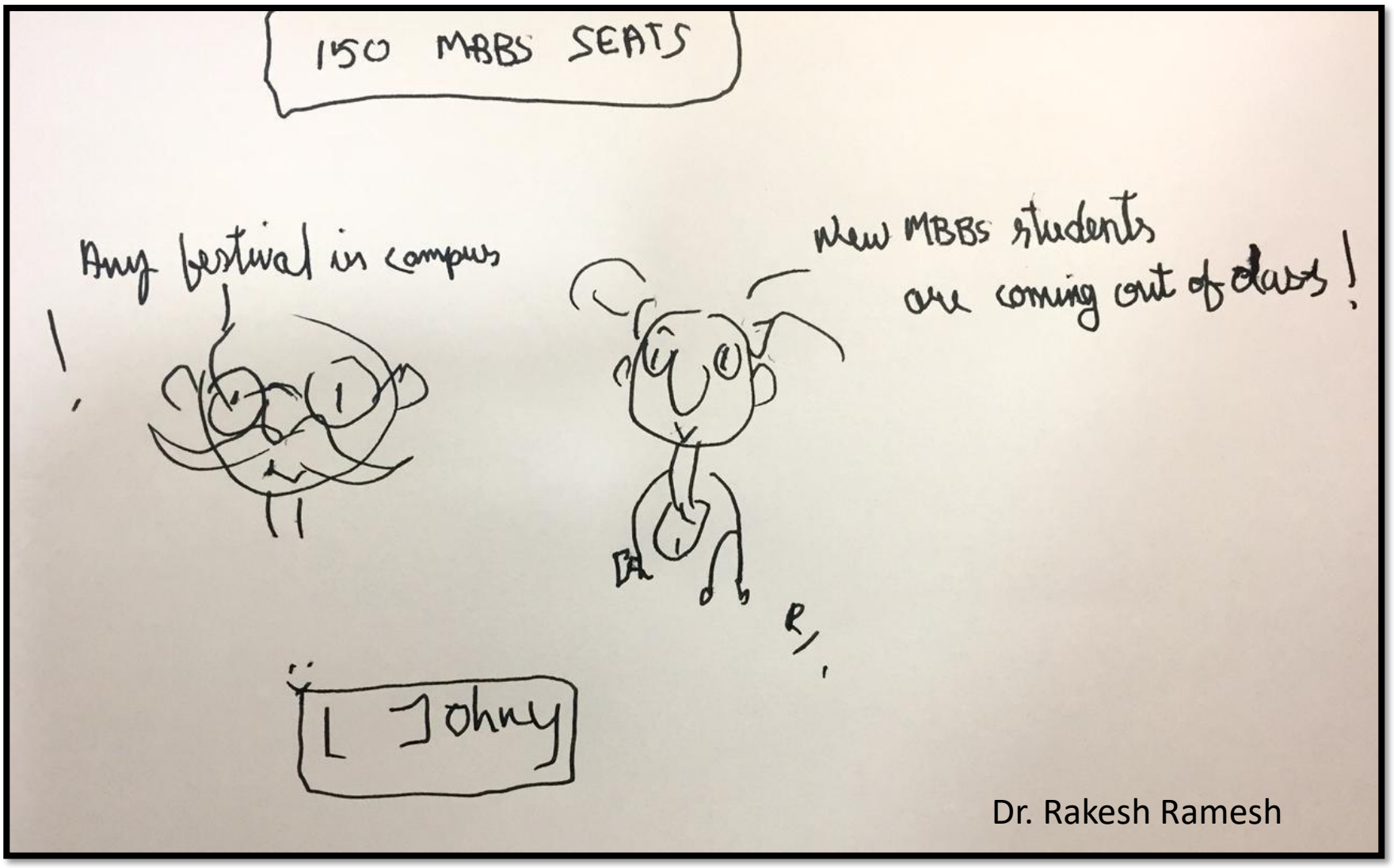

DO YOU HAVE ANY INTERESTING CONTENT TO BE PUBLISHED?

Write to Dr. Avinash. H. U: ***avinash.hu@stjohns.in***