What's Up?
@St John's Hospital

Issue 32, September 16th, 2019

Golden Deers.
PC: Dr. Rakesh Ramesh

PEDIATRIC CANCER AWARENESS MONTH

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

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MESSAGE FROM THE EDITORIAL TEAM

Dear All!!!

We are pleased to share the thirty second issue of “What’s Up? @ St John’s Hospital” magazine today.

Friends, as you all are aware, the section ‘St. John’s Fountainhead’ will publish abstracts of 2 published research articles from the year 2018. The articles are selected by criteria laid down by the editorial team. We request you all to please mail your publications to us.

The present issue is dedicated to Pediatric Cancer Awareness month which is observed every year in the month of September. The magazine is themed ‘Golden Yellow’ to observe the same. We thank Dr. Anand Prakash (Associate Professor, Division of Pediatric hematology Oncology, Department of Pediatrics) for providing us a brief write up on the role of teaching hospitals in management of pediatric cancers.

This issue introduces you to ‘PFT, Sleep lab and Bronchoscopy services’ under Department of Pulmonary Medicine in St. John’s Medical College Hospital in Know your hospital section. The ‘Utensil Washers’ from the dietary department are Team of the month.

Do not miss loads of updates in this issue. Please feel free to communicate with us to publish your achievements and events. Your feedback motivates us to work harder. Happy Reading!!

Editorial Team

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UPDATES THIS WEEK

Pediatric Cancer Awareness Month (September)

Pediatric or Childhood Cancer Awareness Month is recognized every September by childhood cancer organizations around the world. ***Be Bold and Go Gold!***

Dr. Anand Prakash (Division of Pediatric hematology Oncology & Stem cell transplantation) has provided us a write up on the role of a teaching hospital in treatment of pediatric cancers.

PEDIATRIC CANCER : THE ROLE OF A TEACHING HOSPITAL

Around 300000 new cases of childhood cancer are diagnosed around the world annually. Children have excellent cure rates of 70-80% across the various cancer types. The spectrum of cancers in children differs from adults. While carcinomas are common in adults, in children hematolymphoid malignancies (leukemias and lymphomas) are most common. Almost any organ system in a child can be affected including brain tumors, bone and soft tissue sarcomas, nephroblastoma (kidney), hepatoblastoma (liver), retinoblastoma (*eye*) and germ cell tumors (gonads). Survival rates of pediatric cancers has improved to upto 90-95% in some groups of malignancies from < 10% in just 4 decades.

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Pediatric Cancer Awareness Month

The main modality of treatment for leukemias and lymphomas is intensive multi-agent chemotherapy. The modalities of treatment for solid tumors include chemotherapy, surgery and in some cases radiotherapy. The duration of treatment varies from a few months to upto 3 years. The main challenges to treatment, especially in our country include timely diagnosis and referral to centres with expertise in pediatric oncology. Prompt supportive care during infections and nutritional support during and after completion of chemotherapy are major factors which contribute to cure. Multidisciplinary facilities with Pediatric Intensive care, Pediatric Surgery, Radiotherapy, Immunohematology and Blood banks are all an integral part of the care of these very challenging patients.

Pediatric cancer units in teaching hospitals ensure that more patients have access to treatment at reasonable costs. Units in teaching hospitals also helps sensitise and train generations of MBBS doctors, paediatricians and nurses to the needs of children with cancer. This will ensure early diagnosis and appropriate supportive care for these patients in the community. Caring for children with cancer and moving towards a cure in many of our little ones is indeed a most gratifying area of pediatric care at St Johns.

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INAUGURATION OF NURSING COURSES OF BATCH 2019

College of Nursing

12th September 2019

A total of 200 Nursing students of various courses of the batch of 2019 were welcomed into the Academy on 12th September 2019 at the College of Nursing. A formal inauguration ceremony was held for the 31st Batch of BSc, 30th PBBSc, 40th GNM & 24th batch of MSc Nursing students. Rev. Dr. Paul Parathazham (Director, SJNAHS) presided over the function & briefed the students on the mission and vision of St John's in his inaugural message. The freshers also received words of wisdom through messages from Rev. Fr. Pradeep Kumar Samad (Associate Director Hospital) & Sr Fatima (Chief of Nursing Services). Ms Brinda Benny the former SNA (Student Nurses' Association) vice-president of the outgoing batch shared her experiences to put the freshers at ease.

Acknowledgement: Mrs. Reena Menon
(Principal, St. John's College of Nursing)

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“The Dr. Mary Ollapally Memorial Cash Prize”

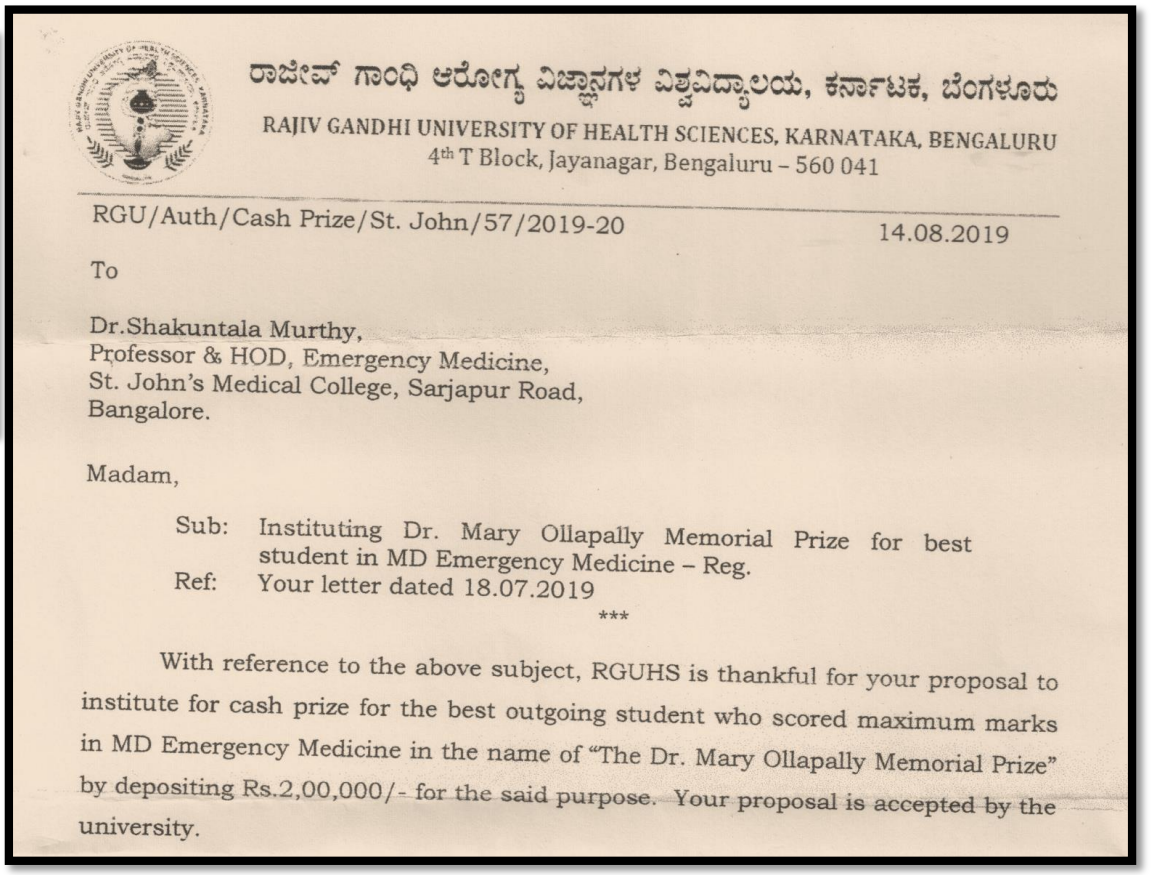
DEPARTMENT OF EMERGENCY MEDICINE

14th August 2019

"The Department of Emergency Medicine has instituted "***The Dr. Mary Ollapally Memorial Cash Prize***", which will be given by Rajiv Gandhi University every year to the best outgoing student of MD Emergency Medicine, who has scored the maximum marks in the Final University exam. This will be given from the next University convocation i.e. 2020.

Dr. Mary Ollapally was instrumental in starting the Department of Emergency Medicine in 1998 and always lent all her support, encouragement and wisdom during the early years of the department. Hence this award in her name is considered a fitting tribute to her memory."

Click on the picture to access Special issue of What’s Up on Dr. Mary Ollapally



ರಾಜೀವ್ ಗಾಂಧಿ ಆರೋಗ್ಯ ವಿಜ್ಞಾನಗಳ ವಿಶ್ವವಿದ್ಯಾಲಯ, ಕರ್ನಾಟಕ, ಬೆಂಗಳೂರು

RAJIV GANDHI UNIVERSITY OF HEALTH SCIENCES, KARNATAKA, BENGALURU
4th T Block, Jayanagar, Bengaluru – 560 041

RGU/Auth/Cash Prize/St. John/57/2019-20 14.08.2019

To

Dr.Shakuntala Murthy,
Professor & HOD, Emergency Medicine,
St. John’s Medical College, Sarjapur Road,
Bangalore.

Madam,

Sub: Instituting Dr. Mary Ollapally Memorial Prize for best student in MD Emergency Medicine – Reg.
Ref: Your letter dated 18.07.2019

***

With reference to the above subject, RGUHS is thankful for your proposal to institute for cash prize for the best outgoing student who scored maximum marks in MD Emergency Medicine in the name of “The Dr. Mary Ollapally Memorial Prize” by depositing Rs.2,00,000/- for the said purpose. Your proposal is accepted by the university.

Acknowledgement: Dr. Shakuntala Murty (Professor and Head, Department of Emergency Medicine)

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Thanksgiving Time

Several departments organized thanksgiving parties for all the nursing and administrative support staff for their invaluable support and hardwork during the NABH and MCI inspections.

4th September: Department of Medicine

10th September: Department of Ophthalmology, celebrated Onam for all the faculty, Postgraduates, nurses, nursing aides and ophthalmology technicians.

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ONAM Celebrations

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FRIDAY CLINICAL MEETING

Suicide Prevention Week (8th to 14th September 2019)

13th September 2019

Department of Psychiatry and Emergency Medicine

The Friday clinical meeting on 13th September was organised by Department of Psychiatry and Emergency Medicine to commemorate Suicide Prevention Week which is observed from 8th September to 14th September 2019. There were four short talks giving the audience a brief overview of suicide and suicidality.

Dr. Shakuntala Murty (Professor and Head, Department of Emergency Medicine) spoke about '***Initial Emergency Department (ED) assessment of patients who attempted suicide***'. Most common mode of suicide is drug/toxin overdose followed by attempted hanging. The emergency department does the standard initial assessment using ABC followed by stabilisation of patient by managing the life threatening issues. The difficulties in eliciting history were highlighted. Most often there will be a denial of suicide and false claim of accident. It warrants more time to understand the kind of consumption or attempt. The ED questions patient and attenders separately, also if required makes phone calls to close ones to understand the exact nature of attempt. Past history of suicidal attempts, psychiatric illnesses, medications, personal social history and occupational history are elicited and recorded. Psychiatric consult is made as a protocol for all the patients.

The second talk was by Dr. Bhuvaneshwari Senthuraman (Senior Resident, Department of Psychiatry), on '***Risk assessment in suicide attempters***'. Suicide is a major public health problem. 2,30,300 suicide deaths were reported in 2016 in India. It amounts to an incidence of 21 for 1lakh men and 15 for every 1 lakh women. Risk assessment tells us 'How much is the risk of suicide now?' It involves identifying risk factors and protective factors. The assessment will be done addressing lethality and intentionality.

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FRIDAY CLINICAL MEETING

Suicide Prevention Week

Identification of vulnerable groups is important. The psychiatrist analyses the reason behind the person's unambiguous wish to die, tries to obtain communication of intent. The myths and facts about the suicidal risk were also discussed. In a study involving 1087 PUC students in a college, it was found that 12% of the students had made an attempt to commit suicide and 25% had a suicidal ideation. Engaging families of individuals who attempt suicide is of utmost importance.

The third talk was by Dr. Srinivasa (Lecturer, Psychiatric social worker) on '***Rationale for involvement of families, for support and prevention of further attempts***'. The first year after an attempt is considered very crucial. It is important to train the family members to recognise the early warning signs. Strict instructions are given, on not to leave the person alone. And need based intervention to address the psychosocial issues were discussed.

The last talk was by Dr. Priya (Department of Psychiatry) on '***Management of attempted suicide and suicidality***'. It must be noted that not all those who want to take their lives have mental illness. However, all of them who attempt suicide need help. St John's data on 630 people who had attempted suicide showed that 60% were women and 25% of them had a past event. Assessment of suicidality is required. A psychiatrist also assesses, the degree of care, in-patient versus out-patient care and the duration of stay. Standard tools like Beck scale for suicidal ideation and Beck hopelessness scale are used.

Acute management - for a treatable psychiatric disorder is done using pharmacological measures like parenteral benzodiazepines, anti-psychotics and non-pharmacological measures like modified electro-convulsive therapy, psycho-education, supportive therapy and engagement of family are used. Long-term planning incudes follow up of patients based on assessment of risk of suicidality, use of antidepressants, monitoring of the treatment and social support.

Assertive management of attempted suicide (AMAS) - a nurse coordinated service is in place in St. John's. Here a trained nurse ensures the necessary psychiatric support provided to the patient.

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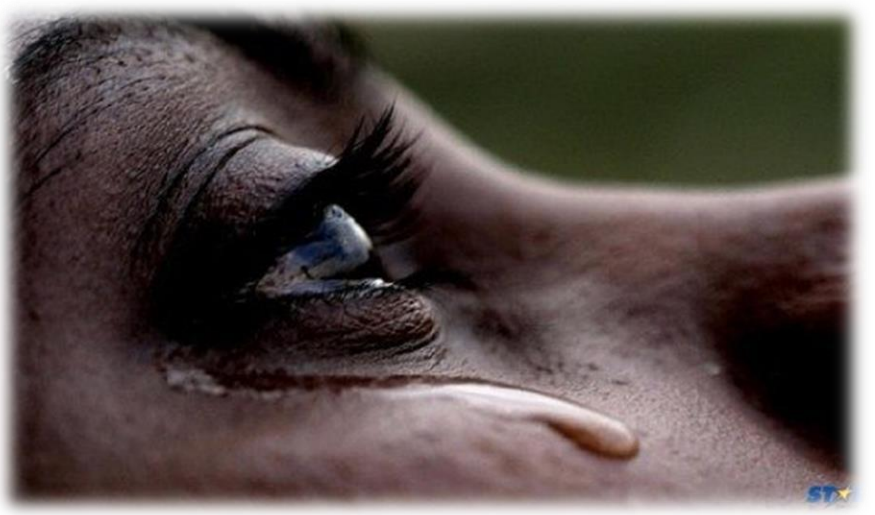
A Mystery It is...!

- Dr Shakuntala Murty
(Professor and Head, Emergency Medicine)



My daughter's sixteen –
She Has Diabetes
But isn't that wrong?
It's not been very long
Since she was a baby
Could it be a mistake? Maybe (1)

Now she's not speaking
They say she's not breathing
Could she be dead?
Has it been left unsaid?
But you are the healer
Tell me you can heal her
I've come here with hope
Will she wake up and speak?
I want her to dance
To romance
Will she go to college?
Or is it going to be a cortege? (2)

Yes I'm the healer
Should I also be a feeler?
She's not breathing
She has no feeling
Do I tell her mother?
Can I bear her tears?
Confirm her worst fears?
We should pull the plug
The girl is not breathing
Her life is ceasing (3)

The mom is asking - will she live?
Whatever you want, I will give
But the truth is known
Her soul has gone
To Heaven or Hell?
No one can tell
Should we play God?
Or leave it to Him? (4)

Are we forgiven?
For sending her to Heaven?
We pull the plug
Hand over to the mom (5)

But she's only sixteen
Just a teen...
How does she have diabetes?
A mystery it is.. (6)

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RESEARCH SNIPPETS

Types of data collection methods and tools

METHODS	INSTRUMENTS/TOOLS
Interview 	Interview schedule (structured, semi-structured, unstructured)
Questioning (self report) 	Questionnaire Opinionnaire Attitude scale Visual analog scale
Observation 	Observation(structured, unstructured, participatory, non-participatory) Checklist Rating scale Anecdotes Videotapes/films
Biophysiological methods/measurements  	In vivo biophysiological measurements In-vitro biophysiological measurements Physical , chemical and microbiological measurements
Psychological measurements 	Projective techniques Q – sorts Vignettes Cognitive and neuropsychological tests
Other methods	Records, documents and available data

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IG NOBEL 😂

1995 – PUBLIC HEALTH

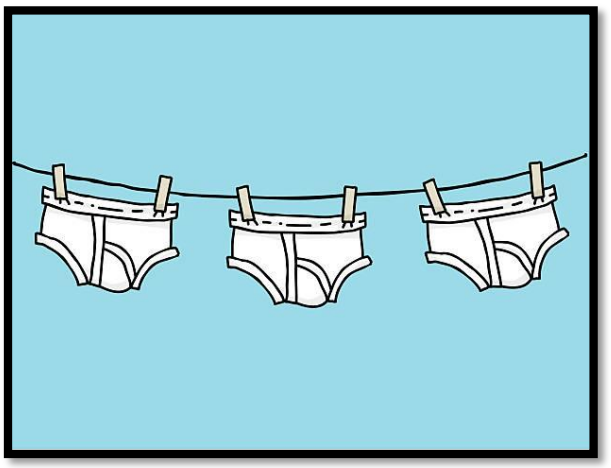
Martha Kold Bakkevig

Wet Underwear and Thermoregulatory Responses

Martha Kold Bakkevig of Sintef Unimed in Trondheim, Norway, and Ruth Nielsen of the Technical University of Denmark, for their exhaustive study, "Impact of Wet Underwear on Thermoregulatory Responses and Thermal Comfort in the Cold."

The purpose of this study was to investigate the significance of wet underwear and to compare any influence of fibre-type material and textile construction of underwear on thermoregulatory responses and thermal comfort of humans during rest in the cold. Long-legged/long-sleeved underwear manufactured from 100% polypropylene in a 1 -by-1 rib knit structure was tested dry and wet as part of a two-layer clothing system. In addition cotton (1-by-l rib knit), wool (1-by-l rib knit), polypropylene (fishnet), and a double-layer material manufactured from 47% wool and 53% polypropylene (interlock knit) was tested wet in the clothing system. In the wet condition 175 g of water was distributed in the underwear prior to the experiment. The test was done on eight men (T_a = 10°C, RH = 85%, V_a < 01 m/s), and comprised a 60min resting period. Skin temperature, rectal temperature, and weight loss were recorded during the test. Total changes in body and clothing weight were measured separately. Furthermore, subjective ratings on thermal comfort and sensation were collected.

The tests demonstrated the significant cooling effect of wet underwear on thermoregulatory responses and thermal comfort. Further, the tests showed that textile construction of underwear in a two-layer clothing ensemble has an effect on the evaporation rate from clothing during rest in the cold resulting in a significant difference in mean skin temperature. The thickness of the underwear has more of an influence on the thermoregulatory responses and thermal comfort, than the types of fibres tested.



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

PFT LAB, BRONCHOSCOPY & SLEEP LAB SERVICES

The Department of Pulmonary Medicine was established under the leadership of Dr George D'Souza and is functional since the year 2000. The range of diagnostic and therapeutic services offered in the department have expanded exponentially in the past 15 years.

Pulmonary function testing (PFT), Cardiopulmonary Exercise Testing (CPET), Bronchoscopy, Medical Thoracoscopy, Thoracic Ultrasonography and Polysomnography(Sleep Study) are the services provided by the pulmonary medicine department in the PFT Lab.

LOCATION:

The PFT lab' located in the 3rd floor Oncology block has the following designated areas:

1. Pulmonary function and exercise testing laboratory
2. Sleep laboratory
3. Bronchoscopy and Thoracoscopy suite

Know Your Hospital!

PFT lab, bronchoscopy & Sleep lab services

PULMONARY FUNCTION TESTING LABORATORY (PFT LAB)

This laboratory is manned and run by trained respiratory technicians. The following tests are performed in the PFT lab:

1. Spirometry, Plethysmography, DLCO (Diffusion capacity of lung for carbon monoxide), and Exhaled Nitric Oxide measurement
2. Cardio-Pulmonary Exercise Testing (CPET), Six- minute walk test

SLEEP LABORATORY

The Sleep laboratory at SJMCH is one of the few fully equipped laboratories in the city. The lab has two fully equipped sleep laboratories for Level 1 polysomnography and four portable monitors for Level 3 polysomnography. About 50 to 60 sleep studies are performed every month and the service is highly overbooked with a waiting period of 2-3 weeks for new tests. The following tests are performed in the Sleep Laboratory:

1. Polysomnography: involves monitoring of multiple physiological parameters during nocturnal sleep for the diagnosis of sleep disorders like Obstructive Sleep Apnea, Restless Legs Syndrome, REM behaviour disorder, Narcolepsy and parasomnias.
2. CPAP (Continuous Positive Airway Pressure) titration studies: performed during overnight sleep to estimate optimum non-invasive ventilation pressures in patients diagnosed with OSA.
3. Multiple Sleep Latency AND Maintenance of Wakefulness Tests (MSLT and MWT): done during daytime to determine the propensity to fall asleep and stay awake respectively.

PORTABLE POINT OF CARE ULTRASONOGRAPHY

Diagnostic and therapeutic thoracic USG are performed regularly in the department by senior residents and faculty with assistance from technicians and nursing staff. Some of the procedures performed include

1. Guided thoracocentesis,
2. Pigtail and intercostal drain insertion
3. Pleural/ lung biopsy

Know Your Hospital!

PFT lab, bronchoscopy & Sleep lab services

BRONCHOSCOPY SUITE

This endoscopy suite is equipped with three bronchoscopes, one endobronchial ultrasound bronchoscope, Cryo-biopsy equipment and Rigid thoracoscope. Some of the procedures performed in the bronchoscopy suite are listed below:

1. Broncho-alveolar lavage
2. Endobronchial and transbronchial lung biopsies (EBB, TBLB)
3. Transbronchial cryobiopsies
4. Transbronchial needle aspiration (TBNA)
5. Foreign body removal
6. Endobronchial ultrasound (EBUS) guided procedures
7. Medical thoracoscopy

Know Your Hospital!

PFT lab, bronchoscopy & Sleep lab services

TRAINING AND RESEARCH AT PFT LAB

In addition to providing diagnostic services, the department also undertakes training of technologists and residents as part of the technician training program and super-specialty training respectively. Annual workshops are also conducted in Point of care ultrasonography, Pulmonary function testing, Sleep technology and No-invasive ventilation in the institute as well as in regional and national conferences.

The faculty of the department of pulmonary medicine are also actively engaged in research in ultrasonography and sleep disorders and the department has over 25 conference presentations and 20 publications in these sub-specialties till date.

THE TEAM: Last row (Left to right): Joy Santosh Kumar, Dr.Priya Ramachandran, Dr.Uma Maheshwari, Dr.Varghese Louis
First row (Left to right): Ms.Rita Peron, Ms.Sangita Topno, Dr.Kavitha V, Dr.Uma Devraj

GREY Matters!

The Dr.Jekylls and Mr. Hydes!
PART 2: DOCTORS AND FILMS!!

1) This American doctor had his own sitcom and is most known for playing a druglord for "the hangover" movies. Name the physician and his show.

2) An English comedian, actor , author and writer .He was one of the members of a famous British comedy group. Name the physician and his comedy group.

3) When she is not being an astronaut, she's appearing in shows like Star trek. Who is this former NASA astronaut?

4) He is the first clown of medicine and believes the best prescription is humor and play . A movie was made in his name.

5) He was most famous for his role as Uncle John Carson in the "petticoat junction“

6) He started out as a comedian and then worked in detective shows and medical dramas. He is also the host of hit show the " American Ninja warriors“

7) He is a physician and one of the famous script writing duo, who also happens to be a Johnite!

8) He was director of the first movie ever to use CGI. Name the physician and the movie

9) This Indian psychiatrist has acted in many stage plays and movies and was conferred the Padmashri in 1990. He played Dumbledore in the Indian spoof of Harry Potter.

10) This Indian doctor-cum-model-cum actor has won the title of Mrs.World in 2001 and has been dubbed ‘Beauty with Brains’

CLICK HERE FOR ANSWERS

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Team of The Month

UTENSIL WASHING TEAM
Dietary Department

As a general rule, everything that has direct contact with food needs to be cleaned and sanitized. Food safety in hospitals should be of utmost importance because, the consuming patients are at a higher risk of developing illness. In order to ensure cleanliness and sanitation of the utensils that are used for cooking and serving food in our hospital we have a dedicated group of men and women who wash utensils in the dietary department.

This task though seems simple but at the dietary department doesn't seem so, with them serving about 1700 people per day. These unsung heroes tackle this herculean task every single day with immense dedication. At any regular day, the washing starts by around 7am and finishes by 10pm, with 10 members working in 3 different shifts. The utensils are first washed with soap and water after which they are thoroughly washed and dried in the dishwasher. The Incharge, Sr. Sophia, inspects and supervises the activities in the washing area very keenly.

We appreciate the service of this team and applaud them for their devotion to the work they do.

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Team of The Month

UTENSIL WASHING TEAM
Dietary Department

THE TEAM (from left-right): Mrs. Muniyamma, Mrs. Roopa, Mrs. Bharathi, Mrs. Satya, Sr. Sophy, Mrs. Gauri, Mrs. Varalakshmi, Mr. Kanikaswamy, Mr. Mahadevswamy

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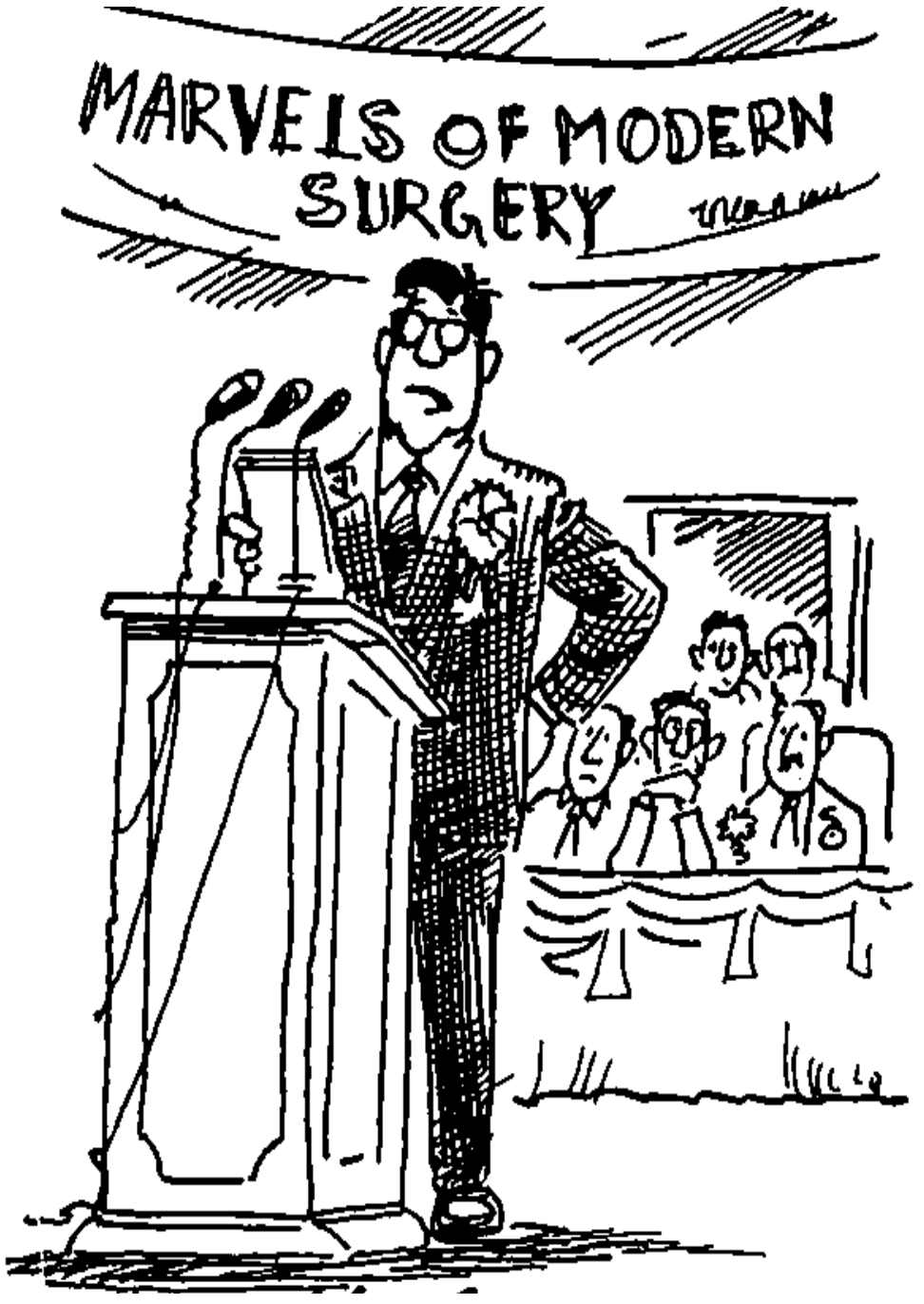
LAUGHTER IS THE BEST MEDICINE...



They can fix anything these days, kidney, heart, bone, eyes….actuallyI myself am 96% transplant!

We are lucky! We are in a civilised desert!

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Best of RK Laxman, Times of India

New Section!!

"ST. JOHN'S FOUNTAINHEAD"

We will publish Abstracts of your published research……

Based on criteria laid down by the Editorial Board……

Email your Full Articles at the earliest to Dr. Santu Ghosh

santu.g@stjohns.in

Articles published in the year 2018
(1st January to 31st December 2018)

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Prevalence of Restless Leg Syndrome in Pregnancy-A Follow-up Study (PEARLS Study)

[1]Divya Devaraj, [2]Uma Devaraj, [3]Mark Bothello, [4]Priya Ramachandran, [5]Uma Maheswari, [6]George A D'Souza

[1,3]Student, [2]Associate Professor, [4]Additional Professor, [5]HOD and Professor, [6]Professor and Dean [1-6]Department of Pulmonary Medicine, St. John's Medical College Hospital, Bengaluru, India Corresponding Author: Uma D

Abstract

Background: Restless leg syndrome (RLS) is a sensorimotor sleep disorder. The prevalence of RLS during pregnancy is 2 to 3 times more than in the general population.

Objectives: To estimate the prevalence of RLS in pregnancy in Indian population and its association with serum ferritin levels.

Materials and methods: Three hundred twenty-five pregnant women were enrolled. Subjects were grouped as RLS positive (49 subjects) and controls (276) based on the personal interview and were followed 6 months later by telephonic interview.

Results: The subjects' mean age was 25.15 ± 3.86 years (range 18 to 38 years). The mean BMI of the subjects was 26.22 ± 5.31 kg/m2 . The prevalence of RLS was 15.1% (49 subjects), 30 of whom were primigravida. Three, 6 and 40 subjects were in their first, second and third trimester of pregnancy respectively. The distribution of age, body mass index (BMI), diabetes, and hypertension were similar in the two groups. The number of hours of sleep was significantly less in the RLS positive group (7.93 vs. 7.5 hours; p-value = 0.017). The levels of hemoglobin, oral iron supplements and serum ferritin and baby's birthweight did not differ significantly between the two groups. Forty-five women reported resolution of RLS symptoms, while two women had persistent RLS symptoms, six months after delivery. Two women were lost to follow-up.

Conclusion: The prevalence of RLS in pregnant Indian women is 15.1%, which was previously undiagnosed. RLS was more prevalent in the third trimester of pregnancy. Neither multiparity or low serum hemoglobin or ferritin were associated with RLS in pregnancy.

Indian Sleep Med 2018;13(4):57-61.

Restless legs syndrome in patients with chronic renal failure on hemodialysis: Does peripheral iron status matter?

Priya Ramachandran, Uma Devaraj, Stallon Sebastian, Uma Maheswari Krishnaswamy, George A D' Souza

Department of Pulmonary Medicine, St. John's Medical College Hospital, Bengaluru, Karnataka, India

Abstract

BACKGROUND: Scant information is available on the prevalence of restless legs syndrome (RLS) among patients with chronic kidney disease (CKD) on hemodialysis and its correlation with peripheral iron status. This study was carried out to estimate the prevalence of RLS among patients with chronic renal failure on hemodialysis and to correlate the presence of RLS with peripheral iron status. **METHODS:** Adults diagnosed with CKD were studied. Demographic details, comorbid illness, and the number of years diagnosed with CKD and on dialysis were noted. RLS was diagnosed based on the International RLS Study Group criteria. Severity of RLS was assessed by international restless legs scale (IRLS) severity score. The presence of RLS was correlated with peripheral iron status. **RESULTS:** The mean age of 116 subjects was 50.7±13.6 years. Of the total subjects, 79 (68.1%) were men. The mean body mass index of the subjects was 22.02±3.5kg/m^2. The subjects had CKD for a mean duration of 3.5±3.2 years and were dialyzed for 2.5±2.3 years. The prevalence of RLS was found to be 10.3% (12/116). Five subjects each had mild and moderate RLS by IRLS severity score and two had severe RLS. All 12 patients with RLS were hypertensive. Hemoglobin and serum ferritin levels were higher in patients with RLS as compared to those who were RLS negative with CKD.

CONCLUSION: RLS was previously undiagnosed in this population. Considering RLS, peripheral iron measures are of questionable validity in patients on hemodialysis. Measures to early diagnosis and prompt treatment should be taken, as RLS is known to cause impairment of daytime functioning, disturbed sleep, and increased mortality.

Ann Mov Disord 2018;1:39-43

THE QUOTABLE OSLER

Stay Calm:

Educate your nerve centres so that not the slightest dilator or contractor influence shall pass to the vessels of your face under any professional trial.

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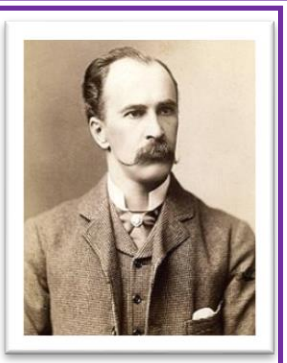

SIR WILLIAM OSLER

© https://www.bitfeed.co

We are influenced by those we admire:

Not by the lips, but by the life, are men influenced in their beliefs.

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

MEDICINE DIS WEEK

A Bird's Eye View.....

Oral therapy for severe hypertension during pregnancy.

Treatment of severely increased blood pressure is widely recommended to reduce the risk for maternal complications. Typically IV medications are used.Although effective, these drugs require venous access and careful fetal monitoring and might not be feasible in busy or low-resource environments. In a multicentric, parallel group, open label, RCT from India, 894 patients were assigned to oral nifedipine, oral labetalol and oral methyldopa groups. The primary outcome was blood pressure control. Primary outcome was most common with Oral nifedipine (extended release). All oral antihypertensives reduced blood pressure to the reference range in most women. As single drugs, nifedipine retard use resulted in a greater frequency of primary outcome.

- Easterling T et al. Lancet. 2019 Aug 1. pii: S0140-6736(19)31282-6.

Low ligation of inferior mesenteric artery (IMA) in Rectal Cancer (HIGHLOW Trial)

In low anterior resection high versus low ligation of IMA is controvertial. In a RCT of over 200 patients undergoing laparoscopic low anterior resection, which compared the ligation of IMA at its origin with ligation below the left colic artery. Low ligation resulted in fewer obstructive urinary symptoms and better preservation of urinary continence, sexual function, and quality of life at nine months postoperatively. Complication rates (eg, anastomotic leak) and short-term oncologic outcomes were similar for both approaches.

-Mari GM et al., Ann Surg. 2019;269(6):1018.

Oral antihypertensive regimens (nifedipine retard, labetalol, and methyldopa) for management of severe hypertension in pregnancy: an open-label, randomised controlled trial

Thomas Easterling, Shuchita Mundle, Hillary Bracken, Seema Parvekar, Sulabha Mool, Laura A Magee, Peter von Dadelszen, Tara Shochet, Beverly Winikoff

Summary

Background Hypertension is the most common medical disorder in pregnancy, complicating one in ten pregnancies. Treatment of severely increased blood pressure is widely recommended to reduce the risk for maternal complications. Regimens for the acute treatment of severe hypertension typically include intravenous medications. Although effective, these drugs require venous access and careful fetal monitoring and might not be feasible in busy or low-resource environments. We therefore aimed to compare the efficacy and safety of three oral drugs, labetalol, nifedipine retard, and methyldopa for the management of severe hypertension in pregnancy.

Methods In this multicentre, parallel-group, open-label, randomised controlled trial, we compared these oral antihypertensives in two public hospitals in Nagpur, India. Pregnant women were eligible for the trial if they were aged at least 18 years; they were pregnant with fetuses that had reached a gestational age of at least 28 weeks; they required pharmacological blood pressure control for severe hypertension (systolic blood pressure ≥160 mm Hg or diastolic blood pressure ≥110 mm Hg); and were able to swallow oral medications. Women were randomly assigned to receive 10 mg oral nifedipine, 200 mg oral labetalol (hourly, in both of which the dose could be escalated if hypertension was maintained), or 1000 mg methyldopa (a single dose, without dose escalation). Masking of participants, study investigators, and care providers to group allocation was not possible because of different escalation protocols in the study groups. The primary outcome was blood pressure control (defined as 120–150 mm Hg systolic blood pressure and 70–100 mm Hg diastolic blood pressure) within 6 h with no adverse outcomes. This study is registered with ClinicalTrials.gov, number NCT01912677, and the Clinical Trial Registry, India, number ctri/2013/08/003866.

Findings Between April 1, 2015, and Aug 21, 2017, we screened 2307 women for their inclusion in the study. We excluded 1413 (61%) women who were ineligible, declined to participate, had impending eclampsia, were in active labour, or had a combination of these factors. 11 (4%) women in the nifedipine group, ten (3%) women in the labetalol group, and 11 (4%) women in the methyldopa group were ineligible for treatment (because they had only one qualifying blood pressure measurement) or had treatment stopped (because of delivery or transfer elsewhere). 894 (39%) women were randomly assigned to a treatment group and were included in the intention-to-treat analysis: 298 (33%) women were assigned to receive nifedipine, 295 (33%) women were assigned to receive labetalol, and 301 (33%) women were assigned to receive methyldopa. The primary outcome was significantly more common in women in the nifedipine group than in those in the methyldopa group (249 [84%] women *vs* 230 [76%] women; p=0·03). However, the primary outcome did not differ between the nifedipine and labetalol groups (249 [84%] women *vs* 228 [77%] women; p=0·05) or the labetalol and methyldopa groups (p=0·80). Seven serious adverse events (1% of births) were reported during the study: one (<1%) woman in the labetalol group had an intrapartum seizure and six (1%) neonates (one [<1%] neonate in the nifedipine group, two [1%] neonates in the labetalol group, and three [1%] neonates in the methyldopa group) were stillborn. No birth had more than one adverse event.

Interpretation All oral antihypertensives reduced blood pressure to the reference range in most women. As single drugs, nifedipine retard use resulted in a greater frequency of primary outcome attainment than labetalol or methyldopa use. All three oral drugs—methyldopa, nifedipine, and labetalol—are viable initial options for treating severe hypertension in low-resource settings.

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Introduction

Hypertension is the most common medical disorder in pregnancy, and this condition complicates one in ten pregnancies.[1] Hypertensive disorders of pregnancy include chronic hypertension (ie, hypertension diagnosed before 20 weeks of gestation), pre-eclampsia and eclampsia, chronic hypertension with superimpos
eclampsia (a diagnosis of chronic hypertension

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REFERENCE 2: MEDICINE DIS WEEK

Low Ligation of Inferior Mesenteric Artery in Laparoscopic Anterior Resection for Rectal Cancer Reduces Genitourinary Dysfunction

Results From a Randomized Controlled Trial (HIGHLOW Trial)

Giulio M. Mari, MD, Jacopo Crippa, MD,† Eugenio Cocozza, MD,‡ Mattia Berselli, MD,‡ Lorenzo Livraghi, MD,‡ Pierluigi Carzaniga, MD,§ Francesco Valenti, MD,¶ Francesco Roscio, MD, PhD,|| Giovanni Ferrari, MD,** Michele Mazzola, MD,** Carmelo Magistro, MD,** Matteo Origi, MD,** Antonello Forgione, MD,** Walter Zuliani, MD,†† Ildo Scandroglio, MD,‡‡ Raffaele Pugliese, MD,§§ Andrea T. M. Costanzi, MD,* and Dario Maggioni, MD**

Objectives: The aim of the present study was to compare the incidence of genitourinary (GU) dysfunction after elective laparoscopic low anterior rectal resection and total mesorectal excision (LAR + TME) with high or low ligation (LL) of the inferior mesenteric artery (IMA). Secondary aims included the incidence of anastomotic leakage and oncological outcomes.

Background: The criterion standard surgical approach for rectal cancer is LAR + TME. The level of artery ligation remains an issue related to functional outcome, anastomotic leak rate, and oncological adequacy. Retrospective studies failed to provide strong evidence in favor of one particular vascular approach and the specific impact on GU function is poorly understood.

Methods: Between June 2014 and December 2016, patients who underwent elective laparoscopic LAR + TME in 6 Italian nonacademic hospitals were randomized to high ligation (HL) or LL of IMA after meeting the inclusion criteria. GU function was evaluated using a standardized survey and uroflowmetric examination. The trial was registered under the ClinicalTrials.gov Identifier NCT02153801.

Results: A total of 214 patients were randomized to HL (n = 111) or LL (n = 103). GU function was impaired in both groups after surgery. LL group reported better continence and less obstructive urinary symptoms and improved quality of life at 9 months postoperative. Sexual function was better in the LL group compared to HL group at 9 months. Urinated volume, maximum urinary flow, and flow time were significantly ($P < 0.05$) in favor of the LL group at 1 and 9 months from surgery. The ultrasound measured post void residual volume and average urinary flow were significantly ($P < 0.05$) better in the LL group at 9 months postoperatively. Time of flow worsened in both groups at 9 months compared to baseline. There was no difference in anastomotic leak rate (8.1% HL vs 6.7% LL). There were no differences in terms of blood loss, surgical times, postoperative complications, and initial oncological outcomes between groups.

Conclusions: LL of the IMA in LAR + TME results in better GU function preservation without affecting initial oncological outcomes. HL does not seem to increase the anastomotic leak rate.

Keywords: genitourinary function, inferior mesenteric artery, laparoscopic surgery, low ligation, rectal cancer

(*Ann Surg* 2018;xx:xxx–xxx)

The proper surgical treatment of rectal cancer includes total mesorectal excision (TME)[1] and the potential use of neoadjuvant chemoradiation therapy protocols.[2,3] Although laparoscopic resection of colon cancer has become the standard worldwide, the role of laparoscopy in the treatment of rectal cancer is controversial, as reported by 2 recent multicenter, randomized trials.[4,5] Rectal cancer specifically raises issues related to its anatomical location: difficult exposure in a narrow pelvis, low intestinal transection, TME, and challenging nerve-sparing techniques.[6,7] Moreover, due to these unique challenges, the specific impact of arterial ligation and its effect on genitourinary (GU) function is poorly understood.[8–10]

The practice of ligation of the inferior mesenteric artery (IMA) at the origin and mobilization of the splenic flexure is assumed to be common; however, this technique is not routinely performed worldwide.[11] In addition, there remain disputes regarding the level of resection of the IMA: the origin from the aorta (high tie) or below the origin of the left colic artery (low tie).[12] These different techniques are known to affect GU function by potentially injuring the superior hypogastric plexus. These technical aspects may additionally affect the extent of lymphadenectomy and distal colonic arterial perfusion.[13,14] It has been suggested that the incidence of anastomotic leak in rectal surgery depends on the level of ligation.[15,16] To date, data in the literature have not provided consistent findings with level 1 evidence regarding the preservation of GU function based on IMA ligation at the origin versus left colic artery preservation in laparoscopic low anterior resection with TME (LAR+ TME) for extraperitoneal rectal cancer.[12,14–17] Therefore, well-designed randomized controlled studies (RCTs) comparing different vascular approaches in rectal surgery are needed.[18] The aim of this RCT is to compare the incidence of GU dysfunction based on urodynamic examination and uroflowmetric examination in patients undergoing elective

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THE STORY OF MEDICINE

SLEEPING SICKNESS

Aldo Castellani

Sir David Bruce

As European empires penetrated Africa in the late 19th century, one of the most puzzling diseases they came across was called 'Negro lethargy'. Victims would become so drowsy that they would starve for want of energy to eat, and could die of any opportunistic infection. Epidemics were known to wipe out whole communities, and it seemed that the opening up of territories by the Europeans was spreading it.

The British government sent out a commission to study the disease. One member was the Italian doctor, Aldo Castellani, who in November 1902, while carrying out post-mortems, discovered the presence of unknown protozoa in the spinal fluid of victims of Negro lethargy or sleeping sickness.

The following year, the commission was joined by Colonel David Bruce, who had been working on nagana, a related disease in livestock. He had established that nagana was spread by the tsetse fly (Glossina palpalis) from wild animals to domesticated cattle and horses, and was caused by a protozoan called a trypanosome. He and Castellani now found trypanosomes in the spinal fluid of 70 per cent of sleeping sickness victims. Bruce went on to discover that the tsetsefly was also involved in the spread of what came to be known as human trypanosomiasis.

Tsetse fly

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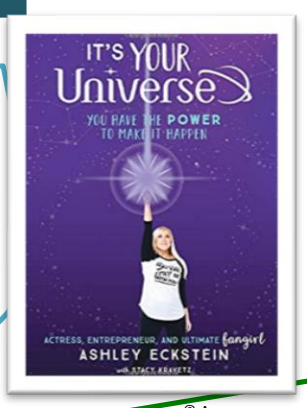
PEARLS OF WISDOM

The universe is what you illustrate it to be.

- *Rory*



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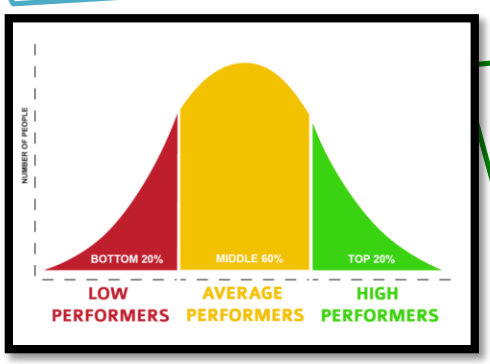

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The difference between ordinary and extraordinary is that little extra.

-*Jimmy Johnson*

The goal of life is to make your heartbeat match the beat of the universe, to match your nature with Nature.

- *Joseph Campbell*

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REF: 365 Days of Wonder: R.J.Palacio.

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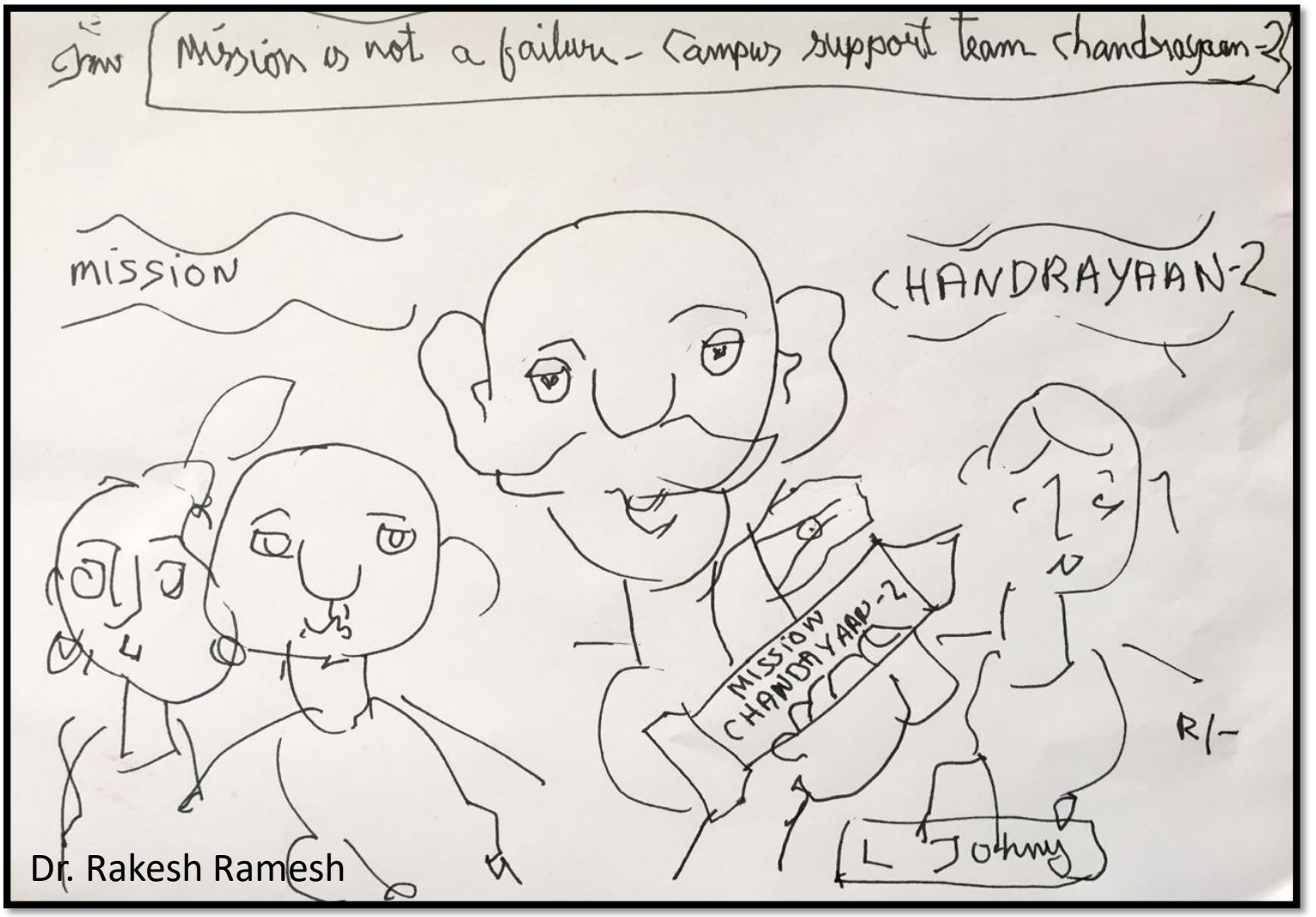
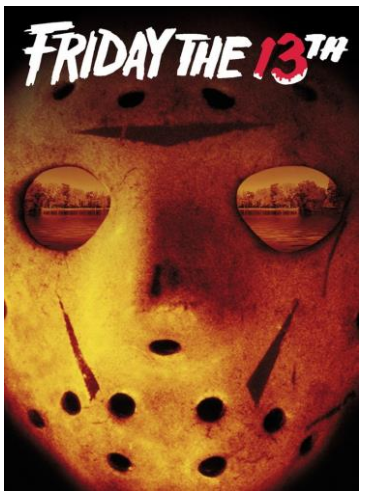


Did You Know?

paraskevidekatriaphobics or **friggatriskaidekaphobics** — or those with an irrational fear of Friday the 13th. The fall of the Aztec empire, Delhi's Uphaar Cinema fire tragedy and the 2017 Paris attacks — all happened on a Friday the 13th. On average, a Friday the 13th occurs every 212.35 days. There's one more Friday the 13th scheduled this year — in December.

REF: Times of India



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DO YOU HAVE ANY INTERESTING CONTENT TO BE PUBLISHED?

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

GREY Matters!

QUIZ ANSWERS

1. Ken Jeong , Dr.Ken
2. Graham Chapman , Monty Python
3. Mae Jemison
4. Patch Adams
5. Edgar Buchanan
6. Michael Isleman
7. Bobby Cherian Of Bobby And Sanjay In Malayalam Film Industry
8. Michel Crichton, Westworld
9. Dr.Mohan Agashe
10. Dr.Aditi Govitrikar

CLICK HERE TO GO BACK TO THE QUESTION!

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ANNOUNCEMENTS

John's National Academy of Health Sciences, Bangalore

St John's College of Nursing

FUND RAISER

for a Cause

Let's beat cancer

Entertainment By

26th October 2019, 6.00-8.00pm

Venue: Main Auditorium St John's National Academy of Health Sciences, Bangalore

For donations: Account details

CBCI Society for Medical Education, Bank of Baroda, St John's Medical College Campus, John Nagar Branch, Bangalore-560034 **Account No - 05210100000484**
IFSC/NEFT/RTGS **BARB0STJOHN** (fifth letter from left is zero)
Mandatory to mention: Fund raiser/Name/PAN no/Address/send a mail with transfer details to marywalton_sw11@rediffmail.com once amount is transferred

For queries/tickets contact Mrs. Mary Walton (9741021014)

ANNOUNCEMENTS

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ANNOUNCEMENTS

PROJECT GIFT-A-LIFE

IN AID OF TREATMENT OF CHILDREN
DIAGNOSED WITH LEUKAEMIA

Leukaemia is the 9th most common cause of death in the childhood age group and with a 5 year survival rate of 40%, its impact in an Indian setting is tremendous.

To combat these shocking statistics, Project GIFT-A-LIFE aims to broaden the scope of treatment of this disease and reduce associated morbidity and mortality rates.

CONTACT US AT
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autumnmuseofficial@gmail.com
www.autumnmuse.com

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ANNOUNCEMENTS

HOW TO DONATE

PROJECT GIFT-A-LIFE

1. CASH: Please drop at Dept. of Paediatric Haematology Oncology, St. John's Medical College Hospital
2. CHEQUE: In f/o CBCI SOCIETY FOR MEDICAL EDUCATION. Mention Project Gift-a-Life at the back and mention your contact details
3. BANK TRANSFER:
Savings Account Number: 05210100000484
IFSC CODE: BARB0STJOHN (Fifth letter from left side is Zero)
Once donated please contact us with the UTR number through Email or SMS

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ANNOUNCEMENTS

27th

KEY:
- LH-3 - Lecture Hall 3
- BCR - Boys' Common Room
- MA - Main Auditorium
- NA - Nursing Auditorium

TIME	EVENT	VENUE
10 AM	Painting	LH-3
10 AM	Indian Music	Ground
10 AM	Slam Poetry	LH-1
11 AM	Street Play	Amphitheatre
11 AM	Sketching	LH-4
12 PM	JAM	LH-3
2 PM	Western dance	MA
2:30 PM	Personality	LH-1
4 PM	Mime	NA
4 PM	Debate	LH-3
5 PM	Muse Hues	Ground

28th

KEY:
- LH-3 - Lecture Hall 3
- BCR - Boys' Common Room
- MA - Main Auditorium
- NA - Nursing Auditorium

TIME	EVENT	VENUE
9 AM	Western Acoustic	Ground
10 AM	Pot pourri	LH-1
10 PM	Poetry	LH-3
10 AM	Face painting	BCR
11 AM	Indian Non-theme Dance	MA
11 AM	Creative writing	LH-4
12 PM	General Quiz	LH-1
2 PM	Indian Theme Dance	MA
2 PM	LOL	NA
2 PM	Spelling Bee	LH-1
5 PM	Muse Tranz (PRO SHOW)	Ground

29th

KEY:
- LH-3 - Lecture Hall 3
- BCR - Boys' Common Room
- MA - Main Auditorium
- NA - Nursing Auditorium

TIME	EVENT	VENUE
8.30 AM	Muse Jam	Ground
10 AM	Treasure Hunt	Regn Desk
12 PM	Play	MA
2 PM	Mad Ads	NA
3 PM	Solo Dance	MA
4 PM	Sangeeth	NA
5:30 PM	Muse Rock (PRO SHOW)	Ground

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