News Letter

Sister Doctors Forum of India

THE WOMAN ALPHA AND OMEGA

18th AGBM

28th February, 1st & 2nd March, 2014

Pastoral Centre, Jalandhar, Punjab

No. 19, June 2014


Mary the Mother of God and
the Mother of Humankind.

Contents

From Editor's Desk……

Rediscovering the Feminine has become an emerging theme in the world consciousness. Never before have women issues taken as much center stage as in the recent past thanks to women like Malala Yousafzai of Pakistan and Nirbhaya of India who have succeeded in moving the collective consciousness. In this context the theme of XX-AGBM of SDFI "Woman: ALPHA and OMEGA" could not have been more apt. Life is God's greatest gift in the universe and woman conceives this precious life in her flesh,nurtures it in her before she is ready to sustain it outside her.For us sister doctors this physical life-giving throws light on the spiritual fruitfulness in the consecrated virginity.When lived in its radical limits generates so much life, and helps create a new humanity as witnessed around us day in and day out.

This year we had an overwhelming response to our request for articles and experiences from sister doctors around the country. This year our focus has also been on the AGBM held at Jalandhar from Feb 28 to Mar 2, 2014, which was a great success, thanks to many a helping hand.My heartfelt thanks to Dr. Nayanthara J. and Dr. Praneet Raj Pathivada, the resident doctors at St. Mary's Hospital, Malur for their selfless and enthusiastic work in proof reading and editing the articles.

The index theme flows through the pages of this book so skillfully and evidently, for which the editorial team is grateful to the authors of each and every article. In the president's message Sr. Dr. Lucian has dissected the theme plainly and beautifully. So also the Vice President Sr. Dr. Emily's message, where a woman is highlighted as a life-giving mother. A very inspiring and practical article 'Midlife and Beyond' by Sr. Dr. Liza enlightens the reader on how midlife is an invitation of self towards greater wholeness and holiness. As the thrill and the excitement of our trip to Punjab is still vivid in our memories the write up 'A glimpse into Punjab' ignites the flame of patriotism when the pictures of Jallianwalabagh and Wagah border appear on the pages.

We hope you enjoy the journey through this book and are not only proud of our sister doctors who are extraordinary in their being women with a difference but also in carrying out the healing ministry to the lesser privileged, so that many more may benefit from our endeavors, all in the name of our Lord Jesus Christ,

Sr. Dr. Hilda R. Lobo,
St. Mary's Community Health Centre,
H.D.Kote., Mysore.

Foreword...!

It gives me immense pleasure to have been a part of the editorial team this year for the annual newsletter of the SDFI. Being associated with sisters ever since I was a child, and now, working in a rural centre with religious sisters, I have always seen them work very hard as they strive to serve humanity in all the ways they can. The sister doctors of the country have truly been giving their heart, mind and soul to their mission of healing and upliftment of the millions in need in our country.

The sister doctors have especially been working with great zeal in the area of women and child health, treating and supporting millions of women and girls around India. Truly their work is commendable.

This year we had an overwhelming response to our request for articles and experiences from the sister doctors from around the country. It has been a wonderful experience reading and working on the various stories and reports we received. We have also concentrated this year on the AGBM held at Jalandhar which was a huge success, thanks to many a helping hand.

We hope that you enjoy your journey through this book and are not only proud of our sister doctors who are doing extraordinary work in the farthest, deepest and most distressed parts of India, but are also inspired to carry on in the mission of the healing ministry, so that many more may benefit from our endeavours, all in the name of our Lord Jesus Christ!

Dr. Nayanthara. J
Junior Doctor,
St. Mary's Hospital,
Malur.

The editorial team
Sr. Dr. Hilda R. Lobo UFC
Sr. Dr. Lucian SCC
Dr. Nayanthara. J
Dr. Praneet Raj Pathivada
A. Roger Cyril

PRESIDENT'S MESSAGE

My Very Dear Sister Doctors,

I am the "Alpha and the Omega", the Beginning and the End. To the thirsty I will give water without cost from the spring of the water of life." Revelation 21:6 as well as our theme for the XX - AGBM "Woman, Alpha and Omega" still resounds in my ears. More especially, during this Lenten season as we meditate on the 'Woman standing at the foot of the Cross and hear the words of the Son of God declaring that this woman is the Mother to all Mankind. As she participates in the Pascal Mystery and the redemptive work of Jesus we are affirmed that Mary our Mother is the "Alpha & the Omega". Are we not who are called and consecrated to participate in this great mystery also "the Alpha & the Omega" for those who are suffering in one form or another.

"WOMAN: ALPHA & OMEGA" Does it require great depths of philosophy, psychology or medicine or in modern terms rocket science, to come to the simple conclusion - that at the beginning of life itself there was woman?

Today women in the world over are leaders, guides, models, path breakers and history makers. Every walk of life has a leading lady, be it science, art, finance, marketing, technology or even rocket science. Indeed she influences thought and action, not only at home, at work, at community, nay every sphere of our very existence on the face of the earth. She has surpassed all boundaries to cross all limits to make known that nothing is impossible for her.

On the other hand today many a woman in India is tortured with Gender discriminations. The rights of women are trampled upon, opportunities for growth, development and empowerment are denied. They are waiting for redemption. Every Sister Doctor is called to be "The ALPHA & OMEGA" - the agents of empowerment for them.

Before I conclude I would like to place gratefully on record the services rendered by Rt. Rev. Franco Mulackal, Bishop of Jalandhar, All the Priests of Pastoral Centre, The Faculty of St. John's Medical College, IMA Jalandhar Unit, Goverment Officials and Sr. Dr. Lyla, Sr. Dr. Rose Mary, the community of Sacred Heart Hospital, Jalandhar and every participant. Your presence and service dear friends have made this AGBM and CME enjoyable and educative.

May God Bless You!

Bye dear Sisters, till we meet again for the XXI AGBM!

Sr. Dr. Lucian SCC,
President, Sister Doctors Forum of India.

Message from Vice President SDFI

The woman Alpha and Omega.

'The woman Alpha and Omega ' is the laudable theme of our XXth AGBM. Life begins in the womb of a woman at conception. It is the beginning place. So the woman is the Alpha of life, of all humans on this earth. Not only does she welcome life, but continues to nourish the same within her, with her own blood she loves the child from the first moment of its life, until the last moment of her life.

For children mothers are the only Quran they read in their life time ; the only Vedas they see ; the only Bible they experience ; the only Dharma they follow. It is an awesome responsibility of a mother.

That is why, it is said by ***His Holiness Pope Francis, ' Because the word came in flesh, God became flesh for us, and this will give you a human sanctity great, beautiful, mature, the holiness of a mother, mother to give life'.***

The woman accompanies the child at every stage of its life. She is the life giver, the guiding star, the protector and she stands by her son / daughter in all joys and sorrows of their walk of life.

Dear Sister Doctors, we as women Alpha and Omega are in close contact with the precious life from womb to tomb. We are privileged to play such an integral part of Human Life.

Our Life is, like a game of Chess
And you play this game with HIM
After every move of yours
HE makes the next move
Your moves are called ' CHOICES '
His moves are called ' CONSEQUENCES '
You will be tested.....
You will be challenged.....
You will be pushed to the brink
However, when you are found to play your game well,
HE wins by allowing you to win the game

So let us play the game of
' WOMAN ALPHA AND OMEGA ' FOR THE YEAR 2014 2015 !

- *Emily Susai. FMM*
Vice President SDFI .

My Dear Friends,

Greetings of peace from Jalandhar!

I am happy to write few lines for SDFI. I am pleased to know that you are doing wonderful things. But still more can be done. Yes we are called to witness Jesus Christ our Master where ever we are working. Pope Francis in his exhortation calls each one to be active in evangelization. We all have capabilities to spread the Gospel. We must be genuine, must be passionate and need to witness our faith. It's not about using theological terms or doctrine. It's about talking to people's hearts, to share the joy of the Gospel. Evangelization is not meant to be hitting someone over the head with the Gospel. It is not meant to be in your face. "It is sharing the love and hope of the Gospel that we have in our hearts. If we bring joy to the one of the needy patent , if we can bring solace to the one of the afflicted, if we can give peace of Christ to any one who comes to us we have received our target. This is the Mission of Christ and he wants to carry out the mission through us.

May God bless you all.

+ Franco Mulakkal
Bishop of Jalandhar

THE REPORT OF XX AGBM OF SDFI AT PASTORAL CENTRE, JALANDHAR, PUNJAB

28TH FEB, 1ST& 2ND March, 2014

THE XX AGBM of SDFI was held at pastoral center, Jalandhar, Punjab on Feb 28th, 1st & 2nd March, 2014. There was total 140 Sr.Drs registered. They were accommodated at Pastoral center, religious flats and Holy family convent, Sacred Heart Hospital at Jalandhar.

The inaugural holy mass was celebrated by Rt.Rev BP. Franco Mulakal. He exhorted the gathering with the following words. God has given us the power to be his hands and feet on behalf of Christ and the church. Time is short, life is short but if there is will much can be accomplished. He reminded us that in the church we are not ordinary doctors, but catholic Doctors. Not only catholic Drs But religious Sister Doctors through whom Jesus is continuing the mission, handed over to the church. The mission of spreading the good news. "Do this in memory of me". As St. John said this is the Lamb of God. He invited all the sister Doctors to become the good news for the people who are dying in the world. The good news is that Jesus; son of God became son of man, died on the cross, and was raised up to save us from sin.

Sr. Dr.Liza. FSLG national secretary of SDFI greeted the participants and welcomed everyone to the land of five rivers. The land which is adorned and dressed with its stately trees, its lovely flowers heavy with sweet odours, its grassy swards, with the far reaches of its five placid rivers Jhalem,Beas, satlaj,Chenab and Ravi which adds the silver border for green dupetta of wheat and paddy. Punjab is known for its holy place Golden Temple, grains and milk & milk products. Punjab is sweet with sugar cane. Punjab is rich but very poor number of females. So it is apt that we are here to celebrate Woman Alpha and Omega.

Sr.Dr. Lucian was invited to introduce SDFI to the gathering. She explained the vision and mission of SDFI. After which the programmed was started with inspiring prayer dance by the nursing students of Sacred heart Hospital, Janandhar. They sang and swayed to put everyone in the presence of God and get a touch from the Lord.

Sr. Dr. Lucian, President of SDFI, welcomed the chief guest and the dignitaries with a heart full of happiness and joy and hand full of lovely roses. She welcomed each one present there with a warm heart.

Sr. Dr.Liza FSLG the MC of the programme invited the chief guest and the dignitaries to light the lamp reminding everyone that light eliminates darkness. And Jesus is the light of the world as he said' I am the light of the world'.

Then Dr. Dhillon, DIG in BSF gave the inaugural address. She explained Punjab's rich heritage of spiritual gurus and phirs. She expressed her happiness of being with Sr.Drs. She also invited us to know oneself to be an effective woman in the world. She reminded every Sr.Dr. to the role models for the rest of the doctors in the world. To be available, to be affordable and be accessible. Then she officially inaugurated the XX AGBM.

Then Dr.Navjot Sindhu Chief Parliament secretary for health gave the keynote address. She started with a note of joy for being with Sister Doctors. who have the PG degree in service and love. She reminded us about life being all about service sacrifice and love of God. God has given us the body to allow the energy of God to flow through us. Hence there is no place for 'I' in our life. The moment we say 'I' this energy get blocked. Ignorance doesn't exist in God's dictionary. Hence the need to update ourselves. She said that Sister Doctors make a difference in this planet. That is the vocation we are given. To do the extra karma of service. We should not only heal the body but also the soul and mind.

Dr.Kapil Gupta, member of Punjab medical council gave his message. He gave 2 more Alumini Associations to SDFI and reminded us that if we stop learning today we are uneducated for tomorrow. He invited each one of us to live the word compassion.

Rt.Rev.Bp.Franco gave his presidential address. He said. If all of us become concerned about each other the world would be a better place to live in. Today hospitals are increasing. Not only because of sickness but also because of the greed……..corruption of human mind. It is not enough to give medicines. It is important to touch the soul and mind of the person. God the father is watching us playing.

Dr. SushamaChawla IMA president Jalandhar and Rev.Fr.Tomi Thomas, Director General CHAI gave their felicitation. Sr.Dr.Emily Susai, vice president proposed vote of thanks.

Post Lunch session :

Post lunch session was spiritual animation by Sr.Dr.Melba who spoke about the importance of evangelization in our healing mission. She spoke to us with full enthusiasm how we should give the good news to our patients. She told us how she was inspired by BP. Franco's spiritual input on the day of Northern regional meeting and how she is practicing it in her life. She taught us that" Jesus son of God shed His blood on the cross arose from the dead to save us from sin. Thus the biblical saying was fulfilled that is "ask your elders, they will tell you."

We juniors have to learn a lot from our seniors. Sr.Dr.Gabriel ASMI who was a life member of SDFI from Rampur Northern region went for the eternal reward on 29th Nov 2013. Sr.Dr.Tessy. ASMI briefed us about Sr.Dr.Gabriel and all of us remained in silent prayer for her soul. May her soul rest in peace.

Then the group was in their regional meetings for 30min after which every one gathered to continue the session.

The secretary Sr.Dr.Liza .FSLG presented the report for the year. It was proposed by Sr.Dr.Hermina and seconded by Sr.Dr. Marie stella. Then Sr.Dr.Hilda presented the treasurer's report. It was proposed by Sr.Dr.Beena UMI and seconded by Sr.Dr.Ida.BS. The whole group was asked to have their regional meeting and to return after 45min.

Then the regional meetings reports' were read. After which there was a small discussion on the pilgrimage to be organized by SDFI. The President entrusted a team of Sister Doctors to study the possibilities of this program me. Sr.Dr.Hermina, Sr.Dr.Vida, Sr.Dr.Little Flower, Sr.Dr.Alphonse and Sr.Dr. Liza were suggested to this team. Our president congratulated and thanked Sr.Dr.Laila.SH and the LOC for organizing this AGBM very well. It was indeed the fruits of the hard work of Sr.Dr.Laila's community which we could see there from the time of our arrival till we left.

The evening of the first day was very colorful with the cultural programmes by the nursing students of Sacred Heart Hospital, Maqsudan. All of us enjoyed the Punjabi evening.

The day was ended by a CME by a vibrant and young gynecologist from SJNAHS Dr. Annamma. She was introduced by Sr.Dr. Annie JMJ and thanked by Sr.Dr.Deena.HC. It was a thought provoking session. Though tired of the hectic activities of the day the lively and interesting discussion and presentation kept every one very active and in a learning spirit.

The second day 1st march was started with invocation of God's blessing by the Holy Eucharist by the VG of Jalandar Rev Fr. Joseph.

He reminded us ' You as catholic religious and sister doctors ardently desire to totally embrace the compassionate love of Jesus and share it freely with all who are in need . With your natural inclination to selfless service and sacrificial love you could by all means participate in the personality of Jesus Christ who came to give life and life in abundance.' It was followed by a group Photo graph

Then the rest of the day was spent in touching experience of Golden temple along with thousands gathered there and sharing their spiritual richness and nourishing with their tasty lanker .

The Jalianwala Bagh and the heart throbbing experience of waga border filled every one with rich patriotic experience. The day was full of sharing, fun and wonderful new experiences for all of us. All of us really recharged ourselves to be a better citizens if India and to serve better.

The 3rd day 2nd March was started with holy Eucharist. Then the day was the day of CME. The 1st session started with Dr.GD. Ravindran MD, DNB, FCGP, and Professor SJNAHS who was introduced by Sr. Dr.Rochana SMMI and thanked by Sr.Dr.Gladys and the memento was given by Sr.Dr.Lillian. The topic was case studies and management of Malaria, DM, sepsis, pneumonia and acquired hospital infection.

2nd session was by Dr. Indumathi .CK DCH, DNB asso. Pro. SJNAHS who was introduced by Sr. Dr. Wilma and thanked by Sr. Dr. Alphonsa and the memento was given by Sr. Dr. Josephine. She discussed Dengue Management Algorithm.

3rd session was by Dr.Suman Rao MD, DM Asso. Pro. SJNAHS Bangalore.

She was introduced by Sr.Dr.Cynthia and was thanked by Sr. Dr.Alena and the memento was given by Sr.Dr.Melba. All the three sessions were very informative and educative.

Everyone was enriched spiritually, emotionally and intellectually. There was a real joy of meeting each other and the sadness of biding good bye. All of us thanked God for allowing us to experience His love at Jalandhar and started our journey back home full of new life. Sr.Dr.Lucian and her board members personally went and thanked the Sacred Heart Community for their cooperation to make our AGBM a success at Jalandhar.

Sr. Dr. Lucian SCC
President, SDFI.

Sr.Dr.Liza.FSLG
National secretary, SDFI

SDFI NORTHERN REGION REGIONAL MEETING 2013-14

The Northern Region SDFI had their meeting at Sacred Heart Hospital, Maqsudan, Jalandhar on 20th October 2013 from 9 am to 8 pm. The theme for the meeting was "Women empowerment and save the girl child"

Most. Rev. Franco Mulakkal, Bishop of Jalandhar, offered the Holy Mass for the 13 sister doctors who had gathered for the meeting. He exhorted the group to be like Jesus the Healer, who died for the cause of the poor immolating himself as a lamb who is slaughtered and bringing about redemption for all. He described the healing ministry as one of the best ways to be an evangelizer, spreading the good news of Jesus who was sent by the Father as a victim for our iniquities and as the savior of all the ailments of the world. Bishop Franco applauded the healing work done by the sister doctors and encouraged us to continue our dedicated work.

This meeting was also held in order to plan for the XXth AGBM of the SDFI to be held at Jalandhar. Thus the hall mark of the day was the presence of the National team of SDFI- Sr.Lucian, the President, Sr. Emily, the Vice President, Sr. Liza, the secretary and Sr. Hilda the treasurer in the midst of us. The National team and the members of the Northern region planned for Annual AGBM to be held at Jalandhar Pastoral centre from 28/02/2014 to 02/03/2014. The members visited the pastoral centre and had an on the spot study of the place. We met the respective authorities at the pastoral centre for the planning and execution of the AGBM. The contribution by Sr.Dr. Lyla S.H, Medical Superintendent, and Sr. Mercy S.H, the Administrator from Sacred heart Hospital, Maqsudan, Jalandhar is commendable. Taking time out from their busy schedule they took the task of arranging for the dignitaries, resources persons, Mementos, gifts etc., for the AGBM. I should say it was such a generous contribution of time and talent for the SDFI.

Dr. Sanjeev Lewin, the Head of Paediatics department from St.John's Medical College, Bangalore was so magnanimous to come all the way to Jalandhar to give us inputs on child health and was the resource person for the day. He enlightened us on many health topics like Dengue fever, Malaria, Diarrhoeal diseases, respiratory infection in children and their

management. The participants were truly enriched by the inputs given by this esteemed paediatrician and appreciated his concern to deliver the inputs to the sister doctors. Sister Doctors of Northern region is grateful to Dr. Sanjeev Lewin for his kind gesture of interest in us. Truly it kept up the "ALUMNI ASSOCIATION SPIRIT"

The members also had planning and evaluation of the region's health programmes run by the sister doctors. We decided to work on women empowerment, save the girl child, Vitamin A and Anaemia programmes, school health programmes, and community outreach programmes wherever possible. In the evening the members gathered along with the sisters of the Sacred Heart community at Maqsudan and thanked them for their generosity and hospitality and dispersed for each one's destination. It was a tedious job for all to come from far and wide but truly worthwhile. Thanks to all

Sr.Dr.RoseMary CFMSS
Regional President, Northern Region

The regional meeting on 28th Feb at Jalandhar- There were 15 of us present. We congratulated Sr.Dr.Liza fslg for being elected as the national secretary. And also thanked Sr.Dr.Melba for her energetic spirit and for sharing her rich experiences and enriching all of us. We congratulated Sr.Dr.Laila SH and her sisters for all the arrangement done so beautifully for the success of this AGBM at Jalandhar. Some of the members shared their activities in their institutions. There are health camps, school health programmes, Vit A drops supply, moble clinics, DOT centers, microscopy centers, prison ministry is conducted in various centers. Sr.Rose is working at slum areas. Sr.Dr. Melba takes care of a HIV center. Sr.Dr. Liza is organizing Save the girl child programme with teachers and local leaders forming a group called Kanya Chhaya to create awareness in the society. They have decided to celebrate the girl child week from Jan24th to 31st in all the schools of the locality. And also Programmes on the parent teacher meet. We decided to have the next regional meeting at Lucknow in July. The theme is not yet decided.

Sr.Dr.Jyoti serrao SA
Regional secretary

Sr. Dr. Rose Mary CFMSS
Regional President, Northern Region

SDFI CENTRAL REGIONAL MEETING 2013 - 2014

THEME:-1) Issues of clinical establishment-Nursing home act in Chattishgarh state Govnt.
2) Spiritual Healing in Health Ministry
3) Updating of Comprehensive management of Diabetic Mellitus

In Jn10:10, Jesus says, I've come to give life, life in its fullness.

We had the SDFI central region meeting at Raipur on 18TH&19TH January, 2014. Our deep thanks to all the resource persons, who helped to arrange this meet in Raipur. On behalf of SDFI Central Region, we extend our heartfelt thanks to National Board members, Resource persons, Sister Doctors, all participants & well wishers who supported for the success of this Event.

Participants

Around 18-20 Sister Doctors were present for the meeting; everyone took active part especially of discussion on Chhattisgarh clinical establishment problems faced by health centres, where there are no doctors. We sr.drs of C.G trying to help out this problems along with CBCI, CMAI & CHAI. We also prepared Standing Treatment Guidelines for the use of health centres, where there are no doctors.

THEME

Themes on spirituality &Healing Ministry were dealt by eminent speakers - RT.REV.DR.HIS GRACE.EMERTIUS. JOSEPH. AUGUSTINE, Spiritual Healing in Health Ministry - by Rev. Fr. Francis-spirituality centre Raipur& Faith Experience in Health

Ministry- by Rev. Fr. Dr. John Ponnore, Director PASTORAL -CENTRE, RAIPUR. They highlighted on this theme with their own spiritual richness &experiences .They appreciated the dedicated service of the sr. Drs & SDFI at large. The Topics on Diabetics were dealt by Dr. Pradeep Beck M.D. Medicine Professor Medical College, Sr. dr. Jyothy, Sr. Dr. Rochana & sr. dr. Vimal jyothy SMMI

Conclusion

We had very fruitful discussion during this Central Regional meeting with two days programs. We also had evaluation& proposed for the future planning. Votes of thanks with mementos were also presented to resource persons with much appreciation. We concluded the session by thanks giving prayer &song with power point presentation.

Sr. Dr. Vimal Jyothy SMMI
CENTRAL REGIONAL-PRESIDENT

The regional meeting on 28th Feb at Jalandhar- There were 18 of us present.

We decided to have the next regional meeting at Ranchi on July.

Action plan 1.School health programmes for adolescent girls, Anemia detection programme & Prevention.

Next AGBM at Tamil Nadu or Holy Land.

Sr. Dr. **Vimal Jyothy SMMI**
PRESIDENT, CENTRAL REGION.

REPORT OF THE WESTERN REGION MEETING 2013 14

Once again the Sister-Doctors of Western Region gathered together in Bandra Holy Family Hospital, for the Regional meeting on 1st December 2013. The meeting commenced with a beautiful prayer conducted by Sr. Dr. Ashreena. She made it very meaningful and creative through an audio-visual presentation. Following that, Dr. Ronak, Intensivist, from Holy Family Hospital, enlightened us on the topic "Emerging trends in the management of common medical ailments". It was an interactive session and all the participants appreciated it.

We are ever grateful to Rev. Bishop Percival Fernandez, who shared with us few tips on the significance of communication in Healing Ministry, through his session, "How to be more effective by improving our communication skills. We were delighted by the very presence of Bishop Percy in our midst.

Following lunch break, we came together and discussed our various activities, especially on "Save the Girl Child Project". Many of our Sister-Doctors are actively involved in creating public awareness through classes, free medical camps and non-formal education of women. Some of us also shared our experiences and challenges faced in the Healing ministry. This in fact enriched us and filled us with newer insights..

The meeting concluded with a short prayer.

Dr. Sr. Beena UMI
President, Western Region.

REPORT OF THE WESTERN REGION MEETING DURING AGBM
28TH FEBRUARY, 2014 - JALANDAR

We were delighted to come together once again for the Regional Meeting. It began with a short self-introduction by each member, as we had two new members in our group.

We have chalked out following activities in relation to this theme "Women Alpha and Omega"

1) To hold more health awareness and health education programme.
2) To focus on preventable diseases of women by conducting screening camps and by promoting HPV Vaccination.
3) To conduct non-formal education to patients and women attenders, regularly.
4) Continue with the Save the Girl Child project.

Theme for next AGBM "Care for the Care giver".

Venue - `North East'

We concluded the meeting with a short prayer.

Dr.Sr. Beena UMI

President, Western Region.

REGIONAL MEETING ANDHRA PREDESH REGION 2013 -14

The A.P.S.D.F.I. regional meet was held on 17-11-2013 at St. Joseph's Hospital, Guntur, A.P. The day started with the joy of meeting one another. 15 Sister Doctors of the A.P. Region were present.

Sr. Dr. Annie JMJ
Sr. Dr. Ajaya FCC
Sr. Dr. Lellis FCC
Sr. Dr. Lalitha JMJ
Sr. Dr. Lancy Maria SD
Sr. Dr. Theresine DSL
Sr. Dr. Vijaya Rani MSI
Sr. Dr. Francis JMJ
Sr. Dr. Jain RFTS
Sr. Dr. Sheeja Varghese MSI
Sr. Dr. Mary John MSI
Sr. Dr. Lizy Chacko JMJ
Sr. Dr. Lilly Pushpa .K JMJ
Sr. Dr. Alphonsa .P MSI
Sr. Dr. Rosa Basani JMJ

The inaugural function started at 9:00 A.M. Sr. Dr. Francis led the group in prayer. The lighting of the lamp was done by Sr. Cletus, the Administrator and sister Doctors, Rosa Basani, Alphonsa, Lellis, Theresia, Annie and Dr. Sailaja.

Sr. Dr. Annie, the president of A.P. Region welcomed the members with special remembrance of Dr. Sr. Mary Glowrey, the founder of St. Joseph's Hospital. She had appreciated the JMJ Sisters, specially Sr. Cletus, and the Administrator, who had generously contributed and made all the arrangements for the regional meet.

Updates.

1. Fetal Medicine: The resource person was Dr. Sailaja Vuppu, MRCOG, CCT, Rainbow Hospital Consultant, Vijayawada. Sr. Dr. Annie who had conducted an interactive session where many of the sister doctors cleared their doubts.

2. Urogynecology: Dr. Sailaja Vuppu continued the discussion in this area too. She explained the need to clearly differentiate between various urinary complaints and the treatment for the same. Sr. Dr. Francis thanked Dr. Sailaja and presented a memento of Dr. Sr. Mary Glowrey to her. This was followed by coffee break.

3. Infertility and PCO and Management: The resource person was Dr. Prabhavathy, Professor, dept of OBG at Guntur Medical College & Hospital. The resource person was introduced by Sr. Dr. Annie, who had taken an elaborate session for the group. The vast topic of infertility and PCOS was revised in the sessions. Sr. Dr. Vijaya Rani MSI had thanked the resource person and honored her with the memento of Dr. Sr. Mary Glowrey.

Then we had a meaningful Eucharistic celebration by Fr. Fatima Marreddy, who reflected on the parable of the Good Samaritan and the role of the inn keeper who was kind and compassionate towards the injured person and the need to follow the parable. Sr. Cletus, the administrator had thanked Fr. Fatima Marreddy for the wonderful celebration. Sr. Lancy Maria proposed the vote of thanks. Everyone was given mementos of Dr. Sr. Mary Glowrey and the small booklet on her life.

After a delicious dinner arranged in St. Joseph's Convent, we shared our experiences of some difficult cases, medico legal problems, etc., Many of the sister doctors left to their respective places after lunch and sharing.

About seven of us went to St. Joseph's Nature Cure Centre, Kakani - a relaxing and refreshing experience. By 5:00 P.M. everyone dispersed to their respective places.

Regional Meeting at Jalandhar-

There were 11 members present.

Action plan :

1.School health programmes for adolescent girls, Anemia detection programme & Prevention.

2. Village health programmes- Gediatric health, calcium supplementation, early detection of Cancer cervix, HPV & Rubella vaccination.

Next AGBM at Goa or Gowhati

Sr. Dr. Lilly Pushpa. K JMJ
Secretary

Sr. Dr. Annie .P JMJ
President

ANNUAL C. M. E. REPORT - KARNATAKA REGION 2013 -14

The annual regional CME of SDFI Karnataka region was held at Honavar, North Karnataka on 9th and 10th of November 2013. A good number of Sr.Doctors attended the meeting. The meeting was hosted by Sr. Dr. Anrita D Souza SRA at St. Ignatius hospital. It was well planned and went on smoothly as per schedule.

The meeting began at 9.15 a.m. with a meaningful prayer service prepared and conducted by Sr. Dr. Adelcia A.C., after which the participants were warmly welcomed by Sr. Maria Goretti. The first session began at 10.a.m.which was a spiritual input session. Rev. Fr. Dr. Baptist was the resource person who spoke on Faith and Mission. He said Faith is belief in the Absolute. Every human person has faith, even atheist has faith. Every human being has a spark of the Divine. Faith and Reason are complimentary. When reason stops faith begins. Faith transcends reason. Faith and works go together. Mission is God's initiative but God requires our response. Jesus called not only 12 Apostles, many more but only 12 responded. God has a purpose in choosing us. God's mission can take different forms. We fulfil our vocation through different profession. The word mission is now termed now as Evangelization.

After a short break for a cup of Tea, the second session was resumed at 11.15.a.m.

It was an academic session the topic being Post partum Psychiatric Syndromes. The resource person was Dr. Jayanth Kumar, Psychiatrist at St. Ignatius Hospital. He classified Post partum Psychiatric Syndromes into 3 categories : Post partum Blues, Post partum Depression and Post Partum Psychosis.

Post partum Blues occurs in upto 50% women. It is :

- Self limiting
- Onset shortly after child birth
- Lasts only a few days,resolves in 4 weeks.
- Characterized by tearfulness, fatigue, anxiety and irritability.
- May have increased risk of mood disorders later on.

Related to : Dyspnoea during pregnancy
Past history of depression
Neuroticism
Pre menstrual depression.

Post Partum Depression occurs in 10 - 20 % women. It is more severe than Post partum Blues. Symptoms last for 6 months. Related to :

- Single status
- Lower SES, multiparity
- Unplanned pregnancy
- Negative birth experience
- Lack of social support
- Stressful life events

Treatment : Reassurance. Anti depressants and education.

Post partum Psychosis: Occurrence - 1-2/ 1000 births time 4 weeks- 3 months 1yr. Occurs 2-3 weeks after child birth with fatigue, insomnia & restlessness, emotional disability.

Treatment : Psychotherapy after the acute phase. Admission to the hospital of mother with child is necessary as it is a psychiatric emergency.

After a sumptuous lunch and short siesta the group set out for an outing from 3.00p.m. to 7.00p.m. it was an enjoyable, relaxing and refreshing outing at the seashore and nature park. At 8.30.p.m. the sharing / business session was held. The secretary Sr. Dr. Vida read out the minutes of the previous year's meeting. The sister doctors discussed what was done regarding the “save the girl child” project. An important point discussed was to add credit points for our AGBM. Without the credit points renewal of registration once in 5 years will not be done. If credit points are not given sisters would not like to attend regional or AGBM. The venue for next year's regional meeting was suggested to be Bangalore, either at St. John's or at Sadbhavana Rajaji nagar.

The second day began with Sunday Eucharistic liturgy which was very meaningful. The breakfast was stimulating to the taste buds, after which the group came together for the 3rd session which was on Stroke and its Management taken up by Dr. Kenneth Crispin physician at St. Ignatius hospital. He spoke on two types of stroke , **Ischemic stroke** caused by thrombosis of cerebral vessels or emboli from proximal arterial sources or a carotid artery pathology. The second one, **Haemorrhagic stroke** caused by bleeding directly into or around the brain. "Time is brain! If you lose time you lose brain'. Stroke is a medical emergency.

Clinical features, d/d and management were dealt by him at length.

After the input session a short tour of the hospital was made. The meeting came to an end at 12.30.p.m. with a delicious lunch. The secretary thanked everyone for their presence and participation. It was indeed an enriching session.

Sr. Dr. Vida Olivera
President, Karnataka Region.

Regional meeting at Jalandhar- There were 12 members present. The next regional meeting will be at Bangalore at 2nd week of Nov. The Topic for the CME is Diabetic and Hyper Tension.

Action plan- Training women in general and specific groups on health care. Training the youth for the future responsibilities in the family life.

Next AGBM at Kannyakumari and the Theme "Geriatrics & palliative care.

Sr. Dr. Vida Olivera
President, Karnataka Region.

REGIONAL MEETING TAMIL NADU REGION 2013 - 14

It was a pleasant and enthusiastic morning on 23rd November, when we the members of Tamil Nadu region SDFI members came together for 2days gathering. Coimbatore the Manchester of Tamil Nadu with its cool and chill weather Sr. Emili Susai, Sr. Pramila Jaddu and Sr. Agnes welcomed us warmly and took care of our stay which was very comfortable, food that was delicious and meticulously planned for the smooth functioning of the programme and conveyance to travel around Coimbatore. The first day began with meaningful Holy Eucharist celebrated by Rev Fr. Joe Francis, Professor at Good Shepherd Seminary, Coimbatore, when he highlighted the importance of our sharing in Jesus healing ministry specially we are called to touch Jesus in the sick and the suffering amidst the medical world that is gone as business. He also quoted God as multi specialist, who did surgery on Adam and genetically created the creatures and human being, who put the bones together in a dry land like the orthopedician, who gave manna for their food as a good dietician and nutritionist.

In the introduction of the mass, Jesus was highlighted as multi specialist

<u>JESUS AS MULTISPECIALIST</u>

JESUS THE **GOOD PHYSICIAN** - he cured Peter's Mother I Law from fever. (MT 8:15)
JESUS THE **PEDIATRICIAN** He blessed the children (MK 10:16)
JESUS THE **GYNECOLOGIST** he cured a woman with hemorrhage (MT 9:20 -22)
JESUS THE **OPHTHOLMOLOGIST** he cured many blind men (MK 8:23 25)
JESUS THE **MASTER SURGEON** he touched and healed the ear of Malchus (LK 22:51)
JESUS THE **ENT SPECIALIST** he healed the deaf and dumb men (MK7:33-35)
JESUS THE **DERMATOLOGIST** - he cured the lepers (MT 8:3)
JESUS THE **NEUROLOGIST** he heals the paralytic (MK 2:11-12)
JESUS THE **RHEUMATOLOGIST** he heals the woman who was bent for 18 years
JESUS THE **PSYCHIATRIST AND PSYCHOLOGIST** - he healed the boy with evil spirit LK 9:42)
JESUS A **GOOD DIETICIAN** - he fried fish at the shore for the disciples

After being enriched by the Word of God and the Eucharist, we moved on to Karunya Bethasdha Prayer house founded by Pastor Dhinakaran, we enjoyed the lush green and prayer filled atmosphere in the campus. We had our regional meet and discussion in their beautiful campus.

Many of our sister Doctors are vibarant in their mission specially in imparting health awareness and values of life. Keeping in mind the theme "save the girl child" and the theme of our Pope Francis for this year "Evangelization to the families" we discussed that how we could reach out through our healing ministry to the families. The group felt that to achieve protection and safety for the girl child, we need to work on the value system of the families and people. Keeping this in mind we decided that we would inculcate values and evangelization along with our awareness programme, and at least meet one group of people in a month.

After the meeting of the day we had a delicious lunch at the campus itself after which we proceeded to KOVAI KUTRALAM to stroll awhile in chill water fall to our hearts delight. Many of us got ourselves drenched in the freshness of water.

Next our trip was to ESHA YOGA CENTRE Where the devotees of Siva are seen. It's a huge ashram with many monks of young and old, men and women live in silent and meditative atmosphere. The stillness of movement in spite of the crowd, and the faith of the people to get

the divine light by bathing in the ritual pond, and to be filled with divine wisdom in deep stillness was inspirational. After the delightful day we were hosted a sumptuous dinner by Sisters of Immaculate Conception Community FMM. Thus the day came to an end with God's blessings and happy memories.

The second day was all set to gain knowledge on Diabetes sponsored by Bayer pharmaceutical company. We were hosted in a "THE GRAND REGENT" hotel, welcomed by the sponsors. This is a certificate course on Diabetes and the key lecturer for the day was Dr. Giri MD, PG, Dip DC (Australia), Regional Diabetic centre, KG Hospital, Coimbatore. We had classes on basic concepts, pathology, management, recent advances and management of Diabetic neuropathy by Dr. (Neurologist), and Diabetic cardio vascular complications by Dr.(Cardiologist) and the management of Diabetes in children and in adolescents by Dr. Sangeetha (Diabetologist). We had also useful question hours to clear our doubts and confusions. Classes were enriching and very much practical in our practice. We had also tasty cuisines served for lunch. We thank Dr. Giri and the Bayers company for availing us this opportunity.

We are also happy to mention that many tried their best to attend this meeting and made use of the opportunity. Thus our meeting came to a fruitful end. We thank all the hearts and hands that had worked hard for the success of this gathering. May god Bless you.

Regional meeting at Jalandhar- There were 18 of us present. The next regional meetibg will be at Coimbatore on June 21st & 22nd. The topic will be 'Diabetic course 11.

Next AGBM we want at Shillong. The theme suggested is ' Prevention of noncommunicable disease'

Sr. Dr. Martina SJC
President, Tamil Nadu Region.

Minutes of the Regional meeting Kerala Region

Date: 23, 24 November 2013
Venue: Atmajyothi Pastoral Center, Adimali

About 40 members from various parts of Kerala had actively taken part in the meeting. After the registration we had the opportunity to visit Munnar. We were also lucky enough to get down at Pallivasal tea factory for a visit. We extend our gratitude towards people involved in getting us the permission for the same. The Munnar visit together with a soothing shower of rain was quite refreshing to the mind.

We began our meeting by invoking the Divine Spirit, followed by an enriching talk by Fr.Thomas Anikuzhikattil, on faith (quoting Vatican Council Decree). The Second day, 21/11/2013 was also started by invoking the Divine blessings, through a prayer session conducted by Sr.Dr.Geetha and others followed by a lively and inspiring homily by Rev.fr.Francis Kudiyirickal CMI, Asst Director of APC. Nov24th being the feast of Christ the King ,he urged us to be the "Munnanipadayalikal" of Jesus Christ. After a sumptuous breakfast inaugural session began at 9am with a short prayer by Sr.Dr.Geetha. After that Sr.Dr.Ranitta, the President of SDFI Kerala region welcomed the dignitaries and delegates. The Inaugural address was given by Rev Fr. Francis Kudiyirickal and key note address by Sri.P V Scaria, the

Adimali Grama Panchayath President. He appreciated the members for their valuable services in the rural areas. The Felicitation was delivered by Rev Sr.Alice Maria CMC, the Provincial of Idukki Province. Sr.Dr.Latha, the Regional Secretary proposed vote of thanks. Inaugural session was concluded with the Papal Anthem.

After a short break the scientific session started with a power point presentation on CAD risk factors, its prevention as well as management by Sr.Dr.Anie sheela, Cardiologist, Marad Hospital Kochi. She also enlightened us on atherosclerosis, hypertension and DM in a simple way. Later a memento was presented to Sr.Dr.Anie Sheela by Sr.Dr.Vimala SABS along with words of appreciation.

The most exciting event of the meeting was the panel discussion on various topics which lasted from 11am till 1pm. Sr.Dr.Marcelus had given a short talk on recent advances and problems in the field of infertility management, with the aid of a power point presentation. All delegates had enthusiastically attended the panel discussion headed by Sr.Dr.Suguna, Surgeon cum Provincial FCC Idukki Province. Quoting the life of St.Francis of Assisi, sister had urged the audience to see Jesus in all patients. Sr.Dr.Suguna had then introduced all the panelists Sr.Dr.Anie Cyriac, Sr.Dr. Anie Sheela, Sr.Dr.Marcelus and Sr.Dr.Betty Louis. Even after two long hours members were quite interested to clear their doubts on various issues. The panel discussion ended by 1.15pm. Sr.Dr.Latha thanked the panelists and presented a memento to each resource person.

As Sr.Dr.Latha was going for higher studies, Sr.Dr. Mercy SABS was elected as the new regional secretary .Sr.Dr.Ranita had encouraged all the delegates to attend the AGBM at Jalandhar. The meeting ended with a thanks giving song.

I extend my wishes to Sr.Dr.Anie Cyriac recipient of AIBDA (All India Business Development association New Delhi), International Gold Star Award on 18th November 2013 ,at Dubai for the Individual contribution for International Integration and World peace and Indo-Nepal Sadbhavana award on 19th October 2013 at Kathmandu-Nepal.

Report of the regional meeting Kerala 28-02-2014

Venue: Pastoral Centre Jalandhar

Meeting started with a short prayer.25 members attended the meeting .The venue suggested for the next AGBM was Chennai or Pondicherry. Pope Francis declared 2015 as the year of consecrated. Hence the theme selected was "BE WITH HIM AND BE FOR HIM".

We are proud to announce that Sr.Dr.Annie Cyriac received International peace Gold star award for integral developments of world peace. Also national and district appreciation award from by women council.

Action Plan 2014-2015

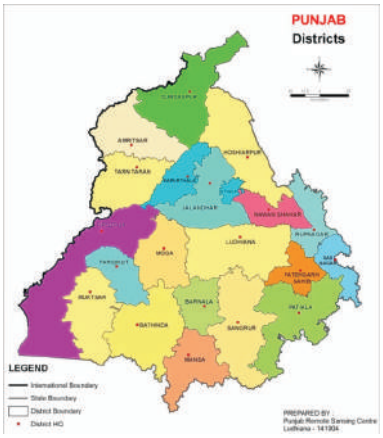
1. Will arrange an intensive spiritual care course by CHAI to all Sister Doctors (Kerala) for three days during the next regional meeting.
2. To attend the spiritual care programme organized by CHAI.
3. To continue anemia control programme in school

Sr.Dr.Mercy SABS
Secretary Kerala Region.

Sr. Dr. Ranita
President, Kerala Region.

A Glimpse into PUNJAB

'Punjab 'the very name signifies five rivers: PANCH AB. It is simply a land of fertility. Because of this rich source of water, everywhere one sees green carpets of wheat and yellow carpets of mustard.



Agriculture is the main occupation in Punjab and it is the largest single producer of wheat in India. The major industries here include the manufacturing of scientific instruments, agricultural goods, electrical goods, financial services, machine tools, textiles, sewing machines, sports goods, tourism, fertilizers, bicycles, garments and the processing of pine oil and sugar.

The main religions of Punjab are Sikhism, Hinduisms, Islam and few Christians. The roots of Sikhism began at the times of the conquest of Northern India by Babar. His grandson, Akbar, supported religious freedom. The Sikh Empire [1801 1849] was formed as the foundations of the Punjab Army by Maharaja Ranjit Sigh. The Punjabis are known to be born warriors. In 1960, Chandigarh was built as a new capital. Until then Simla was named as a temporary capital. In 1966 the Hindu speaking southern half of Punjab became a separate state; Haryana and the pabasi speaking hilly areas in North East were given to Himachal Pradesh; Chandigarh became a separate union territory and served as the capital of both Punjab and Haryana.

The main city Amritsar is known for its Golden Temple which is the largest Gurdwara of the Sikhs. The devotees flock there all through the year from across the world to see its inimitable architecture. It is a holy and pilgrim place not only for Sikhs but also for other religious people.

There are not only gurdwaras, but also temples, churches, mosques and other religious shrines. Jallian Walabagh at Amritsar reminds us of Punjab's sacrifice and the horrors of the British rule Amritsar, Bathunda, Patiala, Mohali, Ludhiana, Jalandhar and Chandigarh are the perfect hub of culture, fun and frolic.

When you say Punjab you are reminded of the traditional energetic folk dances, the Bhangra and the Giddha. Till date Bhangra has survived in different forms and styles all over the world.

Among all the pickets and line of control as the Indo Pakistan border, the Wagah Border is

famous for its ceremony of changing guards at the sun rise and sun set with the hoisting of the national flag. All tourists and natives flock there at the sun set to witness the Wagha border gate operating for trade and the ceremonious taking down of the national flag which keeps everyone present there spell bound and be filled with patriotism.

The State of Punjab has extreme climate with temperature dropping down to Zero degrees Celsius in winter and escalating to 48 degrees Celsius in summer. The people are ready to enjoy both the extreme climate with joy and cheer. Punjab is one of the most beautiful states and is the land of hospitality and infectious zest for life. The century old Punjab culture is renowned for its tolerances, progressive and logical approach to life. It is known for its cuisine, culture and history.

This is only a 'PEEP' into Punjab, in order to know more, you need to enter, and experience for yourself!

Sr.Dr.Emily Susai. FMM,
Vice President, SDFI.

DENGUE FEVER

Dr.Indumathi
Associate Professor
Department of pediatrics
SJMCH

Session Objectives

- **Clinical features**
- Differential diagnosis
- **Classification of dengue fever**
- Complications
- **Management protocol**
- Prevention

1

Dengue fever

- Dengue fever is an acute febrile illness of 2-7 days duration (**sometimes with two peaks**) with two or more of the following:

Headache
Retro orbital pain
Myalgia
Arthralgia
Leucopenia

2

Course of dengue fever

- Febrile phase
- Critical phase
- Recovery phase

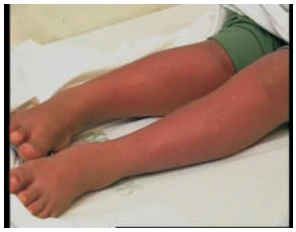
SCENARIO 1

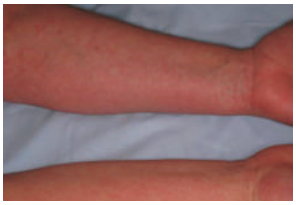
A 5 year old Mohan : Fever-3 days
Pain in the limbs -2 days

On Examination: Febrile, PR-90/min, RR-25/min,
BP-90/60mm Hg CFT-2 sec

Systemic Examination: Normal

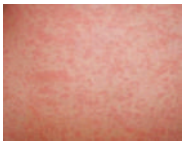
Skin flushed





Dengue rash

Tourniquet test



Phases of dengue fever
Dynamic disease

- Febrile phase
  - Febrile phase mimicsany other viral disease
  - **Flushing of extremities may give aclue**
  - **Positive Tourniquet test**
  - Leucopenia, mild thrombocytopenia

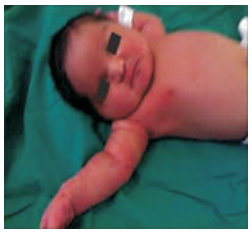
  Majority recover

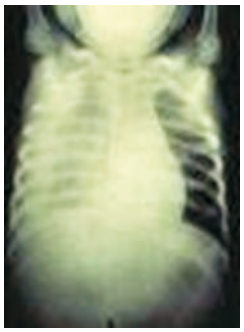
SCENARIO 2

5 year old Mohan: Fever persisting for 5 Days
vomiting, abdominal pain
Black coloured stools since night

On examination: PR-94/min, RR-30/min, BP-90/60 mmHg, CFT-2secs,T-99 F
Petechiae, **Pedal edema,**
facial puffiness
Reduced air entry right side

Systemic Examination:Hepatomegaly& Free fluid in abdomen





Investigations

Investigation - HB- 13 gm/dl
PCV-40%
Platelet count-35000/mm

What is this phase?

Critical phase

Febrile phase to critical phase

Critical phase = plasma leak

WARNING SIGNS

- Abdominal pain or tenderness
- Persistent vomiting
- Clinical fluid accumulation
- Mucosal bleed
- Lethargy, restlessness
- Liver enlargement >2 cm

Good indicators for developing severe dengue

Indicators - Simple lab tests

- Increase in HCT or HB
- Concurrent drop in platelets
- Hypoproteinemia
- AST/ALT

SCENARIO 3

The same child after 24 hours of admission

Afebrile

Are you happy or unhappy?

Examination

Restless, lethargic
bleeding gums, epistaxis
PR-130/min, BP70/50 mm Hg
CFT- 4 sec,RR-44/min

Investigations :
Platelet count-20000 mm, PCV-44%

Critical phase-Severe dengue

Develops shock when apparently recovering
Preceded by warning signs

Critical phase-Severe dengue

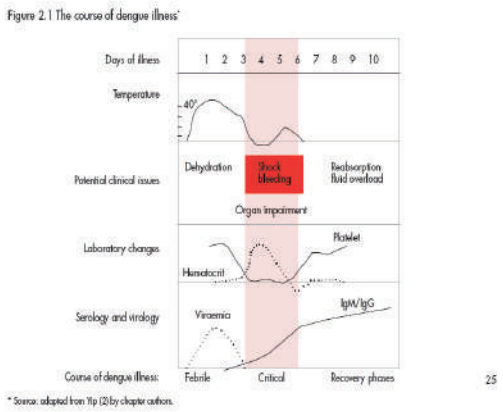
DSS-danger signs

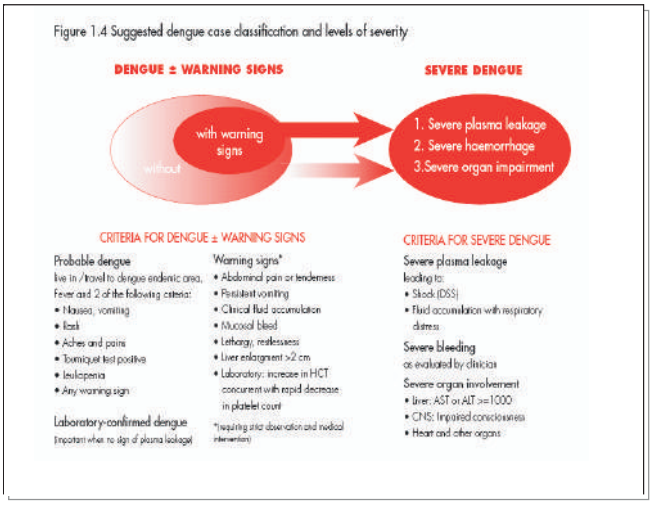
- Circulatory compromise-shock
- Severe bleeding
- Fluid accumulation with respiratorydistress
- Multiorgan failure
- Progressively risingHB/haematocrit

Childrenare at risk for developingsevere dengue

After 2 days- Recovery phase

- Active
- **HR 60**,(bradycardia) RR 30,BP 90\60
- edema, distension decreased
- No further bleeding
- **Pruritis**
- Pc 60000,PCV 3436





Lab confirmation

- Not required for clinical case management
- Important when no typical features

suspect dengue -clinical

probable dengue- Dengue IgM

confirmed dengue- NS1 antigen, culture +

Dengue fever management

Dengue Without warning signs	Dengue With warning signs	Severe Dengue
Group A	Group B	Group C
Send home	In patient	Emergency treatment & referral

Group A

- Plenty of oralfluids,ORS
- Paracetamol
- Do not use aspirin,brufen
- No I.M.injections
- Monitor daily
  - clinically
  - HCT,PC
- **When to return- educate about warning signs**

Warning signs-Group B

HCT BEFORE FLUID THERAPY
ISOTONIC SOLUTIONS LIKE NS,RL

START IV FLUIDS
5-7 ML/KG/HR FOR 1-2 HRS

3-5ML/KG/HR FOR 2-4HRS

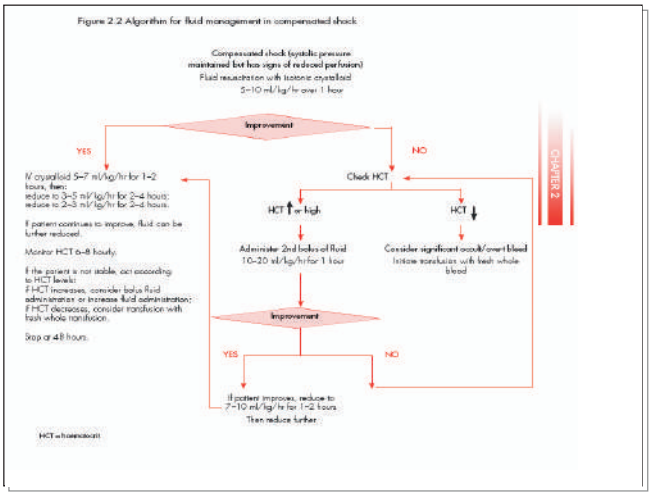
2-3ML/KG/HR

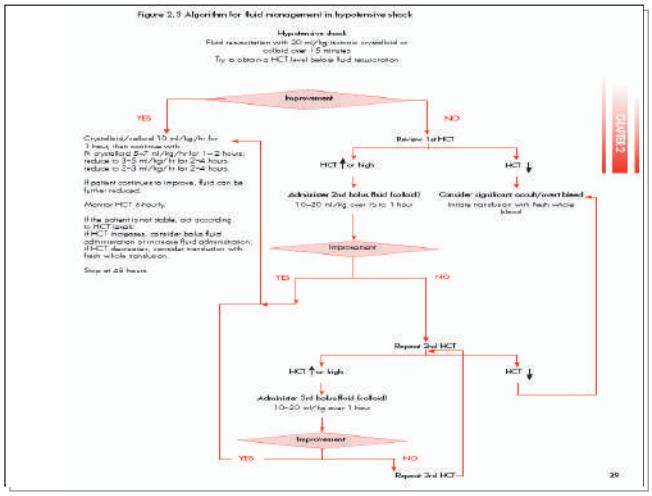
REASSES CLINICAL STATUS & REPEAT HCT

- if HCT is same–continue same rate
- if HCT increased–increase rate to 5-10 ml/kg/hr for 1-2 hrs
- give minimum IVF for minimum period to maintain good perfusion and u/o(0.5 ml/kg/hr)

Severe dengue --Group C

- Emergency treatment
- Referral





Hemorrhagic manifestations

- Minor bleed - no transfusion
- Bed rest and protect from trauma
- NO IM injection
- Urgent blood transfusion in major bleeds
- Dropping PCV with persistent shock

  10-15 ml/kg fresh whole blood

  10 ml/kg of packed cells

? Role of Blood components

- No role for prophylactic platelet transfusion
- May be given if bleeding cannot be managed with blood transfusions

When to refer

- Shock
- Severe plasma leak
- Severe bleeding
- Fluid overload
- Organ impairment

Prevention

Prevention

Prevention

Exercise 1

- 5 year old, fever for 3 days
- 15 KG, well

Classification
Treatment
Education

Exercise 2

- 3 year old with fever for 4 days, abdominal pain, vomiting
- 12 KG, flushed, tachycardia.

Classification
Investigations
Treatment

Exercise 3

- 10 year old fever, lethargy, decreased UO
- 25 KG, puffiness, tachycardia, low volume pulse,BP -90/60

Classification

Treatment

Exercise 4

After few hours

- Lethargic, cold peripheries, tachycardia
- BP-80/60

Classification

Treatment

Exercise 5

- 5 year old dengue fever, few drops of epistaxsis
- o/e- stable

Treatment

Exercise 6

- 5 year old dengue fever, epistaxis , malena
- Tachycardia, BP low

Treatment

Diagnosis and management of atypical preeclampsia - eclampsia.

Dr. Annamma Thomas , Professor
Dept of OBG
St. John's Medical College Hospital

- Hypertension ? M/C medical disorder during pregnancy

- Gestational hypertension -preeclampsia ? wide spectrum ? mild elevation in BP or severe hypertension with various organ dysfunctions ? acute gestational hypertension, preeclampsia, eclampsia and HELLP syndrome.

- Preeclampsia, eclampsia , and HELLP syndrome ? major obstetric disorders ? substantial maternal and perinatal morbidities.

- It is important ? clinicians make timely and accurate diagnoses to prevent adverse maternal and perinatal outcomes.

- Most women ? classic presentation of preeclampsia

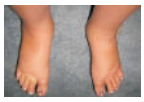
- Recent studies ? some women will experience preeclampsia without 1 of these classic findings and/or outside of these time periods ? Atypical cases

- AIM ? ? Awareness of the nonclassic and atypical features of preeclampsia -eclampsia .

- A stepwise approach toward diagnosis and treatment of patients with these atypical features

Definition of classic preeclampsia

Classic triad ? hypertension, proteinuria, and edema.



Now general agreement? edema should not be considered as part of the diagnosis? edema is neither sufficient nor necessary to confirm the diagnosis? edema is a common finding in normal pregnancy, and approximately 1/3 of women witheclampsia never demonstrate the presence of edema.

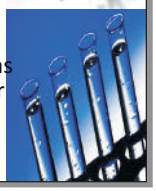
Hypertension ? systolic BP of at least 140mmHg and diastolic BP of 90mmHg on at least 2 occasions ? at least 4 hours (but not 7 days) apart.

- Severe ? systolic BP is at least 160mmHg and/or the diastolic pressure is at least 110 mm Hg on 2 occasions at least 4 hours apart.

- PROTEINURIA? concentration of 30 mg/L in at least 2 random urine specimens that were collected at least4 hours apart (but within a 7 day interval) or 0.3 g in a 24-hour period.

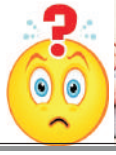
- Traditional criterion? diagnosis of preeclampsia? proteinurichypertension? appropriate to use in most nulliparouswomen

- **Recent data**? in some women, preeclampsia and eveneclampsiamay develop in the absence of either hypertension or proteinuria
- In many of these women, there are usually other manifestations of preeclampsia (such as the presence of signs and symptoms or other laboratory abnormalities).



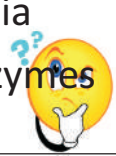
Atypical preeclampsia

- **1. Gestational hypertension plus 1 of the following items:**
  - Symptoms of preeclampsiaHemolysis
  - Thrombocytopenia (100,000/mm3)
  - Elevated liver enzymes (2 times the upper limit of the normal value for aspartate aminotransferase or alanine
  - aminotransferase)




Atypical preeclampsia

- **2. Gestationalproteinuriaplus 1 of the following items:**
  - Symptoms of preeclampsia
  - Hemolysis
  - Thrombocytopenia
  - Elevated liver enzymes




Atypical preeclampsia

- **3. Early signs and symptoms of preeclampsia - eclampsia at 20 weeks of gestation**

- **4. Late postpartum preeclampsia eclampsia (48 hours after delivery)**

1. Gestational hypertension without proteinuria

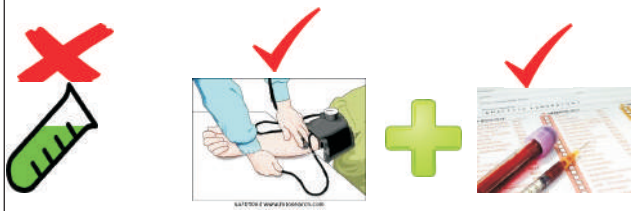
- The pathophysiologic abnormalities in preeclampsia are viable and can manifest as either 1 organ ormultiorgan dysfunction ? S/S ? reflect the org involved.

Proteinuria ? manifestation of rena involvement ? glomerulo endotheliai injury (altered permeability to proteins) and abnormal tubular handling of filtered proteins.

- Traditionally, proteinuria ? hallmark for the diagnosis of preeclampsia ? usually develops after the onset of hypertension and/or onset of symptoms.

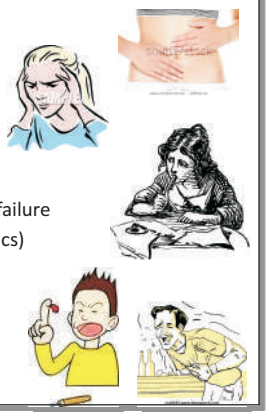
- Its onset in clinical practice ? variable in onset in relation to hypertension and/or other end-organ effects ? its presence should not be considered mandatory to establish the clinical diagnosis of preeclampsia or eclampsia.

- In the absence of proteinuria, the syndrome of preeclampsia should be considered when gestational hypertension is present in association with persistent symptoms or with abnormal laboratory tests



Signs and symptoms and laboratory test results consistent with preeclampsia

- **Signs and symptoms**
  - Right upper quadrant pain
  - Epigastric pain
  - Retrosternal chest pain
  - Nausea and vomiting
  - Shortness of breath/congestive heart failure
  - Headaches (not responsive to analgesics)
  - Visual changes
  - Altered mental status
  - Bleeding from mucosal membranes
  - Jaundice



- **Laboratory tests**
  - Persistent proteinuria (300 mg/24 h)
  - Platelet count (100,000/mm3)
  - Liver enzymes (aspartate aminotransferase or alanine aminotransferase) 2 times the upper limit of normal
  - Serum creatinine (1.2 mg/dL)
  - Lactic dehydrogenase 2 times the upper limit of normal

- Important ? 25-50% of women with mild gestational hypertension ? progress to preeclampsia.

- The rate of progression ? gestational age at onset of hypertension ? rate approaches 50% when gestational hypertension develops before 32 weeks of gestation.

- In most of these women, the progression will result in preterm delivery and/or fetal growth restriction? require close observation for early detection of preeclampsia?

- (frequent prenatal visits and serial evaluation of platelets and liver enzymes) and/or fetal growth (serial ultrasound).

- Preeclampsia should also be considered gestational hypertension is severe, because associated adverse maternal perinatal outcome reported in such women.

- In a secondary analysis from 2 multicenter trials severe gestational hypertension is associated with higher maternal and perinatal morbidities than those found in mild preeclampsia.

- The results? women with severe gestational hypertension had adverse maternal or perinatal outcomes that were similar to those seen in women with severe preeclampsia

Adverse pregnancy outcomes in severe gestational hypertension and in mild and severe preeclampsia

	Buchbinder et al			Hauth et al		
Outcome	Severe hypertension (n 24)	Mild preeclampsia (n 62)	Severe preeclampsia (n 45)	Severe hypertension (n 32)	Mild preeclampsia (n 217)	Severe preeclampsia (n 109)
Mean gestational age at delivery (wk)	35.8	37.8	34.8	38	39.2	37
Mean gestational age at delivery (wk)	35.8	37.8	34.8	38	39.2	37
Preterm delivery (%)	25	9.7	35.6	3.1	1.9	18.5
Mean birthweight(g)	2637	3196	2490	2967	3212	2642
Weight 10th percentile (%)	20.8	4.8	11.4	9.7	10.2	18.5
Abruptio placenta (%)	4.2	3.2	6.7	3.1	0.5	3.7
Respiratory distress syndrome (%)	6.5	3.2	16.7	12.5	4.8	15.7
Perinatal death (%)	0	0	3	3.1	0.5	0.9

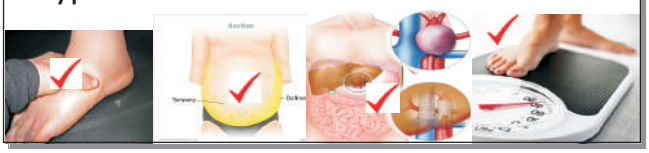
- However ? these 2 studies included only a total of 56 subjects ? more data are needed.
- Nevertheless ? **women with uncontrollable severe gestational hypertension or women with signs and symptoms of end-organ disease with any hypertension should be treated as if they had severe preeclampsia.**

- Recommend ? hospital admission until hypertension is well controlled without symptoms and delivery at 34 weeks of gestation if severe hypertension or sympto persist, or earlier if indicated.

CAPILLARY LEAK SYNDROME: facial edema, ascites and pulmonary edema, gestational proteinuria

- Hypertension ? considered ? hallmark for the diagnosis of preeclampsia; however? in some patients with preeclampsia, the disease may manifest itself in the form of either a capillary leak (proteinuria, ascites, pulmonary edema), excessive weight gain, or a spectrum of abnormal hemostasis with multiorgan dysfunction

- These patients ? clinical manifestations of atypical preeclampsia (e, proteinuria with or without facial edema, excessive weight gain [5 lb/wk],ascites, or pulmonary edema in association with abnormalities in laboratory values or presence of symptoms) but withou hypertension.



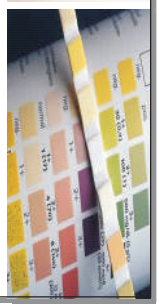
- Recommend ? women with capillary leak syndrome with or without hypertension be evaluated for platelet, liver enzyme, or renal abnormalities.

- They should be questioned about symptoms of preeclampsia.

- Those with symptoms and/or abnormal blood tests should be considered to have preeclampsia.

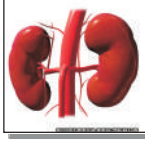
Gestational proteinuria

- Gestational proteinuria ? urinary protein excretion of 300 mg/24-hour timed collection or persistent proteinuria (= 1 + on dipstick on at least 2 occasions at least 4 hours apart but no more than 1 week apart).
- The exact incidence? unknown.
- Two prospective studies in healthy nulliparous women ? approximately 4% of women who remained normotensive had gestational proteinuria ? neither of these studies reported the % of women who had new onset gestational proteinuria and later experienced preeclampsia.



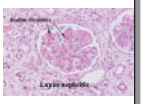
- **Women with new onset gestational proteinuria only ? monitored very closely for the early detection of preeclampsia, because the presence of gestational proteinuria alone may herald the early manifestation of an impending preeclampsia.**

- **No prospective studies that have evaluated the risk of the development of preeclampsia in patients with gestational proteinuria.**

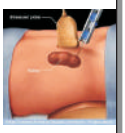


- **Such women should be evaluated for potential preexisting renal disease (such as chronic pyelonephritis, lupus nephritis, immunoglobulin A nephropathy, and other nephropathies).**

- **Evaluation for lupus nephritis is extremely important, ? potentially treatable cause of proteinuria during pregnancy.**



- **If proteinuria persists for 8 weeks after delivery ? evaluated for underlying renal disease ? may require renal biopsy.**



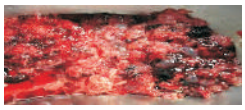
- **Women with proteinuria with cardiorespiratory symptoms, ascites, or pulmonary edema ? evaluated for potential cardiac disease (such as CCF or peripartum cardiomyopathy).**

Preeclampsia-eclampsia at < 20 weeks of gest

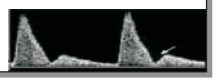
- Preeclampsia and/or eclampsia ? < 20 weeks of gestation ? molar or hydropic degeneration of the placenta with or without a coexistent fetus.
- Preeclampsia-eclampsia ? can occur during the first half of pregnancy without molar degeneration of the placenta ? exceedingly rare

- Presence of hypertension, proteinuria, and abnormal laboratory tests at < 20 weeks of gestation ? lupus nephritis, hemolytic-uremic syndrome, antiphospholipid antibody syndrome, or TTP.
- Such women ? evaluated to R/O ? presence of these disorders. Absence of other disease ? treated for severe preeclampsia.
- Women in whom convulsions ? with hypertension and proteinuria during the first half of pregnancy ? considered to have eclampsia until proved otherwise.

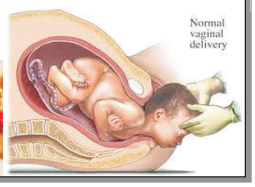
- These women ? USG examination of the uterus to R/O molar pregnancy and/or hydropic or cystic degeneration of the placenta .



- Measurement of uterine artery Doppler velocimetry ? classic "notching" characteristic of increased resistance in the placenta of patients with preeclampsia ? sensitivity of this test in patients with established early onset preeclampsia ranges from 87-96%.

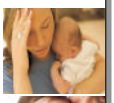


- In the absence of other disease, the treatment of choice for such pregnancies is parenteral magnesium sulfate to control and prevent convulsions, antihypertensive drugs, and termination of the pregnancy as a definitive cure.



Late postpartum preeclampsiæclampsia and HELLP syndrome

- Defined ? development of S/S of preeclampsia-eclampsia for the first time at >48 hours but <4 weeks after delivery.



- Historically ? believed to occur only< 48 hours from delivery.
- Several reports ? existence of late postpartum preeclampsiæclampsia.

Incidence of late postpartumeclampsia

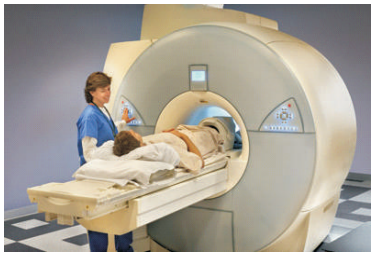
Year	Country	Study	Eclampsia (n)	Late postpartum eclampsia (%)
1994	United Kingdom	Douglas and Redman	383	5
1998	Colombia	Conde-Agudelo and Kafury-Goeta	164	12
2000	United States	Katz et al	53	6
2000	United States	Mattar and Sibai	399	17
2002	United States	Chames et al	89	26
2003	Singapore	Chen et al	62	3

- Recommend ? after delivery, any woman with a history of convulsions at >48 hours after delivery who is hypertensive and has either proteinuria or symptoms of preeclampsia ? considered eclamptic while other causes are being ruled out.

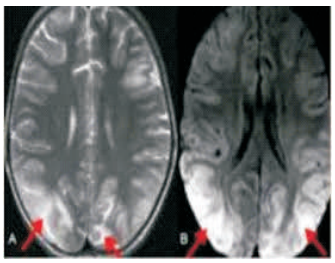
Differential diagnosis of eclampsia

- Cerebrovascular accidents
  - Hemorrhage
  - Ruptured aneurysm
  - Arterial embolism or thrombosis
  - Cerebral venous thrombosis
  - Hypoxic ischemic encephalopathy
  - Angiomas
- Hypertensive encephalopathy
- Seizure disorder
- Previously undiagnosed brain tumors
- Metastatic gestational trophoblastic disease
- Metabolic diseases
- Reversible posterior leukoencephalopathy syndrome
- Catastrophic antiphospholipid syndrome
- Thrombotic thrombocytopenic purpura
- Postural puncture syndrome
- Cerebral vacuities

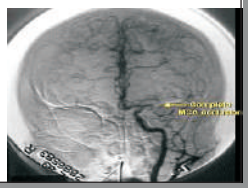
- Patients who do not improve rapidly after control of seizures and control of hypertension and women who have localizing findings on neurologic examination should be evaluated aggressively with neurodiagnostic tests.



- Classic finding in preeclampsia-eclampsia ? posterior reversible encephalopathy syndrome .



- Presence of unexplained blindness or other neurologic deficits ? another differential diagnosis is spontaneous reversible vasculopathy syndrome or cerebral angiopathy ? diagnosed by MRA or traditional cerebral angiography.



- Approx 20-30% of women with HELLP syndrome experience the manifestations for the first time at > 48 hours after delivery.
- In most cases ? delivery is the ultimate cure for women with preeclampsia/ HELLP syndrome ? in some patients, the syndrome ? may get worse after delivery.
- Should have prompt medical evaluation ? laboratory testing to rule out or confirm the presence of severe preeclampsia or HELLP syndrome.
- The D/D ? TTP, HUS, or exacerbated SLE

- Corticosteroids ? recommended to enhance fetal lung maturity in patients with severe preeclampsia at <34 weeks of gestation.

- Some authors recommend corticosteroids, particularly dexamethasone ? partial or complete HELLP syndrome in the antepartum and immediate postpartum periods ? improve maternal laboratory findings and/or to reduce maternal hospital stay.
- The use of corticosteroids antepartum actually may delay the onset of HELLP syndrome until the postpartum period.

- IV dexamethasoneto improve maternal outcome in women with HELLP syndrome in the postpartum period? controversial.
- Almost all studies? were retrospective in design or ? limited number of subjects

- 2 recent multicenter, doubleblind, placebo-controlled trials? revealed no improvement ir. maternal laboratory findings, maternal morbidities, or length of hospital stay.
- However ? limited number of patients with platelet count of 50,000/mm3 (total of 67 patients randomized in both trials).

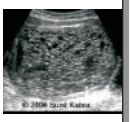
- More data are needed? Until then ? IV dexamethasone? remains experimental.

COMMENT

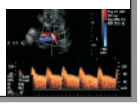
- Preeclampsia ? heterogenous clinical and laboratory findings ? pathogenesis can differ.

- Health care providers in obstetric practice should have a high index of suspicion for the potential atypical clinical manifestations of preeclampsia ,irrespective of gestational age at the time of onset or the number of days after delivery.

- Pregnancies with hypertension and proteinuria that occur at =20 weeks gestation ? ultrasound scan must be performed to exclude the diagnosis of molar or partial molar pregnancy.



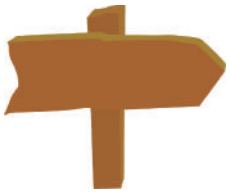
- Uterine artery Doppler velocimetry must be performed to evaluate uterine artery resistance and the presence of a notch ? The presence of notching in the uterine artery is highly suggestive of preeclampsia.



- A CBC, LFT,LDH and a disintegrinlike and metalloprotease with thrombospondin should be considered to rule out TTP.
- An antinuclear antibody screen, antimitochondrial antibodies, serum serology, and serum biochemistry ? exclude the diagnosis of SLE.

- Anticardiolipin antibody and lupus anticoagulant should be performed to rule out antiphospholipid antibody syndrome.
- Urinalysis, a 24-hour urine collection, and renal tests ? possibility of undiagnosed renal disease.

- Gestational hypertension or gestational proteinuria alone may be the first sign for subsequent developmentof preeclampsia.

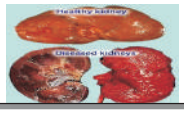


- In women with gestational hypertension, the risk of progression to preeclampsia is related inversely to gestational age at onset ? close antenatal follow-up evaluations
  - New onset of symptoms
  - Regular evaluation (1-2 times/wk) of platelet count and liver enzymes for early detection of preeclampsia.
  - Ultrasound scans for the evaluation of fetal growth and amniotic fluid and
  - Uterine artery Dopplervelocimetry to evaluate the presence of notching.

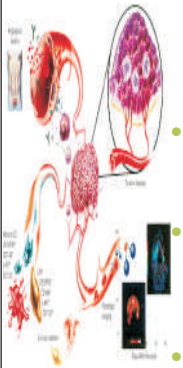
- **Symptoms and/or abnormal laboratory tests or women with abnormal ultrasound findings? atypical preeclampsia? treated.**

- **However, the results from uterine artery Doppler imaging have no prognostic value regarding the timing of delivery.**

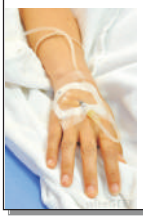
- Patients with gestational proteinuria
  - Evaluated for the presence of undiagnosed diabetes mellitus (glucose testing)
  - Undiagnosed lupus (serology, antibodies, anticardiolipin antibodies, and platelet count)
  - metabolic profile
  - complete urine analysis, and 24 hour urine for creatinine clearance and quantitative proteinuria



- Several circulating angiogenic markers ? predict or confirm the diagnosis of preeclampsia.
  - Reduced serum placental growth factor
  - Elevated soluble fms-like tyrosine kinase-1 receptor
  - Elevated serum soluble endoglin levels.
- Magnitude of the imbalance between these angiogenic markers ? disease severity and with early onset of preeclampsia.
- These markers may be useful clinically to rule out the diagnosis of preeclampsia in women with either gestational hypertension or gestational proteinuria.
- Further research should be performed



- In cases with hypertension, symptoms of headache or blurred vision, with or without seizures at 48 hours after delivery ? $MgSO_4$ therapy ? other possible causes of the aforementioned symptoms are being ruled out.
- Loading dose of 4 g over 30 minutes ? maintenance dose of 2 g/hour for at least 24 hours after the last seizure ? UO, BP, and maternal symptoms ? monitored closely after discontinuation of $MgSO_4$.
- If ? severe hypertension alone ? antihypertensive therapy should be administered to stabilize blood pressure to a level of 150/100 mm Hg.



- Condition does not respond to such therapy or the patient continues to have seizures despite magnesium sulfate therapy or continues to have cerebral symptoms ? brain imaging with MRI and angiography ? to R/O presence of other cerebral disease

- Patients ? persistent nausea, vomiting, epigastric pain, or mucosal bleeding with or without hypertension at >48 hours after delivery ? evaluated for possible HELLP syndrome.
- Platelet counts, liver enzyme tests, and coagulation studies as needed to rule out other disease, such as TTP, HUS and acute fatty liver of pregnancy.
- Abdominal imaging studies may be needed on the basis of clinical and laboratory findings

TAKE HOME MESSAGE

- **Widen the spectrum of the definition of preeclampsia to cases that manifest as hypertension without proteinuria and vice versa.**

TAKE HOME MESSAGE

- Important to obtain a detailed history, to assess for the presence of symptoms, and to obtain targeted laboratory tests, as needed, to confirm the diagnosis of atypical preeclampsia.

TAKE HOME MESSAG

- Further research? measurements of serum angiogenicmarkers and other potential biomarkers in cases of atypical preeclampsia to determine whether these markers can be useful potentially to confirm the diagnosis in such women.

Classification

- GESTATIONAL HYPERTENSION
- PREECLAMPSIA
- CHRONIC HYPERTENSION
- CHRONIC HYPERTENSION WITH SUPERADDED PREECLAMPSIA

COURSE OF DISEASE

- Mild–moderate disease normapreg outcome
- Assoc with complications/hypertension poor outcome(including IUGR)
- Prevabortion/early onset ht inc risk of preeclampsia
- Mild chr ht inc risk PE/ABRUPTION/PTL/SGA

- *Preeclampsia potential to progress to severe PE/BP*

INITIATION OF ANTIHYPERTENSIVES

- Earlier >160/110
- Now >DBP>100

	initiation	**achieved**
Cannada	140-150/90-95	DBP 80-85
Australia	>160/90	80-90

- DRUGS alphadopa (max dose) 2000mg
- nifedipine 120mg
- labetalol 240mg

EFFICIENCY OF ANTIHYPERTENSIVES

- DEC RISK OF SEVERE HT BY 50%
- DEC ABRUPTION
- NO DIFF IN PE/IUGR/PTL/NURSERY ADMISSIONS

COMPARISION OF DIFF ANTI HT

- NO DIFF IN RISK OF severe HT/PE/LSCS/PTL
- NO SINGLE CLASS OF DRUG BETTER THAN OTHER
- 50% REDUCTION IN RISK OF FETAL/NEONATAL DEATH WHEN ANY DRUG COMPARED WITH ALPHA DOPA
- DEC RISK OF PE WITH ATENOLOL BUT INC RISK OF IUGR
- ACE INHIBITOR IN 2ND TRIMESTER RENAL FAILURE IN FOETUS
-

MANAGEMENT

- pts from under resourced region
- Proteinuria
- Chronic HT with target organ damage/prev perinatal loss
- Informed patient choice
- Start antihypertensive agent & reg monitor
- Labetalol for cvs
- Nifedipine for DM with vasculopathy

Case-1

- 32yr old G2P1 at 34wks gest was unwell for 24hrs
- Headache
- Blurring of vision
- ?fever
- Epigastric discomfort
- Nausea
- She had pedal oedema forsome wks but now her hands also are swollen& face puffy
- Baby is moving normally
- No bleeding PV/leakingPV/pain abd

Case -1

- 1st visit at 12wks bp 100/60mmHg
- Blood tests & scans all normal & corresponding till 30 wks gestation

- O/E
- Pedal edema up to knees Face & hands swollen. Pulse98/min BP 140/86mmHg. fundus normal
- ABD tender RUQ &epigastrium uterus 32 wks size non tender relaxed with SLF cephalic presentation FHS regular DTR normal

INVESTIGATIONS

- Hb 10 gm
- TC
- DC
- Platlet 1.1 lakhs
- BU 20 CREAT 0.9 URIC ACID 5.6
- Na 124 K 5.5 CL 135
- S.Bil 2.0 SGOT/SGPT 123/253 Gamma GT 26
- PT 12secs INR 1.0 APTT 29secs
- RBS 85mg

Case-2

- 31 yr old G5P1A3L1 at 35 wks gestation unbooked pt came to the emergency with fever myalgia and headache since 1 week . Her BP 140/90mmHg pulse 102/min. Per abd – SLF of 34wks gestation cephalic presentation FHS reg. PV unfavouable bishops score & adequate pelvis.

Case 2

INVESTIGATIONS

- HB 9.0gm TC 45000 DC n78l20e2 platlet 1.7lakhs pt 26secs INR1.8 APTT 46secs BU 24 CREAT 1.2 UA 6.8 LDH 676 S Bilirubin 5.2 AST 1234 ALT 689 Gamma gt 27 ALP 254 Na 135 K4.6 CL 135 RBS 35mg fundus normal

Evangelization through Healing Ministry

Sr. Dr. Melba CSA

1

Introduction

The mission of the church in the health care industry is to reveal and mediate the healing redemptive love of Jesus Christ in the world. It is the commitment of the church to powerfully promote health and wholeness and to extend Christ's Healing Love to people whose lives have been disrupted by sickness, injury or death Healing as a process of restoring ones health to wholeness has been a genuine and sincere concern through healing Ministry.

2

The thrust of "Healing Power of Love " as a subject of today based on the background that Christ when he was on earth healed the whole person. (holistic care). Our reflection deals today with the secrets of God's hidden healing power of love intervening in our every day encounter with the patients as health care givers. The healing power of love is very important and timely aspect of our health care that needs to be fully activated in our healing ministry.

3

Just as a song goes: '**Great things happens when God mixes with us'.** When we consider the healing mission of Jesus Christ is that he brings into the world everything that God is. He brings love, compassion, kindness, and mercy. He manifests in himself in the very nature of God. Jesus is the fulfillment of God's promises to his people.

4

Psalm 23 tells us: "The Lord is merciful and loving". Jesus is the incarnation of that mercy and love.
Jeremiah 33:36 "Look ,I shall cure them and reveal a new order of peace and loyalty to them".
Jn. 3:16. "For this is how God loved the world; he gave his Son, so that everyone who believes in him may not perish but may have eternal life".

5

Jesus is the New Testament instrument of God's healing and loving mercy to the sinful world. Jesus was well aware of this mission when he declared in the Gospel of Lk 4:18-……
"The Spirit of the Lord is upon me because he has chosen me to bring good news to the poor. He has sent me to proclaim liberty to the captives and recovery of sight to the blind, to set free the oppressed and announce that the time has come when the Lord will save his people

St. Peter summed up the life and ministry of Jesus in these words "**He went everywhere doing good and healing all who were** Healing is to be understood not only as an alleviation of external pressures but also as a response to man's search for internal liberation **under the power of the devil, for God was with Him"** Acts:10:38. In each case , it was the wholeness of the individual, being restored. When presented the heart of his redemptive mission, Jesus said, **"I came that they may have life, and have it abundantly (Jn.10:10).**

7

Health care is a ministerial instrument of God's outpouring love for the suffering person and at the same time it is an act of love of God, shown in the loving care for the person. It is where evangelization becomes an essential part in the healing ministry.

8

What is Evangelization?
Evangelization means :-

- 1. Proclamation of Christ and His Gospel word and the testimony of life in fulfillment of Christ's demands.
- To proclaim God is to introduce to the relation with God, to teach how to pray.
- Prayer is faith in action.

2) Evangelization is witnessing to Christ. Jesus said "you will receive power when the Holy Spirit comes and then you will be my witness (Acts 1:7) "We become witness when through our actions, words, and way of being. Another makes himself presents."

- **It is through our way we live the new life of the Spirit that Christ becomes present to others.**
- **And, it is through his becoming present to others that the evangelization takes place.**

- The goal of the transmission of the faith is the realization of a personal encounter with Jesus Christ, in the spirit thereby leading to an experiencing of His Father as our Father.

When Christ becomes present, through our witnessing, He wants to do for others what we proclaim at Mass. "You were sent to heal the contrite. He is there "to let the oppressed go free". LK (4:18).

11

The healing of the broken oppressed heart is central of the liberating mission of Christ because the Lord knows that the heart was created for love and that love alone can satisfy the heart.

- Effective evangelizations takes its cue from this absolute need for a true and fulfilling love.

12

- It is because each human being is made in the image of God who is love.
- The cause of the famine of love we see today is Selfish self seeking in place sincere self giving.
- Self – Seeking springs from a wound of self –rejection and cannot bring us happiness.

13

- Through healing ministry the deepest healing that a person can experience is the healing of the broken heart that liberates the person to love -with a love of Self-giving.
- "This is the love' that has been poured into our hearts by Holy Spirit who has been given to us". (Rom. 5:5)

14

- This healing of the broken heart comes when we stop living by about ourselves and begin living by God's word to us about ourselves.
- "Humans do not live by bread alone but every word that comes from the mouth of God". (Mt 4:3).

15

- **The word of God reveals to person that truth about ourselves. "We are all sinners, but we are much loved and redeemed sinners."**
- **The inheritance of our heart is deeper than our sinfulness inheritance (John Paul).**
- **People often turn to drugs, drinks, Sex, to be freed, the gnawing, dissatisfied feeling that results from not seeing themselves as God sees them. Due to shame & guilt, unable to accept themselves gratefully.**

✖ A last central element of every true evangelization is eternal life.

✖ Today we must proclaim our faith with new vigor in daily life. Here I would only like to mention one aspect of the preaching Jesus. The proclamation of the Kingdom of God is the proclamation of the God present, the God that knows us, listen to us, the God that enters into history to do justice.

17

- **How will we able to do this better?**
- The more we are able to live under the eyes of God and to communicate the truth of justice to the world.
- This is also how we can understand the connection between the Kingdom of God and the poor, the suffering and all those spoken about in the Beatitudes in the Speech on the Mountain. They are protected by the certainty of judgment by the certitude that there is a justice.

19

- What is Mission?
- Mission is 'Me' because mission can be fulfilled only through me. If Jesus has called You & Me, He has not made a mistake. He is counting on us because others can be saved only through you & me. So Jesus says "Go and make disciples".
- It does not matter what ministry we take up. What matters is how we do it.
- Share the good news with people.

✖ Therefore this preaching is also the proclamation of justice the proclamation of our responsibility.

18

Jesus Healing Ministry

- **"WOE to me, If I do not preach the Gospel"** (St. Paul)
- "To be healthy and be fully alive is everybody dream. It is the basic human drive. Jesus mission was to respond to the fundamental human yearning, as he said "I have come to give life, life in its fullness." (Jn. 10:10).

- **Christ gave the same mandate to his disciples saying, 'Go and heal' (Mt.10: 1, Lk.9:1)**
- **Therefore it is rightly considered that the service to the sick is an integral mission of the church. (Pope John Paul II 1985, 2).**
- **And Jesus said to them "Follow me and I will make you fishers of men".**

21

- **This is the healing ministry of Jesus which we are called to do.**
- **If I know, Jesus gives eternal life and I do not speak to others. Do I really believe in Jesus?**
- **If I believe, Jesus is the Truth but shares that truth with none. Is my truth in Christ real?**
- **If I believe that Jesus is the way and I do not show anyone the way to the Father Is my faith in Jesus true?**

If I fail to make disciples for Jesus, will I be saved?

- Gospel makes clear that Jesus called his disciples to be with Him so that later he could send them out to evangelize.
- **PersON OF God Experience**
- He who has discovered Jesus shares the one he has found with others. He cannot remain quiet and fail to speak about what he has seen and heard.

If I have experienced Jesus I cannot remain silent, I will move myself to others. Explain / proclaims every experience of God to others.

- By following Jesus in His healing ministry others will be drawn to Him, learn to love Him, attached to Him and they will make Him known to others and desire to experience Him more and more.

- **Witnessing life.**

- Evangelization therefore means your union with Christ. The greater we are united with Christ, the greater will be the energy to proclaim Him to others.

Therefore Evangelization is a personal sharing of Christ experience than speaking from pulpit. It is not speaking about some doctrine, or just talking about Jesus.

Example :-

- (Jn:1:35 -41). We found the messiah
- (Is:64) – They were in search for a Messiah?
- **Can you and I say that I found the Messiah?**
- (Jn. 4:29,39) Samaritan woman.
- After she found Jesus. She left the Jar and ran and told **"come & see a person who told me all about me."**
- A public confession. People found change in her and everything has changed in her life.

27

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28

- **Therefore Evangelization is a personal dimension and a personal character.**

(John Paul II)

- It does not mean change in dressing, talk, walk etc.
- Jn. 20:11-18. Mary near the tomb.
- Jesus called 'Mary'. She recognized Jesus and Jesus said to her "Go and tell my brothers, I will meet them". ...
- Mary said to them **"I have seen the Lord."**
- **This is what the Lord asking you & me to tell others.**

How can I compare my God experience with the above characters

- What extent can you and I tell the people about our experience of God?
- When I say, I have seen the Lord, I have met the Lord, and I have experienced the Lord, then the sick whom I serve will ask me **"Can you tell me about Him."**
- **Hence it is essential that an evangelizer must experience Him first and must be a person of God experience. All this depend on how deep is my experience of God. Only then the healing ministry of Jesus become an evangelization by me.**

30

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31

- **Mk.5 -1 - Allow me to follow you – "Go and tell the People what the Lord has done for you".**
- (Share your experience)

32

- Paul said **"Woe to me If I do not preach".**
- **Pre- Requisite of Evangelisation**
- Sharing of Christ - needs encounter with Christ.
- Commitment Comes from conviction
- Conviction Comes from experience.
- Therefore personal encounter is important.
- **This encounter changes my life and make me an Evangelizer.**

How did God intervene in your life?

Acts. 4:20

- "After Pentecostal experience they worked Miracles of healing". (Act 34.19)
- 1 Cor: 9:16
- "Every one who has been baptized and who is a believer has a responsibility to give to the world and a world has a right to know how the Lord Loves them. They have a right to know from you and me because it is given to you and me".

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- **Samaritan Woman**. (Jn 4: 18).
- Lost in flesh.
- Unable to control her sexuality.
- Hiding from everyone.
- Did not want to be disturbed from filth.

37

- **ATTITUDE OF JESUS**
- Jesus : - Looked at her Compassionately
- Jesus was waiting alone with the woman
- Looking at her so tenderly.
- What is my attitude to people of this type when I encounter them in the healing ministry?

- **Jesus healed a man from evil spirit.** (Mt. 5:1 -7)
- **The result of Jesus encounter**
- His mind become orderly and settled.
- He became silent, serene, no more shouting or yelling.
- Became a Liberated person.
- Desires to follow Christ
- Becomes strong.
- His goal of life changed

- **Jesus said to him – "Go and tell your people".**
- He went to 10 towns.
- Proclaiming Jesus.
- **He become the mighty missionary among elite. (Transformation)**
- **So If we want to be an evangelizer**
- Seek encounter.
- Seek Jesus Christ
- Search for the Kingdom (Mr.6.33)
- Search until we possess the Lord.

40

- **Do I have a spiritual appetite to discover Christ?**
- **Is my soul thirsting for God like deer, panting for living water?**
- The Evangelizer should be filled with the love of Christ to evangelize others.
- Do I have the same experience and thirst for Jesus?

41

- **Healing is good news.** It is undoubtedly one of the best tools for evangelization. Jesus is the **Master Healer.**
- Jesus had a unique evangelism method in His healing ministry. Jesus preached about the kingdom of God and healed the people who came to Him.
- Therefore evangelizing is telling people the **Good News** of **how God sees them**. This is the first step in our healing ministry.

43

Jesus carried out His healing ministry. People longed to see Him, to listen to Him and to allow themselves to be transformed by Him. The sick are cured, water is changed into wine, bread is multiplied and the dead came back to life.

This was Jesus's Ministry and He was the Evangelizer. This is what we are talking about Evangelization through healing ministry.

If I continue the healing ministry of Jesus, and I must have the attitude of Jesus and people must find Jesus in me and the people whom I serve will follow Him and His ways because of me.

- Hearing and believing God ‘s word to us about ourselves (God loves you) instill in our hearts a true amazement at **the love** that God has lavished on us, and **Man’s Worth and the dignity** he has bestowed upon us human beings.

44

- The best gift we can give to people who are physically sick is to **awaken within them this sense of amazement at their dignity as sons and daughters of God**. This belief will fill their hearts with a fresh outpouring of **gratitude to God** for the gift of their life. When the grateful heart turns to God, **peace and acceptance expel fear and distrust,** and the **person's whole being becomes open to the healing love of God.**
- When we instill in the hearts of people a desire to live and a life in its fullness we evangelize them (sick) through healing ministry.

- **<u>Praying for healing with the sick</u>**
- With our attitude and love for Jesus, when we pray for healing with the sick, their fear, self-rejection leave their hearts and they are healed physically, mentally, spiritually and socially even morally.

Our main concern in healing prayer should be to bring the person into peace and profound healing either a physical or an inner healing. The whole person is healed. **This is Evangelization through healing ministry.**

49

Spiritual Transformation

The hand of a Nurse that heals points the way to the Saviour.

⊡ **Healing the wounds of sin, the Holy Spirit renews us interiorly through a spiritual transformation. He enlightens and strengthens us to live as 'children of the light' through all that is good and right and true.**

⊡ **In the healing ministry when we serve the sick physically, we also touch their souls. This is the impact of evangelization through healing ministry.**

God is now inviting you and me through the ministry of healing to teach people whom we serve to cast all their worries onto Him, to free their minds and hearts of all anxieties and worries about their family, about their future, so that they will be able to use all their energies to fight the disease. Because he / she is God's beloved child, God wants him to mobilize all his / her inner strengths to fight for recovery and not dissipate his / her energies through worry of any kind.

- **MESSAGE :-**
- **We need to be the Message**
- A letter (Not a Post Man). To be read, to be known and understood by whom we serve (the sick & suffering).
- **Be a Good News:** Having from within
- A rose flower does not need to be advertized.
- **Be an aroma / fragrance of Christ** (2 Cor.2:15)
- Only then you and I **credibly preach Christ.**
- **Our interactions with people, our behavior, our way of life, our attitude should be according to the values of the Kingdom.**

Power of the name Jesus

- Act 4:12.
- Only though the **Name of Jesus** man can receive salvation there is **power in the name of Jesus.**
- Let the people know this fact.
- Help the sick and their families to say the name of **Jesus.**
- **Jesus came to give liberation** - not just to teach liberation.

- Jesus asked people **"Do you love me …"?**
- **"Take care of my sheep".**
- **Love of God** and love of neighbor will go hand in hand. If we do not love God, then we cannot love others. The fruit of love is **service.**
- In order to serve the sick, we need to love God.
- Eg. Mother Teresa

51

Suggestions

Spiritual atmosphere in hospital / dispensary / ward/ department

Allot a day for Intercessory prayers for patients and with them and their families.

Pause for a moment near the patients, touch the patients and say a short prayer, taking the name of Jesus.

Pray with the patients & companions before starting the day, addressing to Jesus the divine healer.

Give short word of God to patients and ask them to repeat them.

- Display the word of God. (Scriptural quotations in the wards / O. P. D etc.)
- Listening to their problems.
- Praying over.
- Soft Spiritual music - hymn
- Kerigma to patient.
- **Every patient is respected with dignity, irrespective of caste, creed, rove, religion.**
- **Allow your own faith to carry over to your work.**

54

- **Questions**

- What are the elements in me that hinder the work of evangelization through healing ministry?
- What are elements in me that help the works of evangelization through healing ministry?
- How can I make myself and our Institutions (Hospitals / Health Centres) more vibrant & viable for evangelization through healing ministry?

NEONATAL SEIZURES

Dr. Suman Rao PN MD, DM
Dept. of Neonatology
SJMCH

Seizure Patterns in NB

NB more prone, No GTC

- Subtle
- Focal clonic
- Multifocal clonic
- Tonic
- Myoclonic

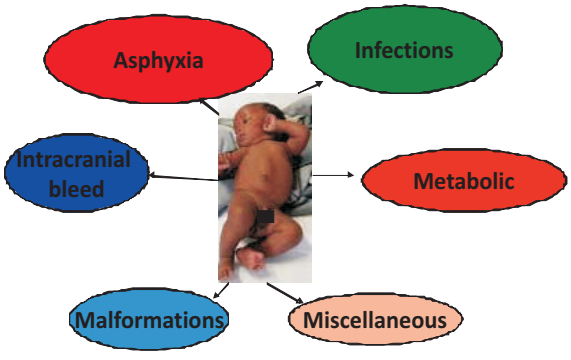
1

Jitteriness

- Stimulus sensitive
- Tremulous movements (5-6 per sec)
- Pendular
- Not a/w abnormal respiration or HR, BP
- No abnormal gaze or eye movements
- Terminated by passive flexion or ext.
- EEG: Normal

2

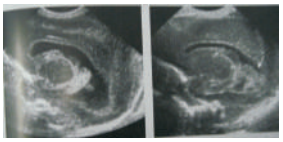
Diverse Etiology



1. Hypoxia–ischemia

2. Intracranial hemorrhage

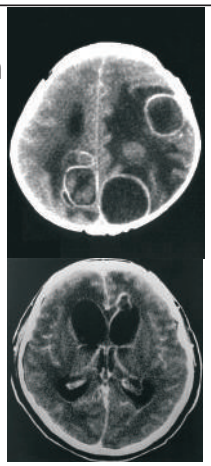
- SDH
- SAH
- GM-IVH – Preterm < day 3
- 15% in term, more in preterm



5

3. Infection

- Bacterial – G - ve, E coli, Klebsiella , GBS, listeria , Staph
- Non bacterial
  - – Toxo , CMV, rubella .....< 3 d
  - – Herpes, coxsackie B……3 -7 d
  - – Candida
- Seizures in septicemia alone ???



6

4. Metabolic

- **Hypoglycemia: PT,LBW, IDMs,sick baby**
- **Hypocalcemia : Early: PT, Asphyxia, IDMs**
  Late : formula feeding,vit.D abn, renal disease
- **Hypomagnesemia**
- **Hypo / hypernatremia**
- **Kernicterus**
- **Pyridoxine dependency**
- **IEM**

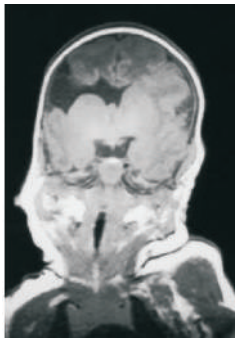
7

Metabolic…..Hypoglycemia

Sz worsens Hypoglycemia

5. Developmental defects

- 5-10%
- Cerebral cortical dysgenesis
- Migration – lissencephaly, pachygyria, polymicrogyria
- Tuberous sclerosis



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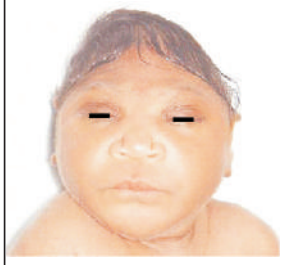
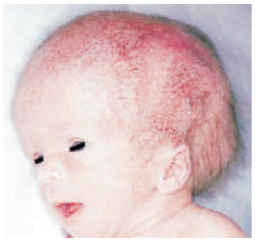
5. Developmental defects





Clues: Dysmorphic face
Abnormal HC

10

6. Miscellaneous

- Drug associated: Passive drug withdrawal, LA, Theophylline
- Polycythemia, Hypertension
- Neonatal epileptic syndromes
- Benign familial
- Fifth day seizures
- Benign sleep myoclonus

11

Investigations

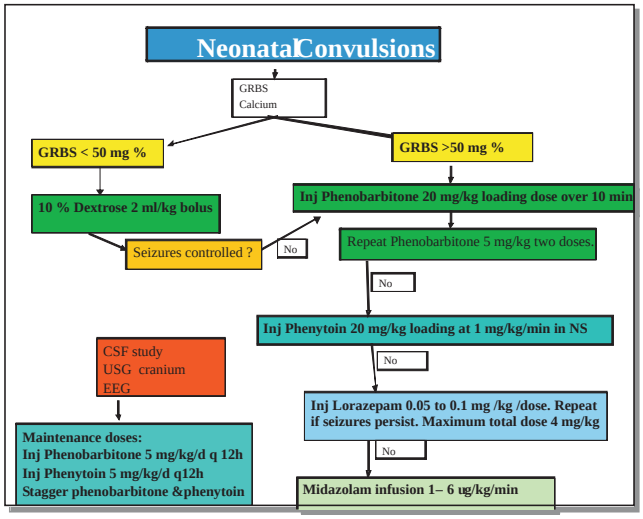
- Blood Sugar
- S. Calcium
- S. Phosphorus
- S. Magnesium
- S. Electrolytes
- Septic profile
- CSF

12

MANAGEMENT- supportive

- Ensure
  - A irway
  - B reathing
  - C irculation
- Ensure Hemodynamic stability

13



Refractory seizures

- Valproic acid
- Levetiracetum, Topiramate, Vigabatrin, Carbamazepine
- Pyridoxine -50 -100 mg
- Diazepam is rarely used in neonatal period

15

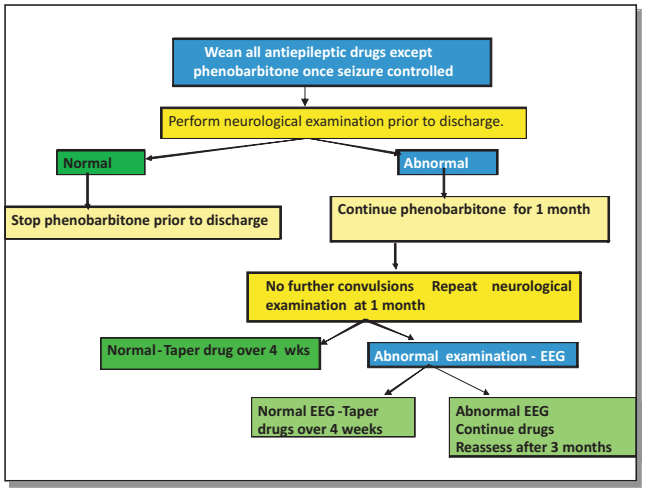
Treatment

- Once under control for 48– 72 hrs., wean the drugs slowly in order to maintenance phenobarbitone
- Treatment of the cause of convulsion eg. Meningitis, hypoglycemia, hypocalcemia, polycythemia

16

PROGNOSIS

NEUROLOGIC DISEASE	% NORMAL
HIE	50
ICH With H'gic. infarct	<10
Primary SAH	90
Hypocalcemia-Early	50
Hypocalcemia-Late	100
Hypoglycemia	50
Bacterial Meningitis	50
CNS malformation	0



Case 1

3.6 kg at 40 weeks

- Fetal dips,
- Resuscitation at birth
- APGAR 2/ 10, 5/10
- Abn movements at 5 h

19

Cause?

- Hypoglycemia
- Hypocalcemia
- Perinatal Asphyxia

20

What to do?

- GRBS
- Collect for Ca
- Start Phenobarbitone20 mg/kg loading dose
- CSF?

21

Case 2

Term 1.8 kg with mother

Feeding well till 24 hours

At 30 hours– lethargic, poor feeding, attempt palladai

Seizures at 34 hours

22

Cause?

- Hypoglycemia

23

Treatment

- Prevention
- Symptomatic hypoglycemia – 2 ml/kg of 10% Dextrose IV followed by
- IVF at GIR of 6-8 mg/kg/min
- Risk of abnormal neurodevelopment

24

Case 3

3 day old

Consanguineous marriage

Uneventful delivery at term

No risk for sepsis

Presents with lethargy and seizures

IEM

Case 4

26 d old 2.2 kg on cow's milk

presents with

- lethargy
- poor feeding
- fever
- seizures

Sepsis

Cases

Term 2.3 kg with focal seizures	
950 g 26 h presents with posturing and sudden pallor	
Dysmorphic face with seizures	

Cases

Term 2.3 kg with focal seizures	Stroke
950 g 26 h presents with posturing and sudden pallor	IVH
Dysmorphic face with seizures	Cerebral malformation

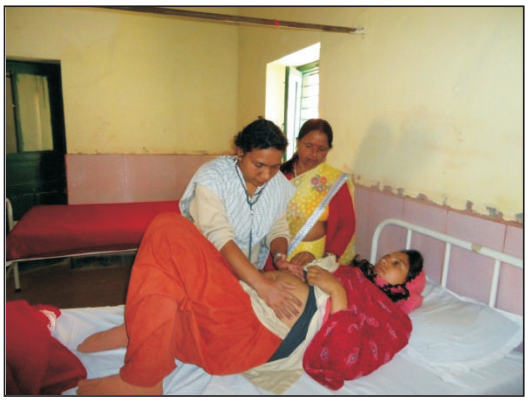
From Guptakashi…

..the beautiful Himalayan valley..

Nature's fury- the disastrous floods hit Kedarnath, washing out so many lives ,live stock , possessions and things that the people of Utharakhand hold dear to the

" It is better to be late than never" was the thought that came to me when I received the invitation for help from CHAI and SDFI. Though many months have gone by after the terrifying tragedy that left this beautiful land at a standstill, rehabilitation attempts are still on by the Government, NGOs and many other organizations.

I was placed in a Government PHC in Guptakashi in Rudraprayag district in Utharkhand. The people were cut off from health facilities and from the city due to lack of roads and transportation considering the narrow mud roads have always been under the threat of landslides , floods and accidents.



It took a whole day's journey from Kotdwar , Karuna Social Service Society, who were the local animators of the relief work in BIJNOR Diocese , to reach Guptkashi where I worked as medical officer for 13 days .The acute phase was already over when serious patients, severely injured persons and pregnant mothers had to be shifted by helicopters to the hospitals in Dehradun.

We had in the PHC , a resident medical officer, a pharmacist, an ANM nurse and myself serving about 60 to 70 patients daily ,with various illnesses, occasionally inpatients and emergency calls. There were men, women and school children. I was happy to attend to pregnant women who were happy to have a lady doctor.

Stay was arranged in a guest room of another NGO, also serving the people to make their livelihood. It was very cold and the journeys were dangerous. We had a few patients attacked by wild animals.

"People of the Hills" as they call themselves were serene, welcoming and simple. It gave me joy to work in a Government facility which lacked staff and facilities so that I could at least be of a little help to them. Medical support including medicines, injections and dressings at a minimal cost of only Rs. 5. Thanks to NGOs and others who have given so much help to these centres.

The cold weather, lack of facilities and comforts for a few days seemed enjoyable and out of the ordinary. The missionary spirit of the fathers and sisters in Bijnor Diocese, few of whom I met and saw their challenging life style to serve those people, inspired me as well as challenged me to question my mediocrity.

It was indeed the generosity of Sr. Lorraine and my community at Yerla who spared me for this trip. I'm also grateful to CHAI and SDFI for the invitation to be a part of this mission.

Sr. Dr. Bindhumol George CSSJ,
Northern Region.

LEAD TO SERVE

It was indeed a great experience when 47 of us belonging to the Batch 1972 and 1973 of St. John's met on 8th and 9th of August 2013 when our Alma Mater celebrated the Golden jubilee.

All of us gathered in a resort where the atmosphere was quiet and surrounded by nature. We were excited to see our class mates, some of them after 30 to 35 years, with a transformed look and with their spouses. With great joy we wished each other.

One of the memorable events of the get together was the session of sharing among ourselves about our activities since the time we left St. John's. Another interesting session was sharing some of the unforgettable events during our student days. With good laughter we enjoyed the session. Some of them have reached the status of grandparents, but with the same old spirit of student days they participated in many games. The next evening we had the opportunity to meet and honor some of our Professors and have dinner with them.

Our experience as Sister Doctors was indeed great. Five of us were present for the get together- Sister doctors Clere, Agnes, Judith, Jacintha and myself. We had a small sharing among ourselves and we prayed for each other and all our classmates by singing a simple but precious prayer taught by Sr. Clere.

Precious Blood of Christ purify us of Lord

Precious Blood of Christ protect us O Lord,

Precious Blood of Christ save us O Lord,

Precious Blood of Christ strengthen us O Lord,

Precious Blood of Christ sanctify us O Lord,

Precious Blood of Christ heal us O Lord.

Glory be to the Father and to the Son and to the Holy Spirit.

As it was in the beginning is now and ever shall be world without end. Amen.

It was a brought home message for us and I felt it was so powerful. I pray this prayer everyday for my community Sisters and for others so that it enables us to commit ourselves to serve our people in a better way.

As our Pope Francis has said "The Christian life is not limited to prayer, but requires an ongoing dedication and courage born of Prayer". **LEAD TO SERVE**: A leader's power does not reside in being right, but in being real. Pope Francis epitomizes a true '**Servant Leader**,' led by his desire to bring hope, equality and opportunity to those who have little, and a role model of mercy, love, compassion and courage of **THE MAN** whose church he leads. All of us are leaders in our own domain. Every one of us can take something from the leadership of Pope Francis and apply it to lead our lives with greater integrity, more courage and deeper compassion.

Sr. Dr. Hermina SSA,

Mother Joseph Hospital,

Chennai, Tamil Nadu.

Medicine Update Lecture Discussion

(Diabetes & Hypertension)

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Outline of the talk

- Approach to fever
- Recent advances
- Approach to bites

Case 1

- A 35 yr male presents with fever and chills of 5 days duration.
- O/E Patient is toxic
- Pallor and Icterus present
- P/ A liver palpable 3 cms below the costal margin - soft and smooth not tender
- Spleen palpable 7cms soft.
- All other systems are normal
- What is your likely diagnosis?
- What test will you order to confirm the diagnosis

Rapid Diagnostic Test

- Rapid Diagnostic Tests are based on the detection of circulating parasite antigens.
- NVBDCP supplies RDT kits for detection of P. falciparum at locations where microscopy results are not obtainable within 24 hours of sample collection.
- Pf HRP2 based kits may show positive result up to three weeks of successful treatment.

- Earlier, any fever case was considered as malaria, until proven otherwise and presumptive treatment with chloroquine was initiated.
- Now, as per the drug policy 2011, presumptive treatment is no longer followed.

Uncomplicated P. vivax-

- Chloroquine for 3 days
  - –Day 1: 10 mg/kg +
  - –Day 2: 10 mg/kg +
  - –Day 3: 5 mg/kg)
- plus Primaquine 0.25 mg/kg daily for 14 days

Uncomplicated P. falciparum

- Artesunate (4 mg/ kg body weight) daily for 3 days and **+**
- Sulfadoxine + Pyrimethamine (25 g/kg + 1.25 mg/kg body weight) on Day 0 **+**
- Primaquine 0.75 mg/kg body weight single dose on day 2

Mixed Infections
(P. vivax + P. falciparum)

- Full course of artemisinin-based combination therapy (ACT) + Primaquine 0.25 mg/kg daily for 14 days

During pregnancy -

- First trimester-
  - – Quinine salt 10 mg/kg daily for 7 days
- Second & third trimester-
  - –ACT to be given

Primaquine - contraindications

- G6PD deficient patients,
- Infants
- Pregnant women

Artemisinin Combination Therapy (ACT)

- Artemisinin derivative combined with a long acting antimalarial
- The ACT used in the national programme in India is
  - artesunate + sulfadoxine -pyrimethamine (SP).
  - Artemether + Lumefantrine fixed dose combination
  - blister pack of artesunate + mefloquine
- Artemisinin derivatives must never be administered as monotherapy for uncomplicated malaria
- Areas which qualify for ACT
  - High Pf endemic districts in seven North -eastern states ,
  - Andhra Pradesh,
  - Chhattisgarh,
  - Jharkhand
  - Madhya Pradesh
  - Orissa

Some points on therapy

- 'Clinical malaria' cases should be treated in full therapeutic dose.
- Avoid starting treatment on an empty stomach.
- The first dose should be given under observation.
- Dose should be repeated if vomiting occurs within 30 minutes.
- Re-examine the patient
  - If there is no improvementafter48 hours or
  - if the situation deteriorates.

Chloroquine for P. vivax and P. falciparum cases in areas considered to be chloroquine sensitive

Age in years	Number of tablets		
	Day 1 (10 mg/Kg)	Day 2 (10 mg/Kg)	Day 3 (5 mg/Kg)
<1	½	½	¼
1 – 4	1	1	½
5 – 8	2	2	1
9 – 14	3	3	1½
15 & above	4	4	2

ACT (Artesunate + SP) dosage schedule for P. falciparum cases in chloroquine resistant areas

Age in years		Number of tablets		
		1st Day	2nd Day	3rd Day
< 1	AS	½	½	½
	SP	¼	Nil	Nil
1 – 4	AS	1	1	1
	SP	1	Nil	Nil
5 – 8	AS	2	2	2
	SP	1½	Nil	Nil
9 – 4	AS	3	3	3
	SP	2	Nil	Nil
15 and above	AS	4	4	4
	SP	3	Nil	Nil

Primaquine for P. vivax (Daily Dosage for 14 days)

Age in years	Daily dosage (in mg base)	No. of tablets (2.5 mg base)
< 1	Nil	Nil
1 – 4	2.5	1
5 – 8	5.0	2
9 – 14	10.0	4
15 & above	15.0	6

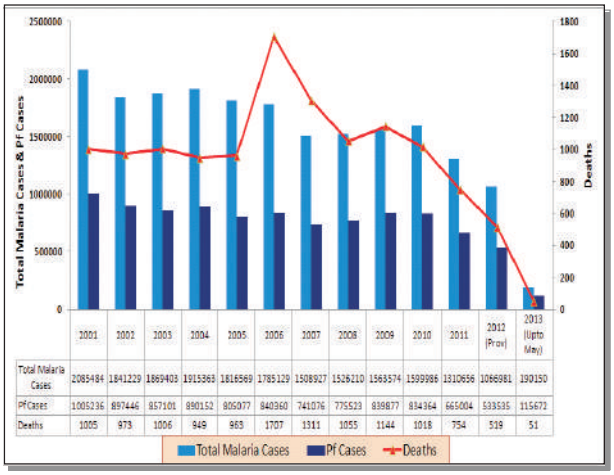
Treatment – IV phase

- Drug of choice - Parenteral
  - Artemisinin derivatives or
  - Quinine should be used irrespective of chloroquine sensitivity
- Artemisinin derivatives
  - Artesunate 2.4 mg/kg i.v. or i.m. given on admission (time=0), then at 12 hours and 24 hours, then once a day
  - Artemether 3.2 mg/kg i.m. given on admission then 1.6 mg/kg per day.
  - Arteether 150 mg daily i.m. for 3 days in adults only (not recommended for children).
- Quinine:
  - 20 mg quinine salt/kg on admission (i.v. infusion in 5% dextrose/dextrose saline over a period of 4 hours) followed by
  - maintenance dose of 10 mg/kg 8 hourly ;
  - infusion rate should not exceed 5 mg/kg per hour. Loading dose of 20 mg/kg should not be given, if the patient has already received quinine .
  - NEVER GIVE BOLUS INJECTION OF QUININE .
  - If parenteral quinine therapy needs to be continued beyond 48 hours, dose should be reduced to 7 mg/kg 8 hourly.

(Care should be taken to dilute artesunate powder in 5% Sodium bi-carbonate provided in the pack).

Oral therapy

- Parenteral quinine
  - oral quinine 10 mg/kg TID X 7 days +
  - Doxycycline 3 mg/kg per day for 7 days.
    - Doxycycline is contraindicated in pregnant women and children under 8 years of age
    - Clindamycin 10 mg/kg bw 12 hourly for 7 days should be used).
- In Patients receiving artemisinin derivatives should get full course of oral ACT.
- Mefloquine should be avoided in cerebral malaria due to neuropsychiatric complications.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012 (Prov)	2013 (Upto May)
Total Malaria Cases	2085484	1841229	1869403	1915363	1816569	1785129	1508927	1526210	1563574	1599986	1310656	1066981	190150
Pf Cases	1005236	897446	857101	890152	805077	840360	741076	775523	839877	834364	665004	533535	115672
Deaths	1005	973	1006	949	963	1707	1311	1055	1144	1018	754	519	51

LEPTOSPIROSIS- Diagnosis

- A high index of suspicion.
- Leptospiral infection is usually associated with obvious exposure
- Routine tests
  - blood urea nitrogen and serum creatinine in conjunction with mixed conjugated and unconjugated hyperbilirubinemia with aminotransferase elevation to less than five times the upper limit of normal.
- Urinalysis may show abnormalities of the sediment (leukocytes, erythrocytes, hyaline and granular cases).
- Hematologic abnormalities are variable but common
- Chest radiography, the appearance of the lungs varies.
- Alveolar infiltrates predominate and are associated with hemoptysis but not with purulent sputum

Ele: leukocytosis (typical in severe disease), leukopenia, hemolytic anemia, mild to moderate anemia, and thrombocytopenia.vation of the noncardiac isoform of creatine kinase may indicate skeletal muscle damage. Troponin levels indicative of myocarditis have not been adequately studied in leptospirosis

- Definitive diagnosis
  - Demonstrating the presence of the organism by
    - culture isolation,
    - detection of nucleic acids or antigen in body fluids, or
    - immunohistochemical visualization in tissue
- Serologic assays are the diagnostic mainstay in leptospirosis
  - the microscopic agglutination test (MAT)
  - Enzyme linked immunosorbent assay,
  - Indirect hemagglutination
  - dot-blot
- Serological tests are generally negative in the first 7 to 10 days after the onset of infection, paired acute and convalescent-phase serum samples are preferred to document seroconversion or a fourfold rise in titer.

The MAT entails growth of a battery of serovars representing the 26 leptospiral serogroups, incubation of a standard quantity of leptospires with the patient's serum on a microtiter plate, and detection of agglutination by dark-field microscopy. Direct examination of urine or blood by dark-field microscopy has the potential to provide a rapid diagnosis but is not recommended because
of complicating artifacts.
Leptospiral cultures do not become positive for weeks and therefore cannot guide clinical care

Treatment

- All regimens are given for 7 days.
- Mild leptospirosis
  - Doxycycline (100 mg PO bid) or
  - Amoxicillin (500 mg PO tid) or
  - Ampicillin (500 mg PO tid)
- Moderate/severe leptospirosis
  - Penicillin (1.5 million units IV or IM q6h) or
  - Ceftriaxone (1 g/d IV) or
  - Cefotaxime (1 g IV q6h)
- Chemoprophylaxis
  - Doxycycline (200 mg PO once a week) or
  - Azithromycin (250 mg PO once or twice a week)

Case 11

- A 60 yr old man
- Smoker
- Cough and fever for five days
- Purulent sputum
- o/e p 94/mt. BP 140/80 RR 18
- Signs of COPD with Consolidation of the right base
- What is the likely diagnosis?
- Will he need admission?
- Antibiotic of choice

- COPD and/or smoking Haemophilus influenzae, Pseudomonas aeruginosa, Legionella spp.,
- S. pneumoniae, Moraxella catarrhalis, Chlamydia pneumoniae
- Alcoholism Streptococcus pneumoniae, oral anaerobes, Klebsiella pneumoniae,
- Acinetobacter spp., Mycobacterium tuberculosis

CURB-65 criteria

- C = confusion
- U = urea >7 mmol/L
- R = respiratory rate 30/min
- B = blood pressure, systolic 90 mmHg or diastolic 60 mmHg
- 65 = age 65 years (65).
- With a score of 2 and patients should be admitted to the hospital

Outpatients treatmnet

- Previously healthy and no antibiotics in past 3 months
  - A macrolide [clarithromycin (500 mg PO bid) or azithromycin (500 mg PO once, then 250 mg qd)] or
  - Doxycycline (100 mg PO bid)
- Comorbidities or antibiotics in past 3 months:
- select an alternative from a different class
  - levofloxacin (750 mg PO qd)] or
  - High-dose amoxicillin (1 g tid) or
  - Amoxicillin/clavulanate (2 g bid);
  - cefpodoxime (200 mg PO bid),
  - cefuroxime (500 mg PO bid)] plus a
- + macrolide a

Inpatients

- A -lactame [cefotaxime (1–2 g IV q8h), ceftriaxone (2 g IV qd), ampicillin-sulbactam (2 g IV q8h)]
- Plus
- Azithromycin or a fluoroquinolone

Case 3

- A 26 yr old man is brought at 2.am
- History of something biting his leg.
- O/E p= 134, RR 20, Bp100/70 normal temp
- Frothing in the mouth
- Pain on touching the bitten limb
- What are the possiblities?

Scorpion stings

How to Treat a Scorpion Sting

Identify the scorpion.

–If you suspect you've been stung by a bark scorpion, then you should seek medical assistance immediately. Children are especially at risk from the bark scorpion's venom. A bark scorpion is a small, light brown colored scorpion that favors dark, moist wooded areas.

1

- **Find the sting location.**

Unlike other venomous insects, a scorpion sting will not swell very much at first. There will, however, be a burning sensation or sharp pain that happens immediately after being stung followed by tingling or numbness. Find the location of the sting and gently remove any clothing from around the area.

2

- **wash the sting area.**

Wash the affected area with cool water and a mild soap. This is to remove any residual venom around the area and to clean it to help prevent an infection.

3

Apply Bleach

If bleach is available, soak a cotton ball with bleach. Rub & hold cotton ball directly on sting sight for 5 minutes or more until tingling sensation stops. Bleach will neutralize venom if treated quickly enough after being stung. 4

Apply a cold pack.I
You were bitten on the hand or foot, elevate the area with the sting and place a cold pack on the site to prevent swelling. The cold pack will also help numb the pain.
5

Watch for serious symptoms.
Respiratory distress, rash, seizures, muscle twitches and weakness all might indicate a severe reaction to the venom and medical help should be immediately sought. If the pain persists and swelling does not appear to go down, then you should call your doctor for assistance. 6

Autonomic Strom

- Transient parasympathetic
  - –vomiting,
  - –profuse sweating,
  - – ropy salivation
  - –bradycardia,
  - – ventricular pre mature contraction,
  - –Priapism in male,
  - – hypotension

7

Prolonged sympathetic

- cold extremities,
- hypertension,
- tachycardia,
- pulmonary edema and
- shock

8

Tap sign

- Sudden tap at and around the site of sting induces severe pain and withdrawal is diagnostic sign of sting called “TAP sign”.

9

- Class I : Local manifestations
- Class II : Systemic involvement
- Class III :
  - – Cardiogenic failure, hypotension, ventricular arrhythmia, bradycardia, cardiovascular collapse,
  - –respiratory failure- cyanosis, dyspnoea, pulmonary edema,
  - –neurological failure Glasgow score < 6 (in absence of sedation), paralysis.

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Scorpion antivenopm

- SAV is specific treatment of scorpion sting's therapy
- intravenous administration of antivenom resolved the neurological manifestations within four hours.
- SAV reduced the requirement for concomitant sedation
- SAV has been available for clinical use from Haffkine Biopharma Mumbai.
- Prazosin is widely used for management of Mesobuthus Tamulussting 11

Snake bites

Do it R.I.G.H.T.' approach

- R = Reassurance,
- I = Immobilization as per a fractured limb,
- G= Getting to Hospital without delay and
- T = Telling the doctor of any symptoms that develops

1

Do not

- Apply a tourniquet.
- Wash the bite site with soap or any other solution to remove the venom. Do not make cuts or incisions on or near the bitten area.
- Use electrical shock.
- Freeze or apply extreme cold to the area of bite.
- Apply any kind of potentially harmful herbal or folk remedy.
- Attempt to suck out venom with your mouth.
- Give the victim drink, alcohol or other drugs.
- Attempt to capture, handle or kill the snake and patients should not be taken to quacks. 2

SNAKE BITE TREATMENT PROTOCOL

- This can be divided into:
  - –The initial management includes dealing with airway, breathing and treatment of shock.
  - –Administer tetanus toxoid if skin is breached
  - –Antibiotics if there is cellulitis or local necrosis 3

Diagnosis Phase

- Wherever possible, try to identify the snake responsible.
- Hemostatic abnormalities are the prima facie evidence of a viper bite.
- Cobras and kraits do not causehemostatic disturbances.
- All the patients should be kept under observation for a minimum of 24 hours.
  - – Many species, particularly the Krait and the hump -nosed pit viper are known for delayed appearance of symptoms which can develop after 6 –12 hours . 4

Saw scaled vipers do not cause renal failure where as Russell's viper and hump-nosed pit viper do.

Russell's viper can also manifest with neurotoxin symptoms in a wide area of India which can cause

5

Investigations-
20 min whole blood clotting test

- Twenty-minute whole blood clotting test (20WBCT) is considered as reliable test of coagulation which can be carried out by bedside and is considered to be superior to 'capillary tube' method for establishing clotting capability in snake bite. 6

METHOD
A few milliliters of fresh venous blood should be placed in a fresh, clean and dry glass vessel preferably test tube and left undisturbed at ambient temperature for 20 minutes.
After that tube should be gently tilted to detect whether blood is still liquid and if so then blood is incoagulable. 7
The test should be carried out every 30 minutes from admission for 3 hours and then hourly after that

Treatment Phase

- Pain can be relieved with oral paracetamol or tramadol .
- Aspirin or nonsteroidal anti -inflammatory drugs (NSAIDs) should not be administered .

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Anti-snake venom (ASV)

- Polyvalent ASV, is effective against all the four common species;
  - Russell's viper,
  - common cobra
  - , common Krait
  - saw -scaled viper and
- No monovalent ASVs are available.
- Apart from these species ASV is not effective in other species 9

Forms of ASV
liquid

- requires a reliable cold chain
- 2-year shelf life
- lyophilized (powder)
- has 5-year shelf life
- requires only to be kept cool.
- There is no evidence to suggest which form is more effective 10

There are known species such as the humpnosed pit viper (Hypnale hypnale) where polyvalent ASV is ineffective. In addition, region specific species such as Sochurek's saw-scaled viper (Echis carinatus sochureki) in Rajasthan, where the effectiveness of polyvalent ASV is questionable. 11

Anti-snake Venom Test Dose

- Test doses have not been shown to have predictive value in predicting
  - –anaphylactic reaction or
  - –late serum sickness
- Not recommended. 12

Anti-snake Venom Dose

- Initial Dose
  - –Mild envenomation (systemic symptoms manifest > 3 hours after bite)
    - 8–10 Vials
  - – Severe envenomation (systemic symptoms manifest < 3 hours after bite)
    - 8 Vials

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Each vial is 10 ml of reconstituted ASV.
Children should receive the same ASV dosage as adults.
Local administration of ASV near or at the bite site should not be done. It is ineffective, painful and can raise the intracompartmental pressure.
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There have been some studies to evolve low-dose strategies.14 These studies have serious flaws and have no validity in India. Similarly are high-dose regimes. The recommended dosages are as following:

- Mode of administration is IV only
- Repeat doses for haemotoxic species is based on the 6 hour rule
- Repeat doses for neurotoxic is based on the 1-2 hour rule.
- The maximum recommended dose for haemotoxic bites in 30 vials of ASV
- The maximum recommended dose for neurotoxic bites is 20 vials of ASV

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Victims Who Arrive Late

- The key determining factor to decide on ASV treatment is presence of current venom activity as venom can only be neutralized only if it is unattached.
- Perform a 20WBCT to determine
  - If it is present, administer ASV
- Treat renal failure.
- In the case of neurotoxic envenoming where the victim is having symptoms such as ptosis, respiratory failure, etc. it is probably wise to administer 1 dose of 8–10 vials of ASV to ensure that no unbound venom is present..

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Anti-snake Venom Reactions

- Anaphylaxis with ASV may be life-threatening.
- Antihistaminics can be administered to control the reaction and if severe, adrenaline should be administered.
- Once the patient has recovered, the ASV can be restarted slowly after 10–15 minutes, keeping close observation.
- Late serum sickness can be treated with oral prednisolone and/or antihistaminics

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- Neostigmine is an anticholinesterase, which isparticularly effectivein postsynaptic neurotoxins such as those of cobra and is notuseful against presynaptic neurotoxin i.e. common Krait and theRussell's viper
- Neostigmine test should be performed by administering 0.5 –2 mg IV and if neurological improvement occurs should be continued 1/2 hourly over next 8 hours

FOLLOW-UP

- Afterdischarge from hospital, victim should be followed.
- If discharged within24 hours, patient should be advised to return if there is any worsening of symptoms such as bleeding, pain or swelling at the site ofbite, difficulty in breathing, altered sensorium, etc.
- The patients should also be explained about serum sickness which may manifest after 5–10 days.

Syndromic approach to snake bite

- Syndrome 1
  - Local envenoming (swelling etc.) with bleeding/clotting disturbances = Viperidae (all species)
- Syndrome 2
  - Local envenoming (swelling etc.) with bleeding/clotting disturbances, shock or acute kidney injury = Russell's viper (hump-nosed pit viper in Sri Lanka and SW India)
  - conjunctival oedema (chemosis) and acute pituitary insufficiency = Russell's viper, Myanmar
  - with ptosis, external ophthalmoplegia, facial paralysis etc and dark brown urine = Russell's viper, Sri Lanka and South India

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- Syndrome 3
  - Local envenoming (swelling etc.) with paralysis = cobra or king cobra
- Syndrome 4
  - Paralysis with minimal or no local envenoming
  - Bitten on land while sleeping on the ground = krait
  - Bitten in the sea, estuary and some freshwater lakes = sea snake

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- Syndrome 5
- Paralysis with dark brown urine and acute kidney injury:
- Bitten on land (with bleeding/clotting disturbance) = Russell's viper, Sri Lanka or South India
- Bitten on land while sleeping indoors = krait (B. niger, B. candidus, B. multicinctus), Bangladesh, Thailand
- Bitten in sea, estuary and some freshwater lakes (no bleeding/clotting disturbances) = sea snake

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- Severe local envenoming:
  - Local necrosis, intracompartmental syndromes and even thrombosis of major vessels is more likely in patients who cannot be treated with antivenom.
  - Surgical intervention .
  - Prophylactic broad spectrum antimicrobial treatment is justified .

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may be needed but the risks of surgery in a patient with consumption coagulopathy, thrombocytopenia and enhanced fibrinolysis must be balanced against the life threatening complications of local envenoming

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Long-term complications (sequelae) of snake-bite

- At the site of the bite,
  - loss of tissue
  - amputation:
  - chronic ulceration,
  - infection,
  - osteomyelitis,
  - contractures,
  - arthrodesis or
  - arthritis may persist causing severe physical disability
  - Malignant transformation

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Conservative treatment when no antivenom is available

- Neurotoxic envenoming with respiratory paralysis:
  - Assisted ventilation with room air or oxygen
- Haemostatic abnormalities:
  - Strict bed rest to avoid even minor trauma;
  - transfusion of clotting factors and platelets;
- Shock, myocardial damage:
  - corrected with colloid/crystalloids, controlled by observation of the central venous pressure.
  - Ancillary pressor drugs (dopamine or epinephrine adrenaline)
  - Hypotension associated with bradycardia should be treated with atropine

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- Acute kidney injury:
  - Conservative treatment or dialysis
- Dark brown urine (myoglobinuria or haemoglobinuria):
  - Correct hypovolaemia with intravenous fluid,
  - correct acidosis with a slow intravenous infusion of 50-100 mmol of sodium bicarbonate
  - consider a single infusion of mannitol. 200 ml of 20% mannitol may be infused intravenously over 20 minutes.

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Antibiotics

- Prophylactic antibiotics were not effective
- Interference with the wound creates a risk of secondary bacterial infection and justifies the use of immediate broad spectrum antibiotics
  - amoxycillin or
  - a cephalosporin + a single dose of gentamicin + metronidazole
- tetanus prophylaxis

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Hypertension guidelines

This template can be used as a starter file for presenting training materials in a group setting.

Sections
Right-click on a slide to add sections. Sections can help to organize your slides or facilitate collaboration between multiple authors.

Notes
Use the Notes section for delivery notes or to provide additional details for the audience. View these notes in Presentation View during your presentation.
Keep in mind the font size (important for accessibility, visibility, videotaping, and online production)

Coordinated colors
Pay particular attention to the graphs, charts, and text boxes.
Consider that attendees will print in black and white or grayscale. Run a test print to make sure your colors work when printed in pure black and white and grayscale.

Graphics, tables, and graphs
Keep it simple: If possible, use consistent, non-distracting styles and colors.
Label all graphs and tables.

Recommendation 1

- In the general population aged 60 years or older, initiate pharmacologic treatment to lower BP at
  - –systolic blood pressure (SBP) of 150 mmHg or higher or
  - –diastolic blood pressure (DBP) of 90mmHg or higher
  - – and treat to a goal SBP lower than 150mmHg and goal DBP lower than 90mmHg. 1

Recommendation 2 and 3

- In the general population younger than 60 years, initiate pharmacologic treatment
  - – DBP of 90 mm Hg or higher and treat to a goal DBP of lower than 90mmHg
  - –SBP of 140 mm Hg or higher and treat to a goal SBP of lower than 140mmHg.

2

Special situations

- CKD,
  - – SBP of 140mmHg or higher or
  - – DBP of 90mmHg or higher and treat to goal SBP of lower than 140mm Hg and goal DBP lower than 90mmHg
  - – Drug of choice
    - An ACEI or ARB
- Diabetes
  - – SBP of 140mmHg or higher or
  - – DBP of 90 mm Hg or higher
- and treat to a goal SBP of lower than 140mmHg and goal DBP lower than 90mmHg

3

Recommendation 6

- In the general nonblack population, including those with diabetes, initial antihypertensive treatment should include
  1. thiazide-type diuretic,
  2. calcium channel blocker (CCB),
  3. angiotensin-converting enzyme inhibitor (ACEI),
  4. angiotensin receptor blocker (ARB)

4

- Each of the 4 drug classes recommended by the panel in recommendation yielded comparable effects on overall mortality and cardiovascular, cerebrovascular, and kidney outcomes,
- with one exception: heart failure.
  - – Initial treatment with a thiazide-type diuretic as more effective than a CCB or ACEI
  - – an ACEI was more effective than a CCB
- The panel also acknowledged that the evidence supported BP control, rather than a specific agent used to achieve that control, as the most relevant consideration for this recommendation

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Beta Blockers

- The panel did not recommend ß-blockers for the initial treatment of hypertension because in one study use of ß-blockers resulted in a higher rate of the primary composite outcome of cardiovascular death, myocardial infarction, or stroke compared to use of an ARB,

Drugs not to be used as first line drugs

1. a-Blockers
2. dual a1- + ß-blocking agents (eg, carvedilol),
3. vasodilating ß-blockers (eg, nebivolol),
4. central a2-adrenergic agonists (eg, clonidine),
5. Direct vasodilators (eg, hydralazine),
6. aldosterone receptor antagonists (eg, spironolactone),
7. peripherally acting adrenergic antagonists (reserpine), and l
8. Loop diuretics (eg, furosemide) 6

Important points

1.many people will require treatment with more than one antihypertensive drug to achieve BP control.

While this recommendation applies only to the choice of the initial antihypertensive drug, the panel suggests that any of these4classeswouldbegoodchoices as add-on agents (recommendation 9).

2. This recommendation is specific for thiazide-type diuretics, which include thiazide diuretics, chlorthalidone, and indapamide; it does not include loop or potassium- sparing diuretics.

Important points

3. It is important that medications be dosed adequately to achieve results similar to those seen in the RCTs

4. RCTs that were limited to specific non hypertensive populations, such as those with coronary artery disease or heart failure, were not reviewed for this recommendation. Therefore, recommendation 6 should be applied with caution to these populations. Recommendations for those with CKD are addressed in recommendation 8

8

Recommendation 9

- The main objective of hypertension treatment is to attain and maintain goal BP.
- If goal BP is not reached within a month of treatment,
  - increase the dose of the initial drug or add a second drug from one of the classes in recommendation.
- If goal BP cannot be reached with 2 drugs, add and titrate a third drug from the list provided
- Do not use an ACEI and an ARB together in the same patient 9

Strategies to Dose Antihypertensive Drugs- A

- Start one drug, titrate to maximum dose, and then add a second drug
- If goal BP is not achieved with the initial drug,
  - titrate the dose of the initial drug up to the maximum recommended dose to achieve goa BP

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Strategies to Dose Antihypertensive Drugs - A

- If goal BP is not achieved with the use of one drug despite titration to the maximum recommended dose,

add a second drug from the list (thiazide-type diuretic, CCB, ACEI, or ARB) and titrate up to the maximum recommended dose of the second drug to achieve goal BP

- If goal BP is not achieved with 2 drugs,
  - select a third drug from the list (thiazide-type diuretic, CCB, ACEI, or ARB), avoiding the combined use of ACEI and ARB. Titrate the third drug up to the maximum recommended dose to achieve goal BP 11

Strategies to Dose Antihypertensive Drugs- B

- Start one drug and then add a second drug before achieving maximum dose of the initial drug
- Start with one drug then add a second drug before achieving the maximum recommended dose of the initial drug, then titrate both drugs up to the maximum recommended doses of both to achieve goal BP
- If goal BP is not achieved with 2 drugs, select a third drug from the list (thiazide-type diuretic, CCB, ACEI, or ARB), avoiding the combined use of ACEI and ARB.
- Titrate the third drug up to the maximum recommended dose to achieve goal BP

Strategies to Dose Antihypertensive Drugs - C

- Begin with 2 drugs at the same time, either as 2 separate pills or as a single pill combination
- Initiate therapy with 2 drugs simultaneously, either as 2 separate drugs or as a single pill combination.
- Some committee members recommend starting therapy with =2 drugs when SBP is >160 mmHg and/or DBP is >100 mm Hg, or if SBP is >20 mm Hg above goal and/or DBP is >10 mm Hg above goal
- If goal BP is not achieved with 2 drugs, select a third drug from the list (thiazide-type diuretic, CCB, ACEI, or ARB), avoiding the combined use of ACEI and ARB. Titrate the third drug up to themaximum recommended dose.

Diabetes

Categories of increased risk for diabetes (prediabetes)

- FPG
  - 100 mg/dL (5.6mmol/L) to 125 mg/dL (6.9 mmol/L) (IFG)
- OR
- 2-h PG in the 75-g OGTT
  - 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) (IGT)
- OR
- A1C
  - 5.7–6.4%

- The A1C has several advantagesto the FPG and OGTT,
  - –Greater convenience(fasting not required),
  - –possibly greater preanalytical stability,
  - –less day-to-day perturbations during stress and illness.
- Haemoglobinopathiescan affect AIC levels

DETECTION AND DIAGNOSIS OF GESTATIONAL DIABETES MELLITUS

- Screen for undiagnosed type 2 diabetes at the first prenatal visit in those with risk factors, using standard diagnostic criteria.
- Screen for GDM at 24–28 weeks of gestation in pregnant women not previously known to have diabetes.
- Screen women with GDM for persistent diabetes at 6–12 weeks postpartum, using the OGTT and non pregnancy diagnostic criteria.
- Women with a history of GDM
  - should have lifelong screening for the development of diabetes or prediabetes at least every 3 years.
  - found to have prediabetes should receive lifestyle interventions or metformin to prevent diabetes.

Screening for and diagnosis of GDM

"One-step" (IADPSG consensus)

- Perform a 75-g OGTT, with plasma glucose measurement fasting and at 1 and 2 h, at 24–28 weeks of gestation in women not previously diagnosed with overt diabetes
- The OGTT should be performed in the morning after an overnight fast of at least 8 h.
- The diagnosis of GDM is made when any of the following plasma glucose values are exceeded
  - Fasting >92 mg/dL (5.1 mmol/L)
  - 1 h: >180 mg/dL (10.0 mmol/L)
  - 2 h: >153 mg/dL (8.5 mmol/L)

"Two-step" (NIH consensus)

- Perform a 50-g GLT (nonfasting), with plasma glucose measurement at 1 h (Step 1), at 24-28 weeks of gestation in women not previously diagnosed with overt diabetes.
- If the plasma glucose level measured 1 h after the load is >140 mg/dL* (10.0 mmol/L), proceed to 100-g OGTT (Step 2).
- The 100-g OGTT should be performed when the patient is fasting.
- The diagnosis of GDM is made when the plasma glucose level measured 3 h after the test is >140 mg/dL (7.8 mmol/L).

Glycemic Goals in Pregnant Women

- Preprandial:
  - <95 mg/dL (5.3 mmol/L), and either:
- 1-h postmeal:
  - <140 mg/dL (7.8 mmol/L) or
- 2-h postmeal:
  - <120 mg/dL (6.7 mmol/L)

Type 1 diabetes

- Consider screening those with type 1 diabetes for other autoimmune diseases (thyroid, vitamin B12 deficiency, celiac) as appropriate
- Use MDI injections (3–4 injections per day of basal and prandial insulin) or CSII therapy.
- Match prandial insulin to carbohydrate intake, premeal blood glucose, and anticipated activity.
- For most patients (especially with hypoglycemia), use insulin analogs.

Summary of glycemic recommendations for adults with diabetes

- A1C, 7.0%*
- Preprandial capillary plasma glucose 70–130 mg/dL* (3.9–7.2 mmol/L)
- Peak postprandial capillary plasma glucose†, <180 mg/dL* (<10.0 mmol/L)
- Postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals
  - Postprandial glucose measurements should be made 1–2 h after the beginning of the meal, generally peak levels in patients with diabetes.

Goals should be individualized based on

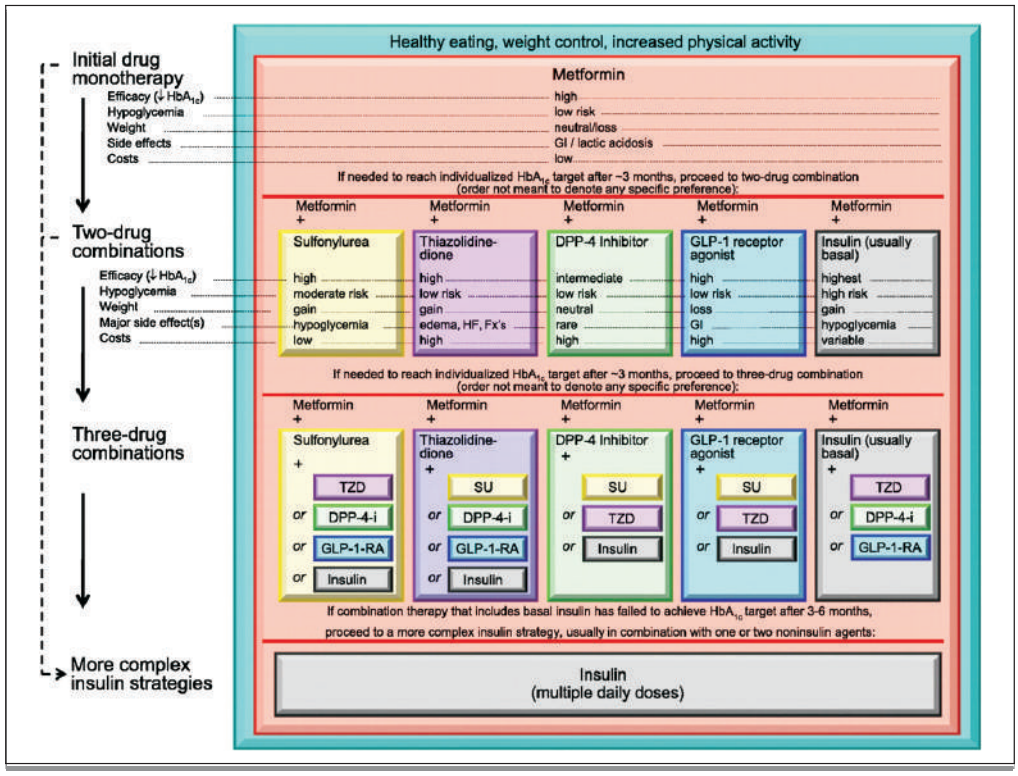
- duration of diabetes
- age/life expectancy
- comorbid conditions
- known CVD or advanced microvascular complications
- hypoglycemia unawareness
- individual patient considerations
- More or less stringent glycemic goals may be appropriate for individual patients

Pharmacological Therapy for Hyperglycemia in Type 2 Diabetes

- A patient-centered approach should be used to guide choice of pharmacological agents.
- Metformin, if not contraindicated and if tolerated, is the preferred initial pharmacological agent for type 2 diabetes.
- In newly diagnosed type 2 diabetic patients with markedly symptomatic and/or elevated blood glucose levels or A1C, consider insulin therapy, with or without additional agents, from the outset.

A patient-centered approach

- Considerations include efficacy, cost, potential side effects, effects on weight, comorbidities, hypoglycemia risk, and patient preferences.
- Due to the progressive nature of type 2 diabetes, insulin therapy is eventually indicated for many patients with type 2 diabetes.



- If noninsulin monotherapy at maximum tolerated dose does not achieve or maintain the A1C target over 3 months, add a second oral agent, a glucagon-like peptide 1 (GLP- 1) receptor agonist, or insulin.

Obesity

Assesment of obesity

- Measure Weight and Height;
  - Weight and height are measured with the patient wearing light clothing or an examination gown and no shoes
- Calculate BMI
  - Manually (weight in kg/ [height in meters] 2), or
  - Electronically resources
- Document in the patient medical record.

- Overweight
- Class 1 BMI 25 < 30) or
- Class 11 BMI 30<35) or
- Class 111 BMI =40 [extreme obesity])

Assesment

- Assess and Treat CVD Risk Factors and Obesity-Related Comorbidities
- Assess Weight and Lifestyle Histories
- Assess Need to Lose Weight
  - YES – BMI >30 or BMI 25<30 with additional risk factor(s)
  - NO – BMI <25 or BMI 25<30
- Weight loss treatment is indicated for
  - 1) obese individuals and
  - 2) overweight individuals with 1 or more indicators of increased CVD risk.

- Sustained weight loss of 3%-5% is likely to result in clinically meaningful reductions in triglycerides, blood glucose, HbA1C, and the risk of developing type 2 diabetes;

Diets for Weight Loss

- part of a comprehensivelifestyle intervention.
- Types of diet
  - a. Prescribe 1,200–1,500 kcal/day for womenand 1,500–1,800 kcal/day for men (kcal levelsare usually adjusted for the individual's body weight);
  - b. Prescribe a 500 kcal/day or 750 kcal/dayenergy deficit; or
  - c. Prescribe one of the evidence-based diets that restricts certain food types (such as high-carbohydrate foods, low-fiber foods, or high-fat foods) in order to create an energy deficit by reduced food intake.
- Prescribe a calorie-restricted diet, based on the patient's preferences and health status and preferably refer to a nutrition professional for counseling.

Cholesterol guidelines

- Lifestyle as the Foundation for ASCVD Risk Reduction Efforts
- It must be emphasized that lifestyle modification remains a critical component ofhealth promotion and ASCVD risk reduction, both prior to and in concert with the use ofcholesterol lowering drugtherapies

Four Major Statin Benefit Groups

1. Individuals with clinical ASCVD
2. Individuals with primary elevations of LDL –C =190 mg/ dL
3. Individuals 40 to 75 years of age with diabetes with LDL -C 70 -189 mg/ dL
4. Individuals without clinical ASCVD or diabetes who are 40 to 75 years of age with LDL -C 70 - 189 mg/ dL and an estimated 10 -year ASCVD risk of 7.5% or higher

Lifestyle Management Recommendations

- Diet
  - vegetables, fruits, and whole grains; includes low-fat iry products, poultry, fish, legumes, nontropical vegetable oils and nuts ;
  - limits intake of sweets , sugar -sweetened beverages and red meats.
- Adapt this dietary pattern to appropriate calorie requirements , personal and cultural food preferences , and nutrition therapy for other medical conditions
- Aim for a dietary pattern that achieves 5% to 6% of calories from saturated fat .
  - Reduce percent of calories from saturated fat
  - Reduce percent of calories from trans fat.

Lower sodium intake.

- Consume no more than 2,400 mg of sodium/day;
- Further reduction of sodium intake to 1,500 mg/day is desirable since it is associated with even greater reduction in BP; and
- Reduce intake by at least 1,000 mg/day since that will lower BP, even if the desired daily sodium

PHYSICAL ACTIVITY

- In general, advise adults to engage in aerobic physical activity to reduce LDL–C and non-HDL–C
  - – 3 to 4 sessions a week,
  - –lasting on average 40 minutes per session, and
  - –involving moderate-to-vigorous intensityphysical activity.

- High-Intensity Statin Therapy
  - Daily dose lowers LDL–C on average, by approximately =50%
    - Atorvastain(40†)–80 mg
    - Rosuvastatin 20 (40) mg
- Moderate-Intensity Statin TherapyD
  - aily dose lowers LDL–C on average, by approximately 30% to <50%
    - Atorvastatin 10 (20) mg
    - Rosuvastatin (5) 10 mg
    - Simvastatin 20–40 mg‡
    - Pravastatin 40 (80) mg
    - Lovastatin 40 mg
    - Fluvastatin XL 80 mg
    - Fluvastatin 40 mg bid
    - Pitavastatin 2–4 mg

- Low-Intensity Statin Therapy
- Daily dose lowers LDL–C on average, by <30%
- Simvastatin 10 mg
- Pravastatin 10–20 mg
- Lovastatin 20 mg
- Fluvastatin 20–40 mg
- Pitavastatin 1 mg

National programs that are likely to change

- TB program
  - Daily regimen
- HIV
  - CD4 count <500
  - TDF regimen
  - HIV positive mother treatment with 3 drug regimen for life.

MIDLIFE AND BEYOND

"THE CALL TO MIDLIFE IS THE CALL TO HOLINESS (WHOLENESS)"

Midlife is a bridge between the 1st and 2nd half of life. This roughly occurs between 35-45yrs of age . As in all transitions, in midlife too, we must come to terms with the past and prepare for the future. One experiences a major shift in perception, values, and purpose. This permits the greatest actualization of one's capabilities and virtues and the greatest contribution to society.

MIDLIFE AS A 'CRISIS'.

This is understood not as a catastrophe but a turning point, a period of increased vulnerabilities, heightened potential and radical challenges. It may creep upon us slowly or abruptly. It makes us stop in our tracks and examine our lives. There are a number of dynamics involved at this crucial developmental passage.

1. Quest for meaning:

One may question the purpose and meaning of one's life lived so far and the quest for a more meaningful life. There are four kinds of questions we ask ourselves- who am I?(Identity), whose am I?(intimacy), what have I accomplished with my life?(generativity), what does it all mean?(Integrity)

2. Midlife journeying:

The quest for more meaning in life leads to 2 kinds of journey- an inward and outward one.

At midlife, we have a new awareness about ourselves. Experiences that were not part of us in the past may come up. For example, issues of sexuality and intimacy that were not awakened or were silenced so far now make their presence with intensity and persistence. Such awareness and acceptance of oneself is a part of this journey. The inward journey also includes a journey into the past. Traumas and conflicts that were buried deep down in the unconscious mind begin to raise their heads seeking reconciliation. Also, certain aspects of one's self that were underdeveloped or distorted by earlier choices or life situations also come to awareness, inviting us to revisit these issues and make peace with them. The outward journey- a journey into the future- inviting us to relate to our environment differently and to be generative and creative in more meaningful ways. Mother Theresa's midlife transition and its fruits are in front of the whole world.

3. Emotional awareness of mortality:

We always knew in an intellectual way that we would die one day. In midlife, we get an emotional awareness that we have lived more years than are left to be lived. There is a diminishment in our bodily and mental powers after 40. Our vision and hearing become less acute and memory diminishes. We are prone to experience various chronic aches , pains and illnesses. Coming to terms with the idea of death is an essential aspect of midlife dynamics. If not, it can go into extremes of destructive behavior like acute anxiety, drunkenness, drugs, gambling or provocation of antisocial activities.

4. Changing sense of time:

Awareness to mortality, forces us to pay more attention in accomplishing something more meaningful. This is all the more true if we feel that our life so far has not been very meaningful and productive.

5. The midlife review:

Midlife is a time of re-assessment- reviewing the past and looking into the future. It is period of asking many questions to oneself- where have I been all these years? What do I want to do with my life now? There is a desire to use the remaining time wisely and meaningfully. The so called 'crisis' of midlife is a catalyst for re-assessment. This forces the individual to take stock, noting what she has and wondering why she does not have others.

6. Reassessing commitments:

We may face serious commitment problems that were ignored previously. We may feel that long held assumptions and beliefs about life (religious) are no longer true. We might have embraced religious life for wrong reasons, we may find other paths more attractive now. A change in commitment is a likely outcome. We may break the existing commitments and make new choices or recommit ourselves on different terms to old choices.

7. Reconciling with the 'DREAM':

Dream is a vision of us for the near future. It is something that motivates and inspires us to make life more attractive and more meaningful. Three things happen with midlife dreams-

a. Reappraising and modifying of idealized dreams- Sometimes in our young age, we create a dream that is far beyond our reach. For example, we may dream of becoming another 'Mahatma Gandhi, Mother Theresa or even 'another Jesus'. As one grows, realization occurs that it is impossible to achieve such dreams to the fullest. One can modify one's dream and make it more realizable and reasonable

b. Recognizing the tyranny of the dream - The question is- 'whose dream is it?' Often, young people may be living their parents' dreams or the dream of a significant person in their lives under pressure. In midlife, such persons recognize how they have sacrificed their own interests and dreams to please others. Then, they try to get away from others dreams and try to pursue their own.

c. Creating new dreams- It is possible that even if the dream is their own, in midlife they recognize that they have failed to realize it. She may then create an entirely new dream .

8. De-illusioning:

This is a recognition that long held assumptions and beliefs about self and the world are not true. In the 1st half of life, we are driven to pursue idealized dreams with the assumption that we can achieve anything if only we try hard enough. Later our life experiences and that of others compel us to adopt more realistic views of life. We are forced to understand that inherent goodness of humanity is often opposed with hate, corruption and other destructive forces in the world. This new awareness in life in turn leads to new definitions and goals in life and ways to reach there.

9. Mourning.

Mourning is grief over lost dreams and opportunities, for foolish decisions and the wrong roads taken in the past. It is not merely regret which is inauthentic, or tied to a nonexistent past, reveling " if only ….". Mourning is coming to terms with our losses and disappointments and moving on. We can't change whatever has happened in the past but we can certainly change our attitudes towards what has happened and then move on in life.

10. Increased self-direction:

There is an urge to liberate oneself from external forces and live life on one's own terms. The 'shoulds' and 'should-nots' enforced upon by others /society seem less meaningful. We are motivated more by internal rewards than by external recognitions. In the first half of life our agenda was mostly a social one- 'what does the world want of me?' In the second half of life, the question changes-' what does my soul- my authentic self- want of me?.'

11. Developing a balanced personality:

At a younger age, our life is one sided and imbalanced with the 4 key psychological functions- thought, feeling, intuition and sensation- only 1 or 2 are likely to have developed. In midlife the others also get strengthened causing great balance in our personality. Integrating the masculine(animus) and feminine(anima) aspects within us is also a very important midlife challenge to bring unity in our personality. Animus- human potential for action, represents ability for rational thoughts, self assertion and decision making. Anima- receptivity, emotions and relationships- these are influenced by hormones. It has been observed that in young ages 'animus' dominates in male and 'anima' in females but this reverses during the second half of life.

12. Integration of 'Shadows'

Our real self (personality) consists of both 'light' and 'shadows'. Ideal self (persona- light)- is what we and others see in us whereas 'true self'(shadows-the dark side) which we are unaware of and may be underdeveloped . In order to experience the unconditional love of God, we need to redeem, accept and honor our shadows too.

13. Integrating sexuality, celibacy and intimacy:

In adulthood, men and women establish a circle of friends of varying degrees of intimacy. It is a psychological closeness (and not merely sexual behavior)- the experience of coming close to another physically, mentally, emotionally and spiritually. It implies the capacity to involve another person in one's choices and decisions and to meet each other's needs and accept each other as they are. Intimacy can be defined as the ability to experience an open, supportive, tender relationship with another person without fear of losing one's identity in the process. Open means, the relationship is known to others besides the two persons involved, also not exclusive but inclusive of others too into their circle. In intimacy, it would be wise and prudent to keep in mind certain important facts of human relationship before we grow deeper. Practice of intimacy: As persons grow in intimate relationships, the distance between them narrows. They should be able to sense/ become aware of their hearts' movements. If one senses that the other is showing undue concern, interest, advances or expressions where one feels uncomfortable, understand that the relationship is moving you away from your commitment of celibate life. You have to let the other person know immediately without compromising the values you stand for. We should have good psychological and spiritual maturity before we could commit ourselves to deeper intimate relationships, otherwise we would be throwing ourselves into dangerous situations. In moments of 'crisis', a person may need support, guidance and effective spiritual direction.

During midlife, the 'internal voice' invites us to deeper integration of self. It is the 'messenger from God' inviting us to greater wholeness and holiness.

POST MIDLIFE YEARS-Moving towards Integrity:

Integrity involves the ability to synthesize a lifetime of experiences, both good and bad, to look back on one's own life without regrets and to look forward to 'death' without fear, coming to terms with life's inevitable disappointments and tragedies as well as being thankful for its blessings. The central process is 'reminiscence', a repeated contemplation and evaluation of the quality of close relationships and our contribution to improve the quality of life for others. The lack of integrity- refusal to accept one's life cycle puts a person into fear of death and despair.

In order to experience integrity, one must incorporate all the life experiences- good or bad- to balance their 'self image'. The opposite of it creates much despair, disgust, fear and regret over the life 'wasted'. The result is more bitterness and resentment. Interiority is the result of making sense of who we are in the world and how our life provides meaning, unity and purpose to ourselves. This in turn leads to an increased act of turning inward, to solitude and reflection.

Wisdom:

With attainment of integrity comes 'virtue of wisdom'- a refined discernment, mature judgment and accumulation of knowledge. This is not merely accumulation of intellectual or experimental knowledge but a way of serene and harmonious living and relating. In the words of the Jewish philosopher Philo,' the face of this wise man is not sombre or austere, contracted by anxiety and sorrow, but radiating serenity, vast delight, playfulness and acting with sense of humor'.

Atonement:

Part of moving towards integrity is 'atonement'- reconciliation with self, others and with God. We need to forgive ourselves for our foolish choices and decisions and for messing up our lives. We need to 'let go' of our grievances against others- real or imagined, and to reconcile with those who stood against us or blocked our ways.

A second journey (in religious life): -

The midlife and post midlife years can be described as a second journey or a second call. The first call from God usually comes in adolescence. It might have started gradually or abruptly as an intense awareness of God's intimate presence within us. This is followed by a deep conviction that this omnipotent God accepts us as we are and is calling us to a special relationship with him. This leads us to embracing a new lifestyle, away from our familiar environments (our entry into religious life). In the next two decades, we are engaged in the demanding works of being formed in this new way of life. We also spend our time and energy in academic studies, professional accomplishments and personal recognitions. We have a feeling that we have achieved something that leads us to a sense of contentment and pride. It is at this stage that midlife dynamics creeps in, throwing us into discontentment and meaninglessness of the life lived. This serves for a second call- the midlife call- a call for deeper spiritual life and intimacy with God. This disenchantment- the dark night of the soul- reminds us powerfully that no matter what our accomplishments are, we are not in control of our life- not self-sufficient and hence we tend to learn humility and dependence in God.

In our final desert journey, we actually experience the need to become a closer companion with the Person who called us, who is the source of all worth and being. We realize that our integrity and worth is rooted in this 'Supreme Being'.

Compiled with 'Sumedha Experience'.

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XX CME & AGBM - PHOTO GALLERY

Inaugural Mass

Prayer Song

Lighting The Lamp

Presenting Memento

Inaugural Session

Keynote address
Dr. Navjot Sindhu,
Chief Parliament Secretary for
Health. Punjab State

Felicitation
Mrs. Gurpreet Deo,
Inspector General of Punjab Police.

Felicitation
Dr. Kapil Kupta,
Member of Punjab Medical
Council.

Felicitation
Dr. Sushma Chawla,
President IMA, Jalandhar Branch.

Felicitation
Dr. Dhillon, DIG in BSF

Felicitation
Rev. Sr. Sobel SH,
Provincial,
Sacred Heart Congregation.

Presidential address
Rt. Rev. Franco Mulakkal,

Rev. Fr. Tomi Thamus, Director General, CHAI. addressing the Sister Doctors

Dr. G. D. Ravindran talking to the Participants...

Dr. Indumathi giving a lecture

Presenting Memento

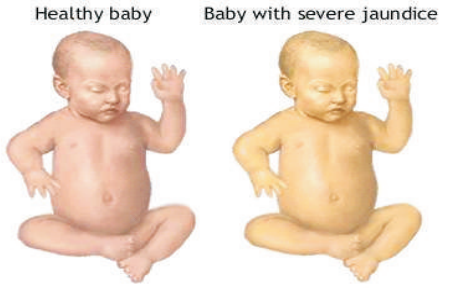
Cultural Evening

Visit to Golden Temple, Amritsar & Waga Border

Neonatal Hyperbilirubinemia

Dr. Suman Rao PN MD, DM
Dept. of Neonatology
SJMCH

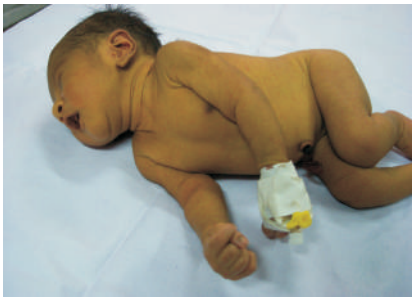
Neonatal Hyperbilirubinemia



Why the concern?

BIND

A/c Bilirubin Encephalopathy (Kernicterus)



Major risk factors (acronym JAUNDICE)

J -	Jaundice	Predischarge TSB in high risk zone
		Jaundice observed in first 24 h
A -	Asian race – east asian/ North Indian race	
U -	Under 37 weeks	
N -	Nursing – Non optimal suckon Excl. BF –Xs wt loss	
D -	Deficiency of G6PD	
I -	Incompatibility – Rh or ABO with hemolysis	
C -	Cephalhematoma or significant bruising	
E -	Elder sibling received phototherapy	

Approach to jaundiced baby

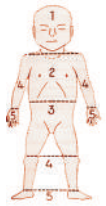
- Birth weight, gestation , age
- Blood groups
- Well or ill
- Physiological or pathological?
- Kernicterus* ? in deeply jaundiced NB

*Lethargy and poor feeding, poor or absent Moro's, opisthotonus or convulsions

5

Monitoring for J is a Vital sign

Area of body	Bilirubin levels mg/dl
Face	4-8
Upper trunk	5-12
Lower trunk & thighs	8-16
Arms and lower legs	11-18
Palms & soles	> 15



Kramer's rule

6

Workup

- Maternal & perinatal history
- Physical examination
- Laboratory tests (must in all)*
  - Total & direct bilirubin*
  - Blood group and Rh for mother and baby*
  - Hematocrit, retic count and peripheral smear*
  - S. albumin (B: A <7 mg/g)
  - Sepsis screen
  - Liver and thyroid function

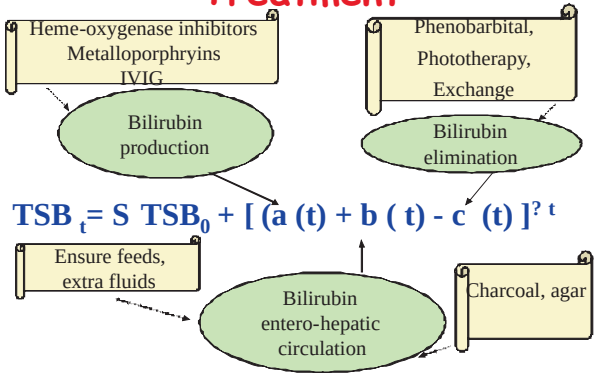
7

Management

- Prevent : early feeds, adequate hydration
- Reduce level of serum bilirubin : phototherapy, exchange transfusion, drugs
- Prevent bilirubin toxicity

8

Treatment

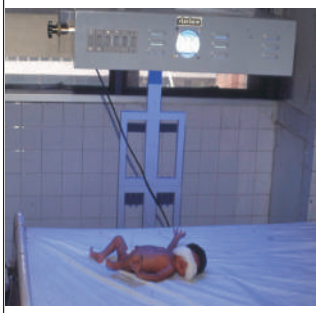


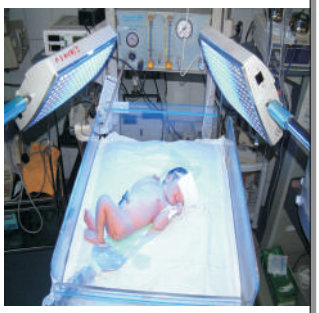
Phototherapy

- Conventional phototherapy
- Compact fluorescent light
- Fibre optic phototherapy …Biliblanket
- Blue-green lights
- Halogen lamps
- Blue Gallium nitride LED

10

Babies under phototherapy





Biliruibin -420-500 nm Daylight, cool white lamps - 550-600 nm

Special blue lamps - 420-480 nm Green lamps -525 nm

Biliblanket

Increase the efficacy of Phototherapy

- Place baby naked. (eye shades) Change position 2 hourly.
- Check all lights are on.
- Shorten distance to as close as possible and maintain euthermia
- Double unit phototherapy
- Cover unit with white sheet
- Highest flux.
- Use special blue lights Philips TL 52 /20 W.
- Change lights every 3 mo/ 1000 hrs of use whichever is earlier

Prevention

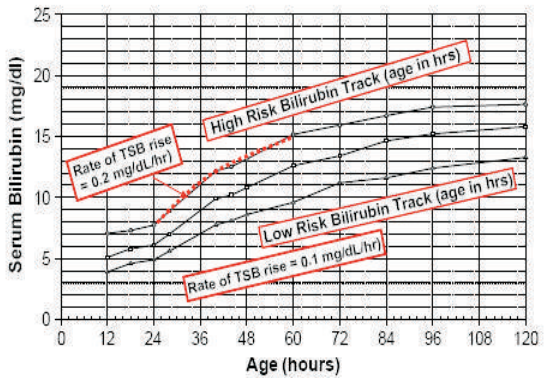
- Send cord blood for group and type for all babies
- Mother O group send also DCT
- Mother Rh negative – send DCT, Hb, Reticcount
- Follow up asap

Monitoring

- In natural light twice a day for jaundice
- Obtain TB/CB if
  - jaundice is evident < 36 hours age
  - icterictill the abdomen
  - baby is being discharged < 72 hours

15

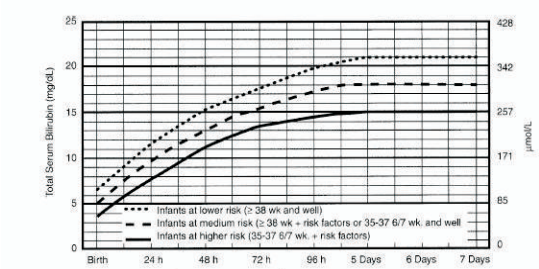
Bhutani's hour specific nomogram



Bhutani's hour specific nomogram

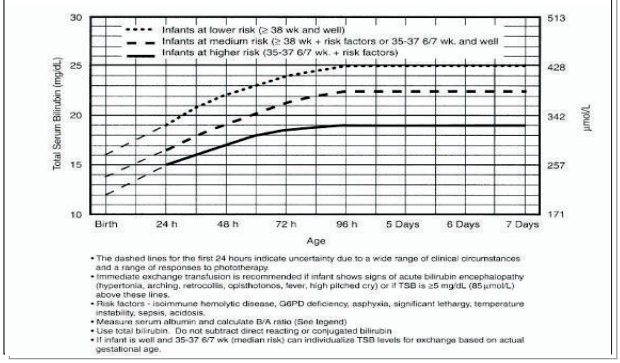
TB-percentile	Management
> 75	Repeat TSB within 8 -24 hours
> 40	TSB follow-up within 48 hours
< 40	Clinical follow up within 48 hours
	17

Guidelines for Phototherapy > 35 wks



Risk factors - isoimmune hemolytic disease, G6 PD def, asphyxia,
Significant lethargy, temperature instability,
sepsis, acidosis or albumin < 3 g/dl)

Guidelines for exchange Tx > 35 wks



Bilirubin monitoring frequency

- Term non hemolytic - once in 24 hrs
- Preterm once in 12 hrs
- Hemolytic jaundice once in 6 to 8 hrs
- Observe for rebound after stopping phototherapy

20

Management of infants with hemolytic diseases……Rh

- Start intensive phototherapy immediately
- Exchange transfusion
  - if serum bilirubin level is predicted to reach >20 mg/dl.(using Allen and Diamond chart).
  - Cord bilirubin is ≥ 5 mg/dl
  - Cord Hb is ≤10 mg/dl, PCV<30
  - Previous sibling history and positive DCT .
- Ensure the mother has received Anti D gamma globulin

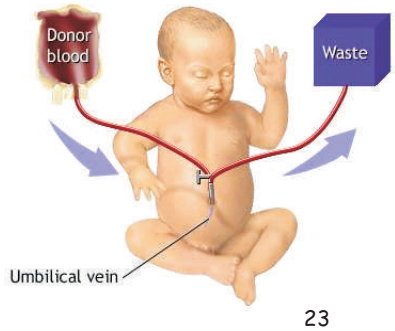
.

Preterms

Weight(gm)	Phototherapy	Consider exchange transfusion
500-750	5-8	12-15
750-1000	6-10	>15
1000-1250	8-10	15-18
1250-1500	10-12	17-20
1500-2500	15-18	20-25

Clinics in perinatology 2000

Exchange Transfusion



23

Key messages

- Moniter for J as a vital sign
- Give effective phototherapy
- Prevent Kernicterus

24

Case 1

Baby of M,

- 3.2 kg, 38 weeks,
- jaundice till abdomen day 3
- Any questions?
- What do you want to do?

age in hours, blood gp mother, father, baby, DCT, feeding, any bruising,

25

Details of Case 1

- Primi, 28 yr, boy
- 60 hr
- Mother blood group A +,
- Baby blood group B+
- No cephal hematoma, bruising, Xs wt loss
- Indian race

26

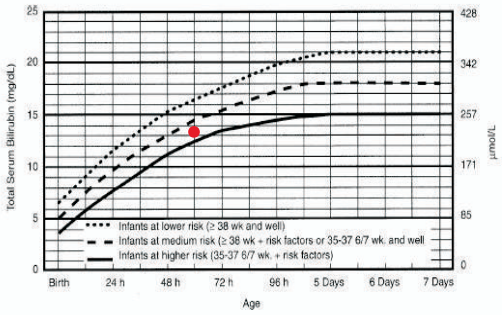
Do you want to sample?

27

Case 1: Bilirubin

- Total bilirubin- 13 mg%, Conjugated bilirubin – 0.4 mg%
- What will you do?

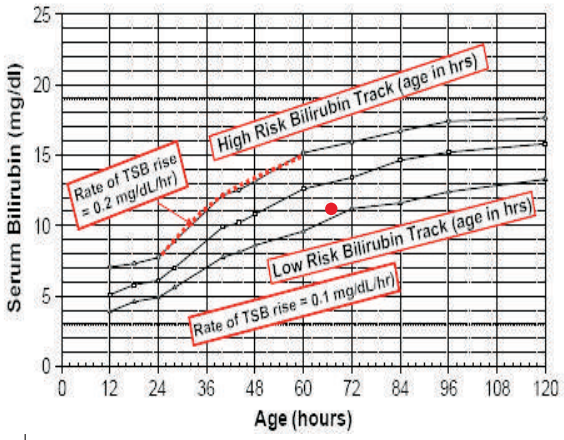
28



Risk factors:isoimmune hemolytic disease, G6PD deficiency asphyxia, significant lethargy, temp. instability, sepsis, acidosis or albumin < 3 g /dl (if measured)

Family wants discharge

30



If discharge < 72 h

Designated risk status	Evaluation	Follow up
High	For hemolysis & risk factors	Intervention strategy
Upper intermediate	For hemolysis & risk factors	May repeat TSB in 8-24 h
Lower intermediate	For risk factors	May repeat in 48 h
Low	For risk factors	Clinical follow up -May not need TSB

Decision Case 1

- Discharge ….Follow up in 24 h
- OR provide phototherapy
  - (optional to provide PT at 2-3 mg/dl less than indication)

33

Case 2

Baby of S,

- **2.4 kg, 35 weeks,**
- **jaundice till thigh day 3**
- **Any questions?**

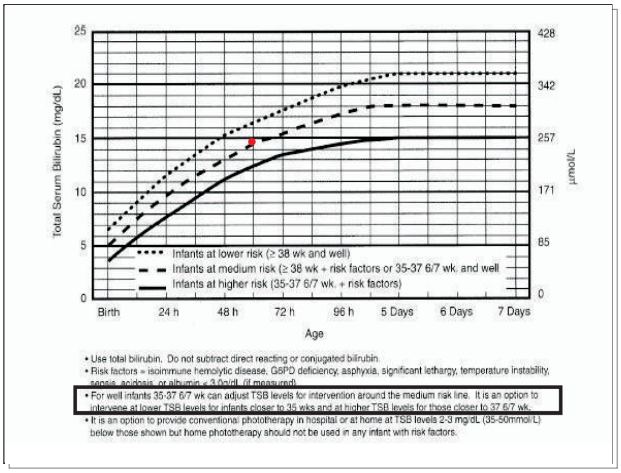
34

Details Case 2

Multigravida 28 yr, girl

- **60 hr , wt– 2.1 kg**
- **M Bld Gp O + , B Bld Gp B+**
- **Previous baby– jaundice, but no PT**
- **No cephalhematoma**
- **TB- 14 mg%, CB– 1 mg%, DCT– ve, Retic count – awaited**

35



Decision….case 2

- **Phototherapy**

37

When will you repeat bilirubin?

Bilirubin monitoring frequency

- Term non hemolytic- once in 24 hrs
- Preterm once in 12 hrs
- Hemolytic jaundice once in 6 to 8 hrs
- Post exchange once in 4 hrs

Moniter PCV in hemolytic jaundice OD

Case 3

Baby of R,

- **3.2 kg, Term,**
- **jaundice till chest**
- **Any questions?**

39

Details Case 3

- Multigravida, 28 yr, girl
- 12 hr
- What will you do?

40

Investigations

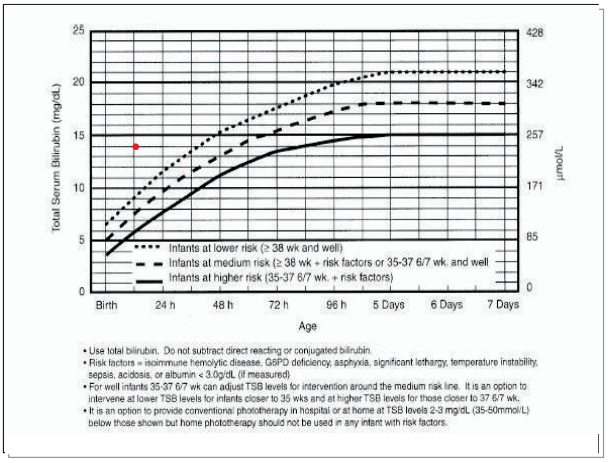
- Mother`s and baby`s blood group & Rh typing, DCT
- Request for compatible blood
- Urgent Serum bilirubin (Total and direct)
- Hb, PCV, reticulocyte count, PS for RBC morphology
- Start Phototherapy

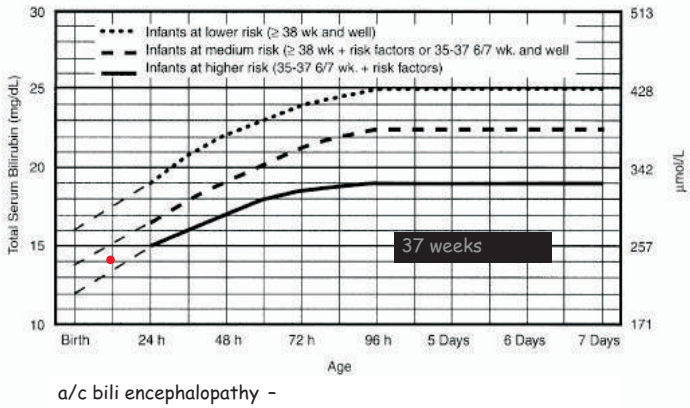
41

Details Case 3

- Multigravida, 28 yr, 12 hr
- 37 weeks
- M bld gp O - , Baby bld gp O+
- Anti D not taken,
- Previous baby bld gp not known,
- Total bilirubin- 14 mg%, Conjugated bilirubin – 0.1 mg%

42

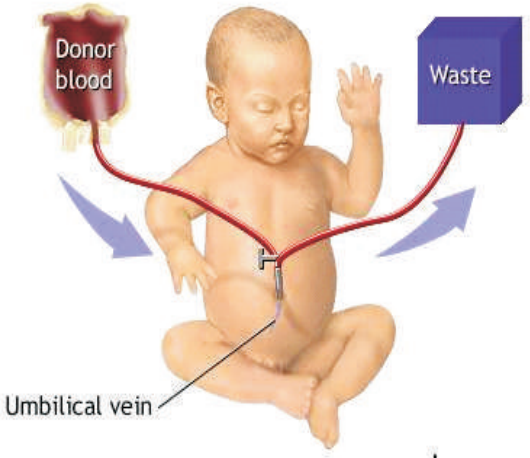




a/c bili encephalopathy –

- cry,
- poor suck,
- inc tone- head lag on pull to sit
- incomplete moro reflex

Decision...case 3



NEONATAL SEPSIS

Dr. Suman Rao PN MD, DM
Associate Professor, Dept. of Neonatology
St. John's Medical College, Bangalore

Neonatal Sepsis

- Early and late onset sepsis - org. Ab sensitivities.
  - –Gram negative
  - –Staphyloccos aureus
  - –CONS

Definitions

- **Sepsis :** SIRS + suspected or proven infection
- **SIRS- – ANY TWO**
  - – Tachycardia
  - – hypo or hyperthermia
  - – RD
  - – High TC or ANC
- **Severe sepsis:** Sepsis plus
  - – cardiovascular organ dysfunction OR ARDS

  OR --2 or more other organ dysfunctions

Definitions

- **Definite sepsis-** bacteremia (culture positive) with clinical features
- **Probable sepsis-** clinical suspicion with positive screen
- **Suspect sepsis-** clinical suspicion only

Definitions

- **Early onset sepsis (EOS)**– onset < 72 hrs
- **Late onset sepsis (LOS)** onset >72 hrs
- **Health care-associated infection (HCAI/ 'hosocomial' or "hospital" infection:**
  - – Any new blood culture positive sepsis after 48 hours of hospital stay

Symptoms

- **Symptoms :** fever , lethargy, difficulty in feeding*, fast breathing, respiratory distress, retractions, grunting, cyanosis, abdominal distension, vomiting, diarrhea, convulsions*, umbilical discharge, pustules

Signs

- **General :** Hypothermia<35.5C / hyperthermia >37..5 C*, abnormal skin color, pallor, jaundice
- **Cardiovascular:** tachycardia / bradycardia , shock, hypotension/delayed CFT, oliguria , metabolic acidosis
- **Respiratory:** apnea, tachypnea (≥60 / min*), severe chest indrawing *, respiratory distress, cyanosis / desaturations , grunt, increased ventilator requirements
- **Gastrointestinal:** abdominal distension, increased aspirates, bleeding
- **Neurological:** lethargy/ hypotonia , stupor . coma, reduced activity(movement only when stimulated*), seizures
- **Late clinical** signs are indicative of severe septicemia: sclerema , shock, features of disseminated intravascular coagulation, pulmonary hemorrhage, collapse.

WHO Young Infant Clinical Study

- Difficulty in feeding
- Convulsions
- Lethargy
- Hyperthermia >37.5 C or < 35.5 C
- Tachypnea (≥60 / min),
- Severe chest indrawing
- Reduced activity

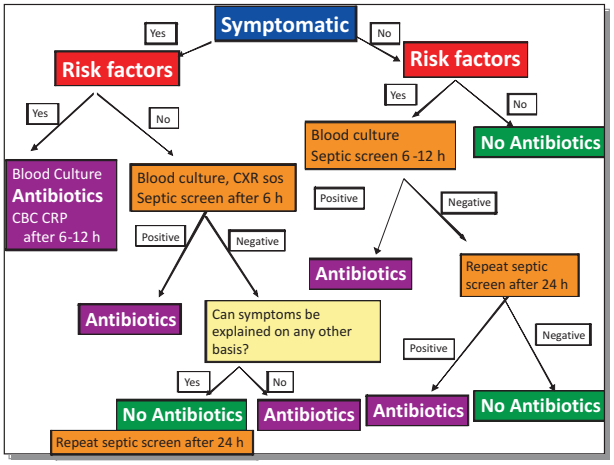
Risk factors for Early Onset Sepsis

- Intra-partum PV =3, (All PV ≥ 6)
- Clinical chorioamnionitis: maternal fever > 38°C (100.4°F) + two of :
  - maternal leukocytosis (> 15000 cells/ mm ^{3}),
  - maternal tachycardia (>100 b/min)
  - fetal tachycardia (> 160 b/min)
  - uterine tenderness
  - foul odour of the amniotic fluid
- VLBW (<1500 grams) or very preterm
- Febrile illness in the mother with evidence of bacterial infection / UTI within 2 weeks prior to delivery.
- Perinatal asphyxia (Apgar score <4 at 1 minute)
- Rupture of membranes >24 hours
- PPROM / Spontaneous preterm

Extreme risk factors

Empirical antibiotics

- Very prolonged rupture of membranes (=72 hours),
- Very prolonged labor (=24 hours),
- Foul smelling liquor,
- Unclean per vaginal examinations,
- Maternal septicemia or other systemic infections



LOS – Risk Factors

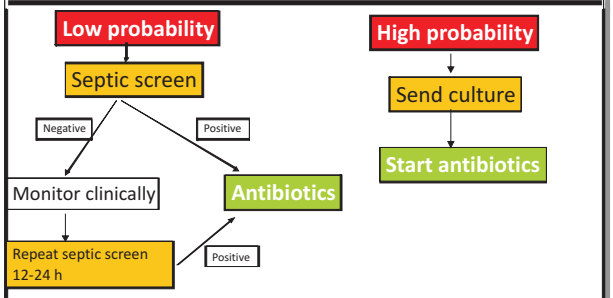
- VLBW
- Mechanical ventilation
- Central lines
- TPN
- Use of antibiotics > 5 days
- Multiple interventions
- Inability to feed with EBM
- Use of H2 blockers, steroids.

Categorize - low probability or high probability of sepsis.

LOS - Risk factors community

- Preterm / LBW
- Alternate feeds
- Bottle feeding
- Family history
- Traditional practices
- Branding / oil
- Poor hygiene practices

LOS



Blood culture

- Asepsis – 3 step
- Dry at least 1 minute
- One-mL sample of blood for a 5-10 ml of culture media.
- Bactec culture reports should be available in 48 hours.

Follow up cultures
Believe culture reports

Sepsis screen

- Symptomatic + risk factors - No need
- High probablity – No need
- To exclude sepsis
- Low probability – to rule out
- Negative screen – Repeat 12-24 hours.
- Two consecutive completely negative screens high NPV

Sepsis screen

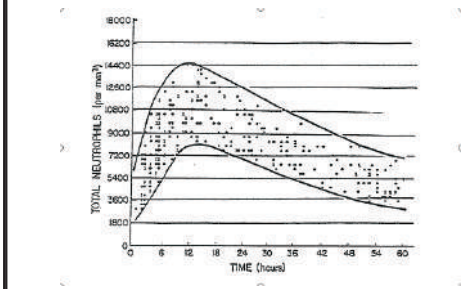
- **Total leukocyte count** <5000/mm3
- **Absolute neutrophil count**
  - **Manroe chart** for term
  - **Mouzinho's chart** for VLBW infants.

Two positive

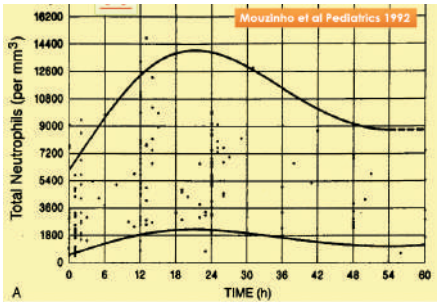
- **Immature/total neutrophil** > 0.2. Immature neutrophils (band forms, metamyelocytes, myelocytes) / Mature + immature neutrophils
- **Micro-ESR** > 3+ age in days in the first week of life or more than 10 thereafter
- **C reactive protein (CRP)** >1 mg/dl

(Collect an airfree column of blood from a heel prick in a standard 75 mm heparinised microhematocrit tube (ID 1.1 mm) and one end of the tube sealed with plasticine. Fix the labeled tube (name and time) vertically on the wallMeasure the height of the plasma column (from the highest point of the plasma column to the meniscus of the packed red cell column) after the first hour distance and report as Micro-ESR in mm / hr.

Manroe chart



Mouzinho chart



Lumbar Puncture

- **Culture + sepsis**
- **Late onset sepsis – even clinical sepsis**
- **Neurological symptoms**

	Term	Preterm
CSF count	< 8	< 10
CSF glucose	> 20	> 25
CSF Protein	<120	< 170

Critically sick neonate postpone under cover of antimeningitic dose of antibiotics.
Traumatic LP - send for gram stain and culture & CSF glucose. Repeat after 48 hours.

WBC cell count must be performed within 30 minutes.

Urine culture

- LOS
- No need in EOS
- FTT / Jaundice
- SPT / catheterization

UTI may be diagnosed in the presence of one of the following: (a) >10 WBC/mm3 in a 10 mL centrifuged sample (b) >104 organisms /mL in urine obtained by catheterization and (c) any organism in urine obtained by suprapubic aspiration

Choice of Antibiotics

Inborn

- First line: Cefuroxime + Gentamycin (inborn)
- Second line : Ciprofloxacin + Netilmycin
- Third line: Piptaz + Amikacin

Outborn

- Second line : Ciprofloxacin + Netilmycin
- Third line: Piptaz + Amikacin
  - *Gram positive: cloxacillin(ampiclox) or vancomycin (if sick)*
  - *Upgrade if no response in 48 h*
  - *Downgrade after culture report*

Duration of Antibiotics- Culture negative

Asymptomaticat risk	Stop antibiotics
Suspect screen negative asymptomatic	Stop antibiotics
Septic screen + -probable EOS or LOS, the neonate becomes completely asymptomatic by day 5	Antibiotics X 5 days
Suspected/ probable EOS or LOS and the neonate improves but does not become asymptomatic	Repeat a CRP ? If CRP + ve: continue Ab ? If CRP–ve: stop Ab
Suspected/probable EOS or LOS and the neonate has not improved or has worsened	Upgrade

Duration of Antibiotics-Culture +

CONSsepsis	5-7 days
Sepsis	14days
Meningitis	21-day
Pneumonia	7 -10 days
UTI	7-14 days
Bone or jointinfections	6 -8 weeks

Isolation

- Blood/urine/CSF culture positive other than CONS
- Open skin lesions /Sclerema
- Colonization with MDR organism
- Clinical certainty of sepsis
- Clinical+labdeterioration with suspicion of MDR organism

Adjunctive therapies

- **Intravenous immunoglobulins (IVIG)** no evidence ± in sick infants < 34 weeks. 1 g/kg
- **Colony stimulating factors)** : no evidence. ± in sick newborns with neutropenia <1000 / mm3 & not improving with antibiotics. 10 mcg/kg SC BD X 3 days
- **Double volume Exchange Transfusion :** may be performed in a case of deteriorating sepsis with sclerema, DIC provided the general condition of the baby allows the procedure. Use fresh whole blood compatible with baby and mother.

Prevention best cure

- Breast milk
- EBM
- Colostrum
- KMC
- Handwashing
- Housekeeping and infection control policies

Key Messages

- No role of septic screen in symptomatic at risk infants
- Septic screen more for ruling out sepsis
- Restrict antibiotic use and duration
- Prevention better than cure

Case 1

- Pushpa delivers a 1.8 kg baby at 34 weeks after rupture of membranes of 1 day. The baby has mild respiratory distress and requires oxygen. The RD score is 2 / 10. The baby is admitted to NICU. She has a GRBS of 39 mg% on admission.

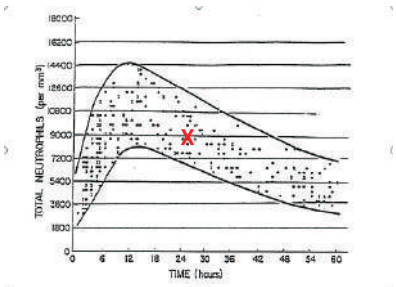
Case 1

- Send a blood culture
- Start antibiotic
- Send mothers cervical swab / Urine culture
- After 12-24 hours do CBC and CRP
- Continue to monitor the baby

Case 1

- Baby's RD settles in 5 hours, Sugar normal
- CBC at 24 h
  - TC 18000 /mm3
  - N 50, L 46, E2, BF 2
  - Plt count 99000 / mm3
- CRP < 0.05 mg/dl
- Micro ESR not done

Manroe chart



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Case 1

- Stop antibiotics after culture report is negative

Case 2

- 26 year day old 2.2 kg newborn is admitted with poor feeding, fever, lethargy.
- On admission temperature is 38 C, weight is 2.3 kg
- Baby has jaundice; urine is less but high colored.
- Multiple petechie

Case 2

- Blood Culture
- CSF Analysis
- Start Antibiotics
- Continue to monitor

- Started on Ciplox, Netilmycin
- CSF TC 25, N20,L5, Glucose 15 mg%, protein 120 mg%
- Blood culture Klebsiella
- Sensitivity pattern awaited

Case 2

- Piptaz – Netilmycin for 21 days

Pediatric TB

Dr. Indumathi
Associate Professor,
Department of pediatrics, SJMCH

Case scenario

History

- 3 year old child Ramu presents with H/O fever and cough of 2-3 weeks.
- Mother says child had fever and rash about a month ago from which child has not recovered completely.
- Not been eating well.

What do we suspect?

- Post measles bronchopneumonia
- Complicated pneumonia
- Pulmonary TB

Pediatric TB

CONTENTS

Pediatric Tuberculosis

- 9 million annual TB cases
- 1-1.5 million occur in children
- Accounts for 10-20% of burden of TB
- Reflection of untreated adult TB
- One sputum positive adult infects 25-30 people in 2 years

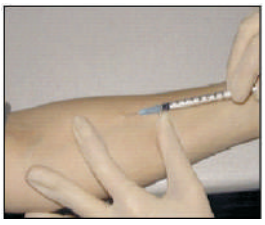
When to suspect TB in children?

- Fever and\or Cough for >2weeks
- Loss of weight or no weight gain
- History of contact with suspected or diagnosed case of active TB disease within last 2 yrs.
- Unresolving or persistent pneumonia (inadequate response to antibiotics)
- When the child fails to recover from measles\pertusis.

Diagnosis

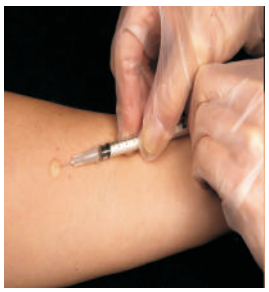
- Combination of history of contact, clinical examination and relevant investigations like TST, chest X-ray, AFB, fluid analysis and histopathology

Tuberculin Test

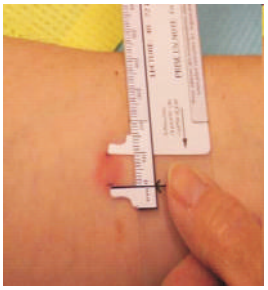


- Volar surface
- 0.1 ml intradermal
- **2 TU- not more than 5TU**
- Raise a wheal of 5 mm
- Do not rub

How to do?



How to read?



How to read

- Scale method

Reading the test

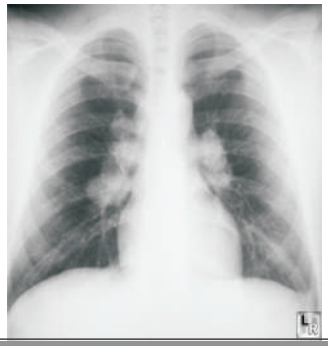
- When to read ? after 48 -72 hours
- How to read? ball point pen or scale
- **Positive if induration of = 10mm in all children irrespective of BCG.**
- Erythema alone in not significant
- **Any exception? =5mm in high -risk group**

Bacteriology

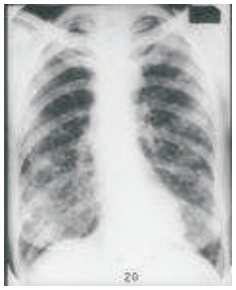
- All attempts should be made for bacteriological isolation
- Sputum: in children > 7 years.
- Induced sputum: 3**%** hypertonic saline increases the yield by 30**%**.
- **Gastric aspirate**
- Fluid analysis – ADA,AMA,PCR not required routinely

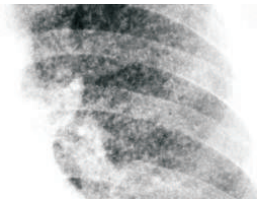
Chest X-ray

Hilar nodes

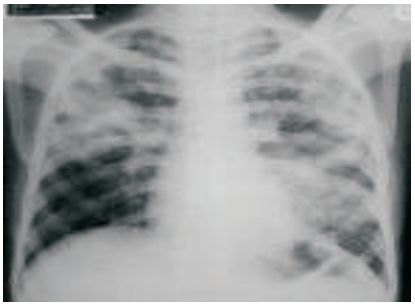


Miliary TB

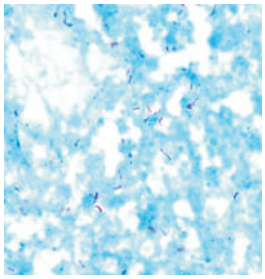




Fibro cavitory TB



FNAC & Histopathology



- FNAC,
- Breast abscess

Treatment

Management -3 components

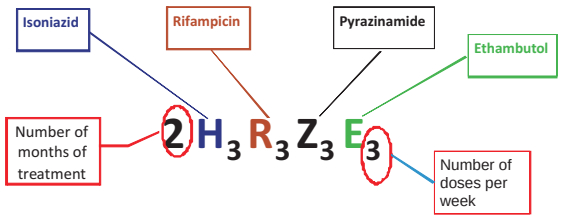
- Treatment of individual child with TB
- Contact tracing
- Chemoprophylaxis

Treatment Categories

Treatment groups	Type of patient	Regimen	
		Intensive Phase (IP)	*Continuation Phase (CP)*
New	New Sputum smear -positive New Sputum smear -negative New Extra-pulmonary New Others	$2H_3R_3Z_3E_3$ TBM,miliary & Spinal TB 2 $(HRZE)_3$ / 7 $(HR)_3$	$4H_3R_3$
Previously Treated	Smear-positive relapse Smear-positive failure Smear-positive treatment after default Others	$2H_3R_3Z_3E_3S_3$ / $1H_3R_3Z_3E_3$	$5H_3R_3E_3$

Each dose is supervised in IP
First dose in each week in CP

Intermittent therapy



Dosage

	Daily	Thrice weekly
Isoniazid	10 mg/k.g	10-15 mg/k.g
Rifampicin	10 mg/k.g	10 mg/k.g.
Pyrazinamide	25 mg/k.g	30-35 mg/k.g
Ethambutol	20 mg/k.g	30 m.g./k.g,
Streptomycin	15 mg/k.g	15 m.g./k.g

Councelling

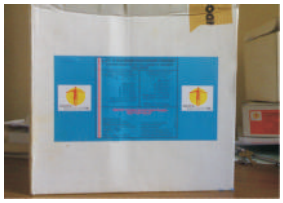
- Duration – how long and why?
- Number of drugs
- Follow up
- Side effects
- Refer to DOTS

Do we have pediatric patient wise boxes?

- India is the first country in the world to provide pediatric patient wise boxes
- Boxes and doses are designed to suit requirement of children weighing 6 - 30 K.G.

More than 30 K.G.

New category



Previously treated

Product 13
6-10 K.G

INH - 75 m.g
Rifampicin - 75 m.g.
Pyrazinamide -250 m.g.
Ethambutol -200 m.g.

Product 14
11-17 K.G.

- INH-150 m.g
- Rifampicin -150 m.g.
- Pyrazinamide -500 m.g.
- Ethambutol -400 m.g.

Product 13+product 14
18-25 K.G.

Product 13

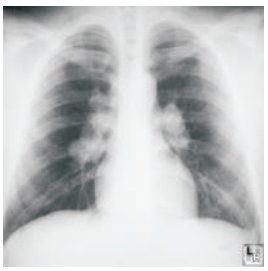
Product 14

Product 14 + product 14
25-30 K.G.

DOT providers - ASHA

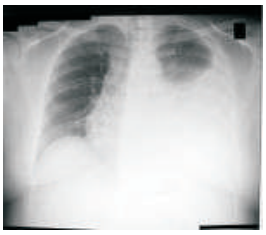
Exercises

Case 1 -Ramu



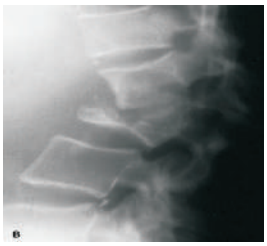
- Contact +
- Mantoux 20 mm
- AFB negative
- Never treated earlier
- Category & regimen?

Case 2 - Peter



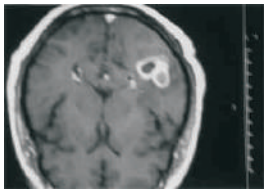
- 8 year old, 12 K.G.
- Fever 1 mon
- Clinical - air entry ↓
- Mantoux negative
- Additional investigation?
- Category?

Case 3 - Seema



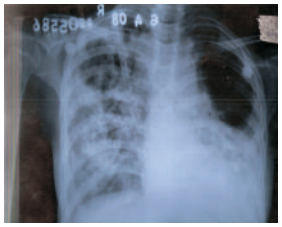
- 12 year old
- Fever 2 mon
- Stiff back
- Duration of treatment?

Case 4 -Nisha



- Partial Seizures
- Category?
- Duration?

Case 5 - chaitra



- 14 year old
- Sputum positive
- Treatment -Jan 2008
- Stops treatment after 1 mon
- Worsening -April 2008
- Category ?
- How many drugs?

Follow up

- **Clinical**
- **Bacteriological**
- Radiological

Schedule of Sputum Examination on Follow Up

	Sputum pre-treatment	Repeat sputum due...	Repeat sputum result	Action required
New PTB Patient	Positive	2nd Month	Negative	Repeat sputum 4 and 6 months
			Positive	Repeat sputum 3, 5 and 7 months
	Negative		Negative	Repeat sputum 6 months
			Positive	Repeat sputum 3, 5 and 7 months
Previously treated		3 rd month		Repeat sputum 5 and 8 months

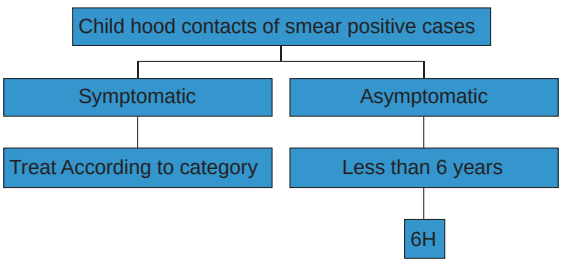
If AFB is positive or slow clinical improvement at end of IP, extend IP for a month. Prolongation pouches are available.

Special situations

Chemoprophylaxis
INH preventive therapy

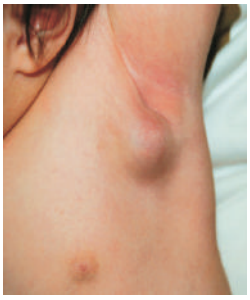
- Children in contact with adult PTB
- Infants of mothers with PTB

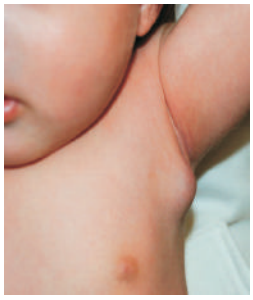
Chemoprophylaxis



INH after ruling out active TB
90-95% protection

BCG adenitis





BCG adenitis

- Self limiting
- Non suppurative - observation
- Suppurative - aspiration/biopsy
- No ATT

Journey on a train.....

Life is like a journey on a train...with its stations...with changes of routes...and with accidents!

At birth we boarded the train and met our parents, and we believe they will always travel on our side.
However, at some station our parents will step down from the train, leaving us on this journey alone.

As time goes by, other people will board the train; and they will be significant i.e. our siblings, friends, Teachers etc…
Many will step down and leave a permanent vacuum. Others will go so unnoticed that we don't realize that they vacated their seats!

This train ride will be full of joy, sorrow, fantasy, expectations, hellos, goodbyes, and farewells.
Success consists of having a good relationship with all passengers...requiring that we give the best of ourselves.

The mystery to everyone is:
We do not know at which station we ourselves will step down.

So, we must live in the best way - love, forgive, and offer the best of who we are.

It is important to do this because when the time comes for us to step down and leave our seat empty –
we should leave behind beautiful memories for those who will continue to travel on the train of life.

I thank Fr.Alex for being one of the passengers on my train……

I met Fr.Alex when he was the Secretary of the CBCI Health Commission. He had an ardent desire to help SDFI make known to the CBCI circle. He collaborated with us in many ways. When I was the President of SDFI he invited me and the Board members to join many

meetings organized by the CBCI Health Commission. SDFI was then known to CBCI and the Chairman of the Health Commission recognized us as a Religious Doctors body of Health sector in the church.

To speak about Fr. Alex, he was a very committed, genuine, hardworking, sincere, simple, loving and efficient person. To mention an incident about his contribution to the mission of SDFI ---

During Tsunami in 2004 when the members of SDFI worked in Nagapattinam Dist. in Tamil Nadu, CBCI released some funds for one deserving village . We decided to give one pair of Sheep to each family as per the request of the villagers. Fr. Alex came in person on the day we distributed the sheep to the villagers. It was symbolic event that Fr.Alex was already chosen by God to be a Pastor and a Good Shepherd…..

Ten years after the Tsunami, the Episcopal consecration of Fr.Alex as the Bishop of Kannur took place On 23rd March 2014. Sr.Drs.Emily Susai, Liza. Fernanda and myself attended the function. On behalf of SDFI we greeted and honoured the new Bishop Alex.

It was a beautiful and divine experience to attend the Episcopal consecration of Fr. Alex with many Archbishops, Bishops, Priests, Religious Sisters and Lay people. After the consecration Bishop Alex went around and blessed all the people who welcomed the new Bishop whole heartedly. His Motto is “To witness His Love and Compassion”. I am sure Fr.Alex being a loving and compassionate person ,with his vast experience with the poor and downtrodden will be a good Pastor, mentor, spiritual guide and a Good Shepherd to the people of Kannur diocese.

Let us continue to pray for him to do his mission with good health and with the wisdom of the Almighty.

wish you a joyful journey for the coming year on the train of life. Reap success and give lots of love. More importantly, thank God for the journey!

Lastly, I thank you for being one of the passengers on my train!

Sr.Dr.Hermina SSA,
Mother Joseph Hospital,
Chennai, Tamil Nadu.

We look forward to collaborate with you
for the benefit of the Indian people

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DO YOU WANT TO BE A CLOAK OF JESUS

That is the cloak worn by Jesus when he was walking among the crowd…she touched that cloak with great faith and there happened a miracle, tremendous power of God at once flow through the cloak and healed her and revived her into life.

WHO IS THAT SHE?..She has no name in the Bible, but she was described as woman with suffering, suffering from hemorrhage[mk5:25].In the Jewish society women were considered as inferior ones .To our surprise every Jewish man was thanking God 7 times a day that he was not born of a woman. Added to that misery menstruation was considered as 'unclean'. Even in our own society menstruating women were ill-treated, deprived of her basic need for food and shelter on those days in many villages. When menses becomes irregular, (heavy bleeding) she goes into frustration, feeling ashamed to express her agony - this is what we call it in our medical terms : DUB/AUB-DYSFUNCTIONAL/ ABNORMAL UTERINE BLEEDING

A BRIEF APPROACH TO DUB/AUB :

DUB occurs most often shortly after menarche and at the end of the reproductive years .20% of cases are adolescents, 50% of cases in 40-50 years. DUB is most frequently associated with chronic anovulation. Heavy menses, prolonged menses, or frequent irregular bleeding are the most common complaints

Dysfunctional uterine bleeding (DUB) is defined as ABNORMAL uterine bleeding with no demonstrable organic cause, genital or extragenital.

Diagnosis of EXCLUSION so rule out organic causes

1.Reproductive Tract Disease: Complications of pregnancy, Abortion, Ectopic gestation, Retained products, Placental polyp, Trophoblastic disease.

. Benign pelvic lesions: Leiomyomata, Endometrial or endocervical polyps, Adenomyosis and endometriosis, Pelvic infections, Trauma, Foreign bodies (IUCD)

Malignant pelvic lesions : Endometrial hyperplasia, Endometrial cancer, Cervical cancer, less frequently vaginal, vulvar, fallopian tube cancers, estrogen secreting ovarian tumors.

2.Systemic Disease: Coagulation disorders, platelet deficiency, platelet function defect, prothrombin deficiency, Hypothyroidism.Liver disease.

3.IatrogenicCauses:Medications,Steroids,Anticoagulants,Tranquilizers,Antidepressants,Digitalis, IUCD.

EVAULATION:

CAREFUL HISTORY WILL CLINCH THE DIAGNOSIS: Onset, frequency, duration, cyclic vs.acyclic, severity ,Pain, change from menstrual pattern (calendar),Age, parity, marital status, sexual hx, contraception medications, dates of pregnancies ,symptoms of pregnancy and reproductive tract disease

Physical Exam : look for anemia,thyroid,pelvic exam,pap for perimenopausal lady

Tests : Choices are extensive.Selection should be tailored to suspected causes

Step One:

– Rapid assessment of vital signs
– Hemodynamically stable/unstable?

Step Two: (simultaneous with step 1)

– Baseline CBC, urine pregnancy

Step Three (adolescents):

– Low risk for intracavitary or cancerous lesion
– High coagulopathy risk
– coagulation profile,thyroid profile

Step Four (Adults):

– Transvaginal ultrasound
– Lesion present:biopsy orhysteroscopy

– No lesion:High risk for neoplasia -endometrial biopsy
– Low risk for neoplasia can assume DUB and treat

Step Five (Adults):

– Secretory endometrium in biopsy rule out polyp or submucosal fibroid

Step Six (Adults):

– Proliferative endometrium or hyperplasia without atypia assume DUB manage according to desired fertility
– Hyperplasia with atypia or CA treat accordingly

TREATMENT OF DUB :ACUTE BLEEDING

MEDICAL MANAGMENT : Correction of hypovolemia is the immediate treatment with blood and fluids

1.NSAID'S : Mefanamic acid is the first choice(tab.Meftalspas 250mg tid) cyclooxygenase inhibitors -inhibits prostacyclin formation administered throughout the duration of bleeding or for the first 3 days of menses.

2.Inhibitors of fibrinolysis EACA (epsilon-aminocaproic acid),AMCA (tranexamic acid)can be given as inj Tranex 500mg IV Q8hrlyalong with oral preparation

ESTROGEN THERAPY

3.Oral conjugated equine estrogens 10mg a day in four divided doses treat for 21 to 25 days if bleeding not controlled, consider organic cause OR 25 mg IV every 4 to 12 hours for 24 hours, then switch to oral treatment as above. Bleeding usually diminishes within 24 hours.

High dose estrogen-progestin therapy

Use combination OCP's containing 35 micrograms or less of ethinylestradiol four tablets per day treat for one week after bleeding stops(or)

Medroxyprogesterone acetate, 10 mg per day for the last 7 days of the treatment

4.Norethisterone progestrate(tab.primolute N/Mensil N)5mg 2-2-2till bleeding stops then taper down to 1-1-1for1 week 1-0-1 for next 2 week

Recurrent bleeding episodes combination OCP's -one tablet per day for 21 days

intermittent progestin therapy

– medroxyprogesterone acetate, 10mg per day, for the first 10 days of each month

– Norethisterone progestrate10 mg/ day from Day5-25 or Day 15-25

5. Progesterone releasing IUD(MIRENA)LEVONORGESTEROL releasing IUD avoids systemic side effects, found to be superior to antifibrinolytic agents and prostaglandin synthetase inhibitors

6. Ormeloxifen (SERM) NOVEX DS60mgtwice weekly for the first 12 weeks and 30 mg twice weekly for 12 weeks, its an estrogen antagonist in uterus and breast

SURGICAL TREATMENT

Dilation and Curettage quickest way to stop bleeding in patients who are hypovolemic ,appropriate in older women (>35)to exclude malignancy but is inferior to hysteroscopy ,follow with medroxyprogesterone acetate, OCP's, or NSAID's to prevent recurrence

Laser ablation,Loop electrode resection LAST RESORT IS HYSTERECTOMY

KEY POINTS :Try with medical methods most of them are cured, if not try with IUCD/D&C, last is surgery Thus we can be part of Jesus mission of healing our own sisters

Any Q?MAIL : srjoycesmmi@gamail.com

Sr. Dr. Joyce SMMI

Case Study

Emergency cervical encerclage in a patient with funnelling of amniotic membrane into cervix.

Case Report:

Mrs. X 22yrs G2P1D1 presented to us at 24 wks of gestation with lower abdominal pain and blood stained discharge since 1 day. She had a similar history in the first pregnancy and delivered a preterm fetus that died immediately after birth.

On examination, fundal height was corresponding to gestational age. Uterus was irritable. On per vaginal examination, cervix was shortened, cervical length around 1cm, membrane protruding through os and it was confirmed by ultrasound. Hence patient was posted for emergency cervical encerclage.

Patient was given spinal Anesthesia. Parts cleaned and draped. Cervix visualized with speculum. Foley's catheter No 16 was introduced into the cervix and gently inflated. This

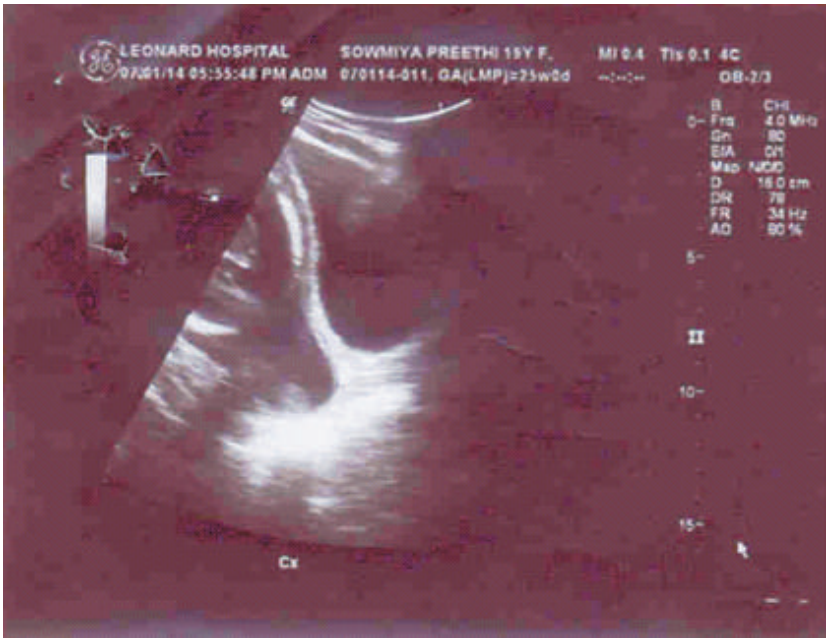


Figure 1 funnelling of membrane

maneuver pushed the membrane back into the uterus. Then cervical encerclage done. Before tightening the suture, the catheter was deflated and removed.

Post procedure period was uneventful. She delivered a live female baby at 36 wks of gestation by spontaneous vaginal delivery.

Discussion

Emergency cervical encerclage procedure is done in an incompetent cervix diagnosed later in pregnancy. The woman's amniotic sac may begin to protrude through her cervix. This may be treated by inserting a catheter through the cervix. The most important step in performing emergency encerclage is making the diagnosis and which would improve the perinatal out come significantly.

Sr. Dr. Maria Vasantha Alphonse SCC,

Leonard Hospital,

Batlagundu, Tamil Nadu

A DARING TRUTH OF A RELIGIOUS - SISTER DOCTOR

In my personal opinion we, the Religious Sister Doctors are the privileged group in the fold of God. We are very and very special in our vocation not because of our degree, but because of our extra responsibilities. Here I just would like to share the heart of majority of Sister Doctors.

LIFE EXPERIENCE

It was not our own privilege or fault that we had to undergo the tension of preparation for entrance exam, and then getting into this professional study. Once we joined the course, we had again two fold responsibility. Keeping up the meaning and essence of our religious life and its commitment, as well growing along with co students with due competence in spite of the long gap we spent through our formation and religious studies. But it was a great pleasure to be, as it called us to grow in maturity, wisdom, knowledge and in deep spirituality. Often enough our evangelical council we professed were tested in fire to bring forth its golden meaning in our life.

While these are the kind of struggles cum growth we went through, I believe it was also a greater challenge to make our Communities and the higher authorities in our Congregation to understand, accept and support. It was not always easy for majority of us to get these things smoothly, though some had good way out of it. The deepest pain most of us had was the intriguing view and back talk of many with their prejudiced ideas and past experience may be, of some Doctor Sisters who left their religious life. But I can assure that these had been the stepping stones towards the strengthening of our religious vocation.

Often in our College we were looked down by our professors as if we were there with grace marks, concessions and due to seat allowance. Only few teachers had the courage to look beyond to see the true potential within us, or few of us had the strength to stand against the current to change these previews. Because of our study we often missed all the privileges of attending seminars, courses; get to gathers conducted for our own groups in the Congregation. In all our sincerity we missed them a lot.

When all these struggles were over and we are to be back in our congregation, in our community there the journey of life begins with different colours.

May be staying in the hostel for 6-9 long years with our own time table, freedom of sleep, prayer, meals, along with our duties which varies from morning to night and night through morning, falling into a set of time table in the community may appear bit inconvenient at the start, but I believe many of the sister Doctors do their best to accommodate and adjust. Very often we are posted in rural hospitals with minimum facilities except few who have well structured hospital, it is a great challenge we take up willingly keeping Christ as our full strength and support. Though equipped with knowledge, we may have less experience in the beginning of this career, but we stand alone often in our work place, because (this fact may hurt many but sister doctors would agree) the nurses or other staff who are there working for years, either criticize us or leave us alone by their indifference. I do not always understand why they have this problem only with our Sister Doctors, but with any lay Doctors who visit our hospitals or clinics, I see them carrying out their orders in perfect obedience. I do not want to generalize still, because few places it is heavenly where we can work together. There is also at times difference of opinions between Sister Doctor with administrator, or superior in terms of policy making, decision making and in supporting their own sister Doctor. If the congregation has educated a sister to be a doctor, we need to develop also among the sisters to trust their ability and good will of the person. Majority of us may not ask for anything extra ordinary than a little flexibility of timetable, a bit of privacy to rest, read or to pray and great support and understanding when things go wrong etc.

OUR RESPONSE AND RESPONSIBILTY

As religious doctors, we also need to put our hands together, with our community and in the work place. We need to learn that those who are there already are loaded with experiences and we need to respect. If what they do may look wrong, we should learn to change them gently, bringing good wrap over, relationship, explanation and evidences, then slowly and succefully bring out the change one feels reasonable according to what we have learned. As our Councilor used to say, in the hospital we need to be empowered and take responsibility as a Doctor, but back in Community we are as equal to any other sisters in the community. Though our good work may bring fame and name etc, we always need to remain simple, humble and truthful as Jesus Christ lived. Living in communion with our co-workers, community and with the people of the locality is the only key to be at your best potential. I

always admire many religious sister Doctors who live still a simple, and edifying life as religious as well as a Doctor.

We have crossed many hurdles and we have learned through our hard life journey the daring truth that it is by God's grace alone we can be what we ought to be. Let us never forget to cling on to God giving all glory and praise to His Holy name.

I always admire our senior Sister Doctors, who are still simple, energetic, creative and prayerful. I also admire the good will and sincerity expressed in the young Sister Doctors. Let us be proud that God has called us very specially to extend His healing touch to the sick and the suffering. According to me healing ministry is the complete ministry, where we can heal body, mind, soul, we can teach and educate, we can empower and lead, we can council and comfort, we can show and give God, giving the fullness of life as Jesus did.

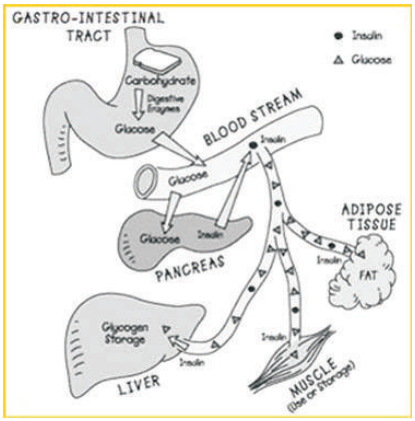
SR. MARTINA SJC,

Arockia Matha Nilayam,

Salem, Tamil Nadu.

DIABETES MELLITUS GENERAL CONSIDERATION

According to the World Health Organization, at least 171 million people worldwide suffer from diabetes (approximately 2.8% of the population). Its incidence is rapidly increasing, and it is estimated that by 2030, this number will almost double. Diabetes mellitus occurs throughout the world, but is more common (especially type 2) in the more developed countries. The greatest increase in prevalence is, however, expected to occur in Asia and Africa, where most patients will probably be found by 2030. The increase in incidence of diabetes in developing countries follows the trend of urbanization and lifestyle changes, perhaps most importantly a "Western-style" diet. This has suggested an environmental effect, but there is little understanding about the mechanism(s) at present, though there is much speculation, some of it most compellingly presented. The Centers for Disease Control has termed the change an epidemic.



Clinical diabetes mellitus represents a syndrome with disordered metabolism and inappropriate hyperglycemia, due to either an absolute deficiency of insulin secretion or a reduction in its biologic effectiveness or both. Classification of diabetes is based upon insulin secretion or insulin sensitivity. It recommends classifying diabetes mellitus into major types.

There are two main types of diabetes.

Type 1 diabetes or juvenile- onset diabetes, occurs due to absolute insulin deficiency, which regulates body energy. People with Type 1 DM must take insulin injections or through an insulin infusion pump.

Type 2 diabetes or adult-onset diabetes, usually develops in adulthood, although increased incidence was also seen in a number of children, especially obese children. Type 2 DM accounts for 90-95% of all diagnosed cases of diabetes. It occurs either due to relative insulin deficiency or insulin resistance. Type 2 DM is associated with older age, obesity, family history of diabetes, and/or history of gestational diabetes..

Gestational diabetes commonly occurs as a temporary condition during pregnancy, although there is a risk of developing type 2 DM even after pregnancy. It is common among obese women and women with a family history of diabetes.

Pre-Diabetes

Pre diabetes or impaired glucose tolerance is a pre diabetic condition where, the sugar levels are more than the normal levels but below the level of diabetes. This condition can fairly be managed by diet and lifestyle modification, although its progression into type 2 DM is sometimes inevitable.

CLINICAL MANIFESTATIONS

The classic symptoms of polyuria, polydipsia, recurrent blurring of vision, paresthesias and fatigue are common to both the types of diabetes. Other uncommon features like pruritus vulvae and vaginitis are seen in adult females with hyperglycemia and glycosuria. Weight loss despite normal or increased appetite is a common feature in diabetes. These latter patients with the insulin-resistance may be relatively asymptomatic and may be detected only incidentally on blood investigation. Diabetes should be suspected in obese patients, in those with a positive family history of diabetes, in patients presenting with peripheral neuropathy and in women who have delivered large babies or had polyhydramnios, preeclampsia, or unexplained fetal losses**.**

Diagnosis:

Fasting plasma glucose of 126mg/dl or more on more.
A post prandial blood glucose or random blood glucose of 200 or more.
Hba1c >5.6, are suggestive of diabetes.

Insulin levels during glucose tolerance test. Normal immunoreactive insulin levels range from less than 10 to 25µV/mL in the fasting state and 50 to I30µV/mL, at 1 hour and usually return to levels below 100µV/mL by 2 hours. A value below50µV/mL at 1 hour and less than 100 µV/mL at 2 hours in the presence of sustained, hyperglycemia implicate insensitivity of B cells to glucose as the cause of hyperglycemia, whereas levels substantially above 100µ V/mL at these times suggest tissue unresponsiveness to the action of insulin.

Complications:

If left untreated or improperly managed, diabetes can result in a variety of complications such as:

Heart disease

Kidney disease

Eye disease

Impotence

Nerve damage

Risk factors:

Being a member of a high risk group (Latino/Hispanic American, African American, Asian American, Native American)

Being overweight (especially if you carry most of your weight around the middle)

Having family history of diabetes

Have health complications that are associated with diabetes

High blood pressure

High cholesterol or other fats in the blood

Prevention:

Lifestyle changes, such as a healthy meal plan, weight control and physical activity, may help prevent or delay the onset of Type 2 diabetes.

Sources

Goals

Treatment goals for type 2 diabetic patients are related to effective control of **blood glucose**, **blood pressure** and **lipids** to minimize the risk of long-term consequences associated with diabetes. They are suggested in **clinical practice guidelines** released by various national and international diabetes agencies.

The targets are:

Hb_{A1c} of 6% [1] to 7.0% [2]

Pre-prandial blood glucose: 4.0 to 6.0 mmol/L (72 to 108 mg/dl)[3]

2-hour **postprandial** blood glucose: 5.0 to 8.0 mmol/L (90 to 144 mg/dl)[3]

In older patients, **clinical practice guidelines** by the **American Geriatrics Society** states "for frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as Hb_{A1c} of 8% is appropriate '.

TREATMENT

The following are initial lifestyle changes used in treating diabetes mellitus:

1) Exercise. Patients are encouraged to have moderate physical activity for thirty minutes, at least thrice a week. This will help in maintaining weight as well will promote the cells' utilization of carbohydrates, enhance the effects of insulin, and improve cardiovascular function.

2) Dietary changes. Calories derived from carbohydrates and saturated fats are generally restricted to maintain body weight. However, diet should consist of a balance of the three macronutrients. Carbohydrate sources that are in fiber content and obtained from fruits and vegetables such as apples and beans are encouraged. Protein should come from lean meat. Fats are used in moderation. You can use the exchange list provided by the American Diabetic Association. Timing of meals is important with avoidance of skipping and delaying intake. Use of salt is discouraged. Frequent snacking is recommended with small meal portions especially in periods of increased activity.

3) Stress avoidance. Stress can cause an increase in glucose needs of the body because of the increased speed at which most bodily functions work.

4) Hygiene. Optimal care of the body especially of the foot should be done meticulously. This will prevent the multiplication of microorganisms from the increased glucose levels in the blood.

5) Regular checkup. This is an important step in treating diabetes. The patient is encouraged to visit his or her physician for routine checkups. This includes regular eye exams and hemoglobin A1C every three to six months

6) Ayurveda considers diabetes a kapha disorder of low agni (digestive fire) and offers a variety of treatments, including the following that can be undertaken with the guidance of a qualified practitioner: Take turmeric daily to control blood sugar (you can take it alone or in combination with ground bay leaf and aloe vera gel); follow a pacifying diet by avoiding too many sweets; and participate in a supervised pancha kanna program. Consult your doctor before starting a new regimen; diabetes must be carefully monitored.

7) Bodywork and Somatic Practices

8) Reflexology, polarity therapy, and Oriental bodywork therapies can be helpful in balancing energy and reducing stress.

9) Herbal Therapy

Garlic can aid in stabilizing blood sugar. Ask your healthcare provider if garlic capsules are right for you.

Many herbs are known to affect blood sugar levels, which in turn can cause significant variation in the need for insulin. Such variation could ultimately result in insulin shock or diabetic coma. Therefore, persons with known diabetic conditions should take precautions and try herbal preparations only under close medical supervision.

10) Traditional Chinese Medicine

11) Acupuncture

Acupuncture can be used to help control stress, which in turn impacts the patient's blood sugar level. Acupuncture also can be used to fortify overall immunity and strengthen

organs that may otherwise be compromised by diabetes. Usually the practitioner works on points associated with the bladder, kidneys, spleen, pancreas, and related organs and meridians.

Acupressure may be used to control diabetes-related symptoms, such as fatigue, cramps, and menstrual problems. In addition, applying pressure to Bladder points 18, 19, 20, and 23 can help stimulate liver and pancreas functioning, making the body better able to cope with the disease.

12) Chinese Herbal Therapy Ginseng has been shown to regulate blood sugar levels and is often used to treat diabetes. Major Four Herbs Formula and Rehmannia. Six Combination also may be used, but a full diagnosis is needed.

13) Yoga and Meditation

Yoga, medication, and breathing exercises can improve blood circulation and enhance digestion, therefore helping you cope with diabetes. Establish a daily routine of at least four poses, such as the Chest-Knee, Sun Salutation, Peacock, Locust, and Leg Lift. Yogic exercises can also be helpful; see a trained therapist for instructions on yogic exercises.

14) **Treatment in Western medicine**.

A. Diet. Caloric restriction for obese patients and regular spaced feeding with a bedtime snack for patients receiving hypoglycemic agents, especially insulin.

A well-balanced, nutritious diet remains a fundamental element of therapy. However, in more than half of cases, diabetic patients fail to follow their diet. The reasons for this are varied and include unnecessary complexity of the prescription as well as lack of understanding of the goals by both the patient and the physician. In prescribing a diet, it is important to relate dietary objectives to the type of diabetes. In obese patients with mild hyperglycemia, the major goal of diet therapy is weight reduction by caloric restriction. Thus, there is less need for exchange lists. Emphasis on timing of meals, or periodic snacks, all of which are so essential in the treatment of insulin requiring non obese diabetics.

Because of the prevalence of the obese mild diabetic among the population of diabetics receiving therapy, this type of patient represents the most frequent and thus one of the most important challenges for the physician. Treatment requires an energetic, vigorous program directed by persons who are aware of the mechanism by which weight reduction is known to effectively lower hyperglycemia and who are convinced of the profoundly beneficial effects of weight control on blood lipid levels as well as on hyperglycemia in obese diabetics. Weight reduction is an elusive goal that can only be achieved by close supervision of the obese patient.

B. hypoglycemic drugs.

Conclusion

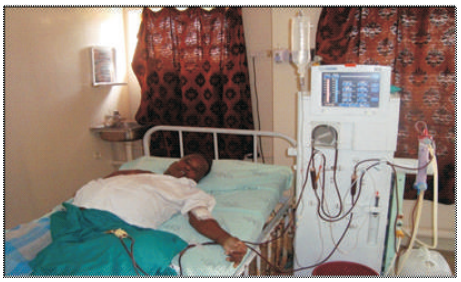
There is increase in incidence of diabetes in developing countries because of changing life style and the termed of urbanization. Asia and Africa are the most commonly affected areas. Diabetes is considered as a big killer and is among the top 5, of the most significant diseases in the developed world .In India too, diabetes is a major health haggard. It is the seventh leading cause of death. In order to known about the incidence of diabetes in the country, several surveys have been conducted by various agencies at different times. But the incidences of diabetes are increasing with every new day (down) and this number will be for ahead of China, which is considered at second rank. It has been estimated that near about 25 million people suffer from diabetes and 90% of these people are above forty years of age. The incidence of diabetes increases with Age, so only 0.2 percent of children are affected while eight to ten percent of elderly people are affected, therefore urgent, needed precautions & preventive measures should be taken.

Sr.Dr.Vimal Jyothy SMMI,

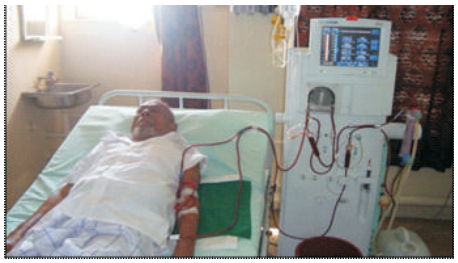
President, Central Region.

SAVING KIDNEYS- SAVING LIVES!

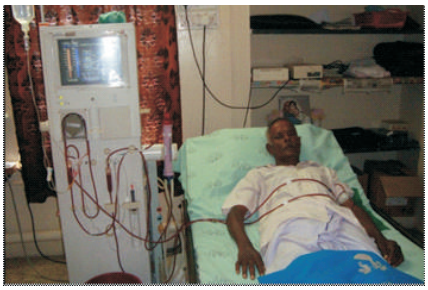
ST. MARY'S HOSPITAL, PODANUR, COIMBATORE



When you see people at the end of the rope just about hanging on, you are urged to raise your hand to help them. I see in my everyday life, so many people just hanging on to that end of the rope. My heart desires to bring them back to life.



The Bible says, "The Lord hears the cry of the poor." The Lord can work wonders through us. We need to comfort those in need. What we do here in St. Mary's is a little effort to show the Lord's wonder to those people in need.



Here, at St. Mary's, Podanur, we have dialysis services for our poor patients with kidney diseases. We desire to provide more free services. Little drops of water make a mighty ocean. Our effort here in St. Mary's is only a drop, however the ocean is not yet complete. We need to contribute our drops in alleviating the pain of the poor.

When you are in real need, the whole universe bends to help you. When the needy raise their hands, we need to put ourselves out there to comfort them. We need to be the Lord's hands for them. We are" tools in the hands of God" says Damien of Molokai who worked among the lepers and died as a leper.

We are happy and grateful to CHAI for coming forward to help our patients, in view of the 70th Anniversary of CHAI. Through this project we hope that many more patients on regular dialysis are benefited. So we express our gratitude for this service rendered.

Dr.Sr. Rani Agnes,
St. Mary's Hospital, Podanur.

Congratulations

Sr. Dr. Annie Cyriac SH Awards,

1. AIBDA (All India Business Development Association ,New Delhi)

   Presented INDO NEPAL SABHAVANA AWARD

   In Recognition of sterling merit excellent performance and outstanding contribution for the progress of the Nation worldwide, on the occasion of International Seminar on 19th October, 2013 at Kathmandu, Nepal.

2. AIBDA International GOLD STAR AWARD

   Individual contribution for International integration and World peace on 18th November, 2013 at Dubai.

3. The Idukki District Women's Council appreciation Award on March, 2012 and 6th March, 2014.

Sr. Dr. Rosa Basani JMJ Wins the "Best Doctor Award"

Presented by AP State Christian (Minorities) Finance Corporation and Minorities Welfare Department

Sr. Dr. Rosa Basani alias Annamma Basani, MRCOG, has been chosen for "Best Doctor Award" presented by AP State Christian (Minorities) Finance Corporation and Minorities Welfare Department for excellent service in the field of health care. Awarded during Chirstmas celebrations in Hyderabad, by Chief Minister Kiran Kumar Reddy.

She belongs to the congregation of the Sisters of Jesus Mary and Joseph (JMJ). Eighty-year old Sr. Dr. Rosa Basani has just completed 60 years of religious life. She has been a doctor since 1976 and is specialized in gynaecology and obstetrics. The major portion of her service has been in Andhra Pradesh (Guntur and Kadapa) almost 38 years. She served in Porumamilla (Kadapa)- a remote area for 15 years. She has also served in the Netherlands, UK, Ireland, England and Odisha state. At present she is serving as a gynaecologist in St Joseph's Hospital, Guntur. She served as Medical Superintendent in the Hospital till 2011. Through her hands two lakh infants have been born into this world.

The award will be presented by Mr. Kiran Kumar Reddy, the Honourable Chief Minister of Andhra Pradesh, on 21 December 2013.

CHAI family congratulates her on her winning this prestigious award!

Sr.Dr Annie.JMJ

Medical Superindent

St. Joseph's General Hospital. Gundur, Andhra Pradesh.

TRIBUTE TO SR. DR. GABRIEL

Sr. Dr. Gabriel Francis ASMI, a life member of SDFI went to the Lord for her eternal reward on 26th November 2013 at the age of 81.

Sr. Dr. Gabriel was born in the family of Kozipoovananickal, at Puthenpuzha Poonjar in Kerala. She joined the congregation of ASMI (Assisi Sisters of Mary Immaculate Green Gardens Chertala) in the year 1958.

She served humanity as a Doctor (DGO) and as a zelous missionary for 50 years. She extended her services to different parts of India; Dalli Rajahra in CG, Allappally in MS, Thalvadi in TN, Roorkee in UP, and Rampur in UP. She served the congregation as the Superior General from the year 1993 to 1999.

Her last years were spent at Rampur. She rendered her service till 2011. She had a sudden attack of breathlessness on 19/11/13. The Parish Priest was called and she was given the Sacrament of Anointing of the Sick and she was taken to the ICU at Moradabad. On 26th November 2013at 4 AM she died of a silent heart attack. She was conscious and praying till her last breath. With deep sentiments of grief we pray that her soul rest in peace at the bosom of Jesus.

TRIBUTE TO SR. DR. MARIYA TEREZINE, KATTAKAYAM

Sr. Dr. Mariya Terezine, Kattakayama born at Vikkom, D/o Joseph Kattakayam and Mary. She did her Medical degree and post graduation from Vienna University. She did her post graduation in Cardiology. She worked in St. John's Hospital, Bangalore in Cardiology dept. During 1978-80. From 1981 to 83 she worked in Sree Chithra Institute of Medical Sciencws, TVM. From 1985 onwards she was working in Carmel Hospital, Aluva. She worked as medial superintend in Carmel Hospital for many years. On this sad and irreparable loss to all of us, let us pray for her departed soul.

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