News Letter

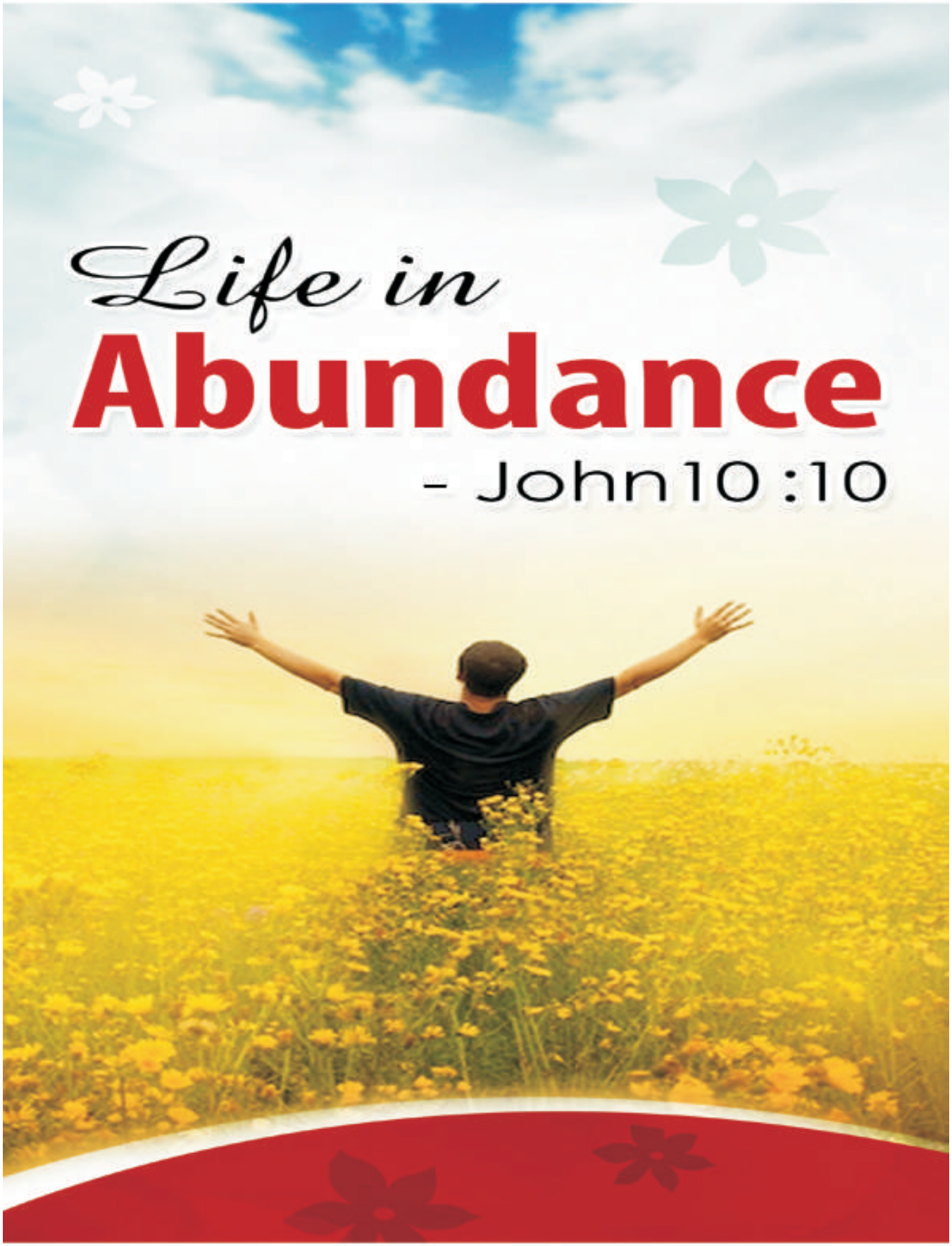
Sister Doctors Forum of India

Healthy Life Style for Healthy Living

21st AGBM

20th, 21st & 22nd February, 2015
The Citadel, Chennai, Tamil Nadu

No. 20, June 2015


Life in
Abundance
- John10 :10

CONTENTS

From Editor's Desk…….

Healthy life style for healthy living – I take this opportunity to pen down few points that is an absolute necessity for us as Sister Doctors,

HEALTHY LIVING STEP NO. 1: TAKE STOCK.

Your first step toward healthy living is to get a handle on your health status right now. Make appointments with your doctor and dentist. Catch up on your routine screening and checkups. Gauge your girth. Measure your height and weight to check your BMI, and measure your waist circumference to see if you're overweight and if your waistline is putting your health at risk. Keep a food diary. Check your mood and energy. Healthy living includes emotional wellness and adequate rest.

HEALTHY LIVING STEP NO. 2: PUT OUT FIRES.

If you know that you have chronic health problems, whether it's heart disease, diabetes, depression, arthritis, or other conditions, treatment is an obvious priority for healthy living

HEALTHY LIVING STEP NO. 3 MOVE MORE.

Make it fun. Go on a hike, walk with friends, or whatever you enjoy. Work activity into your day. "Ten percent of something is better than 100% of nothing. So even if you have 10 minutes, it's better than zero minutes," take a 10-minute walk or walking up and down the stairs. Avoid using lifts, and vehicles.

HEALTHY LIVING STEP NO. 4: UPGRADE YOUR DIET.

Replace "I should" with "I choose." So instead of "I should be eating more fruits and vegetables," it's "I choose to eat more fruits and vegetables" or "I choose not to," Slow down and savor your food. Don't watch TV, work, or drive while you're eating.

HEALTHY LIVING STEP NO. 5: MANAGE STRESS.

Develop positive coping skills, such as meditation and visualization, and look for activities, such as yoga or exercise, to keep your baseline stress level in check. Find ways to handle stressful situations that flare up without warning. Check your perspective. Ask yourself, "Will this matter to me a year from now?" If not, why are you getting so wound up?

HEALTHY LIVING STEP NO. 6: SLEEP BETTER.

No TV or computer two hours before bedtime. No heavy exercise close to bedtime. Set a regular sleep schedule. Don't count on weekend catch-up sleep. Don't ignore chronic sleep problems.

HEALTHY LIVING STEP NO. 7: IMPROVE YOUR RELATIONSHIPS.

Look for people like you. The details of their lives don't have to match yours, but look for a similar level of openness. Spend time with people. If I'm in a relationship that's really causing me a lot of pain, then we need to do something, we need to go and seek help,"

HEALTHY LIVING STEP NO. 8: CHALLENGE YOUR MIND.

Participating in mentally stimulating activities, especially activities that involve other people, may be good for the brain. Observational studies have shown that people who engage in mentally stimulating activities may be less likely to develop dementia.

Wishing all our Sister Doctors a meaningful year of consecrated life, and request you to take check of your health as well, as you extend the healing touch of Jesus to others.

My Heartfelt thanks to the authors of the articles, Sr. Dr. Emily Suasai FMM and Sr. Ancy Joseph SCC who have done the proof reading. We appreciate the hard work done by Mr. A. Roger Cyril who has given a shape to this News Letter, 2015.

We hope that the good news of “A Healthy Life Style for A Healthy Living” will be spread through this News Letter as well as through the model of our own lives.

Sr. Dr. Martina SJC,

Arockia Matha Nilayam,

Gangavalli (Taluk), Salem (Dist),

Tamil Nadu

President's Message

My Very Dear Sister Doctors,

"A Healthy Life Style for a Healthy Living", this declaration that we made at our AGBM in Chennai on 21st February, 2015 has enamored all of us to take steps towards healthy lifestyle. It is also a very good slogan to inspire the people to lead a Healthy life, as we follow Jesus the Divine Healer.

Let us go to the roots and discover the double burden of diseases that affect both urban and rural India. Due to climate change, increased urbanization and globalization, more countries than ever will face the dual disease burden. The factors that enable the spread of infectious diseases are poverty, unclean water, poor sanitation and weak health systems. They exacerbate chronic conditions and contribute to "premature" deaths. Hypertension, heart disease and diabetes are increasing in prevalence, but many Indians don't have the means to live with them for decades, especially in rural areas. Therefore it demands of us that we reach out to the poor as well as the urban people with education for the healthy life style, other preventive measures and curative services.

Before I conclude I would like to place gratefully on record the services rendered by ***Most Rev. George Antonysamy,*** *Arch Bishop of Chennai & Mylapore,* ***Dr. M. Balasubramanian****, President, IMA, Tamil Nadu,* ***Rev. Fr. Joe Mannath, SDB,*** *(Resource Person),* ***Rev. Fr. Tomi Thomus,*** *Director General, CHAI,* ***Rev. Fr. Raphael Jayapalan, SDB,*** *Provincial, Don Bosco Society, Chennai,* ***Rev. Fr. D.J. Sagaya Raj, SDB,*** *Rector, Citadel, Chennai,* ***Rev. Sr. Sagaya Sathya,*** *SSAM, Provincial, St. Anne's Congregation, Chennai, Local Organizing Committee and All Sister Doctors in Tamil Nadu Region.*

Your presence and service dear friends have made this AGBM and CME enjoyable and educative.

It is my duty to express my sincere appreciation and gratitude to Sr. Dr. Emily Susai FMM, for all the great contribution given to SDFI during her tenure as the Vice president for the past six years.

"I have come that you may have life and life in abundance" – John 10:10

May God bless you!

Yours affectionately,

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

Message from the Vice President…

Warm greetings to all our Sister Doctors! I'm pleased to meet you all through this message,! It's already months passed after our gathering for 21st AGBM in Chennai. I would like to share this message which is truly inspirational to myself !

One day I asked God for Instruction how to live Healthy on this earth

God Brought his voice close to my ear and said to be one with the Nature!!

Be Like the Sun	-	Arise early and don't go to bed late
Be Like the Moon	-	Shine in the darkness, but submit to the greater light
Be Like the Birds	-	Have inner freedom always
Be Like the Flower	-	Loving the sun, but faithful to your roots
Be Like the Fruit	-	Beautiful outside and Healthy inside
Be Like the Day	-	Which arrives and leaves without boasting
Be Like the Water	-	Good and transparent
Be Like the River	-	Always moving forward…….!!

My dear Sister Doctors, We become too busy and get burnt out with our daily schedule in our Healing mission! So we the sister doctors need desperately to follow the Healthy Life Style to keep ourselves fit in all the dimensions, to educate others through our life!!

Lord don't let me remain where I'm …….Help me to reach

Where you want me to be!!

Sr. Dr. Alphonse Mary FIHM
Vice President,
Sister Doctors Forum of India.

Message from the outgoing Vice President…

It is with heart full of joy and gratitude I say ' au revoir' to the past and present board members of SDFI. I had the privilege of working with my mentor Presidents Hermina, Lina and Lucian for solid 12 years as National Secretary and Vice President. Our deep sharing of spiritual, academic struggles, of success and joy, sorrows and anxieties of SDFI were rewarding. I am proud of being a witness and part of the 'conception' of sister doctors meeting in Tamil Nadu 26 years ago. At that early stage of SDFI we were very closely knit and shared our success, failures and received mutual support from each other to lead our life in the community and professionally. The strength we received in our fellowship and making retreats with eminent guides have laid a solid foundation in each one's spiritual and religious life. Only 3 years after its conception in Tamil Nadu SDFI National Unit was born in Ernakulam.

I have seen her grow through her 'childhood' to 'adolescence'. Now she is at her 'adulthood' spreading her wings through all seven regions of the nation.

Though the number of registered members have gone over 900, our annual general body attendance still remains below 200. If each one of us try to bring along one or two friends of ours it will double and triple our attendance and we can grow as a powerful body that will be strong enough to take on our petitions even at the central government.

Here, I wish to quote Fr. Jerry Lobo OFM's address to the consecrated persons. Today what is asked of us, as consecrated sister doctors in not so much success in our ministry, but the commitment and fidelity maintained through every moment of our life. Our responsibility is to live in the present faithfully, that the future may be exciting. For a life in abundance and a more consecrated and Franciscan life, we need the witness, the wisdom and the experience of the elders and the responsibility and creativity of the middle aged, the idealism and the enthusiasm of the young. As a body of SDFI, we are comprised of all these three stages of people. Respecting, valuing and learning from each other, SDFI can grow in great heights and depths!

Sr. Dr. Emily Susai. FMM.

THE REPORT OF XXI AGBM OF SDFI
20TH, 21ST AND 22ND FEBRUARY, 2015

Theme: HEALTHY LIFE STYLE FOR HEALTHY LIVING
VENUE: CITADEL, DONBOSCO PROVINCIAL HOUSE, CHENNAI

THE 21st AGBM of SDFI was held at CITADEL, CHENNAI on 20th, 21ST & 22nd February, 2015. It was attended by 140 Sister Doctors.

The inaugural holy mass was celebrated by Rt. Rev. George Antony Samy. He exhorted the gathering with the words of Arch Bishop Keithy from Italy that we are fortunate to have gift of life, gift of faith and gift of love. Sister Doctors are chosen to live this life and share it with others. He reminded us of Jn10:10 'Jesus came to give life, life in abundance'. He led us to reflect on the tree of life and water of life (Rev 22: 1-5). He said "You are the tree planted at the bank of the river. You have received water of life and when you give it to others you become tree of life". Tree of life receives its nourishment from water of life which is God himself. You are collaborators, saviors of humanity with ethical values. The gift of knowledge is given to you to impart and share with others. Eucharist is the source from where we receive the inspiration and wisdom to be healers of the world. No one can give to others what he/she don't possess. We are called to share our life as tree and as a gate to humanity.

He also invited us to understand the value and meaning of our vocation. Our mission should emerge from the temple of origin … The Eucharist…The sacrament of love. He reminded us to safe guard our catholicity in the present day context. He wished that we be blessed by Jesus who is the water of life to be true tree of life to others as Sister- Doctors, and to be the agents of The Healer.

Sr. Dr. Martina SJC, The MC of the programme welcomed every one with a note of joy in her heart.

The AGBM commenced with a prayer dance by the students from St. Antony's middle school Egmore. They implored God's blessing through the rhythmic movement of the music, which put everyone in the presence of God and to bring praises to the Lord our God.

Sr. Dr. Emily Susai FMM vice president of SDFI greeted the participants and welcomed everyone to Citadel for the AGBM with a joy and warmth. The invited dignitaries were welcomed and honored with a shawl, a bouquet of flowers and a memento.

Sr. Dr. Lucian was invited to introduce SDFI to the gathering. She explained the vision and mission of SDFI.

Sr. Dr. Martina the MC of the programme invited the chief guest and the dignitaries to light the lamp as a symbol of God's presence among us reminding everyone that light illumines mind, body and soul.

Rt. Rev. George Antony Samy was invited for his presidential address. He reminded the sister doctors that we are called for a special friendship. He congratulated the SDFI organizers for organizing the meeting at Chennai. He also urged us that this meeting should have some tangible outcome as you have come to pray and reflect together bring to some conclusion.

Friendship with God. Five fundamental questions who am I? Where am I going? What am I doing today? Where is my destiny? Friendship with God is my will growing in conformity with God's will. He quoted Holy Father Pope Francis who met (International Catholic Health association) ICHA "you are called to say life is sacred, not as matter of faith but because of your reasoning and because of science. There is no human life more sacred than another. The credibility of health care system is not measured by the success but the attention we give to the persons. In your mission try to reinvigorate the Catholicism. We should be different than others. It is an apostolate, ministry and mission. It is not a job, profession or business. We may not cure

but we can care .We need to have hands, heart, and mind .Be martyrs. Have the courage and faith of a martyr".

Dr. Balasubramanian IMA president Chennai gave the inaugural keynote address. He spoke that we are vessels that receive showers of graces from God which we channel it to others. Religion and medicine will go hand in hand. He spoke about patient centered approach not disease centered approach to problems. He also shared with us the physician's prayer which is prayed at the IMA meetings.

Rev. Fr. Tomi The director general of CHAI felicitated SDFI as she is 21 years old, the daughter of CHAI. He reminded us about the need to rethink about the vision and mission of SDFI.

Dr Maya, coordinator for rural doctors, from St John's Alumni also was felicitated. She spoke about three ways Alumni association want to help SDFI. They are: 1.Sponsor CME in region wise. 2. To send doctors to work in rural hospital which are eligible as bond center. 3. To conduct medical camp in different areas where ever needed.

She also presented Rs.1lakh to Sr. Dr. Rochna SMMI. And promised another lakh to Sr. Dr. Lucian. After the felicitations Sr. Dr. Liza FSLG the national Secretary proposed the vote of thanks to everyone. Then we proceeded for the lunch.

Post lunch Session

Fr. Joe Mannath.SDB gave a session on Psycho spiritual health of sister doctors. He was welcomed with a shawl and memento by Sr. Dr. Annie.JMJ. It was an encouraging and informative session for all of us. He suggested 10 points to live happily. They are:

1. Exercise, diet and sleep,
2. Silence, prayer, meditation and inner guidance,
3. Counseling, spiritual direction and confession,
4. Community life; plus and minus, clash of cultures, community and religious life,
5. Family and friends,
6. Man and woman relationship,
7. Training in counseling and psychological issues,
8. Gifts and dinners,
9. A meaningful spirituality,
10. End of the day a whole body prayer,

The session ended with a five step body prayer for the day. The group was dispersed for the tea. After the tea break we had a cultural programme by children from St. Antony's middle school Egmore, st.Antony's girl's secondary school from Rayapuram, and Immaculate matriculation school, Rayapetta.

After the cultural programmes there was a session on hospital information system automation by Don Boscoits from Chennai. It was an informative one for every one.

Following which the business session started Sr. Dr. Liza FSLG the national secretary of SDFI presented the annual report. The assembly asked for some corrections. It was proposed by Sr. Dr. Prema and was seconded by Sr. Dr. Alpohonsa Mary, Sr. Dr. Hilda presented the treasure's report. It was proposed by Sr. Dr. Hermina and seconded by Sr. Dr. Martina after some clarifications .Then group was dispersed for the regional group meetings.

After 30minutes all gathered back for the regional reports presentation. All the regional reports were read. After which there was a small discussion on central activities of Anemia detection programme and reproductive health, FCRA and some financial constrains which we are going through by Sr. Dr. Lucian. She encouraged all the Sister Doctors to

continue their good works and improve our spiritual health. She then requested all to come after the dinner for the continuation of the business session.

After the dinner we had the election of the vice president. Sr. Dr. Hermina, Sr. Dr. Ranitta, Sr. Dr. Alphonse Mary and Sr. Dr. Martina were the nominees. Except Sr. Dr. Alpohonse Mary rest all withdrew themselves from contesting for the post. Sr. Dr. Alphonse Mary was unanimously elected as the vice president. Sr. Dr. Lucian congratulated the vice president Sr. Dr. Alphonse Mary and welcomed her to the executive board with a flower. She also thanked Sr. Dr. Emily for her dedicated service to SDFI. She was a strong pillar of support for SDFI. She presented her a gift as a token of gratitude for her on behalf of all the SDFI members. Of course the photo session was not forgotten. We all thanked the Lord for the day and ended day with a happy note.

Day II 21st Feb 2015 (Saturday)

The day started with the holy Eucharist by Rev. Fr. Joe SDB. After the spiritual nourishment all proceeded for the breakfast. We had the 1st session on The SILENT KILLER- Dealing with HYPERTENSION by Dr. Vijay Lakshmy MD who was welcomed with a shawl and memento by Sr. Dr. Ranitta FCC. The second session was on PCOD by Dr. T. K. Shanty Gunasingh MD, DGO who was welcomed with shawl and memento by Sr. Dr. Roshini and a session on BE SMART and EAT SMART by Dr. SAVITA. M Sc, M Phil, PhD She was welcomed with a shawl and a memento by Sr. Dr. Lillian JMJ. After the session all proceeded for the lunch.

The joy and happiness of all the Sister Doctor was multiplied by thought of outing. All were set to go to Mahabalipuram and then to JOE beech. All were immersed in joy and some of us took the chance to be fully immersed in the water of the swimming pool of Joe beech. It was a indeed relaxing and rejuvenating moments. The group came back with fresh mind and body and wished good night to everyone.

Day III: 22nd Feb2015 (Sunday) started with guided meditation by Rev. Fr. Joe mannath SDB. The holy Eucharist was offered by Rev. Fr. S. J. Antony samy, Vicar General of Chennai. After the breakfast the CME continued. The 4th session was on Diabetes- because it matters and Thyroid disorders by Dr. Usha Sriram.MD. Sr. Dr. Vida welcomed her with a shawl and memento. After the session it was time to express the gratitude for the AGBM. Sr.Dr. Martina president of Tamil Nadu region proposed vote of thanks .She thanked all the board members and presented them all shawl and memento Sr. Dr. Lucian congratulated and thanked the Tamil Nadu region president and members for the cooperation and successful AGBM. She appreciated all group leaders with a shawl. The grand 21st ABGM at Chennai came to an end with lunch.

Everyone was full life and joy to be friend ship with JESUS and Humanity to serve them in their pain and suffering. To be that gate and living water for people of God. Sharing brought all closer to each other and revitalized. All left the Citadel with a new life and aspiration to continue the healing ministry of JESUS the divine healer. The echoes of goodness were heard and all left to their destination full of joy.

Sr. Dr. Lucian SCC
President, SDFI.

Sr. Dr. Liza.FSLG
National secretary,SDFI

NORTHERN REGION REGIONAL MEETING REPORT 2014-2015

The regional meeting of the Northern Region was held on 10th August 2014 at Holy Cross Provincialate, Lucknow, Uttarpradesh. Though the members have to travel long distances, and face the difficulties of managing their centres most of the time alone, as the only sister doctor of the centre, there was good participation and we had 13 sister doctors for the meeting.

The theme for the meeting was "Sister Doctors as agents of empowerment in the society especially for women-the Alpha and Omega".

We had two resource persons for the day, enlightening the group with their eminent inputs.

We were lucky to have the Bishop Elect and now the Bishop of Lucknow, Most Rev. Ignatius D' souza offered the Holy Mass for us.

He enlightened the group as to how the sister doctors can be the compassionate presence of Jesus in this world especially to the Women who are disproportionately vulnerable in our society. He exhorted the group to respond to the health care crisis of today, with a willingness to take up the risks and challenges involved in the healing Ministry and respond to the call of God to new ways of reaching out to the poor. Bishop Ignatius continued that for the sake of the Gospel we need to bring transformation to the society and imitate the compassion of Jesus, the golden rule for all ministries especially the healing ministry, always recognizing the deepest needs of the people. And thus being compassionate people, imitating the compassion of Jesus we can be agents of change in the healing ministry.

Sr. Vijaya HCM, who is a well known Speaker to many a gatherings of RUPCHA, CHAI, CBCI-CARD, CNGI, SIGNET etc., and a well known administrator for the Holy cross sisters, was our

second resource person of the day. She with her eloquence, enlightened the sister doctors about our worthy powerful presence in the Church and the healing ministry and encouraged the group to be healers with a difference especially for the women of today. She motivated everyone to be healers and leaders in this world, highlighting the examples of all the brave women of Old and New Testament.

At the end of the input sessions the group members shared about the future plans of each centre to launch more to the needs of the women. Each one also shared about their work in the community outreach programmes, anaemia eradication, Vitamin –A programme and school health programmes taken up by the centres.

All were very happy to have come for the meeting and thanked Sr. Dr. Immaculate HCM who had hosted the meeting along with Sr. Dr. Cynthia HCM and their Provincialate community at Lucknow. Truly it was a generous hospitality.

REGIONAL MEETING AT CITADEL, CHENNAI

The next regional meeting will be at Holy Family Hospital, New Delhi on August 2015. The theme suggested is “Geriatrics”.

The venue suggested for the next AGBM was Bhopal. The theme suggested is “Geriatrics”.

Sr. Dr. Rose Mary,

President, Northern Region.

Minutes of the Regional Meeting Central Region

Date: 20th & 21st September 2014

Venue: SDC – CENTRE, FR CAMIL BULKE PATH(PURLIA ROAD), RANCHI

During this year Central Region had conducted programme on Anaemia & issues of Reproductive Problem in Women rural centres by sister doctors of various states of central region. Reports are sent by them to National SDFI. In Chattishgargh the Health Institution had lot of trouble of Nursing Home Act Registration. With help of CCHI (Catholic-Christian Coalition of India) in collaboration with CHAI, CMAI, SDFI, CBCI & Govt; the problems had been partially solved. Central Region also took part to serve for the Natural calamities of Uthrakant & Kashmir valley. Sr. Dr. Teena helped in Uthrakant.and Sr. Dr. Vimal Jyothy in Kashmir Valley.In the month of September we had Regional meeting in Ranchi on the Theme of Healthy Life Style for Healthy living. Report as follows :-

The Central Regional Meeting was conducted in Ranchi –Jarkand state on 20/9/14 to 21/9/14. Around 17 members participated in the meeting, Sister Doctors were from C.G, M.P, Orissa, Jarkand, Bihar states. Everyone appreciated the topic chosen for this meeting, and the eminent Resource persons highlighted on the subject very clearly with practical points to live personally and to instruct others the same. His Eminence Cardinal Telespore Toppo in his homily of the Holy Eucharist gave a message that Sister Doctors are the healers chosen by Jesus to carry out the healing ministry of His with Compassionate Love adopting His character of gentleness & humility, he also insisted that we need to engage in the work of evangelization as like that of Jesus by giving total life to God & people and he stressed in his presidential talk that, the holistic health is important in order to have - Healthy Life Syle for Healthy Living. Sr. Dr. Vimal Jyothi- Regional president central region cordially welcomed all the resource persons & participants on behalf of National and central

region SDFI. She in her welcome speech highlighted on the same topics with message of Jesus that "I have come to give Life, Life in its Fullness" (Jn10:10), this bring forth Health & Healing for all.

Rev .Fr. Joseph Pinto gave very detailed explanation on the theme Healthy Life Style for Healthy Living, by various ways of approach to health such as mystical, spiritual, emotional, mental, psychological & physical aspects of life. He said spirituality is nothing but a life style governed by life-giving core beliefs and values that give meaning to life in its fullness, he also stressed the importance of stress free life, balanced diet, exercises& hygiene. Sr. Britto. Holy Cross Hazaribag, director of community health care for Hiv/Aids, gave a talk on the practical points to approach Healthy Life Style for Healthy Living especially when dealing with vulnerable & marginalized people with following points:-

<u>points to maintain a positive health</u>

1. Having purpose in Life
2. Maintaining positive attitudes.
3. Using one's ability fully
4. Having the will to be whole and healthy
5. Being adaptable
6. Cooperating with other people
7. Accepting responsibility for one's thoughts and action

On 21/9/14 Holy mass was celebrated by Rev. Fr. Marianose the Jesuit Provincial of Ranchi. In his homily he gave the message on the gospel theme & also on the topic of our meeting- Healthy Life Style for Healthy Living. He posed a question to us that how is it possible to live healthy life style when our country is home for so many poorest - there is wide disparity between poor & rich, he also gave current statistics of socio economic situation in India.

Rev. Fr. Christu Das -Director of SIGN dealt with same theme on the next day. He enlightened with message that Human Dignity is, fundamental to healthy living. Each person is created in the image of the maker, dignified and noble and is a unique part of the tapestry of creation, of the mosaic of the human family.

Indeed, the foundational principle of creation is the sanctity of human life and the inherent dignity of every human person who is the clearest reflection of God among us. Human Dignity is the paramount condition for healthy living and there with respecting the other, celebrating the life, serving the other and living for the other would be fundamental healthy lifestyles. Normally, we are focused on the self when speaking of healthy lifestyles. The truth is that we need to move out of the self to strike the chord of right relationships which is the foundation for healthy lifestyles." Dr. Saritha Tirky OBG professor Ranchi Medical college

gave lecture on the topic of reproductive health and sexuality. We had more of dialogue & discussion on this subject, and she cleared many doubts of the Sister Doctor on this very subject with her academic experience.

We also took this opportunity to facilitate & thank Sr. Dr. Prema Devraj former National Secretary SDFI & T.B. state co-ordinator C.G. At the end of the Inaugural Session Sr. Dr. Eileen OSU –LOC Secretary gave vote of thanks and on conclusion of the meeting Sr. Dr. Alfy OSF Regional Secretary gave word of thanks to all. We also presented bouquets' & mementoes to invited guests and resource persons. After the meeting an outing was arranged by Sr. Dr. Eileen. Thus the central Regional meeting was concluded fruitfully &successfully with abundant Blessings of God.

These are the main events in Central Region.

Sr. Dr. Vimal Jyothy SMMI.
President, Central Region.

Report of the Regional Meeting Central Region

Venue: Citadel, Chennai

1) Meeting started with a short prayer. The venue suggested for next AGBM was Andhra Pradesh. The suggested theme is Geriatric Care (Old is Gold), Infertility, Orthotropic.

2) Venue for the next Regional meeting is Bhopal or Jabalpur.

Sr. Dr. Alphy,
President,
Central Region.

Minutes of the Regional Meeting Western Region

***Date:* 6th & 7th September 2014,**

Venue: Holy Family Hospital, Bandra, Mumbai.

The SDFI Western Regional Meeting was held at Holy Family Hospital, Morello Hall (Piccolo), 6th Floor. It was a day of joy and excitement, sharing and caring, as twelve Sister Doctors from different parts of Maharashtra, Gujarat and Goa gathered together.

The day commenced with a short prayer. Dr. Lipeeka Parulekar, MD Physician of Holy Family Hospital, delivered the first session of the day. She enlightened the group on the topic "Management of Communicable Disease".

Thereafter, Rev. Dr. Joe Pereira, enriched the group with spiritual input, for one hour. He emphasized the need to experience the love of God to radiate compassion and joy in our mission. This was followed by a lively talk by Rev. Bishop Percival Fernandez, who highlighted the value of communication skills in medical practice, to be more effective as Sister Doctors.

The post-lunch session was conducted by Sr. Dr. Sally, MD Psychiatrist, who spoke on the topic "Care for the care givers". Her elaborate session, suggesting practical methods to combat burnout syndromes, was appreciated by all.

The meeting concluded with a group discussion, wherein, the participants shared their experiences, suggestions and their valuable opinions.

Report of the Regional Meeting Western Region 20-02-2015

Venue: Citadel, Chennai.

The next regional meeting will be at Bombay on August 28th & 29th, 2015.

The venue suggested for next AGBM was Hyderabad. The theme is suggested is "Care for the Caregivers".

Sr. Dr. Beena UMI,
President, Western Region.

Minutes of the Regional Meeting Andhra Pradesh Region

Date: 23rd & 24th August 2014,

Venue: St. Joseph's Hospital, Guntur,

The Regional meet of SDFI Conducted at St. Joseph's Hospital, Guntur. There were 10 Sister Doctors Were Present.

The meeting started with a Prayer by Sr. Juli Asst. Administrator of St. Joseph's Hospital. Lighting of Lamp by Fr. Martin VC, Sr. Pauline Joseph superior of St. Joseph's convent, Sr. Cletus the Administrator of St. Joseph's general hospital, Guntur, Sr. Alphonse MSI, Sr. Dr. Annie.

Sr. Dr. Annie President of AP Region welcomed Fr. Martin, the resource person of the day, with a bouquet. As Sr. Paulina joseph was the diamond jubilarian she was presented with a bouquet and memento.

Sr. Dr. Annie gave the inaugural address about the SDFI Aim & Objective and this year's national theme of SDFI.

Sr. Cletus the Administrator gave words of wisdom for Sister Doctors. She said that It is good to reflect on the days Gospel reading where in Jesus asked Who do people say that I am? Each one of us also can be asked this question who does people say that I am as a sister and doctor. What do they see in us? Our dealings with Patients, relatives' co-workers and community sisters. She also advised to have space for oneself and have some relaxation.

Sr. Juli presented a tribute to late Sr. Dr. Rosa Basani through Power point.

We had a very inspiring and challenging spiritual input from Fr. Martin V. C, Why suffering in this world? The meaning of suffering; we must suffer many hardship in order to enter the kingdom of God. Not to be afraid of death because there is eternal life after death. We must have the mind, of Christ.

Reason for suffering 1. Poverty , Teach the rich to share with the poor Luke 16; rich man and Lazerus. There is no Divine mercy after death . If we neglect the poor we will suffer because God is a just God . Hunger and thirst for justice.

2nd cause of suffering – Sin and immorality, world and its attraction. Rejoice whenever you are having suffering. Holiness consists of three things. **Charity, chastity and Faith** speak the truth that truth is found only in Jesus.

Living God is in Blessed Sacrament spend time with him and tell him every suffering we go through and all that is happing around us then get strengthened .

Then an informative session on cord blood banking by 'Life Cell' Company. We cleared some about cord blood banking and its usefulness. At 12 noon we had holy Eucharist by Fr. Martin who inspired and challenged us with his homely. Sr. Deepa FCC proposed vote of thanks. She thanked Fr. Martin and St Joseph's community sisters and everyone for the days programme. We had delicious meal, At 2.30pm we had sharing among ourselves. Some of the problems we are facing, medico legal cases, national meet topic and the activities done by region. Sr. Alphonsa, Sr. Francis, Sr. Lilly and Sr. Annie conducted anaemia detection Camp. Then evaluation of the day. Every one appreciated the well arrange a meeting, venue, food and spiritual input. Suggestions were for more academic session. Next Regional meet in Hyderabad.

Report of the Regional Meeting Andhra Pradesh Region

Venue: Citadel, Chennai

1) Meeting started with a short prayer. 12 members attended the meeting. The venue suggested for next AGBM was Kerala or Jammu Kashmir. The suggested theme is "Future Challenges of Catholic hospitals and Sister Doctors" or "Social Awareness".

2) Venue for the next Regional meeting is Hyderabad. Topics: IUGR, Oligo amniotic, Update on infertility.

Sr. Dr. Annie

President, Andhra Pradesh Region.

Minutes of the Regional Meeting Karnataka Region

The annual regional meeting of SDFI Karnataka was held at St. John's medical college Bangalore on 30 & 31 August 2014. It was jointly organized by the department of Medicine & Endocrinology and co sponsored by Tameside NHS Trust, Manchester, UK.

The meeting began with a short prayer followed by welcome and messages by the Director Rev. Dr. Lawrence D Souza, and Ex Dean Dr. Prem Pais. The topic for CME was **Diabetic Update 2014**. Various topics such as Diabetes diagnosis & Management by Dr. Jyothi Idiculla, Diabetes Complications Nephropathy, prevention and treatment by Dr. Llyod Vincent, Nephropathy diagnosis and management by Dr. Edward Jude were dealt in the pre- lunch session.

In the post lunch session, Peripheral Vascular disease, infection and management by Dr. Suresh Kal, microbiology of foot ulcers by Dr. Soumya Umesh , management of infected diabetic foot by Dr. Edward Jude, diabetic foot deformities – charcot foot by Dr. Edward Jude, rehabilitation of diabetic foot by Dr. Rajalaxmi Iyer. were dealt. The sessions were very enriching.

On the 2nd day glycemic control in the prevention of diabetic complications by Dr. Ganapathy, diagnosis and management of hyperglycemia in pregnancy by Dr. Vivek Mathew, what to do after Metformin, UK – Nice guide lines by Keren D. Brown, managing the patient from conception to delivery by Dr. Annamma Thomas were dealt in the pre- lunch session.

In the post lunch session cardio vascular risk management was dealt by Dr. Kiran Varghese. There was also a workshop on how to off load the diabetic foot by Dr. Rajalaxmi, debridment of foot ulcers by Mrs. Gayaatri and Vinaya.

A good number of Sister Doctors from Karnataka and a few from other states as well attended the programme. The Sister Doctors Of Karnataka had a general body meeting to share and to plan the course of action to implement the programme of SDFI.

All in all it was truly a well organized beneficial CME with credit points allotted to te participants by KMC Karnataka. With vote of thanks by Sr. Dr. Malathi the CME was concluded at 5 p.m.

Report of the Regional Meeting Karnataka 20-02-2015

Venue: Citadel, Chennai

1. Meeting started with a short prayer. 17 members attended the meeting. The venue suggested for next AGBM was Bombay. The Suggested theme is Mental Health or Palliative Care and Terminal illness.
2. Venue for the next Regional meeting is St. John's Medical College, Bangalore. The Suggested theme is Cardiac Disorders or emerging diseases (H1N1, Ebola) Date: 22nd and 23rd August, 2015.
3. Activities: Health Education on Healthy life style at our own place.

Sr. Dr. Vida Olivera
President, Karnataka Region.

REGIONAL MEETING TAMIL NADU REGION SDFI MEET 2014 - 15

THE BEST OM IS HOME

THE BEST AGE IS COURAGE

THE BEST MILE IS SMILE

THE BEST STAND IS UNDERSTAND

It was with great enthusiasm we gathered together at citadel, at Chennai – Kizhpak, Don Bosco Provincial House. With a meaningful prayer we started our day's session. Keeping the theme "Women Alpha and Omega", we had 3 scientific sessions in the morning. Sr. Dr. Anne Joyce throw light on new emerging topic "EPIGENITIC", and the need to act fast and smart on women even before they enter in to reproductive age.

The next class was taken by Sr. Dr. Martina on "Menopause". Which enlightened us how to grow old gracefully, and specially take care of ourselves and others.

Sr. Dr. Vasantha updated us on PCOD – the most common case scenario we come across in our daily practice and how to handle the problem confidently, and cleared clinical dilemma with practical answers

The climax of the day was meaningful Eucharistic celebration by Rev. Fr. Joe Deva, Vice Provincial of Salesian priests of Chennai Province. His musical participation with guitar and powerful sermon made the celebration alive, active and participatory.

After a delicious lunch, we had a very important discussion for the forth coming AGBM, here at Chennai and LOC (Local Organizing Committee) was elected to shoulder various responsibilities. And the day ended with joyful note of being together.

Part of our TN-SDFI action plan, we had a group visited Andaman Island and I share their report in their own words

ANDAMAN SOJOURN

Under the leadership of Sr. Hermina, We the Sister Doctors of Tamilnadu region set out on our journey to the emerald Blue Island – the Andaman on August 27th from Chennai.We landed in Andaman on 27th August at 12.30PM. We were warmly welcomed and received by Fr.Evanz, Director, pastoral centre at the airport, port blair.

We had a very delicious lunch served by the pastoral centre on our arrival with variety of sea food. After accommodating ourselves in the pastoral centre, Fr. Evanz took us to different places in portblair, to the beach, to the park etc., In the evening we were warmly welcomes by Rt. Rev. Alex (Bishop of Andaman) and we had high tea and Informal sharing about our mission.

The climax of the day was the sound and light programme at the cellular Jail. Cellular Jail is acknowledged as a National Memorial Monument; it depicts the heroic freedom struggle and the sacrifices made by our freedom fighters and truly touches our souls. This show gave us a brief idea about the brutal happenings in the jail prior to India's Independence and other historical events regarding this place. This place also has a Martyr's Memorial, a Museum and a photo gallery and art gallery as well, reminiscing India's struggle for Independence .

Next day was day of outing and picnic. We visited the North Bay Island and the Ross Island. North Bay is known for its fringing coral reefs and numerous varieties of fishes and other marine life. The glass bottom boat ride was amazing which gave us a closer view of the vast coral colonies.

Ross Island was the administrative head quarters for the British before Independence. It contains the reminiscent of British regime.

On 29th we conducted Medical Camp by dividing ourselves into 3 groups covering 6 villages. It was a free Medical service to the people of Andaman. It is heart rendering to see the people over there struggling for Medical facilities. Their only hope of medical care is the Government hospital at portblair. To get an advanced medical care, they have to travel to Chennai or other parts of India. We were happy to render our service to them.

We had one more day left with us to visit some more places in Portblair. We had the chance of visiting Corbyn's cove beach where we enjoyed the soft white sands that sparkled under the ray of warm sun. The next day was a day outing and picnic. We visited the tribal and Anthropological museums. These Museums have preserved artifacts of the different Andaman tribes that would help us to understand the tribal culture and the life of tribal over there. And the day came to an end with a surprise dinner arranged by Fr. Evanz sponsored by a well wisher.

With heart full of memories we left the Andaman on 31st early morning to Chennai. It would be ungrateful if we do not mention Fr. Evanz for his meticulous arrangement for our stay there. He did everything silently but with a note of surprises. Thank you dear father.

REGIONAL MEETING AT CITADEL, CHENNAI

There were 30 of us present. The next regional meeting will be at KOTAGIRI on August 28th & 29th, 2015.

The venue suggested for next AGBM was Goa or Mumbai. The theme is suggested is "Consecrated life with Healing Ministry", "Healing the Healers".

Sr. Dr. Martina SJC

President, Tamil Nadu Region.

Minutes of the Regional Meeting Kerala Region

Date : 23rd & 24th August 2014

Venue: Nestt, Muvattupuzha

The two-day Conference of SDFI, Kerala region was held at Nestt, Muvattupuzha, on 23,24 August 2014. Entrusting everything in the hands of god and setting aside the busy schedule, 64 Dr. Sisters from different parts of Kerala assembled with great zeal and spirit. The Conference commenced with a memorable pilgrimage to Mannanam and Kudamaloor. The President of SDFI and the inmates of Alphonsa Bhavan welcomed the members and it was followed by an agape.

After registration and supper the members assembled in the auditorium at 9pm. The Agenda of the conference and other important items were discussed in the session.

After the discussion on general maters Sr. Dr. Ranitta welcomed Sr. Dr. Sudha for the PPT presentation on Anemia causes, investigation and management. The presentation was well appreciated and memento was presented by Sr. Dr. Mary Therese CSN. Invoking god's blessings the members dispersed for personal prayer and sleep.

On 24th August, after the morning prayers Rev. Dr. Paul Parathazham said the solemn mass. Fr. Paul, the new director of St. Johns Medical College, Bangalore expressed his great happiness on being invited for this conference and delivered an inspiring and thought provoking homily on the very familiar Biblical parable of 'The Rich man and Lazarus.' The rich man was not cruel or bad. There was no reference that he acquired wealth through fowl means. He failed to notice and respond to the misery of Lazar. Today many suffer from maladies and misfortunes. We all come across 'Lazer's- outside the doors of our hearts – pleading for love, understanding, encouragement etc. As sisters working in the healing

ministry they are rich, privilege, with the ability to heal. During the Last Judgment as in Matthew 25, it will be the criteria of judgment – who is going to be on the right side? Isn't it the one who love endlessly and selflessly?

The inaugural function at 10.00 am marked the official opening of the conference. Sr. Dr. Lucy Thomas and Sr. Dr. Celinda invoked god's blessings through the prayer song. After that Sr. Dr. Ranitta, the President of the Forum welcomed the Chief Guest and the other dignitaries including the delegates. The inaugural address was given by Mr. Joseph Vazhakkan MLA followed by the lighting of the lamp. A brief summary of the inaugural speech in the words of the MLA is:

I consider this as a unique and special program and I am really proud of being a Christian when I witness the selfless and committed services rendered by Catholics, specially sisters. When sisters work in the healing ministry, it has double effect as they are service oriented and least bothered of monitory games. After that Dr. George Karakkunnel, Director of NESTT and the chief guest of the function exhorted the gathering to proclaim and continue the healing ministry through words, deeds and lives as healing ministry is very dear to god. Quoting the former President Dr. APJ Abdul Kalam's 'India Vision 2020', Father emphasized on public health education and prevention of diseases. The wide dissemination of health and nutrition related information through traditional channels should be supplemented and is a must in this fast food and easy life style age. Health insurance can play a vital role in improving the overall health care system. In the stage itself the father entrusted this task to the MLA for implementation.

Sr. Alicia FCC, Asst Provincial, Kothamangalam Province felicitated and reminded the participants the nobility of their profession. Together with the healing service the society expect deeds of mercy and compassion. Mementos were presented to the invited dignitaries. The commentaries made by Sr. Dr. Alphonse Kureethadam during the inaugural session about the nature and functioning of SDFI was commendable. Sr. Dr. Mercy proposed vote of thanks and the inaugural session came to a close with the National Anthem.

The scientific session commenced with an inspiring and interesting class on 'A Physician's Perspective on Medical Nutrition Therapy for Diabetics' by - Dr. E.V. George, The chief physicians of Holy Family Hospital Muthalakodam. Doctor stressed on the importance of maintaining a healthy life style and diet control.

After tea break the Panel Session was conducted by Sr. Dr. Alphonse Kureethadam, Cardiologist, Sr. Dr. Jancy Treesa Gynecologist, Sr. Dr. Anjitha Homeopathy, Sr. Dr. Jhoncy

Dental Surgeon and Sr. Dr. Sholi Francis Ayurvedic medicine. Authentic and reliable aspects of various medical practices were shared during this session and the members appreciated the presentation of each Doctor Sister on their respective areas.

Sr. Dr. Mercy, Secretary of SDFI extended a cordial vote of thanks and the meeting came to an end at 1.30 pm. After the concluding prayer and the lunch the participants bid goodbye to each other with revitalized vigour cherishing sweet memories of the conference and to continue their healing ministry with a new vigour in their respective fields.

Report of the Regional Meeting Kerala 20-02-2015

Venue: Citadel, Chennai

1) Meeting started with a short prayer. 60 members attended the meeting. The venue suggested for next AGBM was Bhopal or Bombay.
2) The year of 2015 is declared as the year to "Consecrated life" dedicated by Pope Francis. Hence the theme is suggested is "Discipleship in Healing Ministry" our dedication, faithfulness and loyalty to our commitment.
3) Venue for the next Regional meeting is Shanthidam, Thrissur. Date: 22nd and 23rd August,2015.

Sr. Dr. Ranita FCC
President, Kerala Region

Sr. Dr. Mercy SABS
Secretary, Kerala Region

Chennai The Cultural Capital Of India

XXI AGBM of SDFI took place in the Legend City – CHENNAI – TAMIL NADU from 20th – 22nd of February, 2015. If you don't mind the heat of the sun but love to enjoy some warmth from the hearts, if you don't mind the lack of rich greenery but happy with the richness of reception and if you consider the rich cultural background and the unassuming people more important, then Chennai is the city for you to be on a holiday. Chennai is not only the 4th largest Indian city but it is the 36th metropolitan city the world over. It is also one of must-visit places in Tamil Nadu. The rich heritage and tradition of the city are the reasons for it being referred to as the cultural capital of India. Chennai was established by the British during the 17th century. However, the city has a great historical past that is evident from some of the famous constructions in the city that stand the test of time to prove that the city is much more ancient than its accounted years.

1. Marina Beach

Marina Beach is naturally the instant choice for everyone that visits Chennai. This is the second longest beach in the world. The large expanse of silver sand allows for a great walk along the seashore. Sunrise and sun set views are picturesque in this perfect setting. Some of the sports activities possible in Marina Beach include fishing, wind surfing and beach volley ball.

Though Marina Beach owns the credit of being the second longest beach in the world, it is not as well maintained as it should be. However, if you love the soul of the city, you will love the place. This a place where you do not have an entrance fee but a lot of entertainment. You can watch fishermen starting their day out on the sea if you are here in the morning. The evenings are quite busy with people coming along with their families to have some entertainment here. The richest and the poor, famous celebrities and unknown common man frequent the beach. If you love to watch people, you could have a whale of a time here in the beautiful atmosphere.

2. Semmozhi Poonga

Semmozhi Poonga offers a great escapade from the scorching sun and it is a visual delight for your eyes tired seeing manmade buildings. The park was opened towards the end of 2010. Located at

city's center, the 20-acre park offers to view scenic landscapes and lush gardens. The well-maintained gardens have over 500 varieties of trees and plants from all parts of the world.

This is apart from the trees that already exist in the area before the establishment of the park. Some of the trees are over 100 years old. The species of plants include medicinal plants and aromatic herbs. The artificial waterfall in the park looks real. Children will love the park, as there are many play structures to keep them entertained. Elders can go for a walk and several seating arrangements are provided to stretch.

3. The Huddleston Gardens Of Theosophical Society

The aim behind the establishment of Theosophical society is to create universal brotherhood where there is no distinction among human beings. The essence of the society is to blend the best of teachings of all religions to elevate the quality of humanity and its power.

The world headquarters of Theosophical society is in Chennai. Located in Adyar, a part of Chennai, it commands respect from people belonging to all faiths. The society was established here in the year 1883. The 260-acre Huddleston Gardens is a birdwatchers' paradise. You will find a wide range of migratory birds here. The banyan tree at the center of the garden immediately comes to mind amongst the people of Chennai, as the 450 and odd year old tree is one amongst the largest trees the world over. The tree covers a massive 59500 sq. ft area of land. This is one of the few places to feel one with nature and enjoy fresh air. This place elevates your soul.

4. Arignar Anna Zoological Park

Arignar Anna Zoological Park is the first ever zoo in India. The zoo was established in the year 1855. The zoo was initially in the Moor market from where it was shifted to Vandalur in 1976. The massive 510-hectare zoo houses over 170 species of wildlife. Some of the wildlife found here includes tiger, hyena, lion, panther, elephants and many more. Elephant rides and lion safaris are available.

5. Pulicat Lake

Pulicat Lake is a 'must visit' place if you are in Chennai. Chennai is not green and you do not chance upon many places in Chennai that help you get closer to nature. Hence, taking a time away to be at Pulicat Lake becomes all the more important. Pulicat Lake is located on Tamilnadu's border.

The atmosphere is serene and you can have a relaxed day here. Boat rides are very popular here. Here you will find rare species of birds such as flamingoes, kingfishers, pelican, ibis and many more. You could also find the ruins of a 17th century Danish fort.

6. Kapaleeswarar Temple

Kapaleeswarar Temple is one of the oldest temples in the city. It is not clear as to who built the temple. Going by the songs by Nayanmars, it is believed that Kapaleeswarar Temple was built during the 7th century by Pallava Kings. The architecture is not as old as they seem to be around 400 years old. The temple stands a classic example of the Dravidian style of sculpture and architecture.

7. National Art Gallery

National Art Gallery was established in 1907. The influence of Indo-Saracenic architecture is evident in the red sandstone construction, which has four sections namely Tanjore Painting Gallery, Ravi Varma Painting Gallery, Indian Traditional Art Gallery and Decorative Art Gallery. Artists would love this place as it has on display some of the ancient paintings and handicrafts that date back to 11th century.

8. Connemara Public Library

Connemara Public Library was established in the year 1896. You could find many unique and rare collections in the library, which boasts of possessing wealthier information across various subjects. The library itself is intricately designed and the architecture is a blend of Southern Hindu Deccani, Gothic,

Rajput and Mughal. The library houses periodic hall, a video room and a reference room. Braille library is also found here. The collection of books is very impressive and they cater to the needs of the students and professors alike. The library is one among the four National Depository Libraries in India that receives copies of all newspapers, periodicals and books published in India.

9. Little Mount Shrine

Little Mount Shrine has a rich history associated with it. You can find the cave where St. Thomas went hiding before being martyred here. The lack of attention in preserving important structures and monuments is evident here too as you can find a rock that bears St. Thomas' footprints, which was not given due attention earlier to preserve it for future generation's view. The place offers a good view of the city and the Chennai airport. It is a worth a visit if you want to experience a touch of the past and enjoy some pleasant atmosphere.

10.Mahabalipuram

Mahabalipuram, also known as Mamallapuram is a town in Kancheepuram district in the Indian state of Tamil Nadu. It is around 60 km south from the city of Chennai. It is an ancient historic town and was a bustling seaport during the time of Periplus (1st century CE) and Ptolemy (140 CE). Ancient Indian traders who went to countries of South East Asia sailed from the seaport of Mahabalipuram.

An 8th-century Tamil text written by Thirumangai Alvar described this place as Sea Mountain 'where the ships rode at anchor bent to the point of breaking laden as they were with wealth, big trunked elephants and gems of nine varieties in heaps'. It is also known by several other names such as Mamallapattana and Mamallapuram. Another name by which Mahabalipuram has been known to

mariners, at least since Marco Polo's time is "Seven Pagodas" alluding to the Seven Pagodas of Mahabalipuram that stood on the shore, of which one, the Shore Temple, survives.

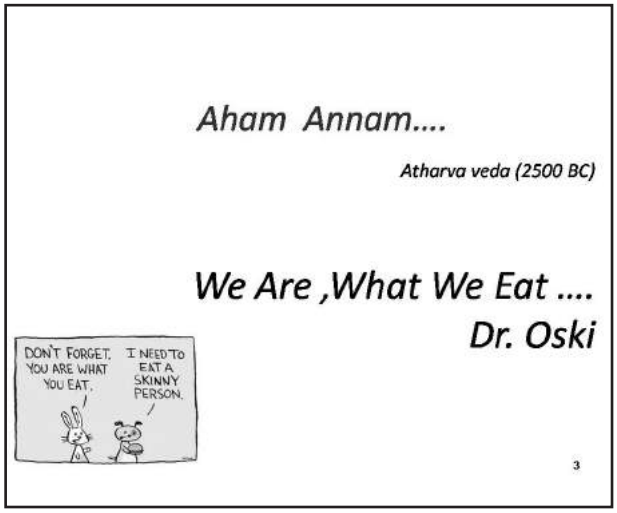
The temples of Mamallapuram, portraying events described in the Mahabharata, were built largely during the reigns of Narasimhavarman and his successor Rajasimhavarman and showcase the movement from rock-cut architecture to structural building. The city of Mahabalipuram was largely developed by the Pallava king Narasimhavarman I in the 7th century AD. Themandapa or pavilions and the rathas or shrines shaped as temple chariots are hewn from the granite rock face, while the famed Shore Temple, erected half a century later, is built from dressed stone. What makes Mamallapuram so culturally resonant are the influences it absorbs and disseminates. The Shore Temple includes many bas reliefs, including one 100 ft. long and 45 ft. high, carved out of granite.

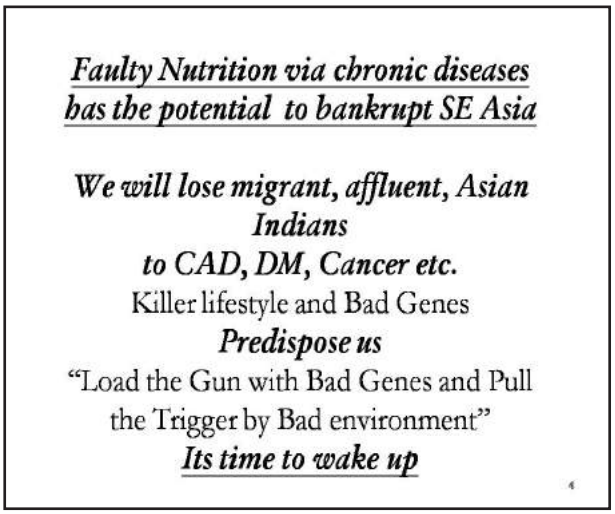
Chennai's top attraction is the warmth of the people. You will find perfect harmony among the people of Chennai, who do not take into account the forced differences in terms of religion, race and color. While the worst failing in Chennai is the lack of effort to preserve places of historic significance and keep the city clean, the awareness seems to be increasing. You will find that sincere efforts are being taken by individuals and organizations and one such example is Chennai Turtle Walk to save the endangered species. With consistent and genuine efforts, there may be more attractions to mention in Chennai, which is of world class.

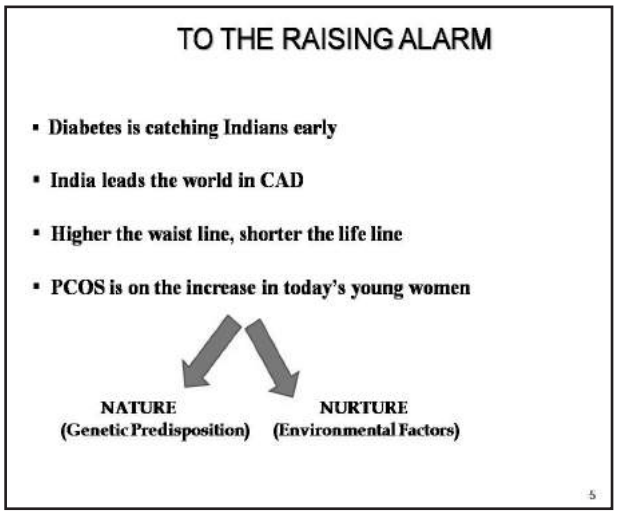
Sr. Dr. Emily Susai FMM

Be Smart And Eat Smart

Dr. P. Savitha
Consultant Nutritionist & Research Scholar
Chennai







Experiencing an epidemiological health transition characterized by rapid decline in nutritional and parasitic diseases with an alarming rise in NCD'S

6

7

Burden of Major NCD's in India

- 50 million cases of Cardiovascular Diseases
- 63 million cases of Diabetes
- 1.2 million new cases of cancer/year
- 23 million Obesity
- 1 million cases of Cerebrovascular Disease/stroke every year
- Every 5th Diabetic is an Indian
- Every 5th to 10th Asian Indian Native Urbanite is a Diabetic

Overweight and obesity

Caloric Consumption Increasing Worldwide & Physical Activity Decreasing

Health effects

- Women: Reproductive Health
- Endocrine conditions - Diabetes and Polycystic Ovaries
- Cardiovascular Condition – Coronary Heart Disease, Ischemic Stroke, Congestive Heart Failure.
- Respiratory Conditions
- Digestive Conditions – Gallbladder Disease
- Musculoskeletal - Osteoarthritis.

9

We are to find the right way out...

At Our Disposal

Nurture (Environmental Factors)

10

What does Food Do?

- Best Way to live a healthy life is to eat a balanced

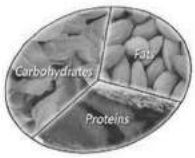
- To provide nutrients that your body needs to function
- To give you more energy & alertness throughout the day
- To prevent future disease and sickness (like Diabetes, Obesity & Cancer)

11

Food Components

MACRONUTRIENT

- Carbohydrates
- Proteins
- Fats



MICRONUTRIENTS

- Vitamins
- Minerals

12

Carbohydrates

Primary source of energy – main staple food (bulk of the calories)

Sources: Cereals, Fruits, Vegetables, Milk

Carbs are of two types

Simple carbs:

SUGARS, HONEY, COLAS, FRUITS, JUICES, JAGGERY, MAIDA, BAKERY PRODUCTS

Complex carbs:

CEREALS, VEGETABLES, PULSES

13

How to choose carbohydrates?

- Complex carbohydrates are good for our health.
- Simple carbohydrate easily increase our blood sugar, so decrease their consumption.
- Eat carbohydrates only in recommended amounts.
- Choose complex carbohydrates high in fiber e.g. unpolished rice, ragi ,whole wheat

14

FIBER

(Boon of nature)

- **Fiber is non digestible carbohydrate, It forms a bulk and hence makes us feel full.**
- **Soluble – oats, barley, fruits (guava, apple), gum**
- **Insoluble-whole grains, pulses, vegetables, fruit (oranges, sweet lime)**
- **Fiber delays gastric emptying and glucose absorption thus lowering plasma glucose concentration.**
- **Diet with low GI are generally rich in fiber and high fiber improves glucose tolerance.**
- **As foods of low GI and high fiber content raise the blood glucose to a lesser extent, diabetic diets have been planned on these two factors.**

15

Fiber Content of Foods

Low Fiber	Moderate Fiber	High Fiber
Milled rice	Whole wheat flour	Rice bran
Refined wheat flour	Wheat germ	Bengal gram
Bread white	Brown bread	Whole
Whole gram (Bengal)	Field beans	Rajmah
Lentil	Red gram dal	Peas
Green gram dal		Red gram
Bottle gourd	Brinjal	Green gram whole
Ash gourd	Cauliflower	
Cucumber	Radish leaves	Drumstick
Tomato	Fenugreek	
Spinach	Cabbage	
Lettuce		
Banana	Apple	

16

Fiber Content of Foods

Low Fiber	Moderate Fiber	High Fiber
Sweet lime	Peaches	Parwar
Litchi	Pears	Double beans
Water melon	Orange	Colocasia
Prunes		Amaranth
		Amla / Dates
		Grapes / Guava
		Pomegranate Sapota / Papaya

17

Proteins

- Repair of tissues, immunity
- **Sources**: pulses, nuts, milk and milk products, meat, egg, fish, poultry.
- Egg ,poultry and red meat have saturated fats in them
- Good source of proteins are dales, sprouts, fish, egg whites, chicken breast.

18

Advantages of proteins

- Is not converted into sugar as fast as carbohydrates.
- It keeps us full for a long period of time.
- It takes a lot of energy to burn proteins, therefore you store less energy.

19

Soya Protein

- Soya bean apart from being rich source protein also has other phytochemicals which are unique
- Soya fibers reduces insulin requirement in diabetes
- Decrease cholesterol synthesis in humans.
- Use only processed soya : Atta, nuggets, drinks

20

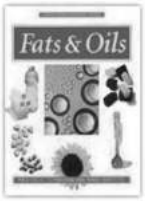
FATS

Fats –contribute flavour & texture to food and gives a sense of fullness.

Saturated fats : increase blood cholesterol level, are solid at room temperature.

Unsaturated fats : lower blood cholesterol are liquid at room temp.
MUFA : mono unsaturated fatty acids.
PUFA : poly unsaturated fatty acids.
Omega 3 fatty acids
Omega 6 fatty acids

Trans fatty acids : processed unsaturated fats. Vegetable oils are processed to make them solid. However they cause increase in LDL.



21

Invisible Fats

- Coconut
- Peanuts, Almonds, Cashew nuts etc.
- Condiments like pappad, pickles, chutney's etc.
- Garnishes like cheese, cream, white sauce, etc.
- Bakery items like biscuits, kharis, puffs, etc.
- Farsans and sweets
- Non-Vegetarian food
- Milk & milk products

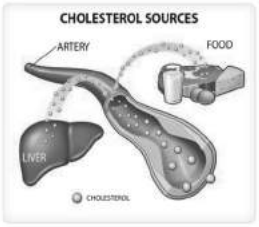
22

Total Fat

- Total fat intake is most important
- Invisible sources of fat should be included in the total fat intake
- Total fat intake is closely related to serum lipids
- Recommended intake is 20 gms per person per day
- Diets should not provide more than 30% calories from fat

23

Dietary cholesterol



- Associated with Animal fat
- **Sources of Dietary Cholesterol :**

Ghee, Cream, Butter
Non-vegetarian Foods.

Prudent fat intake : 3 - 4 tsp/day/person body

•Good oils :ground nut oil, olive oil, rice bran oil

•Excess consumption of fat leads to production of fat in our

24

CHOICE OF A HEALTHY COOKING MEDIUM:

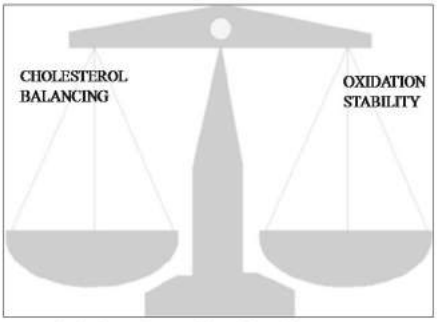
A CONTROVERSIAL SUBJECT

A consumer is a confused lot as far as choosing the right kind of cooking medium is concerned.

Every supplier of any type of cooking oil claims the same to be best for health

A common man is not aware of the yardstick by which any cooking oil could be rated as the best one

25



Recommended fats (heart friendly oils)are MUFA eg. ground nut oil, rice bran oil, olive oil

26

Choose the Healthy Fats

Saturated and trans fatty acids - Main dietary determinant LDL cholesterol

Total Fat - 20-25% of Total Calories, SFA <7% and limit Trans Fat

PUFA Fats N-3	MUFA Fats	PUFA Fats N-6	SFA Fats	Trans Fats
Soya bean oil	Olive oil	Corn oil	Coconut oil Vanaspati Palm oil	Partial Hydrogenated oil
Rapeseed oil	Canola oil	Sunflower oil	Butter	Cakes
Mustard oil	Nuts & Nut oil (Peanut)	Safflower oil	Cream	Cookies
Walnut oil Flax/linseed oil	Seed oil (Sesame)	Grape seed oil	Lard/ margarine*	Fried snack
Fatty Fish	Rice bran oil Wheat germ oil	Cottonseed oil	Fatty red meat	

* Plant based margarine healthy

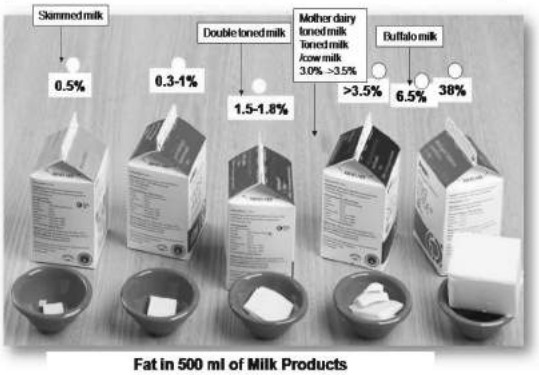
27

What to Eat? (Quality of food)

How food is cooked is important

28

Amount of fat in food matters



Fat in 500 ml of Milk Products

AHA recommendation is dairy products to have <1%

29

Choose the lean meat

30

HOW DO WE GO ABOUT EATING SMART?

eat smart!

Ensuring adequate nutrition with proper eating habits

31

Prevention of Heart Diseases

Give up one, reduce two, and increase three

1. Give up smoking
2. Reduce food and alcohol intake
3. Increase exercise

- ✓ Antioxidants and Anti accidents prevent heart attack
- ✓ Omega-3 fatty acids –heart's friend

32

Dietary Constituents and Cardiovascular Diseases

Dietary Antioxidants

- Prevents atherosclerosis, improves lipid profile, reduces blood pressure.
- High intake of fruits and vegetables- specifically isoflavones, flavonoids and polyphenols associated with reduced risk.
- Garlic, cocoa and curcumin associated with heart health.

Plant Fibers and Proteins

- Cereal bran, nuts, soy proteins associated with lowered risk.
- Increased intake of dietary fiber reduces blood pressure and LDL cholesterol.

33

Dietary fats

- High intake of cholesterol and fatty acids : detrimental
- Trans fatty acids : adverse effect on lipid profile.
- Fish - beneficial - high omega -3 fatty acids.
- Intake of monounsaturated and polyunsaturated fats.
- Saturated fat = <10% of calorie intake.
- Cholesterol intake < 300mg /day.

Vitamins and minerals

- Increased folic acid, reduces homocysteine levels.
- Reduced sodium and increased potassium and magnesium - beneficial.

34

To be heart friendly

- Twice a week - fish
- Twice a month - chicken (country)
- Twice a year - meat

STRESS BUSTERS

- **Spend time on yoga / meditation to refresh your mind**

H-ealthy
E-ating
A-ctivity
R-ight
T-hings

35

Effect of nuts

- Rich in MUFA and PUFA
- Rich in plant Protein, fiber, micronutrients like Cu and Mg
- Plant sterols
- Vitamin E, thiamin, riboflavin
- Peanuts are good source of folate and fiber
- Walnuts are good source of omega 3 oils

36

Diet - The cornerstone in the management of diabetes

Nutrition prevents diabetes in those with pre-diabetes

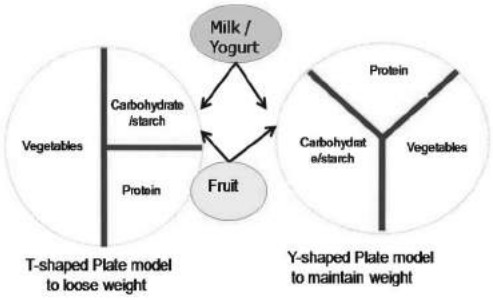
37

- Diabetic diet need not be a complete deviation from a normal diet
- Even a normal Indian diet is ideal for a diabetic, however the nutrient intake has to be tailor-made to the individual based on the age, gender, weight, height, physical activity and physiological needs of the patient
- Selection and distribution of CHO to suit individual habits
- Proteins and fats from vegetable sources are of better quality than those from animal sources
- Combination of vegetable oils should be preferred
- Fruits and vegetables, except for a few, are rich in micronutrients and fiber and are good for diabetics
- During infection and other complications, diabetics may require higher amounts of vitamins and minerals in the form of supplements

38

Healthy Plate Model

Portion Control



T-shaped Plate model to loose weight

Y-shaped Plate model to maintain weight

Prev Chronic Dis, 2007 Jan

39

Recommended Calorie intake (Kcal/Kg Body Wt/Day)

Category	Sedentary activity	Moderate Activity
Overweight/Obese	20	25
Ideal Weight	30	35
Under Weight	40	40

Distribution of Dietary Calories

	% of Total Calories
Carbohydrates	55-65
Protein	15-20
FAT	20-25

40

Effect of Green Tea

- Bioactive principle CATECHIN
- Enhances fat oxidation
- Improves PP glucose response
- Stimulates insulin secretion

41

Some Indian remedies : methi seed

- It is an herb and a spice
- Fenugreek contains an active ingredient of blood glucose control an active ingredient for blood cholesterol control
- The typical range of intake for diabetes or cholesterol-lowering is 5–30 grams with each meal or 15–90 grams all at once with one meal.

- Use of more than 100 grams of fenugreek seeds daily can cause intestinal upset and nausea. Individuals with peanut allergies use with caution or avoid. Otherwise, fenugreek is extremely safe.

42

Meal Patterns

Breakfast:

- Meal consumed within one hour of rising
- Most important meal of the day
- Should be rich in complex carbs and protein

e.g. - cereal, porridge, roti, dosa idli, upma, daliya, paratha, eggs, milk, fruits. Avoid :bakery products

43

Meal Patterns

Lunch

- Eat balanced meal
- Make right food choices
- Do not skip lunch
- Include protein as a important part of meal

E.g. - Thali, Roti-Subzi , Dal Rice, Curd Rice

44

Meal Patterns

Dinner

- Meal should be as light as possible
- Low in carbohydrates especially simple carbs
- Make clear soups as integral part of dinner
- Include a fruit and milk at bed-time

45

Eating Out (Make Right Choices)

Meal time | Cuisine | Meal selection |Hygiene

A la carte

- Either starter, main course or dessert never all together
- Clear soup should be an integral part of menu
- Choose grilled, tandoori, broiled, stir fry
- Do not order for deep fried, makhani, white sauces, mayonnaise
- Salad(?)

46

Buffet

- Choose wisely
- Do not have to eat it all
- Select hot, steaming foods
- Select a live counter so dish can be made as per your choice
- Avoid greasy foods

47

Mid Meals/Snacks

- Avoid high calorie snacks- split it into two
- Avoid super sized snacks
- Fruits, channa, unbuttered pop corn, sukha bhel with less sev, cooked channa chat are ideal snacks
- Avoid bakery products, colas, juices, chaat etc
- The best drink with and between meals is water

48

Alcohol

- Causes hypoglycemia if consumed without food
- Foods consumed with alcohol are usually fried foods/junk food empty calories)
- Alcohol is high in calories 7 kcals/gm and is metabolized in a manner to fat.
- give up alcohol, if not then fix the quantity, frequency and exchange it with fat.
- consume salads with alcohol.

49

Fountain
PEPSI

WATERFOUNTAINS

50

Fast Food Joints

- Order wisely
- Find a low fat option and order
- Do not over indulge
- Eg: just a burger no fries ,one unbuttered pav instead of two buttered pav, bhel puri instead of sev puri, ragada pattice instead of panipuri, samosa ,kachori

FAST FOODS –IT ENDS LIFE FAST

51

Maharaja Mac ?

Jumbo Vadapav?

Double
Cheese Pizza?

DO NOT UPSIZE !!!
We Need To Minimize
Not Maximize

52

Sodium

- Sources: salt, bakery products
- Blood pressure is significantly related to sodium intake(inter salt study)
- High salt intake has been implicated in hypertensive target organ diseases

Strategies to limit salt intake

Reduce salted foods bakery, processed food, pickle, ketchup

Avoid :salt shakers, salt on salads, fruits, atta, rice, sherbet

Use of lime, tamarind, pudina to bring flavour to foods

53

Killer Diet

- Fast Foods kill fast
- Fried, Calorie Dense
- Oils and Butters
- Lack of Fiber
- Cola Culture

Replace with.....

- Traditional Diet
- Less oil /eliminate trans- fat
- Fiber rich
- Reduce eating out optio

Remember...

54

RICE AS SIDE DISH AND SIDE DISH AS RICE

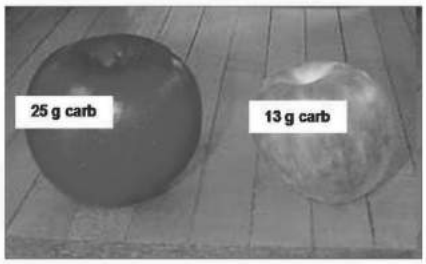
Rice boiled – 80gm
Carbohydrates – 20gm

Rice boiled – 160gm
Carbohydrates – 40gm

PORTION SIZE IS IMPORTANT

55

Size of food matters



56

Designer Foods

- Low calorie mithai's
- Diet cola's
- Low calorie or diet farsan's
- Diabetics adjunct's
  E.g.jam, jelly, pickles

Sugar free?

My pancreas is broken..
not my taste buds

57

Free Foods

Foods that can be eaten in unlimited amounts

1. Vegetables – Cabbage, cauliflower, leafy vegetables, tomatoes, cucumber, gourds.
2. Clear soups
3. Tomato juice (without sugar)
4. Thin butter milk (without sugar)
5. Nimboo Pani without sugar
6. Salads ,sprouts and
7. Eat whole fruits avoid fruit juices

58

Diet Advisory

- VITAMINS - Choose at least one source of vitamin C, folic acid, vitamin A every day.
- IRON - About 35 mg of Iron / day in the form of enriched grain products, egg, green leafy vegetables, lean meat, poultry and fish
- CALCIUM & ANTIOXIDANTS - Include diary products, green vegetables and foods, fortified with calcium.

59

Healthy versus Unhealthy food choices[7]

Food group	Green zone	Yellow zone	Red zone
Rice	Steamed rice	Pulao	Fried rice / biryani
Bread	Whole wheat bread	White bread	Croissants & cakes
Noodles	Steamed noodles		Deep fried noodles
Indian breads	*Chapatti*	Plain *naan*	Butter naan/puri
Potatoes	Baked potato		French fries
Vegetables	Steamed vegetable	Sauteed vegetables	Deep fried vegetables
Salad	Green salad		Salad with mayonnaise
Sauce	Tomato-based		Cream-based
Fish	Steamed fish	Fish curry	Fried fish
Chicken	Grilled chicken	Pan-fried	Butter chicken
Fruit	Whole fruit	Unsweetened fruit juice	Sweetened fruit juice

These constitute healthy food choices and should be eaten in recommended amounts as they are high in fiber & low in fat content

These food choices should be consumed in moderate amounts as they are low in fiber & contain moderate amounts of fat

These foods are rich in fat; refined carbohydrates & low in fiber content. Therefore, should be consumed in very limited quantities

60

Handy reminders for estimating portion sizes[3,4]

For each meal:

Hand symbol	Equivalent
	A cereal / starch serving & fruit serving is equal to a closed fist
	Meat or protein alternative is equal to the palm of the hand
	Vegetables should be enough to fill two open hands
	Fats & oils should be not more than the tip of the thumb (1 Tbsp.)

(Note: These portion estimates are based on a woman's hand size. Hand sizes vary, but it is a good approximation)

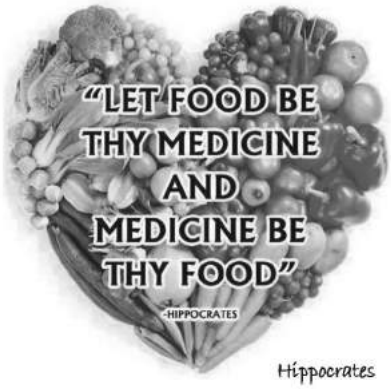
61

TAKE HOME MESSAGE

- ✓ We need to cultivate a good dietary pattern in the first years of our life
- ✓ this is an excellent investment for maintaining health for the rest of our journey
- ✓ For this, we need sustained revolution in the kitchen in every house and
- ✓ those kitchens which cater to food in the public domain by motivation if not by legislation.

62

63



Hippocrates

64

Thank You

65

EFFECTIVE LEADERSHIP

"Great men are little men expanded, great lives are ordinary lives intensified" (Wilfred A Paterson)

An effective leader is someone who is able to visualize the future of the organization and lead the team in that direction. Leadership is about creating a vision, setting a strategy and making an impact through initiatives that are important to the society. Good leaders are creative; they are team builders through motivation and great communication and are able to take the team along with to fulfill their vision and commitment for the cause.

A successful leader leads by example. He has a deep sense of commitment for the organization and passionate about building its future. He would lead from the front in times of crises, constantly encourages the team to get their very best through his 'infectious energy' and unwavering optimism. He is realistic, service oriented, emotional and creates positiveness in others. He has full of conviction in himself, be an independent thinker and enjoys all the things that he does and creates. Foresight, conviction and honesty are his most important traits. Good leaders are unbiased in their approach and attitudes towards their goal and the people sharing their goal. A good leader has an open mind, listens to those around, humble, hard working and simple. He would build a trusted, empowered and motivated team. He would handle conflicting situations efficiently so that the outcome would be peace and success. Empowering and enabling the team members is his way of functioning and consequently the team would feel free to do whatever makes the common goal fruitful. Gandhiji was such a leader, so also, Martin Luther king (junior), Mother Teresa and Nelson Mandela.

Leadership can be acquired through a combination of initiative, high level passion, commitment, open mind to listen to others and with a fair amount of opportunity to learn, analyze and act suitably. A strong sense of purpose makes one determined about one's action. This passion generates energy to improve, influence and empower others. Enthusiasm and persistence can make an average person superior and a superior person average

Motivation is a single minded concentration in the direction of vision/dreams that increases confidence. Self discipline is the art of controlling oneself and knowing when to stop and how to stop. It is the ability to do the right things even when no one is watching. A disciplined person is punctual with good self control, doesn't lose temper, is not lazy and does not waste time. He can be relied upon. Courage in adverse life situations makes one stronger, braver and a better leader. In fact, courage is the antidote to fear.

Decision making is the choice of action at a particular moment. Success and wholeness in life comes only when we own up the choices we make. Willingness to accept responsibility (own up responsibility) is the source from which self confidence springs. Handling responsibility involves taking calculated risks and being accommodative. That means, evaluating the 'pros and cons' and then taking appropriate decisions and actions. Having a positive outlook and maintaining a sense of humor/

optimism and hope in others would build up strength and good will in them. A good leader can lead the team to a better performance by simply holding a positive expectation of them. This is called 'PYGMALION EFFECT'. Positive expectation empowers others with a winning attitude and good self image.

Humility- is an internal disposition that recognizes others in compassion and genuine concern while appraising oneself realistically. Through this, the leader assumes that all the team members have something worthwhile to offer and that the situation requires co-operation/ collaboration and not competition. How to practice Humility? Give credit to where it is due. Do not boast about your achievements / do not project oneself unduly to get attention and approval which, by itself, is a sign of 'insecurity'. Do what is expected of you. It should be the objective to use all the talents and gifts for the common good. When praise comes, accept it with grace and with gratefulness to the 'giver of all gifts'. Constant learning is an essential aspect of good leadership. Anyone who stops learning is old whether twenty or eighty. Anyone who keeps learning stays young (Henry Ford). A true leader knows what he knows and what he does not. He would fill the gap by seeking counsel, learning from others and sensitive to the abilities and experiences of the associates. 'There is no shame in being ignorant but it is a crime to be negligent').

Integrity of life is another quality a good leader should have. It is a state of truthfulness and simplicity of life. We begin the process of character formation right from our childhood. “Truth is to be sought in the pure hearts of simple people and innocent children” (ROUSSEAU). Wealth, name and fame may come and go but a strong character lasts forever. It was the integrity of Gandhiji that made millions trust him and follow his path of truth and nonviolence. His integrity had the power and strength to gain independence for India from the British rule. Honesty and integrity are the corner stone's of success.

A great leader has the ability to transform and create greatness in the followers (Transformational Leadership). He can inspire, care and nurture others. He creates in others a sense of commitment, involvement and duty. He promotes problem solving skills and encourages the team members to take risks. He is willing to sacrifice personal comforts and interests for the good of the group. He works hard, keeps his life in proper balance and absolute mastery over his own emotions. A good leader should be strong but not rude, be kind but not weak, be thoughtful but not lazy, be humble but not timid, be proud but not arrogant and have humor but not sarcasm.

We have a true leader of 'par excellence' in Jesus in whom all the qualities of a good leader is present. As consecrated persons and doctors, we are doubly chosen by our Lord for his mission. According to Pope Francis, consecrated life itself is a call to heal the world from all its miseries. We are called to be leaders in various capacities on each and every day of our lives.

To summarize, LEADERSHIP is - L - Long term vision, E - Excellence, A- Advance planning, D - Discipline, E - Enthusiasm, R- Responsibility, S- Sacrifice, H- Humility, I-Influence, and P - Perseverance.

Dr. Sr. Liza Tom,
Bharat Mata hospital,
Muri, Jharkhand

Diabetes Matters

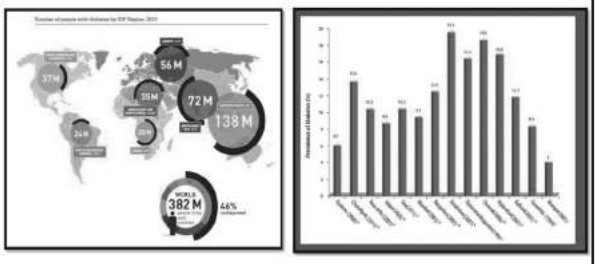
Dr. Bhuma Srinivasan
(AB) Endocrinology and Metabolism

WHY DIABETES MATTERS?

Staggering numbers.. rising morbidity and mortality and costs, influencing productivity, affecting the young & impacting the future

2

Global and National prevalence



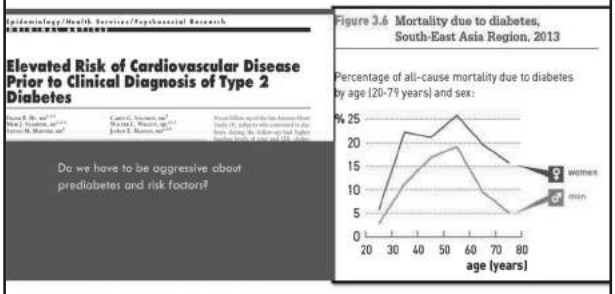
3

Question

Is Diabetes management a critical issue?

4

Diabetes = Higher mortality and morbidity



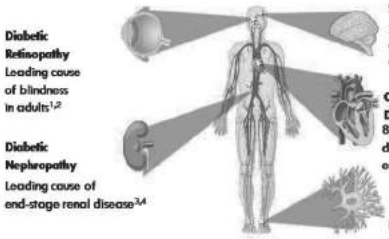
5

Changes in ranking for 15 leading cause of death, 2002 and 2030

Disease or injury	2000 Rank	2030 Rank	Change in Rank
Ischemic heart disease	1	1	0
Cerebrovascular disease	2	2	0
Lower respiratory infections	3	5	-2
HIV/AIDS	4	3	+1
COPD	5	4	+1
Perinatal conditions	6	9	-3
Diarrhoeal disease	7	16	-9
Tuberculosis	8	23	-15
Trachea, bronchus, lung cancer	9	6	+3
Road traffic accidents	10	8	+2
Diabetes mellitus	11	7	+4
Malaria	12	22	-10
Hypertensive heart disease	13	11	+2
Self-inflicted injuries	14	12	+2
Stomach cancer	15	10	+5

Mathers C.D. PLOS medicine 3: 2011-2030, 2006. 6

Type 2 diabetes is associated with serious complications



Diabetic Retinopathy
Leading cause of blindness in adults[1,2]

Diabetic Nephropathy
Leading cause of end-stage renal disease[3,4]

Stroke
2- to 4-fold increase cardiovascular mortality and stroke[5]

Cardiovascular Disease
8/10 individuals with diabetes die from CV events[6]

Diabetic Neuropathy
Leading cause of non-traumatic lower extremity amputations[7,8]

[1]UK Prospective Diabetes Study Group. *Diabetes Res* 1990; 13:1–11. [2]Fong DS, *et al. Diabetes Care* 2003; 26 (Suppl. 1):S99–S102. [3]The Hypertension in Diabetes Study Group. *J Hypertens* 1993; 11:309–317. [4]Mollitch ME, *et al. Diabetes Care* 2003; 26 (Suppl. 1):S94–S98. [5]Kannel WB, *et al. Am Heart J* 1990; 120:672–676. [6]Gray RP & Yudkin JS. Cardiovascular disease in diabetes mellitus. In *Textbook of Diabetes* 2nd Edition, 1997. Blackwell Sciences. [7]King's Fund. *Counting the cost.* The real impact of non-insulin dependent diabetes. London: British Diabetic Association, 1996. [8]Mayfield JA, *et al. Diabetes Care* 2003; 26 (Suppl. 1):S78–S79.

7

Stroke and women with Diabetes

- **Association between diabetes, stroke found in women but not Men**
- February 24, 2014 Diabetologia
- **Summary:**
- Diabetes in women is associated with an increased risk of stroke, indicates a new study, whereas the data do not show the same association among men. Worldwide, stroke is more common among men, but women with stroke appear to become more severely ill following a stroke. These sex differences have profound implications for effective prevention and treatment of stroke. Thus the increased knowledge of stroke risk factors in the population, such as that provided by this study, may lead to improved prevention of stroke.

Diabetes as a risk factor for stroke in women compared with men: a systematic review and meta-analysis of 64 cohorts, including 775 385 individuals and 12 539 strokes
June 2014 Lancet
Sanne A E Peters PhD , Prof Rachel R Huxley DPhil Prof Mark Woodward PhD
Summary: The excess risk of stroke associated with diabetes is significantly higher in women than men, independent of sex differences in other major cardiovascular risk factors

8

Diabetes Mellitus in US: Higher Mortality Risk in Women

	Relative Risk	
Age group	**Men**	**Women**
45-64	3.4	4.6
65-74	2.0	3.1
75+	1.6	2.0

In Adult Treatment Panel III, diabetes is regarded as a CAD risk equivalent; lowers LDL goal <100 mg/dL)

Geiss LS, et al. *Diabetes in America* (2nd ed). 1995

GDM prevalence linked to background IGT rates

	GDM	IGT
	2%	2%
1980s	Agarwal S, Gupta AN. Gestational Diabetes. J Assoc Physicians India 1982;30:203	Ramachandran A, et .al., High prevalence of diabetes in an urban population in south India. BMJ 1988;3; 297(6648):587-90
	7.6%	8.2%
1990s	Narendra J, Munichoodappa C, et al, Prevalence of glucose intolerance during pregnancy. Int J Diab Dev Countries 1991;11:2-4	Ramachandran A, Snehalatha c, Dharmaraj D, Viswanathan M. Prevalence of glucose intolerance in Asian Indians. Diabetes Care 1992; 15:1348-55
	16.6%	14.5%
2000s	V Seshiah, V Balaji, Madhuri S Balaji, CB Sanjeevi, A. Green. Gestational Diabetes Mellitus in India. J Assoc Physicians India 2004;52:707	Ramachandran A, Snehalatha C, Kapur A, Vijay V, Mohan V,Das AK, Rao PV, Yajnik CS, Prasanna Kumar KM, Nair JD.For the Diabetes Epidemiology Study Group in India (DESI).Diabetologia 2001;44:1094-1101.

10

Questions and solutions

- ☐ Is diabetes management a critical issue?
- ☐ Is diabetes management a challenging issue?
- ☐ Is it time to acknowledge the glycemic goals?
- ☐ Is there enough evidence for early aggressive interventions?
- ☐ Is there a roadmap to get to goal?
- ☐ Are there roadblocks on the way to reaching the goal?
- ☐ How can we overcome the inertia and the patient

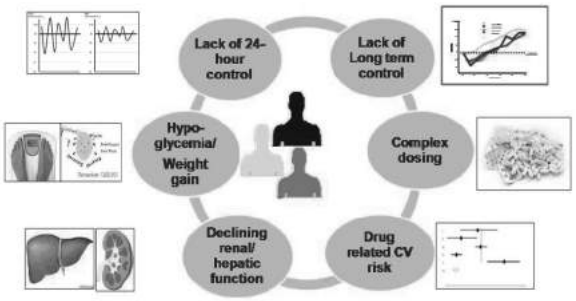
11

Question

Is Diabetes management a challenging issue?

12

T2DM management is complex



1) Forst T and Pfutzner A. Expert Opin. Pharmacother. (2012) 13(1):101-110
2) UKPDS 34 Study. Lancet 1998:352:854–65
3) Gerich JE, Odawara M, Terauchi Y. Curr Med Res Opin. 2007 Aug;23(8):1791-8.

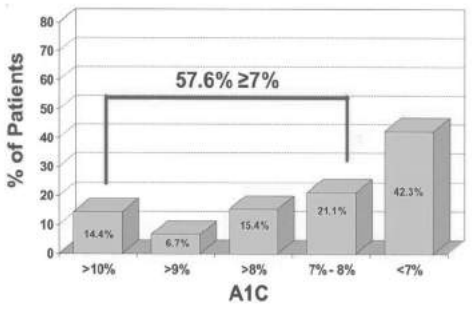
13

Diabetes is a progressive disorder

- Absolute or relative insulin deficiency
  - Impaired beta-cell function
  - Insulin resistance
  - ⇒ *Over time, many patients require insulin*
- Two components
  - Fasting hyperglycemia
  - Postprandial hyperglycemia
  - ⇒ *Different agents may be needed to treat both aspects*
- Associated disturbances
  - Hypertension
  - Dyslipidemia
  - Atherothrombotic changes
  - ⇒ *Multiple interventions may be required*

14

Many Patients Are Not at ADA Goal A1C of <7%



Saaddine JB, et al. *Ann Intern Med*. 2006;144:465-474.

15

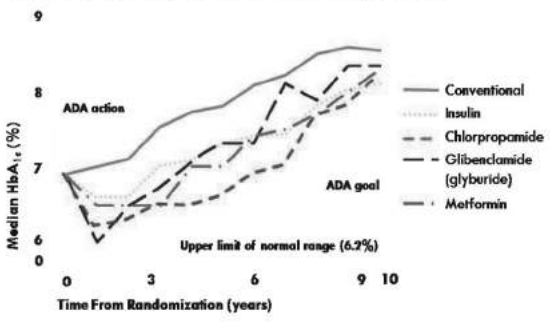
Underlying Causes of Glucose Fluctuations

- Psychological
- Meters
- Illness/medical conditions
- Food
- Insulin
- Activity
- Alcohol
- Stress

16

Intensive Treatments and Increase in HbA_{1c} Over Time

United Kingdom Prospective Diabetes Study (UKPDS)



UK Prospective Diabetes Study (UKPDS 34) Group. *Lancet*. 1998;352:854-65.

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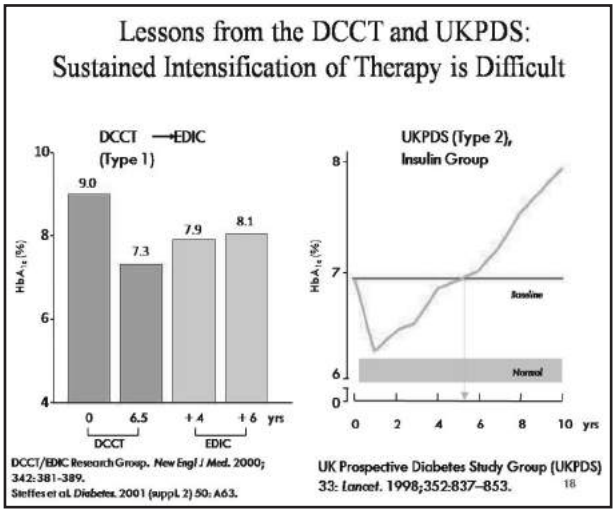
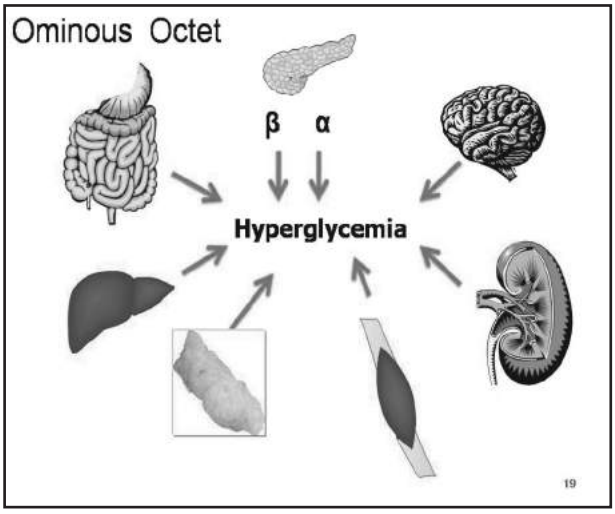




Fundamental Questions

- **Just because a drug may work at one or more of the sites of defect in Type 2 DM - what about:**
- **Efficacy**
- **Side effects**
- **Actually improve outcomes or make them worse**
- **Decrease mortality or increase mortality??**

20

Question

Is there evidence for glycemic goals and improved outcomes?

21

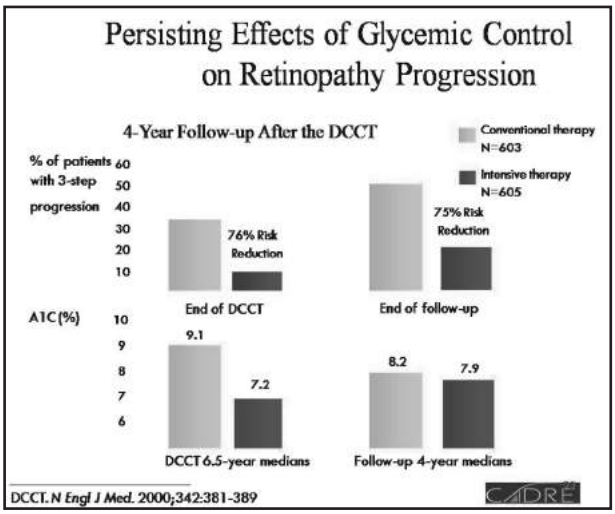
Good Glycemic Control (Lower HbA_{1c}) Reduces Complications

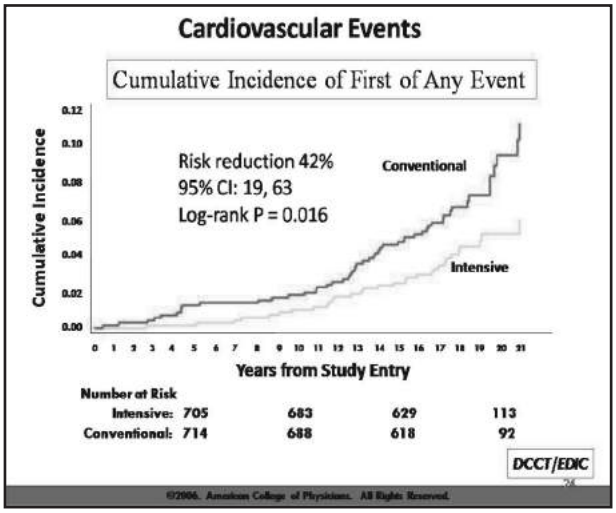
	DCCT	Kumamoto	UKPDS
HbA_{1c}	9 → 7%	9 → 7%	8 → 7%
Retinopathy	76%	69%	17-21%
Nephropathy	54%	70%	24-33%
Neuropathy	60%	-	-
Macrovascular disease	44%*	-	16%*

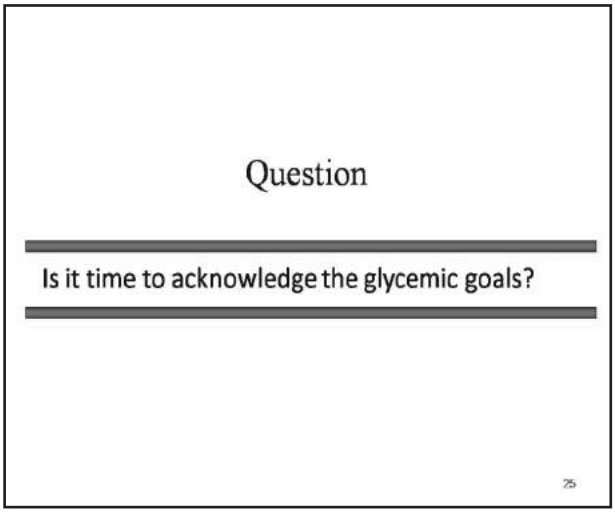
* not statistically significant

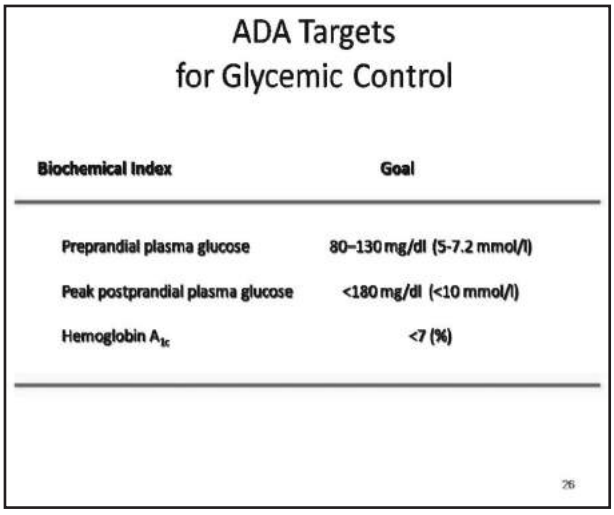
DCCT Study Group: N Engl J Med 329:977-86, 1993
Ohkubo Y: Diabetes Res Clin Prac 28:103-17, 1995
UKPDS Study Group: Lancet 352:837-53, 1998

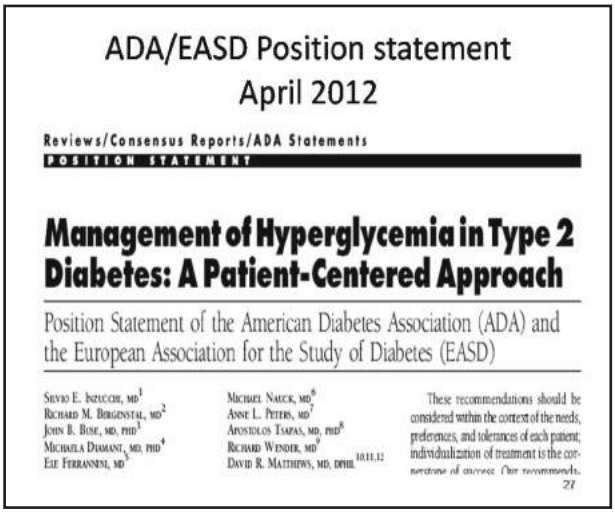
22

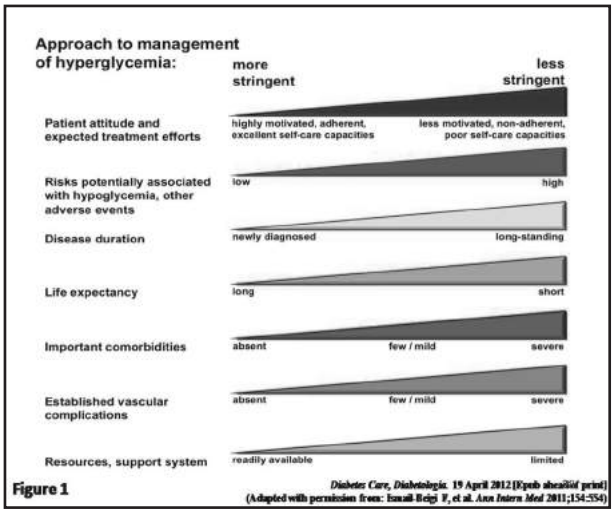


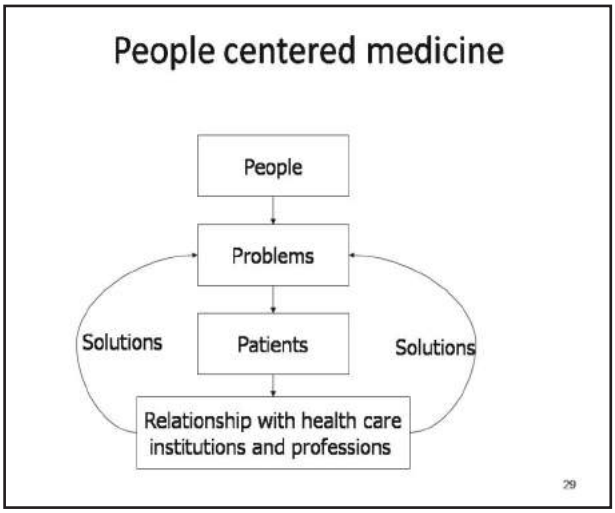

Cardiovascular Events
Cumulative Incidence of First of Any Event
Cumulative Incidence
Risk reduction 42%
95% CI: 19, 63
Log-rank P = 0.016
Conventional
Intensive
Years from Study Entry
Number at Risk
Intensive: 705 683 629 113
Conventional: 714 688 618 92
DCCT/EDIC
©2006. American College of Physicians. All Rights Reserved.


Question
Is it time to acknowledge the glycemic goals?
25


ADA Targets
for Glycemic Control
Biochemical Index
Goal
Preprandial plasma glucose
80–130 mg/dl (5-7.2 mmol/l)
Peak postprandial plasma glucose
<180 mg/dl (<10 mmol/l)
Hemoglobin A1c
<7 (%)
26


ADA/EASD Position statement
April 2012
Reviews/Consensus Reports/ADA Statements
POSITION STATEMENT
Management of Hyperglycemia in Type 2 Diabetes: A Patient-Centered Approach
Position Statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)
Silvio E. Inzucchi, MD
Richard M. Bergenstal, MD
John B. Buse, MD, PhD
Michaela Diamant, MD, PhD
Ele Ferrannini, MD
Michael Nauck, MD
Anne L. Peters, MD
Apostolos Tsapas, MD, PhD
Richard Wender, MD
David R. Matthews, MD, DPhil
These recommendations should be considered within the context of the needs, preferences, and tolerances of each patient;
27


Approach to management of hyperglycemia:
more stringent
less stringent
Patient attitude and expected treatment efforts
highly motivated, adherent, excellent self-care capacities
less motivated, non-adherent, poor self-care capacities
Risks potentially associated with hypoglycemia, other adverse events
low
high
Disease duration
newly diagnosed
long-standing
Life expectancy
long
short
Important comorbidities
absent
few / mild
severe
Established vascular complications
absent
few / mild
severe
Resources, support system
readily available
limited
Figure 1
Diabetes Care, Diabetologia. 19 April 2012 [Epub ahead of print]
(Adapted with permission from: Ismail-Beigi F, et al. Ann Intern Med 2011;154:554)


People centered medicine
People
Problems
Patients
Solutions
Solutions
Relationship with health care institutions and professions
29

Question

Is there a roadmap for early, aggressive Diabetes management ?

30

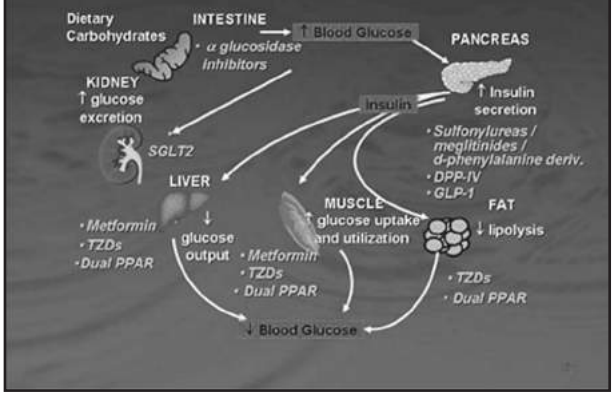
- **Importance of Controlling Diabetes Early– The Concept of Metabolic Memory, Legacy Effect and the Case for Early Insulinisation**

  I Ranjit Unnikrishnan, RM Anjana, V Mohan

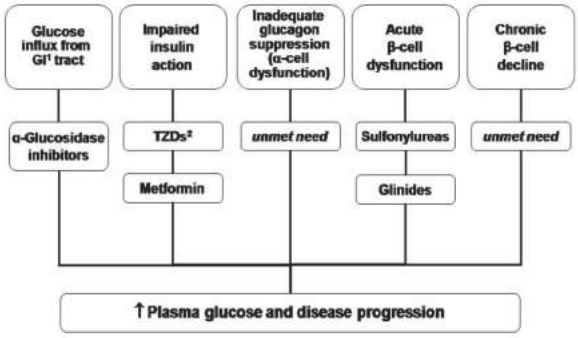
- Early, intensive treatment of new onset diabetes mellitus aimed at tight glucose control reduces the risk of microvascular complications and probably, macrovascular disease as well
- "Metabolic memory" and "legacy effect" are terms that have been used to describe the fact that glucose control early in the natural history of diabetes profoundly influences the prognosis later on in life
- Early use of insulin therapy can help normalize blood sugar and HbA1C levels and thus enable patients to benefit from a favourable "metabolic memory" or "legacy effect"

31

Multiple Targets for Diabetes Therapies



Current Oral Therapies Do Not Address the Multiple Defects in Type 2 Diabetes



1 Gastrointestinal
2 Thiazolidinedione

Defronzo RA. Br J Diabetes Vasc Dis. 2003;3(suppl 1):S24–S40

33

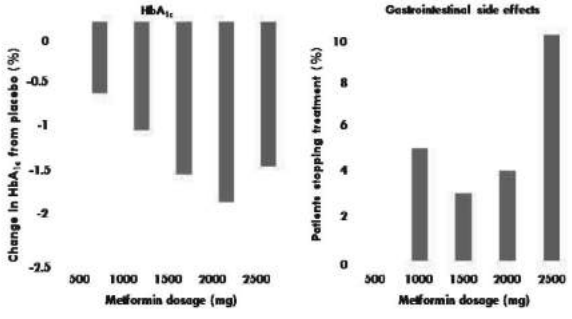
No Single Class of Oral Antihyperglycemic Monotherapy Targets All Key Pathophysiologies

Major Pathophysiologies	Alpha-Glucosidase Inhibitors[1,2]	Meglitinides[3]	SUs[4,5]	TZDs[6,7]	Metformin[8]	DPP-4 Inhibitors
Insulin deficiency		✓	✓			✓
Insulin resistance				✓	✓	
Excess hepatic glucose output				✓	✓	✓
Intestinal glucose absorption	✓				✓	

1. Glyset [package insert]. New York, NY: Pfizer Inc, 2004. 2. Precose [package insert]. West Haven, Conn: Bayer, 2004.
3. Prandin [package insert]. Princeton, NJ: Novo Nordisk; 2004. 4. Diabeta [package insert]. Bridgewater, NJ: Sanofi-Aventis; 2007.
5. Glucotrol [package insert]. New York, NY: Pfizer Inc, 2004. 6. Actos [package insert]. Lincolnshire, IL: Takeda Pharmaceuticals; 2004.
7. Avandia [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2005.
8. Glucophage [package insert]. Princeton, NJ: Bristol-Myers Squibb; 2004.

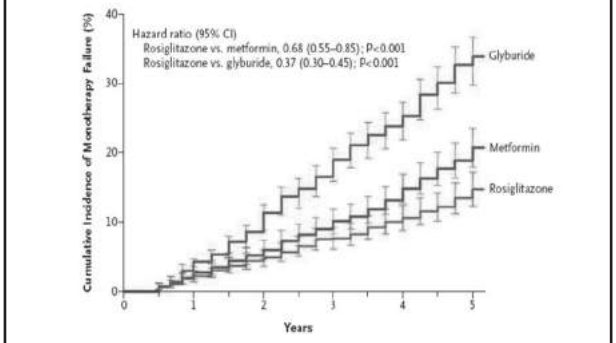
34

Up-titrating monotherapy to the maximum recommended dose may not provide benefit



35

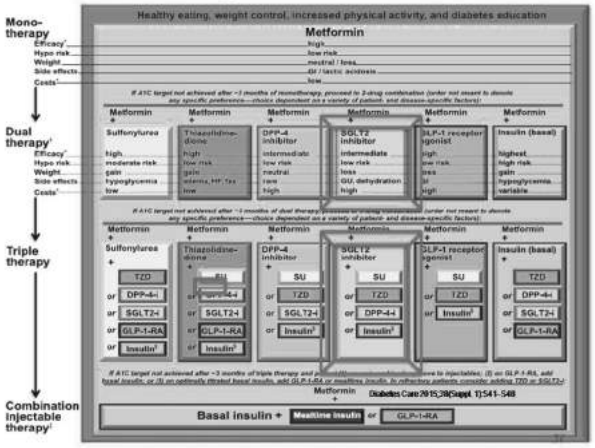
Durability of Action of oral Antidiabetic Agents



N Engl J Med 355; 23 December 7, 2006

36

ADA position statement Dec 2014



Major advance with insulin therapy

- **MDI – Basal and premeal insulin therapy**
- **Delivery by continuous subcutaneous insulin infusion (CSII) pumps**
- Initially regular insulin was used
- Greater impact:

  "basal bolus" therapy

  Standard of care in the next century

  Development of insulin analogues

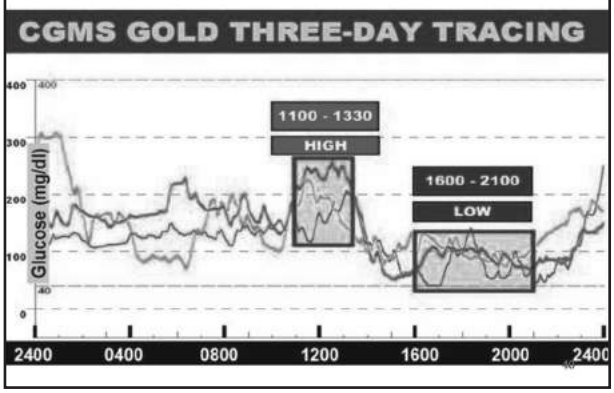
38

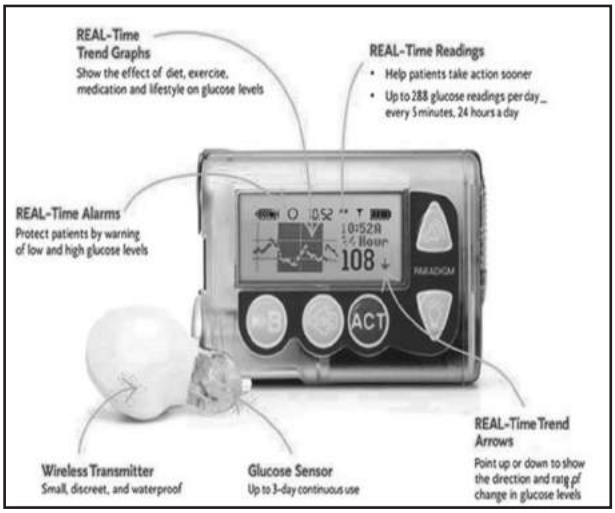
Glucose monitoring

- **Improvements in glucose monitoring**
- SMBG
- CGMS
- Real-time continuous glucose sensors introduced in 2006
- Retrospective 72-hour continuous glucose monitors (CGM) have been available since 1999
- Both real-time and retrospective sensors measure interstitial fluid (ISF) glucose with glucose oxidase

39

CGMS Data





Question

Are there roadblocks to get to goal?

42

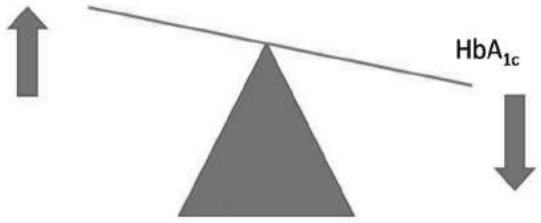
How are we doing

- Treat to Failure v/s
- Treat to target
- Possible consideration of new and emerging therapies
  - Incretin based
  - SGLT2 inhibitors
  - Early use of combinations
  - Early use of Insulin

46

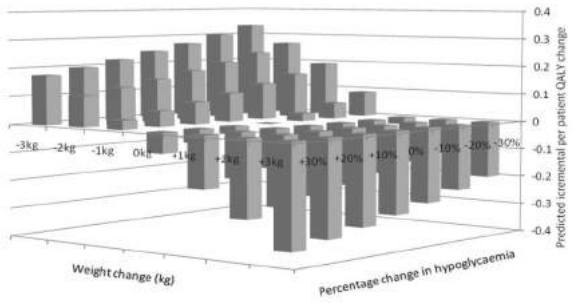
The challenge of blood glucose control

Hypoglycaemia / weight gain



44

Relationship between weight gain, hypoglycaemia and quality of life



The graph illustrates that the QALY decrement associated with an increase in weight and hypoglycaemia by approximately 3 kg and 30%, respectively, will offset the QALY gain associated with a 1% reduction in HbA_{1c} (McEwan, Evans. Diab, Obesity and Metab; In Press)

Failure to Achieve Goals

- Complex disease; Difficult lifestyle
- Natural progression of disease
- Low health literacy/ lower social strata
- Multiple medications – costs associated
- Lack of suppression of Glucagon
- Drug side effects
  - Weight gain
  - Hypoglycemia
  - GI side effects
  - Change in blood pressure
- Cardiovascular safety
- Restricted use (Elderly, CHF, Renal Impairment)
- Failure of health professionals

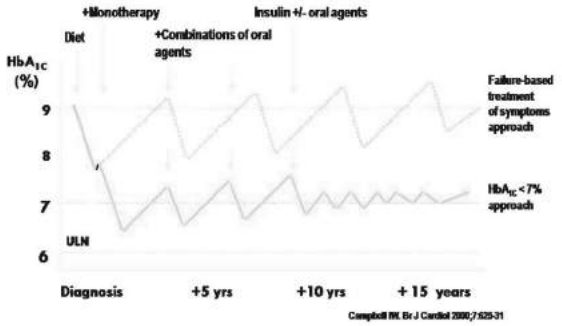
43

Question

How early is early and how aggressive is aggressive?

47

Target-driven approach for sustained glycemic control



48

Elements of Intensification of Therapy

- Try to understand operational pathobiology of disease process
- Consider glucose lowering potential of available therapies
- Treat to targets that are clearly associated with favorable outcomes: Align data with quality
- Avoid Inertia – Remember early intervention has lasting benefits – Legacy Effect
- Use combinations sooner when the benefits are clear and present- such as Incretin based plus metformin
- Consider concurrent morbidities and pay equal attention
- Use guidelines as what they are – Guidelines , not mandates

49

DOES DIABETES HAVE DIFFERENT IMPLICATIONS IN DIFFERENT PEOPLE?

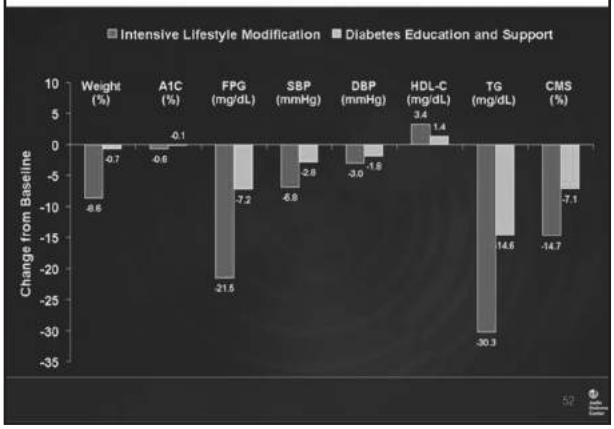
50

Photographer

- Type 2 diabetes for past 3 years
- Both parents diabetic
- Busy 6- 7 months in a year
- Worried about ED
- 31 years old
- Hb A1c 8.4
- Single

51

Lifestyle wins!



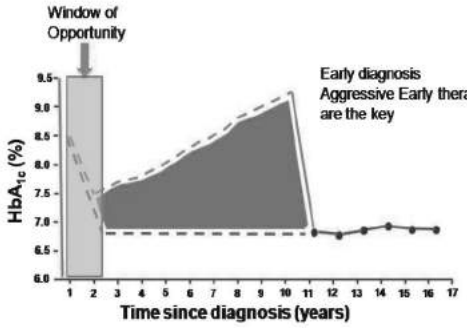
52

Businessman

- 47 years old
- Type 2 diabetes x 1 year
- Father diabetic, CVA
- 3 Brothers diabetes
- Travels 20 days in a month
- Hb A1c 6.2
- Lives with wife and 2 daughters

53

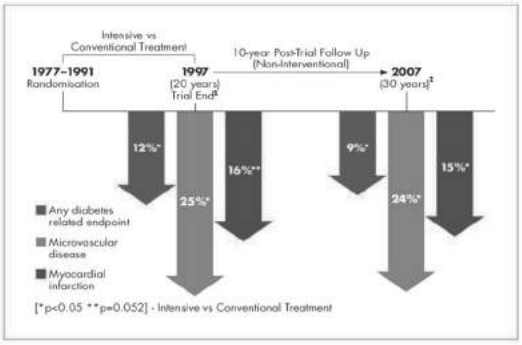
A new paradigm



Del Prato S. *Diabetologia* 2009; 52:1219–1226.

54

The benefits of early tight control – UKPDS 10-year post-trial follow-up



1. Holman *et al.* UKPDS 80. *NEJM* 2008;359:1577–89
2. Unnikrishnan *et al.* UKPDS 33. *Lancet* 1998;352:837

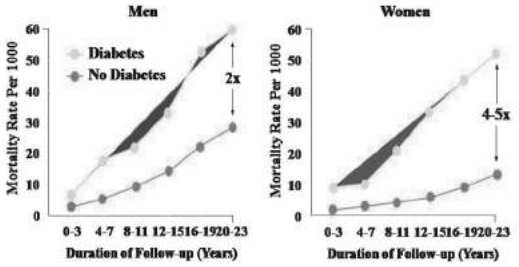
55

Female Banker

- 44 years old
- Type 2 diabetes x 11 years
- Menopause 6 years ago
- Has mild CKD
- Hb A1c 7.3

56

Diabetes is a CV Risk Factor



Krolewski AS, et al. Evolving natural history of coronary disease in diabetes mellitus. *Am J Med* 1991;90(Supp 2A):56S-61S.

57

Flower vendor

- 60+ years old
- Walks 10 km / day
- Type 2 diabetes x 3 years
- Up from 4 am to 10 pm
- Hb A1c 8.1

58

Young IT Consultant

- 28 years old
- GDM last year
- Works 3-11 pm
- PCOS
- Eats out 2-3 times / week
- Hb A1c 6. 9

59

Diabetes Mellitus – the future ?

60

Considering the patient perspective

I am anxious that my therapy will cause side effects

What if my therapy fails?

Why is lowering blood glucose so important?

What happens if I forget to take my medication on a regular basis?

I am afraid of the unknown

I have no symptoms, how can my condition be serious?

I am afraid of needing insulin

61

Use a patient-centered approach

- Active listening
- Negotiation
- Provides information (when required)

INFORMATION EXCHANGE

- Active
- Expresses views
- In control
- Decision maker

Muhlhauser I, *et al. Diabet Med* 2000; 17:823–829.

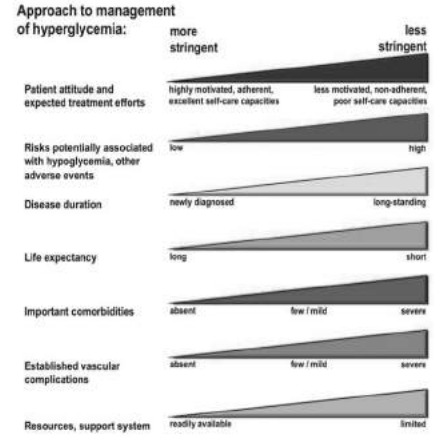
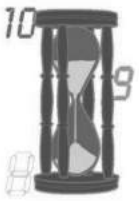


Figure 1

Diabetes Care, Diabetologia. 19 April 2012 [Epub ahead of print]
(Adapted with permission from: Ismail-Beigi F, et al. *Ann Intern Med* 2011;154:554)

Need for an early and intensive approach to type 2 diabetes management

- At diagnosis of type 2 diabetes:
  - **50%** of patients already have complications[1]
  - up to **50%** of β-cell function has already been lost[2]
- Current management:
  - **two-thirds** of patients do not achieve target HbA_{1c}[3,4]
  - **majority** require polypharmacy to meet glycemic goals over time[5]



[1]UKPDS Group. *Diabetologia* 1991; 34:877–890. [2]Holman RR. *Diabetes Res Clin Pract* 1998; 40 (Suppl.):S21–S25. [3]Saydah SH, *et al. JAMA* 2004; 291:335–342.
[4]Liebl A, *et al. Diabetologia* 2002; 45:S23–S28. [5]Turner RC, *et al. JAMA* 1999; 281:2005–2012.

64

SUMMARY

- Diabetes Management should be based on sound principles targeting key pathologies
- Intervention should earlier and aggressive
- New therapies add to our armamentarium
- Early intervention has lasting impact
- Remain informed about unpalatable side effects of even trusted drugs
- Pay equal attention to co-morbidities
- Use fresh evidence to challenge dogma
- Consider possible new targets for reducing macrovascular risk

65

"Medicine is not a trade to be learned, but a profession to be entered." "The treatment of a disease may be entirely impersonal, the care of a patient must be completely personal." And the comment that was abbreviated on the bathroom wall, "For the secret of the care of the patient is in caring for the patient."

CURE VS CARE

66

We need to treat the whole elephant!!

67

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

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Mobile No : +91 9743453644
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Email : sisdocindia@gmail.com

XXI CME & AGBM - PHOTO GALLERY

Inaugural Mass

Prayer Song

Prayer Dance

Lighting The Lamp

Presenting Memento

Inaugural Session

Keynote address
Dr. Balasubramanian,
President, IMA, Tamil Nadu

Felicitation
Rev. Fr. Tomi Thomas,
Director General, CHAI

Felicitation
Rev. Fr. D. J. Sagaya Raj SDB
Rector, Citadel, Chennai

Felicitation
Dr. Maya Mascarnehas,
SJMCAA, Bangalore

Presidential Address
Most Rev. George Antonysamy,
Arch Bishop of Chennai

Rev. Fr. Joe Mannath SDB,
Addressing the Sister Doctors...

Dr.T.K. Shaanthy Gunasingh MD. DGO.,
Talking to the Sister Doctors...

Dr. P. Savitha
talking to the Participants...

Dr. Vijayalakshmi, MD
giving a lecture

Presenting Memento

Cultural Evening

Visit to mahabalipuram and Joe Beach

Sister Doctors in natural calamities

Sr. Dr. Placida FMM, Sr. Dr. Emily Susai FMM at Flood Relief camp Jammu and Kashmir

Sr. Dr. Teena Francis ASMI at Earthquake Relief Medical Camp, Nepal.

Use of Foley's Catheter in the Management of post partum hemorrhage

Case report:

We had five cases of post partum hemorrhage in the year 2014-2015 April to March. Out of these five patients 3 of them had complete placenta praevia. Patients were taken for LSCS, intra operatively they had profuse bleeding from the lower segment of the uterus where the placenta was implanted. Two of them had atonic uterus. In all these cases medical management protocol for PPH (Oxytocin, Ergometrin, prostaglandin F2 Alpha (prostadin) was followed. B-lynch suturing and square suturing for the placental bed bleeding was applied, there was only partial response and patient continued to have bleeding and atonicity.

For the patients who had placenta praevia and placental site bleeding, three 22F Foley's catheters were inserted through vagina in to the lower segment. And for the patients who had atonic uterus 22 F Foley's catheter introduced through vagina in to the fundus of the uterus.

All three balloons were inflated with 70 – 80 ml of distilled water and observed for hemorrhage. Within 10 to 15 minutes there was no active bleeding. Then the uterine incision site was closed. Gentle traction was applied to obtain a continual tamponade effect.

The catheters were then tied together and an examination glove was used for the collection and measurement of blood loss. This also helps to prevent collection in the uterine cavity. Catheters were removed after 36 hours and there was no further bleeding. High antibiotic coverage was given. In all these five cases we were able to control haemorrhage before the patient could deteriorate in to hemodynamic instability.

Discussion:

Post partum haemorrhage is one of the life threatening event that one encounter in everyday practice. In the majority of the cases relatively simple methods as this Foley's catheter balloon tamponade can be used to avert a disaster.

The intra uterine balloon is believed to act by exerting inward to outward pressure that is greater than the systemic arterial pressure to prevent continual bleeding. Tamponade effect of the catheter can be used in atonic as well as traumatic causes of PPH. Early use of intra uterine

Foley's catheter balloon is way of limiting ongoing uterine blood loss.

It is easy to use, no special training required. It is cost effective, it can be a life saving intervention especially in the low resources settings where blood transfusions and surgical facilities may or may not be available.

In few cases of endometritis is reported post natally. Hence it is necessary to have high antibiotic coverage.

For those of us who were presented for the AICOG 2015 at Chennai trade center were lucky to listen to Dr. Sabaratnam **Arulkumaran** (Professor Emeritus of Obstetrics and Gynaecology, St George's University of London, **UK**.) on this topic. He suggested to use 24 F Foley's catheter, so that it can be inflated with 80 to 120 ml of water which would exert a better tamponade effect in preventing PPH.

In conclusion Foley's catheter alone or in combination with uterotonics is an effective way of managing PPH which is one of the leading causes of maternal mortality in India.

Reference is available in

BSOG, ASOG journals and Pub med.

Sr. Dr. Maria Vasantha Alphonse SCC,
Leonard Hospital,
Batlagundu, Dindigul,
Tamil Nadu.

Hypertension

Dr. N. Vijayalaksmi M.D.,FCCP,

Definition

- It is defined as the presence of Blood Pressure elevation to a level that places patients at increased risk for target organ damage in several vascular beds including the retina, brain, heart and large arteries.

2

Blood Pressure:

- Cardiac output x peripheral vascular resistance

3

Aetiology:

It could be

a) Systolic Due to increased cardiac output

(1) Due to left ventricular factors LV contractility – Heart Rate
(2) Fluid overload – { Minerals corticoids Sodium Loading

b) Diastolic: Increased peripheral vascular Resistance.

a) Humoral – angiotenson & catecholamines
b) Sympathetic nervous system.

It happens as past of aging process – vessels become stiff & poor compliance.

4

Recording of Blood pressure

(1) Normal recording of BP using mercury

Sphygmomanometer – patient relaxed – sitting and recorded. Using the sounds of korot kov. 1st sound is appearance of the sounds – muffling of there sound phase IV & disappearance is phase V.

(2) Ambulatory BP recorded at home using electronic devices.

(3) Ideal and accurate recording of BP is recording central BP directly by tapping aortic pressure.

Radial artery – Available in specialised centres only.

5

Factors affecting the accuracy of BP measurement

a)Patient attending a meeting – commuting to work.

b)Ingestion of alcohol, eating, telephone conversation.

c)Watching television & doing desk work.

d)Technique of recoding BP

supine – sitting – position of arm in relation to heart level.

6

Types of hypertension

a) Pre – hypertension: A BP of 140/90 – recorded – you have get cautions – start strict diet – life style modification

b) Masked hypertension: Normal clinic BP<140/90 and high home BP>135/85 - 8% of individuals

c) White – Coat hypertension: 5-6% of individuals have a tendency to record high BP in the clinic – fear on seeing the doctor – but home recording

d) Hypertension : - Found normal

Definitely high BP – It can be only isolated systolic HTN alone or HTN (both sy & chart)

e) Labile HTN BP varying everyday

7

JNC VII Classification:-

	Systolic	Diastolic
• Normal	<120mmHg	<80mmHg
• Prehypertension	120-139mmHg	80-89mmHg
• Stage 1 HT	140-159mmHg	90-99mmHg
• Stage 2 HT	>160mmHg	>100mmHg

8

Hypertensive Urgencies

- Increase in BP, with DBP >120mmHg, occurs in 1% of Hypertensive patients
- Usually associated with progressive end organ complications
- Include accelerated hypertension with SBP>210mmHg, DBP>130mmHg, presenting with headaches, blurred vision, focal neurologic symptoms

– Malignant Hypertension requires presence of papilledema.

– Hypertensive emergencies require immedia control of BP to prevent end organ damage like hypertensive encephalopathy, intracranial haemorrhage, imstable angina etc.,

9

Clinical Features:

1. About 5.7% individuals are asympt. Routine BP recording in the clinic reveals high BP.
2. Main presenting complaint will be head – ache – constant with nausea – vomiting.
3. Vertigo – shortness of breath – PND
4. Some – times present with angina for the first time
5. Most of the time patients present with complications ausing as a result of HTN.

Clinical Features:

11

6. Namely – CVA, acute MI, nephropathy retinopathy – ESRD.

7. IInd organ damage due to HTN – worsens due to associated co – morbid conditions. Like diabetes, dyslipedemia, Hypothyroidism, obesity, smoking, alcoholism .

8. The importance of cont inued & medication to be thrust on every patient - rather than its side – effects.

□ →

Isolated Systolic Hypertension

12

- SBP > 140mmHg with a normal DBP, occurs frequently in the elderly.
- Etiology:-

I). Primary or Essential Hypertension:-

- a). Accounts for 85% of cases
- b). 70% of them have positive family history

II). Secondary Hypertension:-

- Due to Coarctation of aorta

- Renal causes:- glomerulonephritis, chromic pyclonephritis, collagen vascular diseases, polycystic kidney disease, renal artery sternosis.
- Endocrine Causes:- Pheo chromocytoma, Cushing's syndrome, Conn's & syndrome, hyperparathyroidism, acromegaly,
- Alcohol & drugs like:- OCP's, steroids, NSAIDS, cox 2 inhibitors, carbenoxolone, sympathomimetics, cyclosporin, sibutramine, bromocryptine,
- Pre eclamptic toxaemia
- Obstructive sleep apnea

13

Risk factors:-

- → overweight, obesity
- →increased sodium intake
- → decreased physical activity
- → increased alcohol intake

Clinical features:-

- → transient headache, polyuria
- →left ventricular hypertrophy, heaving apical impulse
- →left atrial hypertrophy, fourth heart sound
- →A2 accelerated
- →very short early diastolic murmur

14

Complications

CNS	CVS
• Transient ischaemic	Coronary artery
• attacks	disease
• CVA (Stroke)	Left ventricular failure
• Subarachnoid hge	Aortic aneurysm
• Hypertensive encepha	Aortic dissection
• Lopathy	
• Ophthalmic complications	
• Renal	
• Proteinuria	
• Progressive renal failure	

15

Laboratory Investigations

Basic

- Hematocit
- Urianalysis
- Plasma glucose
- S Potassium
- S Creatinine
- Calcium
- Uric acid,
- Fasting lipid Levels
- ECG
- Chest X-ray
- Echo cardiography
- Renal artery stenosis → captopril enhanced cardionuclide scan, DTPA scan, Doppler USG, CT angiogram, renal arteriogram
- Others USG, intravenous neogram,

Secondary Studies

- Phaeochromocytoma
- Plasma
- calecholamine levels,
- 24h urinary VMA levels
- Cushing Syn→Plasma
- cortisol levels,
- dexamethasone
- supression test, 24hrs
- urinary cortisol

16

Treatment

17

- Non Pharmacologic Therapy:-
- Lifestyle modifications:-
- Reassurance
- Control of obesity, cessation of smoking, reduction in body weight,
- DASH eating plan:- diet rich in fruits, vegetables, potassium and low fat dairy products
- Regular exercises, medication

Indications
Treatment goals:-

Patient population	Target blood pressure
1.Most patients	<140/90mmHg
2.Patients with DM	<130/80mmHg
3.Patients with CKD	<130/80mmHg
4.Patients with LV Dysfunction	<120/80mmHg

- ALLHAT → Anti hypertensives & lipid lowering treatment to prevent heart attack trial

18

JNC 8 recommendations

- Patient >60years, without diabetes or chronic 150/90mmHg kidney disease goal is
- Patient 18-59years without co-morbidities & - 140/90mmHg
- Patient >60years with diabetes & Kidney disease goal is
- First line drugs →thiazide duretics, calcium channel blockers angiotensin conve enzyme inhibitors. Angiote3nsin receptor blockers
- Second or third line drugs →higher doses or combination of ACE inhibitors, ARB's CCb, thiazide duretics

19

Stage 1 (SBP 140-159, DBP 90-99mmHg)

- Thiazide diuretics maintine can add ACE inhibitors, Angiotension receptor blockers, calcium channel blockers

Stage 2(SBP>160, DBP>120mmHg

- 2 drug combination(Use thiazide duretics with an ACE inhibitor) Blockers ca channel blocker

20

JNC 8 recommendations

- Other medications are later line alternatives
- Patients of African descent without kidney disease → Use calcium channel blockers and thiazides instead of ACE inhibitors
- Use of ACE inhibitors & Angiotensin receptor blockers is recommended for all patients with kidney disease
- ACE inhibitors & Angiotensin recpetor blockers should not be used in the same patient simultaneously
- Patient >75years + impaired kidney fundctioon → use calcium thiazide type duretics instead of ACE inhibitors & Angiotensin receptor blockers

21

Drugs used to treat Hypertension

- Diuretics:-
- Thiazide Diuretics
- Hydrochlorothiazide – 12.5-25mg OD
- Chlorthalidone 12.5 – 50mg OD
- Block sodium absorption in the distal convoluted tubule
- A/E:- weakness, muscle cramps, impotence, Also hypokalemia, hypomagnesemia, hyperlipidemia, hypercalcemia, hyperglycemia.

22

- Loop Divretics:-
- Furosemide – 10.40mg BID
- Turosemide – 5-10 mg OD
- Block sodium reabsorption in the thick ascending loop of Henle.
- Most effective in patients with Renal Insuffieciency
- A/E:- hypomagnesemia, hypocalcemia, hypokalemia, irreversible ototoxicity

23

- K+ Sparing Diuretics
- Amiloride – 2.5-10mg OD
- 50-150mg OD
- They are weak agents when used alone
- ALDOSTERONE Receptor Blockers
- Spirolonolaclone 25-100mg OD
- Eplerenone 25-100mg OD
- S/E:- hyperkalemia, gynecomastia, breast tenderness

24

- B-Blockers
- Cardioselective nonselective
- (only B1) (B1&B2 action)
- Metoprolol(25-100mg BID) peopanalol(10-40mmHg)
- They can be used in Sympatholytic
- Patients with mild effect
- Airway obstruction Anti hypertensive
- (COPD, asthma), peripheral anti-anxiety
- Vascular disease S/E:- gasteric disturbances bradycardia, cardiac failure, bronchospasm
- → B.Blockers are useful in young hypertensives those with Ischaemic heart disease.

25

- ACE inhibitors:-
- Captopril – 25mg BID/TID
- Ramipril 2.5mg OD
- Enalapril 5mg OD
- Perindropril
- OD
- They are very beneficial in patients with diabetes, congestive cardiac failure, renovascular hypertension
- →acts as artenolar & veno dilator, diuretics aldosterone release
- →A/E:- dry cough, angio neurotic edema, hypertension
- →conteamdicated in patients with impaired renal function & B/L renal artery stenosis.
- ANGIOTENSIN RECEPTOR BLOCKERS:-
- Losartan - 25-50mg BID
- Telmisartan - 20-80mg OD
- Olmesartan - 20-40mg OD

26

Calcium Channel Blockers:-

- Generally they are effective agents for HT, but due to the increase in the number of ischaemic cardiac events, they are not used in hypertension management.
- Only long acting agents are considered safe, especially in patients with low renin levels, bronchial asthma and peripheral vascular disease
- Verapamil - 40-120mg TID
- Nifedipine - 30-90mg OD
- Diltiazem -30-120mg TID
- Amlodipine - 2.5-10mg OD
- Felodipine -2-5-20mg OD

27

Centrally Acting Adrenergic Agents:-

- **Potent antihypertensive agent**
- **Also available as a transdermal patch**
- **Reserpine**
- **Guanethidine**
- **Guanadiel**
- **S/E:- sedation, nasal stiffness, postueal hypotension, ejaculatory failure**
- **PARENTERAL ANTIHYPERTENSIVE AGENTS:-**
- **Indicated for immediate reduction in BP,**
- **like preoperative hypertensive urgency**

28

- Sodium Intropruside:-
- Reduces BP rapidly
- Therapy for long time can lead to renal insufficiennt & accumulation of toxic metabolitis (throcyanatis)
- Onset of action <5mins
- 0.1 – 0.3 mcg/kg/min

29

30

- Nitroglycerin - 0.5-2mg / min
- Continuous IV infusion
- Given in patients where nitroprusside is contraindicated, like severe coronary insufficiency & advanced renal & hepatic disease.
- Prefered agent for patients with moderate hypertensive in the setting of acute coronary ischaemia, or after bypass.

Labetalol:-

- Used in hypertensive crisis / hypertensive emergencies during pregnancy
- Particularly beneficial during adrenergic excess 9like clonidine withdrawal, pheochromocytoma)
- 20-80mg upto 300mg over 5-10mins
- A/E hypotension, heart block, heart failure
- Other Drugs:-
- Esmolol – useful in aortic dissection
- Nicardipine – approved for post operative hypertension
- Fenoldopam – used in organ transplantation patients

31

- SPECIAL CONSIDERATIONS:-
- Treatment for Hypertensive Crisis:-
- Goal is to reduce the Mean arterial pressure or a reduction of the DBP to 100-110mmhg over mins to hours.
- Sodium nitroprusside, B adrenergic antagonistic therapy – Esmolol IV given →IV labetalol

32

- Follow Up:-
- For patients with BP stabilised by mgmt follow up to be done three monthly
- Measurement of BP & weight
- Reinforcement of non pharmacologic advise
- General health and drug side effects
- Test urine for proteinuria

33

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

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MANAGING OUR MISSION LIKE JESUS

I. Two styles of Conventional Management:

- **Alpha Management style:** Based on masculine and authoritative use of power.
- **Beta management of style:** Based on feminine cooperative use of power.

Omega Management: Effectively incorporates and enhances these two methods. **Abel Kabiru**: Contents that never is the history anyone practiced this concept than Jesus Christ.

II. Jesus` Managerial Skills:

- Based on three categories of strengths
  - Self- Mastery
  - Actions
  - Good public relations

Which are impeccable and can be used to train, motivate, those in managerial field?

- Jesus **trained** twelve human beings who influenced the whole world.
- He worked with the staff whoever totally human, In spite of their Illiteracy, fractious feelings, momentary cowardice, **accomplished** the tasks he trained them to do.
- He knows to **satisfy His clients** (people) and market His product.
- **Self- Mastery**: Jesus believed in Himself emanated self- confidence and millions of people continue to place their trust in him and his product **"Christianity".**
- HE called Himself- The **"Way"**… The **"Life**" ….. The **"Shepherd"**….. The **"Light"**….
- He did not care what others said or thought as long as he was doing the right thing.

III. Jesus had tremendous Energy and knew how to use it Best:

- He refused to engage in meaningless endeavors that would sap His energy unnecessarily.
- A leader and Manager requires tremendous amount of energy and to know how to use it.

IV. Willing to stand- alone at times:

- Jesus stood alone and said "**NO"** sometimes.
  - No- to ambitious young man who wanted to follow him.
  - No- to temptations.
  - No- to Himself not to run away from His Crucifixion and death……. But to drink the cup. John 18:11

So when a leader attracts followers, at any moment he should be ready to stand-alone.

V. Jesus was a VISIONARY LEADER:

Jesus embraced the concept of the globalization 2000 years ago. He spread the doctrine of his religion to the whole world globally to the millions of people.

VI. Not to waste time on judging others, rather in creation and restoration:

John 5:45 I do not judge you…….

Managers and leaders when they judge others they inhibit their own forward motion.

VII. Express Yourself:

Jesus expressed Himself; loud and often He gave clean message through His teaching.

VIII. Passionate Commitment:

- Nelson Mandela- Struck to his vision of redeeming South Africa and refused to compromise his commitment to freedom.
- Jesus Passionately committed to saving mankind up to the extent of crucifixion.

IX .Good Leader should be aware of his Resources:

Jesus constantly identified His Resources.

- A fish with a coin to pay Tax.
- Loaf of bread to feed 5000 people.
- A leaders` most trusted resource is "**Human Resource**s"
- Joe Girard- pictures "**250"** engraved on every person.
  He says that each person knows other 250 people.
- Peoples` skills, proposals, talents are very much valuable to make use of.

X. Sense of Destiny:

Jesus said – "**I know where I come from and I know where I am going**".

This is a key of management which inspires everyone.

Great Leaders inspires others to the extent of inspiring themselves.

XI. Creating a Team:

- If you intend to accomplish anything significant, the first step is to create a team.
- So, to execute good ideas, noble intentions, brilliant inventions and miraculous discoveries need a team to act on them.

Jesus said **"Follow me; I will make you fishers of men"**. Even Jesus needed a team.

XII. Boldness:

This is lacking in many leaders.

- Jesus was bold enough – shouting at Pharisees, emptied the table in his Father`s House, and carried the cross.
- Francline D Roosevelt: Accredited with putting America back as its feet again. But he when was warned by his staff- His plans are too costly, large and rough…. **He** said even though they are not perfect but by God we have to-do something.

XIII. Concept of "wows": (**with or without somebody else**): It is a tool for those facing ups and downs on leadership. Jesus was committed to healing, teaching and preaching regardless of whether his disciples came along or not.

XIV. Setting Example:

When Jesus washed the feet of His disciples, He said **"I am doing this to set an example for you".**

XV. Public Relationship: (PR)

- ✓ Jesus` PR was the best and he was open to people and their ideas.
- ✓ He believed and treated them as equals.
- ✓ He educated and he set an example.
- ✓ He acknowledged them in public and private.
- ✓ He saw people as God`s gifts to him and saw them as his greatest accomplishment and loved them to the end. So, Jesus was a true Omega leader one who used force to accomplish his mission but never lost his compassion for his people. Every one of us can awaken the **Omega leader** or Manager within us by realizing that people are our greatest resources and passionately being committed to a cause.

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PCOS

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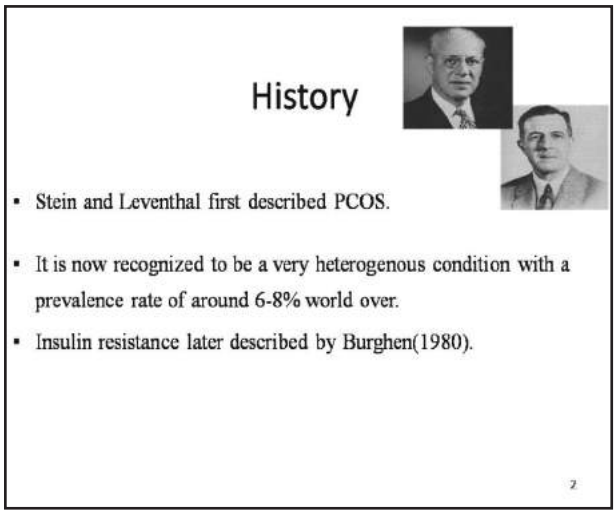
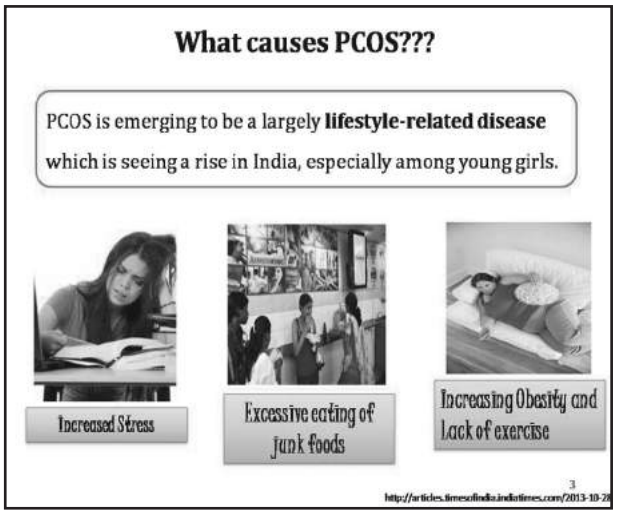
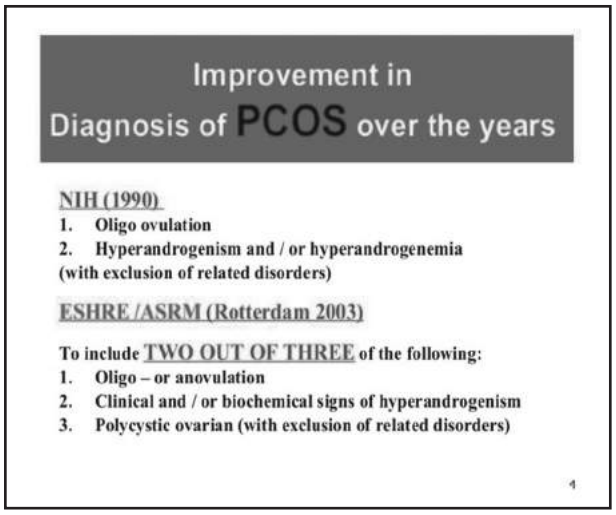
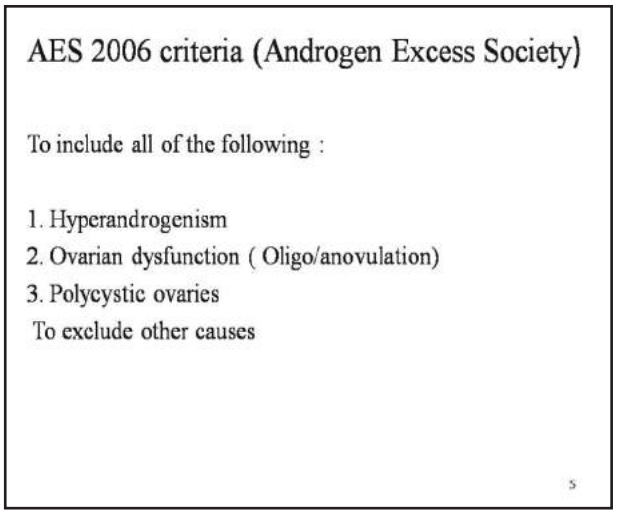








Exclusion of related disorders would mean: ruling out other causes of androgen excess

- **Non classical adrenal hyperplasia (NCAH)**
  Late onset value of 17OHP<200ng/dl excludes diagnosis
  Level of 17OHP >800ng/dl confirms diagnosis
  Between these two values do ACTH stimulation test
  Take blood before & 1hr after giving syn.ACTH .25mg IM,IV. In women with NCAH 17OHP >1500ng/dl
- **Adrenal tumours** -Do adrenal CT + High levels DHEAS
- **Cushing syndrome** -Do overnight dexamethasone suppression test. Give 1mg of oral dexa at 11pm & measure morning S.cortisol at 8am. Value < 1.8 µg /dl is Normal
- **Ovarian androgen secreting Tumour** .S. total Testosterone >200ng/dl definite diag. Also do USG to confirm diagnosis.

6

Rule out

- Ovulatory dysfunction due to hypothyroidism
- Hyperprolactinaemia, drug induced etc.

7

Pitfalls Rotterdam Definition

1. Neglects role of Insulin Resistance

8

Genetics of PCOS

- PCOS is familial and various aspects of the syndrome may be differentially inherited.

9

PCOS - Genetics

- Believed to be
  ? autosomal dominant,
  ? ?X-linked inheritance
- Dysregulation of the **P450c17 gene** controlling steroidogenesis,CYP11a is suspected
- Insulin receptor gene defect
- Follistatin gene defect

Studies in large families has suggested autosomal dominant inheritance with premature balding as the male phenotype

10

Any Genetic or Familial Basis ?

- **FAMILY Clustering is known :**

Risk of PCOS

- 40% - if her sister is having PCOS
- 20% - if her mother suffered from PCOS
- N = 5-10%

GENETIC ETIOLOGY NO LAST WORD AS YET

11

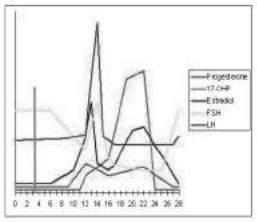
Neo-hormones in PCOS

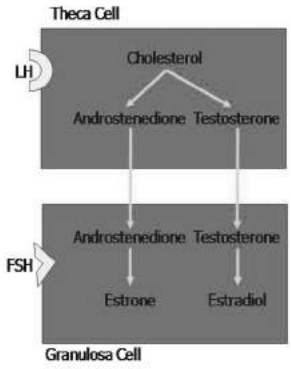
- **Adiponectin** produced in adipose tissue and has anti atherogenic effect.
- Lower levels in PCOS
- **Resistin-** antagonizes insulin action
- Higher levels in PCOS
- Proportion of adiponectin and resistin influence cardio-metabolic risk in PCOS

Seow 2004 Hum Reprod

12

PATHOGENESIS





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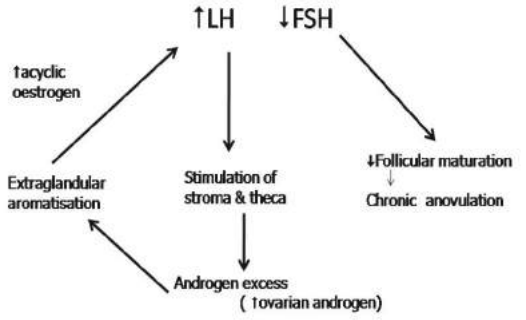
Abnormal Hormone feed back mechanisms



Low levels of FSH is due to _ve feed back of chronically elevated estrone from peripheral aromatisation & ↑ levels of inhibin B from small follicles.

14

Obesity
↓
Insulin
↓
Hyperinsulinemic state (↑Insulin)
↓
↓SHBG
↓
↑ Free testosterone

↑IGF-1

15

Blood tests for diag.of PCOS

- S.TSH
- S.prolactin
- 2hr OGTT
- Fasting lipid profile
- LH FSH ratio 3:1 instead of 1:1
- S. free Testosterone
- Endometrial sampling SOS
- USG Abdomen & Pelvis
- Follicular phase 17 OHP
- Overnight dexa suppression in women with hyper corticolism

16

Diagnostic Criteria for PCOS

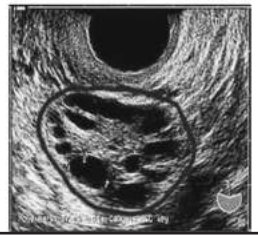
Ovarian Morphology

The criteria to be fulfilled in the morphology of PCOS

12 or more follicles measuring

2-9mm in diameter seen in atleast one ovary

Increased ovarian volume > 10 cm ^{3}.



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Menstrual disturbances associated with PCOS

- Oligomenorrhoea is seen in 60-85%
- Secondary amenorrhoea. denotes a severe form of the disease.
- DUB is another menstrual irregularity seen in association with anovulation
- About 10-15% have regular menstrual cycle.

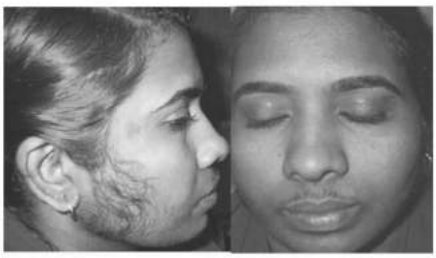
18

- HYPERANDROGENISM is the key feature of PCOS primarily due to excess production by ovaries & lesser extent by adrenals

19

Hirsuitism

- Features of androgen excess in the form of excessive terminal hair of the male pattern.



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Hirsuitism (65-75%of PCOS)

Androgen excess on the modified Ferrimen and Gallwey scoring (mFG)

- Excessive terminal hair of the male pattern
- 9 body areas namely the upper lip, chin, chest, upper back, lower back , upper abdomen, lower abdomen , arms and legs
- A score of 0-4 is given (vellus → terminal)
- Score > 8 denotes hirsuitism

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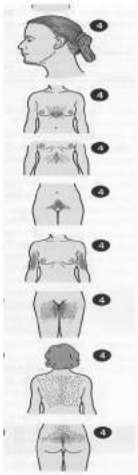


22

Hyperandrogenism

DHEA, DHEAS
Androstenedione

(Weak androgens metabolized in skin)

Testosterone

(Principal circulating androgen)

Dihydrotestosterone (DHT)

Potent androgens

Dermal papilla

Vellus hair

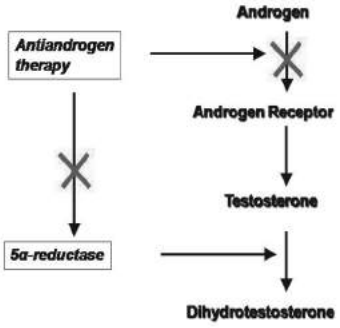
Terminal medulated hair

23

To demonstrate the presence of hyper androgenemia the free Testosterone is the best marker

24

Anti-Androgen Therapy



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Treatment of hirsuitism

- 30 μg Ethinyl oestradiol with 3mg drosperinone
- Ethinyl oestradiol with cyproterone acetate 2mg
- Spironolactone 50-100mg twice a day
- Flutamide (62.5mg/daily)
- Finasteride 5mg reduces 5α reductase activity

26

Insulin resistance

- PCOS have insulin resistance50-75%
- Also notice that 25-50% don't have insulin resist

- Impaired glucose tolerance 35%
- Type II diabetes 10%.

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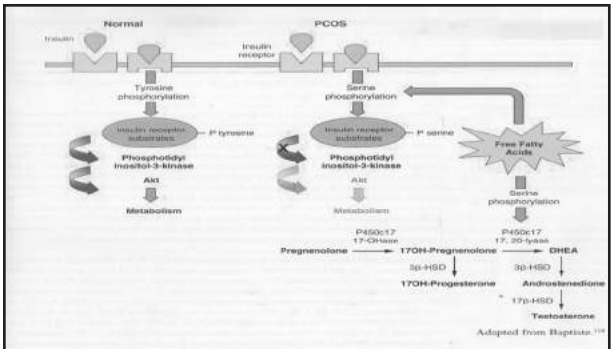

Normally insulin binding to its receptors induces a conformational change resulting in tyrosin phosphorylation of the receptor and protein substrates for glucose regulation and metabolism. But here there is serine phosphorylation which inhibits insulin signaling

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- Insulin resistance and hyperinsulinaemia are the primary factors that are the cause and not the result of hyperandrogenism

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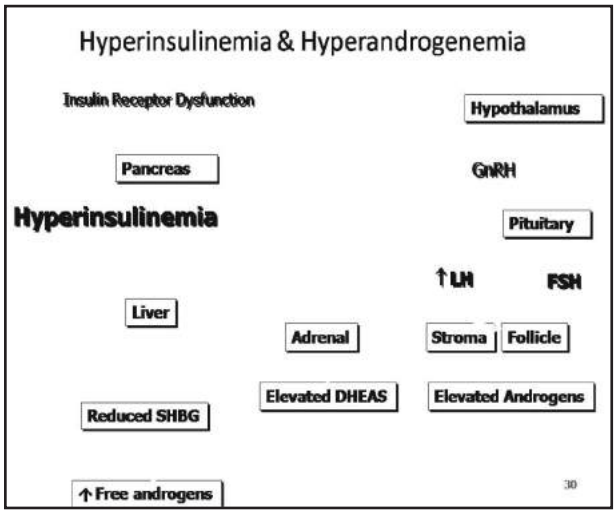
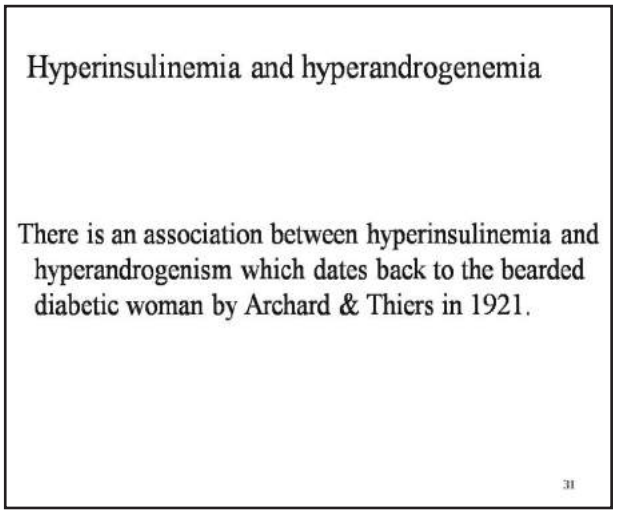
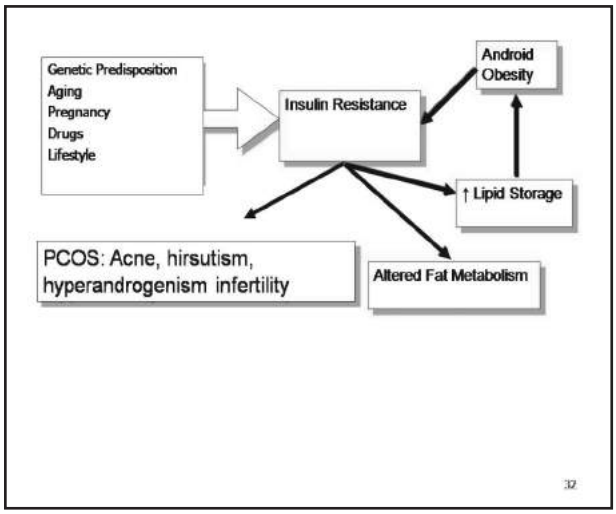
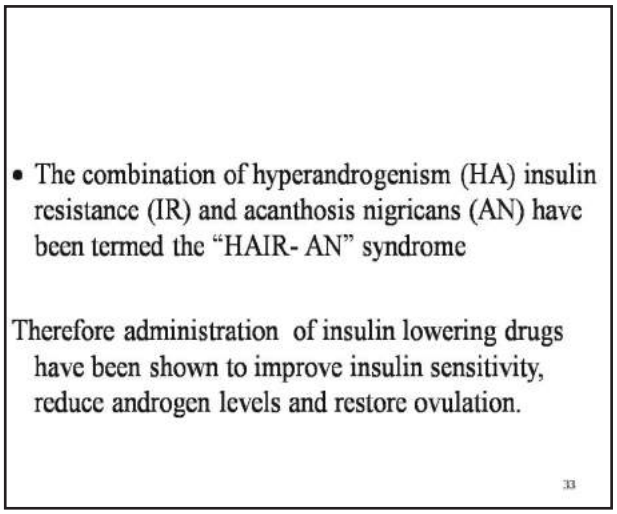

Hyperinsulinemia & Hyperandrogenemia
Insulin Receptor Dysfunction
Hypothalamus
Pancreas
GnRH
Hyperinsulinemia
Pituitary
↑LH
FSH
Liver
Adrenal
Stroma
Follicle
Elevated DHEAS
Elevated Androgens
Reduced SHBG
↑ Free androgens
30


Hyperinsulinemia and hyperandrogenemia
There is an association between hyperinsulinemia and hyperandrogenism which dates back to the bearded diabetic woman by Archard & Thiers in 1921.
31


Genetic Predisposition
Aging
Pregnancy
Drugs
Lifestyle
Insulin Resistance
Android Obesity
↑ Lipid Storage
PCOS: Acne, hirsutism, hyperandrogenism infertility
Altered Fat Metabolism
32


• The combination of hyperandrogenism (HA) insulin resistance (IR) and acanthosis nigricans (AN) have been termed the "HAIR- AN" syndrome
Therefore administration of insulin lowering drugs have been shown to improve insulin sensitivity, reduce androgen levels and restore ovulation.
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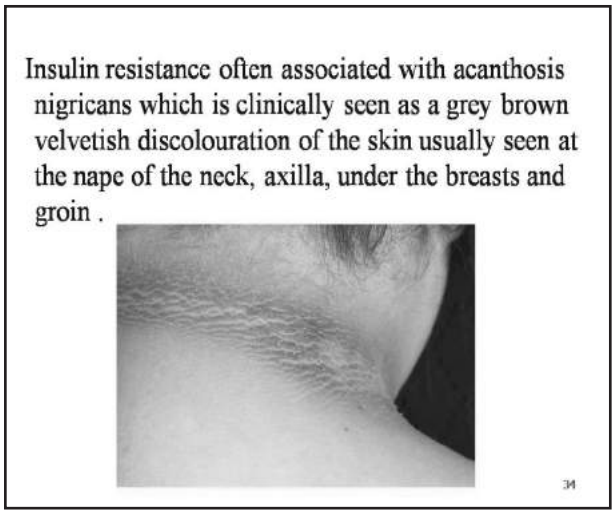
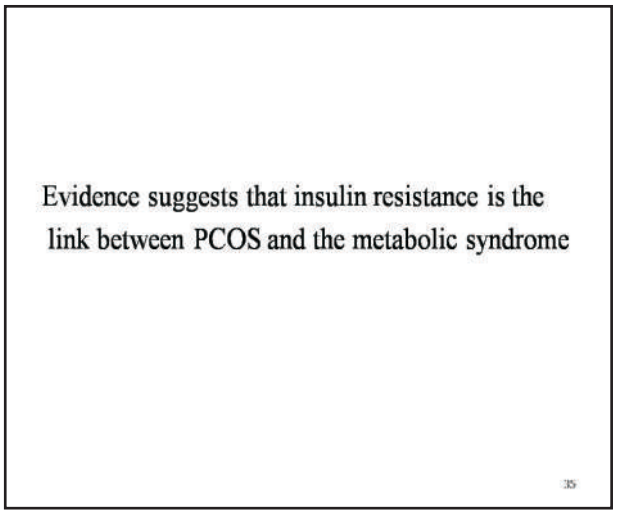

Insulin resistance often associated with acanthosis nigricans which is clinically seen as a grey brown velvetish discolouration of the skin usually seen at the nape of the neck, axilla, under the breasts and groin .
34


Evidence suggests that insulin resistance is the link between PCOS and the metabolic syndrome
35

Diagnosis of insulin resistance

- Hyperinsulinaemic euglycemic clamp
- Fasting serum insulin conc.>20-30μU/ml suggests insulin resistance
- Fasting glucose insulin ratio <4.5
- HOMA-IR (homeostatic model assessment of insulin resistance) used in large epidemiological studies
- QUICKI –quantitative insulin sensitivity check index value >0.33 indicates insulin resist.
- Standard OGTT 2hr

36

2hr OGTT

Interpretation	2hr glucose	2hr insulin
Normal	<140	
IGT	140-199	
DM	≥200	
Normal	--------- ----------	>100-150μU/ml
IR	--------- ----------	>150 -300μU/ml
Severe IR	---------- ---	>300μU/ml

37

Metformin
- biguanide derivative
- decreases hepatic glucose production
- Improves peripheral utilisation of glucose
- More lipid friendly

Dose
500-2000mg. Slowly increase dose
Side effects
G.I symptoms
Abdominal bloating
metallic taste
Lactic acidosis

38

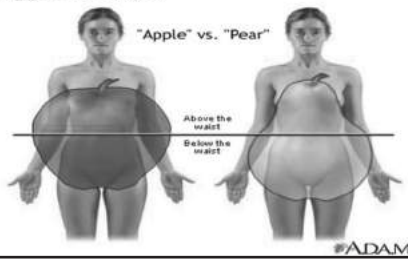
Thiazolidinediones

- Rosiglitazone 4mg daily(improves insulin sensitivity)
- Pioglitazone 30mg daily(↑wt gain category C)
- Troglitazone not used due to hepatic toxicity
- Acts on muscle & liver to ↑ glucose utilisation and ↓ glucose production

39

Obesity in PCOS

- A normal waist: hip ratio of < 0.85. (pear shaped obesity)
- But in the obesity of PCOS , the fat distribution is more central as evidenced by a high waist :hip ratio(apple obesity)



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- Visceral fat is metabolically more active than subcutaneous fat.

41

Treatment for obesity

- Orlistat
- Bariatric Surgery

Bariatric Surgery

- Limited experience in children and adolescents
- Roux-en-Y gastric bypass (RYGB) is performed now

Obese PCOS	Lean PCOS
Less LH ↑	More LH↑
Insulin level high	Insulin not so high but intrinsic insulin resistance.
Menstrual irregularity DUB	
Hirsuitism	
Infertility	Less here
Glucose intolerance	
Obesity	

Clinical Presentation of Women with PCOS

Adolescent Period	Reproductive Period	Menopausal
➢ Menstrual Irregularity ➢ Cosmetic Acne Hirsuitism Hair Loss	➢ Infertility ➢ Early pregnancy loss ➢ PIH,GDM	➢ Metabolic Syn. ➢ Ca Endometrium

Obesity

PCOS in Young Girls

Treatment strategies include:

- Weight loss and exercise
- Healthy approach to eating
- COC or progestin to ↓ testosterone levels and regulate the menstrual cycle
- Insulin-sensitizing agents
- Antiandrogens
- Topical treatment for acne and excess facial hair

Management of PCOS

Diet Control

Exercise

Medicines

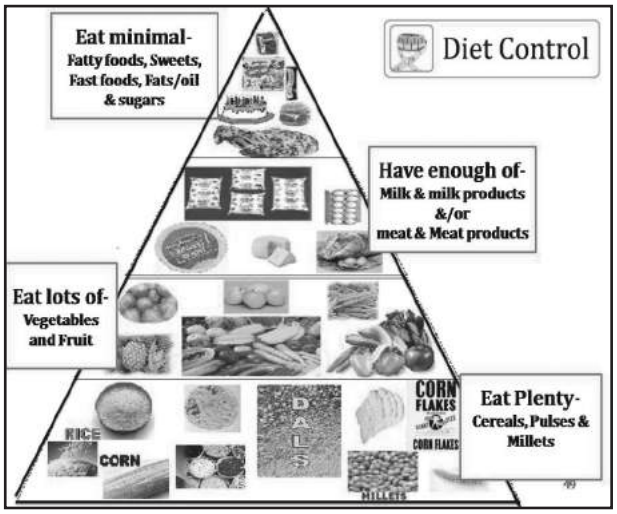
Diet Control

Foods Recommended

- Diet rich in Proteins and Vitamin
- Egg whites
- Fishes like pomfrets, salmon
- Lean parts of chicken.

Foods Restricted

- Diet rich in carbohydrates, like rice potato
- Yolk of the egg
- Shell fishes- prawns, crabs, lobsters
- Organ meats like kidney, liver, brain etc.
- Red meat like mutton, pork,beef etc.



Exercise

How much exercise should I do?

❖**150 minutes per week**, ideally **30 minutes per day** is recommended for PCOS women.
❖Walking swimming and weight lifting, will be of greatest benefit.

Walking **Swimming** **Weight lifting**

50

The metabolic syndrome in PCOS patients

Modified NCEP – ATP III , 2005

Three or more of the following is required for the diagnosis of Metabolic Syndrome

- Central obesity : waist circum > 88cm (35 in) females
- Elevated triglycerides ≥ 150mg / dL
- Reduced HDL < 50mg /dL
- Hypertension : BP ≥ 135/ 85mm Hg
- Elevated fasting plasma glucose ≥ 100mg /dL

51

Treatment options to prevent metabolic syndrome

- Life style modification
- A diet low in saturated fat, high in fibre and low glycemic index
- The addition of insulin sensitisers have helped in reducing the morbidity associated with the metabolic syndrome.

52

Weight reduction: A modest weight reduction of 5-10% lead to restoration of menstruation & ovulation .

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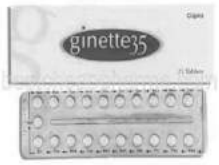
Oral contraceptives : - with cyproterone acetate or drosperinone is a good combination in regularising menstruation in patients with irregular menstrual periods



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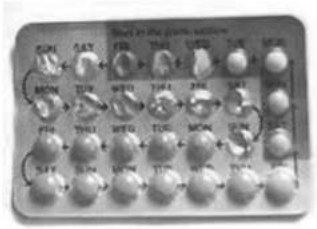
COMBINED ORAL CONTRACEPTIVE PILLS



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Progesterone therapy

- Progesterone 10mg MPA for 10 days every 2 months helps to prevent endometrial proliferation and protects from future endometrial Cancer.

56

Infertility

- Clomiphene citrate is the first drug of choice in PCOS.
- This could be followed by LOD

57

Laparoscopic ovarian drilling

Four punctures per ovary at 40 W for 4 sec/per puncture seems to be optimum
2/3rd ovulate with LOD & 50% conceive within 1st yr.

58

LAPAROSCOPIC OVARIAN DRILLING

- Drawbacks 1. Adhesion formation 30-40%
  2.Premature ovarian failure

Advantages

1.Avoids OHSS
2. Single treatment
3.No increase in multiple pregnancies
4.As effective as gonadotropin treatment

59

- Duration of infertility is the most important independent predictor of ovulation after LOD, followed by FAI then BMI

Conclusions of The Thessaloniki ESHRE/ ASRM-Sponsored PCOS Consensus Workshop Group -2007

- Before any intervention is initiated, preconception counselling should be provided
- Emphasis on:
  - Diet – Hypocaloric diet
  - Exercise - long term, aim to reduce 5-10% body wt
  - Avoiding Alcohol & smoking

62

- Metformin use in PCOS should be restricted to women with glucose intolerance. Based on recent data available in the literature, the routine use of this drug in ovulation induction is recommended.

63

- Insufficient evidence is currently available to recommend the clinical use of aromatase inhibitors for routine ovulation induction.

64

- The recommended first–line treatment for OI is CC.
- Recommended second-line in CC resistance is LOS/ gonadotropins with or without IUI.
- Recommended third-line treatment is IVF, because this treatment is effective in women with PCOS undergoing IVF. Single ET reduces chances of multiple pregnancy.
- IVM(In vitro Maturation) is now being tried in a big way.

65

CONCLUSION

- PCOS is a heterogenous endocrine disordergeneticaly determined, and environmentally modified.
- From adolesence to post menopause
- Effects vary with each period of life
- Long term consequences
- Life style modification,metformin,periodic bleed help

66

They shall bring forth fruits !

For the world TB day programme , we selected a village about 14 kms from our hospital. our staff contacted the president of the village, the headmaster of the school, the Parish-priest and other influential people of the village, well in advance. Locally we mobilized B. Sc Nursing college students and Multi-purpose health workers training centre students.

On 29th March evening we started a rally from the neighbouring village to the place where we were conducting the cultural programme. Rally was inaugurated by Mr. Bala Subramaninan, the coordinator of CBCI CARD, Tamilnadu. The students were carrying the awareness placards and shouting the slogans like "Stop T.B", "Reach the 3 Millions", "Treat and cure everyone".

We also had exhibition depicting the signs and symptoms, diagnosis and treatment of Tuberculosis. How to prevent MDR – T.B and nutritional part of it was also depicted. After the people saw the exhibition stalls, we conducted quiz programme for the children and the youth. We also distributed small gifts to encourage them.

The cultural program was presided over by the District T.B officer. All about T.B was well presented through the Indian Cultural means like Parai, Kollattam, Villupaattu, and an action-song by the students dressed like soldiers warning the people about the side effects of late and irregular treatment of T.B. Every one enjoyed the programme and definitely the Message was driven home to them. The president of the village congratulated everyone who participated in the programme and thanked us for choosing their village. He also promised that they would strive to create a T.B free village since they know everything about T.B now. The DTO in her presidential talk summarized once again everything about T.B so that the message was reinforced. Sister Dr. Conrad brought out the theme of this year "Search, Treat and cure everyone". Finally we distributed sprout for everyone who participated in the programme and told them to prepare and give their children this nutritive food.

We sat back contented because we enquired with the people and found out that they understood the signs and symptoms and the urgency of diagnosing and starting the treatment earlier. So we were happy with the thought –'They shall bring forth fruits!'

Sr. Dr. Conrad Mary,
Holy Family Hansenuriur,
Fatima Nagar,
Trichy

Lighter moments

Jokes

Side effects of alcohol.... and remedies!!!

Symptom: Cold and humid feet.

Cause- Glass is being held at incorrect angle (You are pouring the Drink on your feet).

Cure: Adjust glass until open end is facing upward.

Symptom: The wall facing you is full of lights.

Cause: You're lying on the floor.

Cure: Position your body at a 90-degree angle to the floor.

Symptom: The floor looks blurry.

Cause: You're looking through an empty glass.

Cure: Quickly refill your glass!

Symptom: The floor is moving.

Cause: You're being dragged away.

Cure: At least ask where they're taking you!

Symptom: You hear echoes every time someone speaks.

Cause: You have your empty glass on your ear and trying to drink from it.

Cure: Stop making a fool of yourself, refill your glass and place it on your mouth.

Symptom: Your dad and all your brothers are looking funny.

Cause: You're in the wrong house.

Cure -Ask if they can point you to your house.

Symptom: The room is shaking a lot, everyone is dressed in white and the music is very loud and repetitive.

Cause: You're in an ambulance.

Cure - Don't move. Let the professionals do their job!!!!

A guy asked a girl in a library; “Do you mind if I sit beside you”?

The girl answered with a loud voice; "I DON'T WANT TO SPEND THE NIGHT WITH YOUUU!!!”.

All the students in the library started staring at the guy and he was embarrassed. After a couple of minutes, the girl walked quietly to the guy's table and she told him “I study psychology and I know what a man is thinking, I guess you felt embarrassed right?"

The guy responded with a loud voice: "$200 JUST FOR ONE NIGHT!!!? THAT'S TOO MUCH!!!" ...and all the people in the library looked at the girl in shock and the guy whispered in her ears; “I study Law and I know how to make someone feel guilty"

Life of a Medical Student

1st day of college- mania

Hostel food- dysphagia

Lecture hall- ptosis

Cultural- nystagmus

Seminars- palpitations

CATs- migraine

Study hall- insomnia

Exam hall- amnesia

Viva- aphasia

Day before university exam - depression

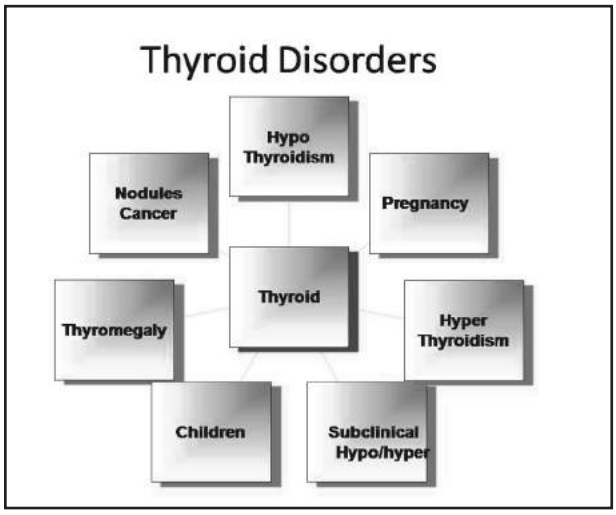
Results – coma

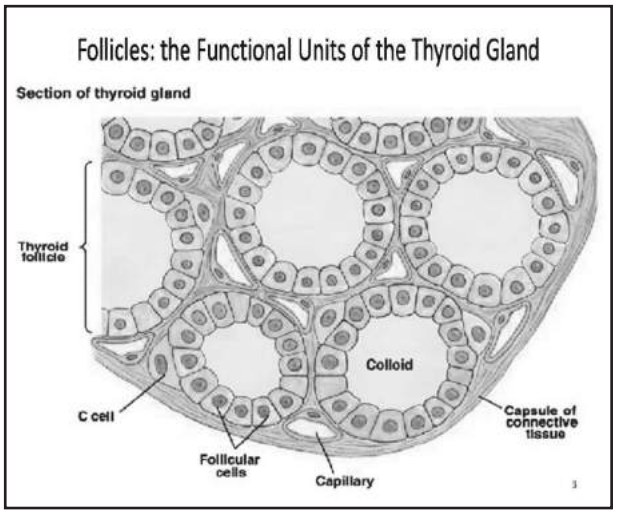
Sr. Dr. Annie JMJ

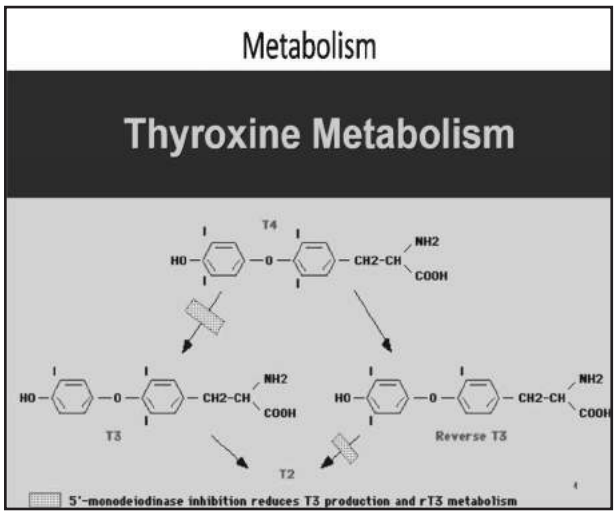
Andhra Pradesh.

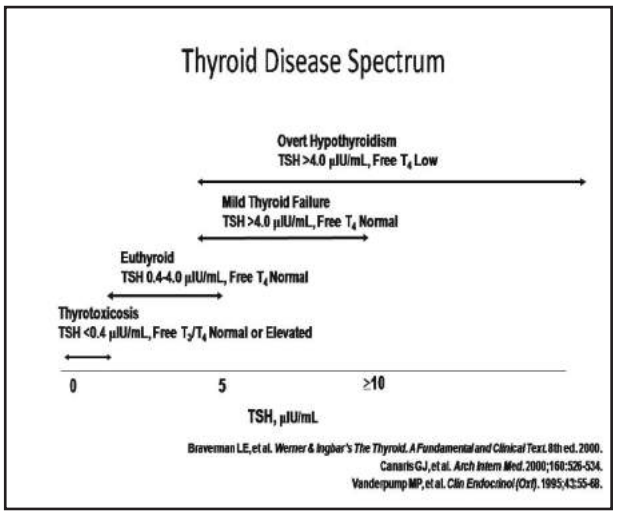
Thyroid disorders

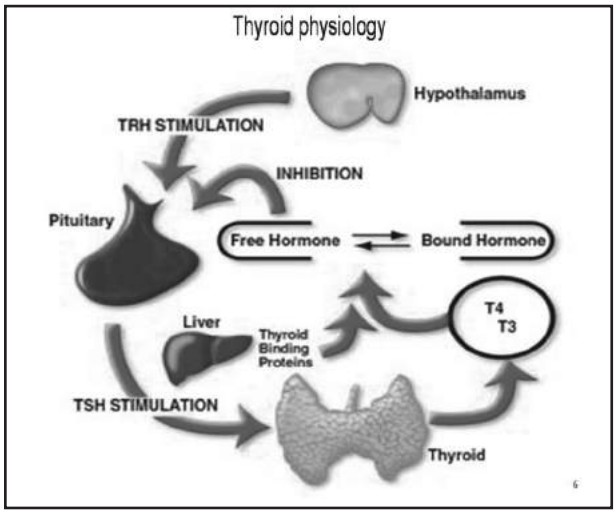
Dr. Bhuma Srinivasan
(AB) Endocrinology,
Metabolism and Nutrition

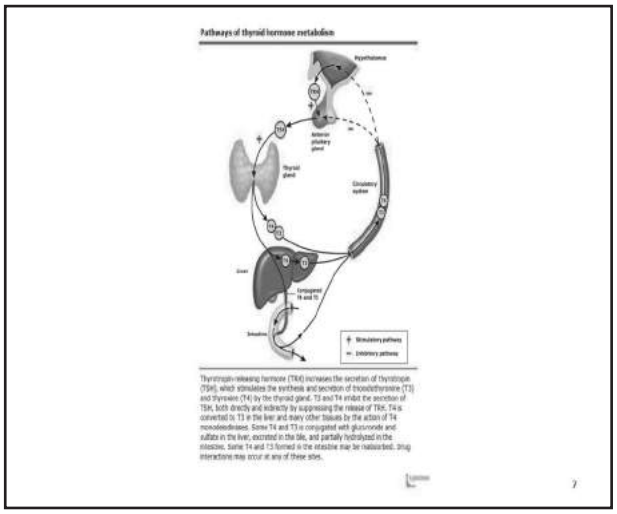


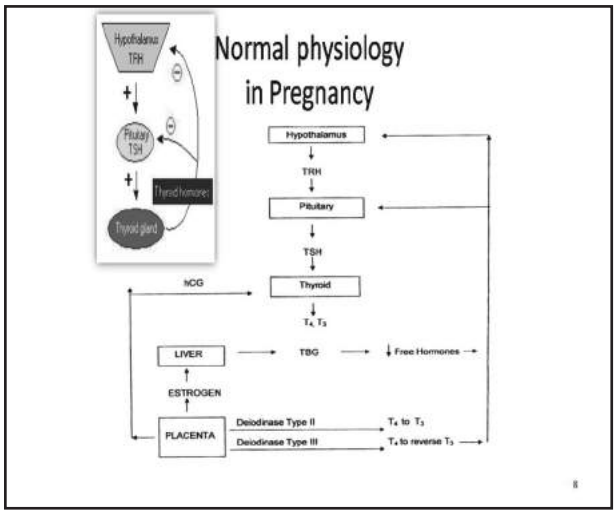






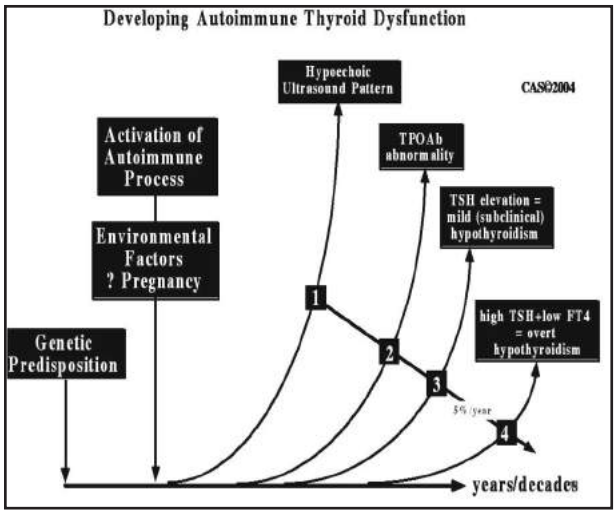






Thyroid disorders

- Hypothyroidism
- Hyperthyroidism
- Thyroid nodule
- Thyroid cancer



Epidemiology

- In community surveys,
- Prevalence of overt hypothyroidism varies from 0.1 to 2 percent
- Prevalence of subclinical hypothyroidism is higher - 4 to 10 percent of adults
- Higher frequency in elderly women
- Age-related shift towards higher TSH concentrations in older patients
- Hypothyroidism is five to eight times more common in women than men

Case 1

- 60 year old female presents with tiredness, weight gain, constipation and inability to do her usual work like before. She has some joint pains and muscle aches at times.
- TSH is 22 and Free T4 is 0.65 (o.8 – 2.0)
- Diagnosis - ?
- Primary Hypothyroidism

12

Case 2

- 32 year old female attempting to conceive, has had 2 miscarriages in the past. She feels uncomfortable when the A/C is on at work, also has intermittent constipation.
-
- She is 75 kg, dryness of the skin is present. On exam, has a mild diffuse goitre.
- Reasons for suspecting hypothyroidism?

13

Case 3

- 45 year old female with history of inability to lose weight, feeling tired and excessive hair loss. She has noticed her periods to be irregular and heavy lately. Her aunt and sister have thyroid problem. She is currently on cholesterol medicine only.
- How to approach this patient?
- Look for signs - Goitre, vitiligo, alopecia
- Investigations? TFT's, Complete hemogram

14

Case 4

- 36 year old young male, IT professional comes with excessive weight gain recently. Has been working long hours and thinks has been sleeping more than usual due to tiredness. He has carpal tunnel syndrome. Overall feels less energy, has some joint pains and depressed about not feeling normal at all. His BP - 150/100.
- What tests would you get?
- TFT's, FBS, Lipid profile

15

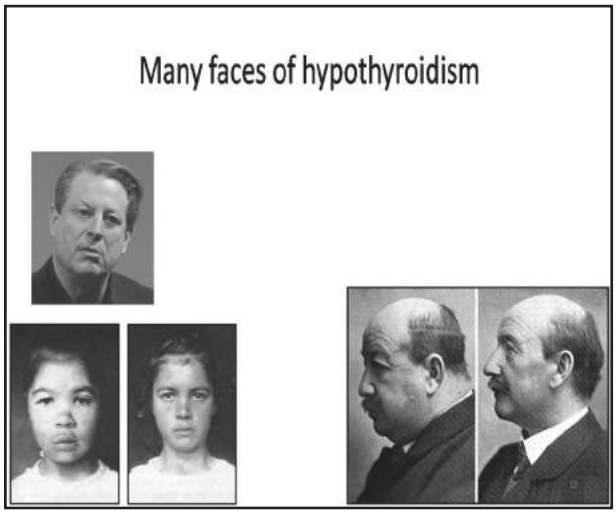
Case 5

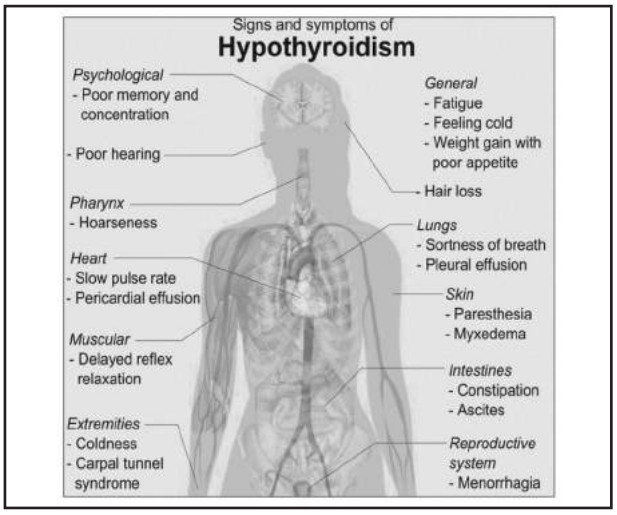
- 52 year old female with history of hypothyroidism for 1 year treated with thyroxine but now stopped meds for 4 months.
- Now she has increasing tiredness, loss of apetite and has lost 5 kg. Menopause 3 years ago.
- Her physician checked TFT's. TSH 4.2, Free T4 0.3(low).
- Diagnosis – Hypothyroidism ?
- Any other tests?

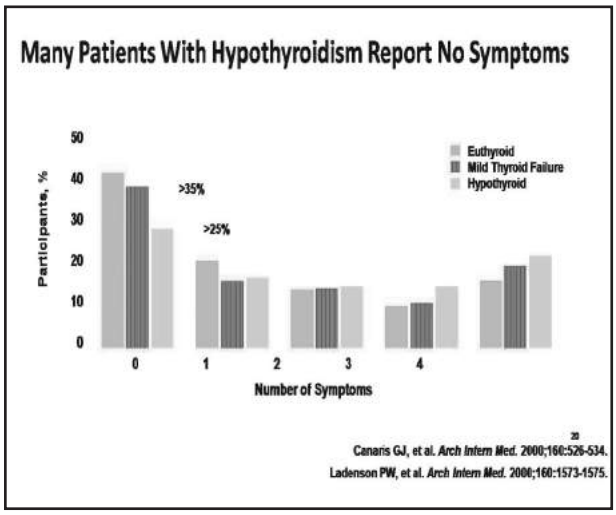
16

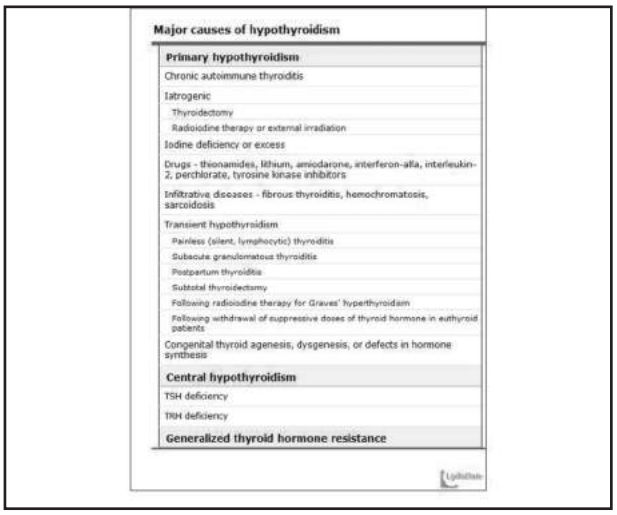
Major symptoms and signs of hypothyroidism

Mechanism	Symptoms	Signs
Slowing of metabolic processes	Fatigue and weakness Cold intolerance Dyspnea on exertion Weight gain Cognitive dysfunction Mental retardation (infant) Constipation Growth failure	Slow movement and slow speech Delayed relaxation of tendon reflexes Bradycardia Carotenemia
Accumulation of matrix substances	Dry skin Hoarseness Edema	Coarse skin Puffy facies and loss of eyebrows Periorbital edema Enlargement of the tongue
Other	Decreased hearing Myalgia and paresthesia Depression Menorrhagia Arthralgia Pubertal delay	Diastolic hypertension Pleural and pericardial effusions Ascites Galactorrhea









Major causes of hypothyroidism

Primary hypothyroidism
Chronic autoimmune thyroiditis
Iatrogenic
Thyroidectomy
Radioiodine therapy or external irradiation
Iodine deficiency or excess
Drugs - thionamides, lithium, amiodarone, interferon-alfa, interleukin-2, perchlorate, tyrosine kinase inhibitors
Infiltrative diseases - fibrous thyroiditis, hemochromatosis, sarcoidosis
Transient hypothyroidism
Painless (silent, lymphocytic) thyroiditis
Subacute granulomatous thyroiditis
Postpartum thyroiditis
Subtotal thyroidectomy
Following radioiodine therapy for Graves' hyperthyroidism
Following withdrawal of suppressive doses of thyroid hormone in euthyroid patients
Congenital thyroid agenesis, dysgenesis, or defects in hormone synthesis
Central hypothyroidism
TSH deficiency
TRH deficiency
Generalized thyroid hormone resistance

Indications to test for hypothyroidism

Clinical symptoms and signs	Personal or family history of associated autoimmune disorders (eg, vitiligo, pernicious anaemia, adrenal insufficiency, diabetes mellitus type 1, ovarian failure, coeliac disease, Sjogren's syndrome)
Fatigue	Primary pulmonary hypertension
Cold intolerance	Multiple Sclerosis
Constipation	**Previous thyroid injury**
Impaired memory	Thyroidectomy or other neck surgery
Slowed mental processing	Radioactive iodine therapy
Depression	External radiotherapy
Nerve entrapment syndromes	Exposure to polybrominated and polychlorinated biphenyls, and resorcinol
Ataxia	**Postpartum status**
Muscle weakness	**Drugs impairing thyroid function**
Muscle cramps	Lithium carbonate
Menstrual disturbance	Amiodarone
Infertility	Aminoglutethimide
Bradycardia	Interferon α
Diastolic hypertension	Thalidomide
Hoarseness	Betarexone
Goitre	Stavudine
Periorbital oedema	**Hypothalamic disorders**
Weight gain	Hypothalamic or suprasellar mass
Galactorrhoea	History of hypothalamic radiotherapy or surgery
Laboratory test abnormalities	Disorders causing hypothalamic dysfunction—eg, sarcoidosis, haemochromatosis, Langerhans' cell histiocytosis
Hypercholesterolaemia	**Pituitary disorders**
Hyponatraemia	Known pituitary tumour
Hyperprolactinaemia	Other elements of hypopituitarism
Hyperhomocysteinaemia	Manifestations of a solar mass (eg, headache, bitemporal hemianopsia, or diplopia)
Anaemia	History of pituitary surgery or radiotherapy
Creatine phosphokinase elevation	History of head trauma
Radiological abnormalities	History of pituitary apoplexy, including Sheehan's syndrome
Pericardial and pleural effusions	History of other disorders causing hypopituitarism—eg, metastatic cancer and lymphocytic hypophysitis
Pituitary gland enlargement	
Risk factors for hypothyroidism	
Autoimmune thyroiditis	
Established serological or tissue diagnosis	
Diffuse goitre	
Previous Graves' disease, de Quervain's thyroiditis, or painless (postpartum) thyroiditis	
Family history of autoimmune thyroid disease	
Down's syndrome	
Turner's syndrome	

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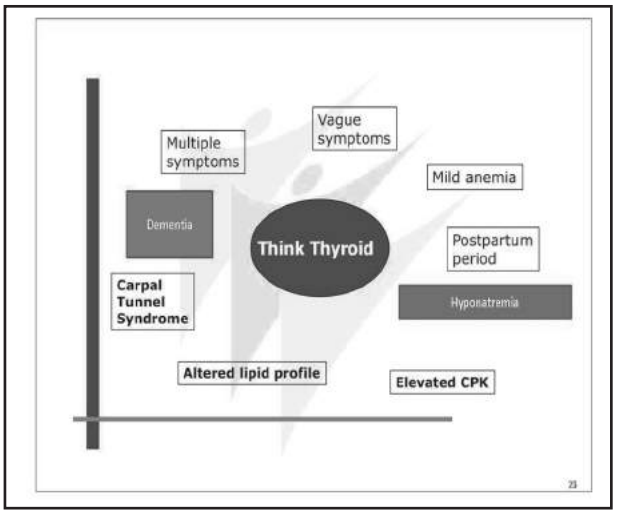
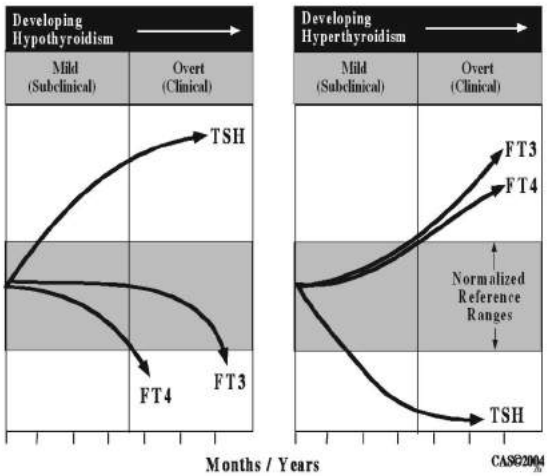


Indications to check thyroid tests

- Symptoms - hypothyroidism
- Goitre
- Infertility
- Pregnancy
- postpartum
- Hypercholesterolemia
- Thyroid surgery or treatment
- Children if symptoms or signs

Investigations

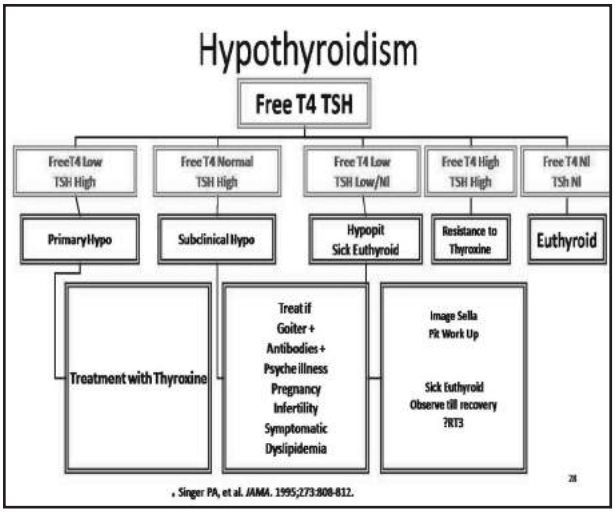
- TSH
- Total T4
- Total T3
- Free T4
- Free T3
- TPO antibodies



Patterns of thyroid function tests during assessment assessment of thyroid function

Serum TSH	Serum Free T4	Serum T3	Assessment
Normal hypothalamic-pituitary function			
Normal	Normal	Normal	Euthyroid
Normal	Normal or high	Normal or high	Euthyroid hyperthyroxinemia
Normal	Normal or low	Normal or low	Euthyroid hypothyroxinema
Normal	Low	Normal or high	Euthyroid: triiodothyronine therapy
Normal	Low normal or low	Normal or high	Euthyroid: thyroid extract therapy
High	Low	Normal or low	Primary hypothyroidism
High	Normal	Normal	Subclinical hypothyroidism
Low	High or normal	High	Hyperthyroidism
Low	Normal	Normal	Subclinical hyperthyroidism
Abnormal hypothalamic-pituitary function			
Normal or high	High	High	TSH-mediated hyperthyroidism
Normal or low**	Low or low-normal	Low or normal	Central hypothyroidism

** In central hypothyroidism, serum TSH may be low, normal or slightly high.



Primary hypothyroidism

- Overt Hypothyroidism
  High TSH and low Free T4

- Subclinical hypothyroidism
  High serum TSH, normal serum free T4

Central hypothyroidism

Serum free T4 value is low-normal or low
Serum TSH may be frankly low
Inappropriately normal
Slightly high (5 to 10 mU/L)

Is TSH testing enough?

- TSH is the most sensitive test for detecting primary hypothyroidism in ambulatory patients
- Testing may pose difficulties in hospitalized patients

30

TPO Antibodies

- Serum concentrations of thyroid peroxidase autoantibodies are elevated in more than 90 percent of patients
- Routine measurement not needed
- In patients with goiter, especially in the absence of hypothyroidism, to identify immunologically mediated goiter
- Useful to predict the likelihood of progression to permanent overt hypothyroidism in patients with subclinical hypothyroidism
- Painless (silent) thyroiditis or postpartum thyroiditis

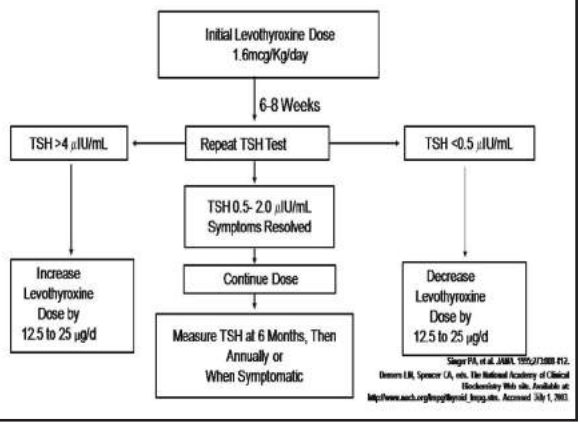
31

Hypothyroidism

- TSH
- Free T4
- TPO antibodies
- Ultrasound?

32

Primary Hypothyroidism Treatment Algorithm



Thyroxine Treatment

- Empty stomach
- Food interference
- Other medications
- Fe, Antacids, Calcium etc.
- Compliance
- Close monitoring needed
- Children, Pregnant women

34

Overreplacement

- Overreplacement with T4 should be discouraged
  Subclinical hyperthyroidism or overt hyperthyroidism
- Atrial fibrillation three times more often in older patients with serum TSH concentrations <0.1mU/L
- In postmenopausal women - accelerated bone loss
- The risks associated with overreplacement of thyroid hormone are greatest in those with the most suppressed TSH concentrations

35

Special situations

- Pregnancy
- Infertility
- Children
- Cardiac patients
- Postmenopausal women

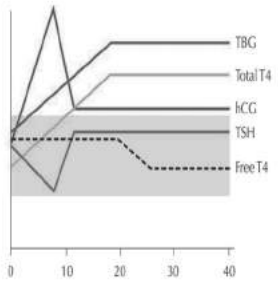
Do you need to treat subclinical hypothyroidism

- 3-8 % of individuals have subclinical thyroid disease
- Most common cause is autoimmune thyroid disease
- 4.3 % progress to hypothyroidism is anti TPO antibody present
- Therapy indicated if
  1. **TSH > 10 mU/ml**
  2. **Anti TPO positive**
  3. **Goiter present**
  4. **Menstrual irregularities/ infertility**
  5. **Childhood**
  6. **Bipolar disease/ depression**
  7. **Increasing TSH**

Case 6

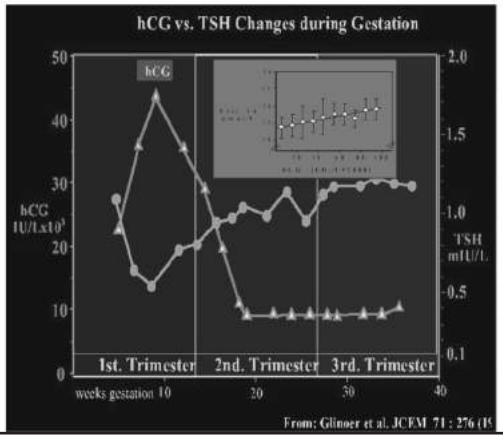
- 26 year old female now 6 weeks pregnant comes with thyroid test reports. TSH 0.1, FT4 1.09. She has some nausea but no other symptoms. There is no family history of thyroid disease.
- On exam, she has very mild goiter. HR – 80/min reg, BP 110/80.
- Diagnosis?
- HCG effect.

Thyroid hormone levels during pregnancy



Changes in serum concentrations of thyroid function studies and hCG according to gestational age. The shaded area represents the normal range of thyroid-binding globulin, total thyroxine, thyroid-stimulating hormone or free T4 in the nonpregnant woman.TBG, thyroid-binding globulin; T4, thyroxine; TSH, thyroid-stimulating hormone.

hCG vs TSH during Gestation



EFFECTS OF PREGNANCY ON THYROID PHYSIOLOGY

Physiologic Change	Thyroid-Related Consequences
↑ Serum thyroxine-binding globulin	↑ Total T_4 and T_3; ↑ T_4 production
↑ Plasma volume	↑ T_4 and T_3 pool size; ↑ T_4 production; ↑ cardiac output
D3 expression in placenta and (?) uterus	↑ T_4 production
First trimester ↑ in hCG	↑ Free T_4; ↓ basal thyrotropin; ↑ T_4 production
↑ Renal I⁻ clearance	↑ Iodine requirements
↑ T_4 production; fetal T_4 synthesis during second and third trimesters	
↑ Oxygen consumption by fetoplacental unit, gravid uterus, and mother	↑ Basal metabolic rate; ↑ cardiac output

HYPOTHYROIDISM IN PREGNANCY

- Elevated serum TSH concentration: 2.5% of pregnancies
- In iodine-sufficient environment
  - –Hashimoto's thyroiditis
  - –Prior radioactive iodine treatment
  - –Surgical ablation of Graves' disease
  - –Less common causes: overtreatment of hyperthyroidism with thionamides, transient hypothyroidism owing to postpartum thyroiditis, medications that alter the absorption or metabolism of levothyroxine, and pituitary/hypothalamic disease)

Clinical / Subclinical Hypothyroidism

- Serum TSH level > 3.0 mIU/l
- Subclinical hypothyroidism → elevated TSH with normal FT4, FT3.

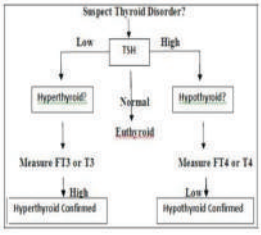
	Clinical Hypothyroidism	Subclinical Hypothyroidism
TSH	High (>10)	High (>3 - <10)
Free T4	Low	Normal
Free T3	Normal or low	Normal

Hypothyroidism – Mother & Fetus

- Some of the same problems caused by hyperthyroidism can occur with hypothyroidism.
- Uncontrolled hypothyroidism during pregnancy can lead to
  - – Preeclampsia
  - – Anemia—too few red blood cells in the body, which prevents the body from getting enough oxygen
  - – Miscarriage
  - – Low birth weight
  - – Stillbirth
  - – Congestive heart failure, rarely

Laboratory Workup

- Overt hypothyroidism:
  - *symptomatic patient*
  - *elevated TSH level*
  - *low levels of FT_4 and FT_3*
- Subclinical hypothyroidism:
  - *asymptomatic patient*
  - *elevated TSH*
  - *normal FT_4 and FT_3*



Screening for Thyroid Dysfunction during Pregnancy

1. Women with a history of hyperthyroid or hypothyroid disease, PPT, or thyroid lobectomy.
2. Women with a family history of thyroid disease.
3. Women with a goiter.
4. Women with thyroid antibodies (when known).
5. Women with symptoms or clinical signs suggestive of thyroid underfunction or overfunction, including anemia, elevated cholesterol, and hyponatremia.
6. Women with type I diabetes.
7. Women with other autoimmune disorders.
8. Women with infertility who should have screening with TSH as part of their infertility work-up.
9. Women with previous therapeutic head or neck irradiation.
10. Women with a history of miscarriage or preterm delivery. USPSTF recommendation level is B; evidence is fair (GRADE II ⊕⊕○○).

The Endocrine Society's CLINICAL GUIDELINES

Management of Thyroid Dysfunction during Pregnancy and Postpartum:
An Endocrine Society Clinical Practice Guideline

THE ENDOCRINE SOCIETY | JCEM JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM

RECOMMENDATIONS

Hypothyroidism and Pregnancy: Maternal and Fetal Aspects

1.1.1. Both maternal and fetal hypothyroidism are known to have serious adverse effects on the fetus. Therefore maternal hypothyroidism should be avoided. USPSTF recommendation level is A; evidence is fair (GRADE 1| ⊕⊕⊕◯). Targeted case finding is recommended at the first prenatal visit or at diagnosis of pregnancy (see Section 8, Screening for thyroid dysfunction during pregnancy). USPSTF recommendation level is B; evidence is fair (GRADE 2| ⊕⊕◯◯).

1.1.2. If hypothyroidism has been diagnosed before pregnancy, we recommend adjustment of the preconception thyroxine dose to reach a TSH level not higher than 2.5 μU/mL prior to pregnancy. (USPSTF Recommendation level: I; Evidence-poor). (GRADE 1| ⊕◯◯◯)

1.1.3. The T_4 dose usually needs to be incremented by 4-6 wk gestation and may require a 30-50% increase in dosage. USPSTF recommendation level is A; evidence is good (GRADE 1| ⊕⊕⊕⊕).

1.1.4. If overt hypothyroidism is diagnosed during pregnancy, thyroid function tests (TFTs) should be normalized as rapidly as possible. Thyroxine dosage should be titrated to rapidly reach and thereafter maintain serum TSH concentrations of less than 2.5 μU/mL in the first trimester (or 3 μU/mL in the second and third trimester) or to trimester-specific normal TSH ranges. Thyroid function tests should be remeasured within 30-40 days. (USPSTF Recommendation level: A, Evidence-good) (GRADE 1| ⊕⊕⊕⊕)

1.1.5. Women with thyroid autoimmunity who are euthyroid in the early stages of pregnancy are at risk of developing hypothyroidism and should be monitored for elevation of TSH above the normal range. (USPSTF Recommendation level: A, Evidence-good) (GRADE 1| ⊕⊕⊕◯)

1.1.6. Subclinical hypothyroidism (serum TSH concentration above the upper limit of the reference range with a normal free T_4) has been shown to be associated with an adverse outcome for both the mother and offspring. T_4 treatment has been shown to improve obstetrical outcome but has not been proved to modify long-term neurological development in the offspring. However, given that the potential benefits outweigh the potential risks, the panel recommends T_4 replacement in women with subclinical hypothyroidism. For obstetrical outcome, USPSTF recommendation level is B; evidence is fair (GRADE 1| ⊕⊕◯◯). For neurological outcome, USPSTF recommendation level is I; evidence is poor ◯◯◯◯

1.1.7. After delivery, most hypothyroid women need a decrease in the thyroxine dosage they received during pregnancy. (USPSTF Recommendation level: A, Evidence-good) (GRADE 1| ⊕⊕⊕⊕)

Pregnancy Hypothyroidism

- The goal of treatment
- Maintain the mother's serum TSH in the trimester-specific reference range
- 0.1 to 2.5 mU/L – First Trimester
- 0.2 to 3 mU/L – Second Trimester
- 0.3 to 3 mU/L - Third trimester

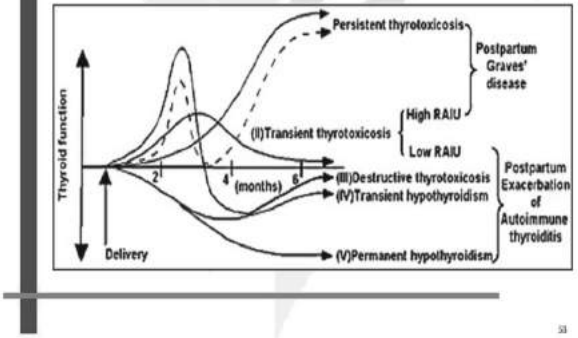
Women with preexisting hypothyroidism who become pregnant need more T4 during pregnancy

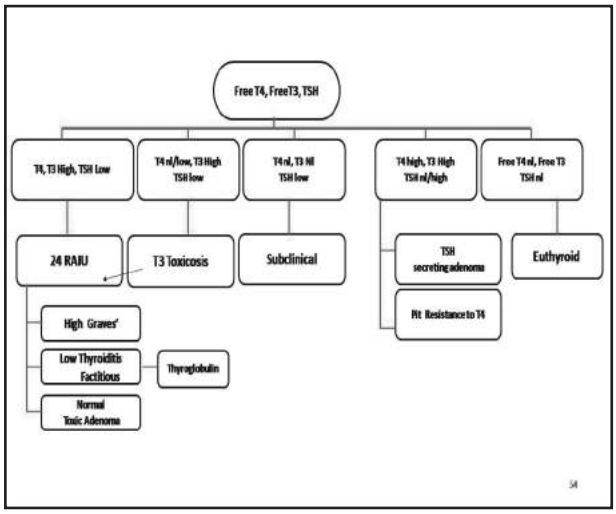
Dose requirements may increase by as much as 50 percent during pregnancy, and the increase occurs as early as the fifth week of gestation

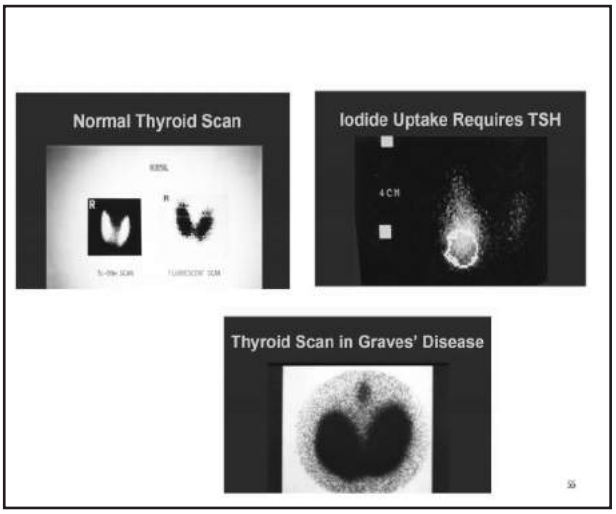
Postpartum Thyroiditis

- ☐Affects 3-10% % of women
- ☐Painless thyroiditis
- ☐Initial hyper phase 1-3 months followed by euthyroid , then hypo.
- ☐Hypothyroidism permanent in 30% of women
- ☐Tends to recur in 25% of subsequent pregnancies
- ☐Post partum depression may be a feature of postpartum thyroiditis.

Postpartum thyroiditis
Clinical course







Management of Thyrotoxicosis

- Graves': RAI or MMI or Surgery
- Thyroiditis: Observe, NSAIDS, Beta blockers, Steroids
- Toxic nodule: RAI or MMI or surgery
- Toxic MNG: RAI or MMI or surgery
- Pit tumor: Surgery / radiation/Octreotide
- Subclinical: Observe or Treat

Management of thyrotoxicosis

- Which Thionamide? MMI safer, quicker, less effect on RAI Rx
- How long? 18-24 months
- How to predict remission? Smaller goiters, women,
- How much? 15-30 mg/day, gradually decrease
- Watch/warn for agranulocytosis.
- No evidence for recommending Block replacement therapy

Pregnancy

- Hyperthyroidism: Pregnancy has calming effect. PTU is preferred. Keep mom mildly hyper. Antithyroid drugs cross the placenta. Iodine is absolutely contraindicated. Surgery in the second trimester
- Fetal surveillance for growth, tachycardia, premature closure of the sutures, fetal goiter.
- Newborn thyroid testing mandatory. Identifies hypo early.
- Newborn hyper may be transient due to TSI or permanant due to Graves'

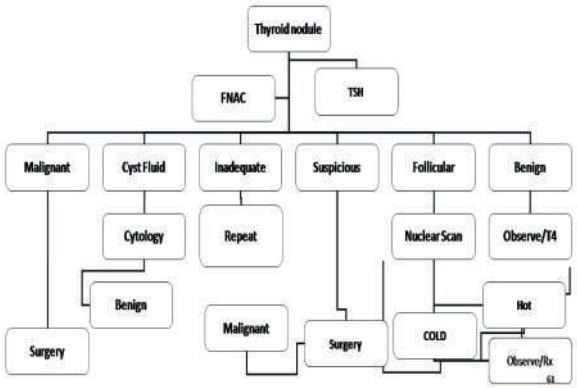
Thyrotoxicosis

	Surgery	MMI/PTU	RAI
Indications	Second trimester of pregnancy Children Coexisting malignancy	Preparation for RAI Children Pregnancy Elderly Preparation for Surgery Storm	Adults Children
Contraindications	Early pregnancy	Agranulocytosis Allergies	Pregnancy Unstable eye disease

Thyroid Nodule

- Is it cancer?
- Is nodule toxic?
- Is patient hypothyroid?
- Is surgery needed?
- Observe or treat with Thyroxine?
- Should we rebiopsy?
- Blind or ultrasound guided?

Thyroid Nodule



- Thyroid disorders are common
- Appropriate tests to be done
- Treatment and regular follow-up
- Special situations – pregnancy, children, cardiac patients

RIGHT TO HEALTH AS A HUMAN RIGHT

Introduction

The right to health is the economic, social and cultural right to a universal minimum standard of health to which all individuals are entitled. The concept of a right to health has been enumerated in international agreements which include the , International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities. However, there remains some international variation in the interpretation and application of the right to health due to considerations such as how health is defined, what minimum entitlements are encompassed in a right to health, and which institutions are responsible for ensuring a right to health.

The preamble of the 1946 World Health Organization (WHO) Constitution defines health broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] The Constitution defines the right to health as "the enjoyment of the highest attainable standard of health," and enumerates some principles of this right as healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.

Right to Health and Indian Constitution: -

The Constitution of India also has provisions regarding the right to health. They are outlined the Directive Principles of State Policy- Articles 42 and 47, outlined in Chapter IV, and are therefore non-justifiable.

Article 42

“Provision for just and humane conditions of work and maternity relief- The State shall make provision for securing just and humane conditions of work and for maternity relief”

Article 47

“Duty of the State to raise the level of nutrition and the standard of living and to improve public health- The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health” [2]

The above articles act as guidelines that the State must pursue towards achieving certain standards of living for its citizens'. It also shows clearly the understanding of the State that nutrition, conditions of work and maternity benefit as being integral to health.

The Indian judiciary has interpreted the right to health in many ways. Through public interest litigation as well as litigation arising out of claims that individuals have made on the State, with respect to health services etc. As a result there is substantial case law in India, which shows the gamut of issues that are related to health.

The right to health, like all human rights, imposes on States Parties three types of obligations.

Respect: This means simply not to interfere with the enjoyment of the right to health ("do no harm").

Protect: This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health (e.g. by regulating non-state actors).

Fulfill: This means taking positive steps to realize the right to health (e.g. by adopting appropriate legislation, policies or budgetary measures).

According to the General Comment, the right to health also has a "core content" referring to the minimum essential level of the right. Although this level cannot be determined in abstract, as it is a national task, key elements are set out to guide the priority setting process.

According to the General Comment, the right to health also has a "core content" referring to the minimum essential level of the right. Although this level cannot be determined in abstract, as it is a national task, key elements are set out to guide the priority setting process.

Included in the core content are:

- essential primary health care
- minimum essential and nutritious food
- sanitation
- safe and potable water
- essential drugs.
- critique

Some scholars have questioned or criticized the concept of a right to health. Philip Barlow writes that health care should not be considered a human right because of the difficulty of defining what it entails and where the 'minimum standard' of entitlements under the right ought to be established. Additionally, Barlow contends that rights establish duties upon others to protect or guarantee them, and that it is unclear who holds the social responsibility for the right to health. [3] John Berkeley, in agreement with Barlow, critiques further that the right to health does not consider adequately the responsibility that an individual has to uphold his or her own health. [4]

Another criticism of the right to health is that it is not feasible. Imre J.P. Loefler argues that the financial and logistical burdens of ensuring health care for all are unattainable, and that resource constraints make it unrealistic to justify a right towards prolonging life indefinitely. Instead, Loefler suggests that the goal of improving population health is better served through socioeconomic policy than a formal right to health. [5]

Conclusion

Our constitution makers were much aware about the public health or right to health that's why they imposed liability on State by some provision (Article 38, 39(e) 41, 42, 47, 48A) of Directive Principles of State Policy (DPSP). Constitution makers included public health in form of DPSP because they were well-known about it that only inclusion of right to health as fundamental right will have only right but it will not ensure medical facilities.

If right to health is included as a fundamental right then what would happen it is clear that State could protect itself by arguing that who is going to take away your right. For example if any person affected by tuberculosis defended for his right to health as a fundamental right, then State could argue that go and be healthy as tuberculosis is not caused to you by State. Thus, right to health as fundamental right cannot give remedy to ill person. For treatment of tuberculosis there are so many requirements i.e. hospital, doctor, medicine. So constitution makers included it in DPSP to impose duty on the State so that State will protect and improve public health.

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Srinagar – in FLOODS

7th September, 2014 was a black day for Jammu and Kashmir. For it was on that day the most beautiful city Srinagar, in the valley of Kashmir was inundated with floods and in a matter of few minutes the water rose up to 24 feet high reaching the second floor, or the roof tops. The gush of water was so sudden, people did not have any time to collect their precious belongings but to run out to save their life. They witnessed with their own eyes, their properties carried out of their homes and someone else's belongings floating into their houses. Till date no one is able to say from where the water gushed into the city and villages filling the mountains and valleys, the lakes and rivers. After 10 days or so the water in Jhelum River has receded but the streets and lanes were filled with stagnant water emitting bad odour and fear of breaking forth epidemics. Srinagar was cut off from the world geographically and there was no communication or electricity.

CARITAS was already on the site engaged in relief services. We had a call from CHAI and SDFI to form medical camp in order to work on preventive measures to save the victims from many epidemics. There was an urgent call from our own sister Sr.Dr.Placida from Baramulla to give a helping hand in forming the medical camp since she found not many NGO's in the affected places offering medical care for the people. That is how Sr.Ursula and I rushed to the spot, preparing ourselves within 2 days and reached Srinagar on the 26th September, 2014. Though 20 days have passed after the event, I found Srinagar devoid of all its beauty and glory; it was only stink and dirt.

I have seen Srinagar in 1980's in all its glory and beauty, crowded with tourists, couples and lovers strolling along the by ways, lakes, meadows and mountains. That was the peace time! Then in 1990's I have witnessed Srinagar filled with militants, military jawans, CRPF and Police, and that is the time of militancy. But on the 26th September, 2014, I was shocked to see the capital all devastated, hardly anyone walking on the road. There was a deserted look all around, only the main roads were free of water, but all the lanes and streets had 4-5 feet of stagnant water with stink and dirt. We saw the houses floating in water and people using small boats for their transport from one lane to the other. There were few tents along the road side with medical aid.

Witnessing such horrible scene in front of us, the very next day we formed a medical team consisted of 2 doctors, 2 nurses, 3 nursing students, a social worker and a driver. Sr. Dr. Placida the Superior and Medical Superintendent of St. Joseph's Hospital, Baramulla hosted the medical team, in her generosity she and her community in Baramulla made all the conveniences and provided all that was necessary for the mobile team to function. Overnight we planned and got ready to serve the suffering victims in Bemena, close to Srinagar, which was still affected with stagnant waters around their houses. They used ladders to go on the roof of one house and then another ladder to get into their house – on the first floor because the ground floor of the houses were still under water.

As soon as we arrived at Bemena, 2 ladies asked us whether we brought medicines. On hearing that we are going to be with them that day to give them medical care, within 5 minutes crowds of people came to us with their ailments. We settled ourselves in a tent which was available in the premises and started our work. There was nonstop pouring in of patients; women, men and children. As 2 doctors were seeing the patients inside the tent, the 2 nurses and students dispensed the medicines from the ambulance itself. The social worker along with the driver helped in keeping order, so that all the patients could be attended to without interruption and difficulty. The long day ended at 06:00 Pm and we returned to Baramulla at 08:00 Pm. Physically we were tired and exhausted but our spirit was fresh and alive to help the needy.

Though I had previous experience of working in the disaster hit areas like floods in Velanganni, Earth Quake in Gujarat, Tsunami in Nagapatinam and Earth Quake in Kashmir, all the time we worked with caritas – CHAI and SDFI –but this is the first time we found ourselves all by ourselves as FMM to face the disaster management and medical camp. When we worked with other Agencies we need to give only our services. But now we had to see to the planning, finance personnel and medicine etc., though it was a great challenge, with the help of our FMM family and the positive nature of Sr. Dr. Placi and full support of Baramulla FMM community we were able to continue our medical aid for the victims for the whole of October 2014.

With the help of a volunteer George and block medical officer we spotted the areas where the people are most hit by the floods and where other NGO's have not reached. Likewise within the short time of 35 days we were able to reach out to Srinagar, Pambur, Nowgan Sopore, Bandipora, Baramulla and Boniyar districts. We extended our medical care to all victims of flood with no distinction of rich, poor, caste or creed. Since three big hospitals of Srinagar were under water people were badly in need of medical camp.

We attended to 300 – 400 patients in a day; they were mostly suffering from body pain, injuries, respiratory infection, skin infections, fungal infections, gastro–enteritis and depression. We were also supplying chlorine tablets to purify water and dettol soaps, all the while instructing them about Hygiene. As the winter was fast setting in, it was heart – breaking to see the victims who are still living in tents, broken houses and on the second floor without having proper warm clothing for the winter. CRS has now reached Baramulla after having taken survey in Bandipora district to supply house hold materials for 1000 houses.

It is a long way to reinstate the valley of Kashmir from their loss of property and houses. May the Good Lord protect them and heal them. I am sure our visits with medical camps to various interior villages will pave way to St. Joseph's Hospital and school of Nursing in Baramulla to choose few villages to continue their extension medical work and promote Health to the people.

Sr. Dr. Emily Susai. FMM

Avinashi .

A TRIBUTE TO SR. DR. A ROSA BASANI

Sr. Dr. A Rosa Basani was taken away from our midst on 22-05-2014 at 12:30 P.M. to her eternal reward. She was active & fully working till one month before her death. Her absence made a great emptiness and vacuum for all her patients, relatives and above all to St. Joseph's Hospital and to me as she was a great moral support. She was a mentor, guide and a spiritual director for me.

Sr. Dr. A. Rosa Basani a blessing to the family and a boon to the society. She was born on 6th September, 1933 in Siripuram, Guntur Dist. as the fourth child of her beloved parents Mr. Showreddy and Mrs. Sujanamma. She did her elementary studies in phirangipuram and from 6th to 10th class with St. Joseph's School, Guntur run by J.M.J. Sisters. It was there that God intervened in her life through the Dutch sisters who encouraged her to become a J.M.J. Sister. With great enthusiasm and eagerness she entered the Society of J.M.J. on 15th July 1953. She made her first commitment on 28th June, 1956. She did her medical studies in Neimegan University in Netherlands .

She is a Gem charming personality of JMJ and ripped in medical experience and spiritual life. She is very simple, ascetic, disciplined, prayerful, punctual, faithful servant of God, deeply rooted in faith. Her motto was to work for the greater glory of God.

Commitment is the realistic value she practiced and dedication is the hallmark of her personality. She spent all her available time with the Lord in prayer. Though she had health problem from long time, she kept on working without complaining, making herself fit to render her service to the needy. She was giving herself till the last moment. She loved to work.

She was always modest and dignified. She presents herself as an ideal JMJ to the public. She lived an exemplary life in the community, upholding and challenging when needed. Her deep love and gratitude towards the society is praiseworthy. She urges every member to love the work, and do it with

much dedication. Her interest in the development of the institution was ever laudable. Her service in blood bank as medical officer is remarkable. She pays keen interest in the well being of each sister, their families and co-workers. She encourages and appreciates the good work done. It is very pleasant to work with her and her presence in the community is an encouraging factor.

She always tells the youngsters to be available to do any hard work for the glory of God trusting and respecting each other in the Society. Be cordial with the public, kind to the poor and cultivate good friendship with the co-workers. She was awarded and honoured by various departments like Rotary Club, Health club, lions club, Central Government and recently from state Govt. by Former Chief Minister Mr. Kiran Kumar Reddy for her dedicated services.

In short,

Simplicity was her life style,

Prayer was her armor,

Love was her energy,

Commitment was her achievement,

Conviction was her satisfaction,

Hard work was her revenue,

Reading was her knowledge Bank.

May your noble soul Rest in Peace.

Sr. Dr. Annie P.A.

St. Joseph's General Hospital,

GUNTUR.

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