News Letter

Sister Doctors Forum of India

GROWING OLD GRACEFULLY AND FRUITFULLY

22nd AGBM

29th, 30th & 31st JANUARY, 2016

PASTORAL CENTER, BHOPAL, MADHYA PRADESH

No. 21, June 2016


Golden stars to be the Diamonds...

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From Editor's Desk……

Greetings to you dear friends.

As this magazine honours the elderly, I honour and salute our senior citizens specially our senior members of SDFI who have toiled, sweated and had their nights slowly passing by in fear and hope.

Though we talk a lot about geriatric care and clinic, a newly learned terminology in my recent past, we nevertheless little worry about the elderly who live with us.

I am often reminded of senior citizens home, especially religious and priest's homes. One can find there, worn out personnel looking sad, gloomy and tired. They spend their time of course in praying and running down rosaries many a times. The world is moving in super fast pace that no one has time to spend even with their own parents who count the hours in loneliness.

Recently, I was listening to the obituary of one of our senior sisters whom I met in our senior sisters home. I felt so bad and upset that we the young generation did not even know of her heroic work and the uniqueness of her vocation which would have been a great inspiration for me even when she was alive. She had pioneered many mission areas which are now supposed to be the back bone of the province.

There was a young religious who met with an accident and was resting in the seniors home. He had lot of visitors with bouquets, gifts and gathering. Seeing this an elderly priest remarked, “no one has come to see me the useless waste product of this society, I wish I should have died young”.

Dear friends we talk a lot about geriatric health but are we ready to give our time which they deserve the most? Are we ready to sit with them to acknowledge and appreciate the great things they have done in their lives? How many of us have really kept track of our teachers from elementary school onwards and have visited them? How many of us are patient enough to listen to their pain and loneliness?

Here I want to share with you an inspiring story

The first day of school our professor introduced himself and challenged us to get to know someone we didn't already know. I stood up to look around when a gentle hand touched my shoulder. I turned around to find a wrinkled, little old lady beaming up at me with a smile that lit up her entire being. She said, "Hi handsome. My name is Rose. I'm eighty seven years old. Can I give you a hug?" I laughed and enthusiastically responded, "Of course, you may!" and she gave me a giant squeeze. "Why are you in college at such a young, innocent age?" I asked. She jokingly

replied, "I'm here to meet a rich husband, get married, have a couple of children, and then retire and travel." "No seriously," I asked. I was curious what may have motivated her to be taking on this challenge at her age. "I always dreamed of having a college education and now I'm getting one!" she told me.

We became instant friends. Over the course of the year, Rose became a campus icon and easily made friends wherever she went. She loved to dress up and she revelled in the attention bestowed upon her from the other students. She was living it up. At the end of the semester we invited Rose to speak at our football banquet and I'll never forget what she taught us. She was introduced and stepped up to the podium. As she began to deliver her prepared speech, she dropped her three by five cards on the floor. Frustrated and a little embarrassed she leaned into the microphone and simply said "I'm sorry. I'm so jittery. I gave up beer for Lent and this whiskey is killing me! I'll never get my speech back in order so let me just tell you what I know." As we laughed she cleared her throat and began: "We do not stop playing because we are old; we grow old because we stop playing. There are only four secrets to staying young, being happy, and achieving success.

1. You have to laugh and find humour every day.
2. You've got to have a dream. When you lose your dreams, you die. We have so many people walking around who are dead and don't even know it!"
3. There is a huge difference between growing older and growing up.

If you are nineteen years old and lie in bed for one full year and don't do one productive thing, you will turn twenty years old. If I am eighty-seven years old and stay in bed for a year and never do anything I will turn eighty-eight. Anybody can grow older. That doesn't take any talent or ability. The idea is to grow up by always finding the opportunity in change."

4. Have no regrets.

The elderly usually don't have regrets for what we did, but rather for things we did not do. The only people who fear death are those with regrets." She concluded her speech by courageously singing "The Rose." She challenged each of us to study the lyrics and live them out in our daily lives. At the year's end Rose finished the college degree she had begun all those years ago. One week after Graduation Rose died peacefully in her sleep. Over two thousand college students attended her funeral in tribute to the wonderful woman who taught by example that it's NEVER TOO LATE TO BE YOUNG.

As SDFI has dedicated this year for geriatric care, let us make a resolution to give a bit of time to be with our elderly sisters who die of loneliness than sickness. Let us try to recall all elderly people who made a difference in our lives. Why don't we visit them and give that life giving moment to them.

Sr. Dr. Martina SJC.

Message from Sr. Dr. Lucian SCC

Loving Greetings to each one of you!

It is with great love and satisfaction that I meet you through this News Letter. Reminiscing the past six years, gratitude and joy wells up in my heart. The peak experience has been at the last AGBM were we reflected on "Growing Old gracefully and Fruitfully".

The two terms of my Office were made eventful and fruitful with the responsible and innovative cooperation of the Executive Board Members. I would like to thank each one of them putting on record their names Sr.Dr. Emily Susai FMM, Sr. Dr. Prema Devaraj SND, Sr. Dr. Betty Jose SH, Sr. Dr. Alphonsa Mary FIHM, Sr. Dr. Liza FSLG and Sr. Dr. Hilda Lobo UFC. If not for the generous response of every leader of the region, I do not think we would have been able to achieve our goal and objectives of the Forum. May the spirit of God be praised for His continuous guidance. Our Coordinators Mr. Praveen, Mr. Soji and Mr. A. Roger Cyril have worked hard and done their best in all our enterprises. Thanks a million and God bless each one of them.

The immeasurable Joy of greeting, meeting, sharing and learning together has strengthened the bonds of love, fellowship and friendship among us. This has become possible because of the participation of each one of you dear Sister Doctors in every activity of the Forum without counting the cost.

As I hand over our Forum so dear to me and to you, to youthful and efficient hands of Sr. Dr. Beena UMI and her team, I wish and pray that our Forum will be led to greater heights by their far sighted vision and selfless leading through unbeaten tracks.

At this moment my prayer for each one of you is to visualize Blessed Mother Teresa soon to be canonized, as our dynamic model for growing old gracefully and fruitfully, full of mercy. At this juncture I am reminded of what Isaiah said,

"Even youth will become weak and tired,
and young men will fall in exhaustion.
But those who trust in the Lord will find new strength.
They will soar high on wings like eagles.
They will run and not grow weary.
They will walk and not faint". (Isaiah 40: 30, 31)

Being the year of mercy, I would also like to pray...

"May the palm of mercy reach everyone, both believers and those far away, as a sign that the kingdom of God is already present in our midst".

So, let us respond to this invitation of Pope Francis and be highly merciful to everyone who is under our care whether old or young…

Thank you one and all,

Yours affectionately,

Sr. Dr. Lucian SCC.

President's Message...,

My dear colleagues and friends,

With deep humility and gratitude, I take this opportunity to thank each one of you for the trust you have placed in me, in electing me as the SDFI President.

My heartfelt thanks to Sr. Dr. Lucian SCC, the immediate former President of the SDFI, who has handed over to me this great responsibility of leading the SDFI. She has done a phenomenal job of steering the SDFI, with her clear vision and unlimited zest for mission. This, now, not only leaves me with a big challenge, but also inspires me to give my best.

Over the last twenty-two years, the SDFI has grown from a small association to a large forum of about 1000 Sister Doctors across India. With a great sense of pride, I wish to thank all the former Presidents of the SDFI, who have paved a smooth path for me, to tread on.

The theme of our 22nd AGBM, which was held at Bhopal, "Growing old gracefully and fruitfully" was another call for each one of us to address the issues of the elderly. In this Year of Mercy, Pope Francis invites us to be a visible expression of the invisible Father. May this invitation propel each one of us, Sister Doctors, to be angels of love, mercy and compassion, in the midst of pain and suffering, especially to the elderly.

"Commit your work to the Lord whatever you do, and He will establish your plans" (Proverb 16:3). Dear Sister Doctors, with this attitude of faith, I surrender my dreams, vision and plan into His hands and begin my journey as the SDFI President.

I request your wholehearted support and prayers in my new endeavour.

May God bless you!

With warm regards,

Sr. Dr. Beena UMI
President,
Sister Doctors Forum of India.

Message from Vice President

Warm Greetings of joy and happiness to our entire sister doctors!

After the last news letter we have gone through various events, changes & experiences. Thank God for His grace to transcend all these and continue our mission.

At this juncture let me thank whole heartedly our outgoing President and members of SDFI Executive Board for their committed team work with a human touch. At the same time I extend my heartfelt warm welcome to the new President and Board members to continue the mission with full of energy and enthusiasm. It's my earnest desire that the new team will be able to focus and implement the needs of our mission… to make a difference as sister doctors!

Somebody asked: "you're a doctor?

How much do you make?"

I replied: **"HOW MUCH DO I MAKE?" …**

I can make holding your hand seem like the most important thing in the world

when you're scared….

I can make your child breathe when they stop….

I help your father survive a heart attack….

I can make myself get up at 4AM to make sure your mother has the medicine she needs to live…. I will work straight through until 4 AM to keep her alive and start the day all over again!

I work all the day to save the lives of strangers….

I will drop everything and run a code blue for hours trying to keep you alive!!!

I make my family wait for dinner until I know your family member is taken care of…

I make myself skip lunch so that I can make sure everything I did for your wife today was correct…

I work weekends and holidays and all through the night because people don't just get sick Monday to Saturday and during normal working hours,

Today, I might save your life.

How much do I make?

ALL I know is, I make a difference.

Sr. Dr. Alphonse Mary FIHM

Vice president, SDFI

THE REPORT OF XXII AGBM OF SDFI

29TH, 30THAND 31ST JANUARY, 2016

Theme: "GROWING OLD GRACEFULLY AND FRUITFULLY"

VENUE: PASTORAL CENTER, BHOPAL. MADHYA PRADESH

THE XXII AGBM of SDFI started with 30 minutes adoration to the Blessed Sacrament led by Sr. Dr. Jisa David and Sr. Dr. Dhanya David followed by breakfast.

The Inaugural session began with a formal welcome by the MC, Sr. Dr. Liza FSLG the National Secretary of SDFI. The prayer dance by SABS congregation set the AGBM to a start. Sr. Dr. Lucian SCC welcomed the dignitaries and briefed those present with goals, objectives and activities of SDFI. Sr. Dr. Lucian extended a warm welcome to Most. Rev. Leo Cornelio SVD. He was presented with a sapling by Sr. Dr. Betty. Rev. Sr. Dr. Liza FSLG welcomed Fr. Tomi Thomas, Executive director of CHAI, Sr. Dr. Prema Devaraj SND welcomed Fr. Kurian and Sr. Dr. Alphy OSF welcomed Dr. Sanjay Gupta, President, IMA, Madhya Pradesh State.

As a symbol of the Divine presence of God, all the dignitaries were invited to light the lamp. Rev. Fr. Tomi Thomas IMS, Director General of Catholic Health Association, in his inaugural address congratulated the SDFI of Tamil Nadu region for their selfless service for flood victims in the joint venture of CHAI and SDFI and implored God's Blessing upon SDFI. Highlighting the theme-Growing Old Gracefully and fruitfully, he quoted Pope Francis invitation 'Do not abandon the elderly. Honor your parents.' He further added the words from the bible; the days of our life are seventy years, and eighty for those who are strong (Ps 90:10). One cannot help being old but one can resist being aged. One can see sunshine in twilight years if one knows age is just a number. Age is a question of mind over matter. Instead of feeling sorry or frustrated, one has to stride ahead into the sunset years like George Burns who won the Oscar at 80; Famous Michael Angelo painted Sistine chapel at 71years of age. Dr. Albert Schweitzer operated at the age of 81yrs.

Fr. Tomi further added to say that by 2030 around 22% of India's population, or about 300 million of its people will be over 60yrs. According to UN, by 2050, the proportion could reach 54% or about 587 million people.

He enlighted us saying that there are various models of elderly care like 'National programme for the health care for the elderly' NPHACE of MOHFW, Senior citizen health services (SCHS) of St. John's Medical college, Bangalore, and other private home care solutions like Epoch Elder care, Sushrutha who focus on institutional health care. But not many models focus on home-based as well as community based care. Catholic Church has 600 elderly homes. He stressed that institutional care is not the solution, but community based care is more important and practical in taking care of the increasing elderly in the country. He also spoke about the new programmes of

CHAI for the elderly. Santwana insurance programme for the laity and the Shradha parish nurses programme for the elderly.

"To be a medical doctor is a path by which to reach and achieve the fullness of human being. It involves a special nearness to and intimacy with God and it also means openness and a total giving to other people. This, then, is the catholic identity of the medical doctor- to be the transmittance of the healing Christ."(Cardinal Javier Lozano Barragan, President of the pontifical Council for Health pastoral Care.)

He reminded us what Pope Francis exhorts "To be the balm of mercy, the oil of consolation, and the oasis of compassion, channels of forgiveness and images of God's love". He also proposes mercy as a universal means of mirroring God's love.

Rev. Fr. Tomi complimented Sr. Dr. Lucian and all the SDFI for their concern, commitment and hard work as he inaugurated the 22nd CME and AGBM.

Then the felicitators were invited. Rev. Fr. Kurian Kachappilly CMI, Provincial, St. Paul's province, Bhopal, Dr. Sanjay Gupta, President IMA, Madhya Pradesh State, Rev. Sr. Jenova OSF, Provincial Superior, OSF congregation, Rev.Fr. Ronald Cardoza, Director, Pastoral Center, Bhopal, Rev. Fr. Varghese, Principal of Higher Secondary School, Bhopal and Rev. Sr. Rashmi Chalissery, Sisters of St. Joseph of Champery, Asha Niketen felicitated SDFI.

Rt. Rev. Leo Cornelio SVD, Arch Bishop of Bhopal in his Presidential address expressed his happiness to welcome all the sister doctors to the diocese of Bhopal which is a city of lakes and the capital of Madhya Pradesh which is known as the heart of India. He acknowledged the sister doctors role and service saying, you are accomplishing an important and unique mission in the Catholic Church with your life of witness and service as a mission. You are trying to bring into reality the words of Christ. "I have come that they may have life, life in its fullness (John10: 10)" which coincides with the motto of St. John's Medical College and hospital where a good number of Sister Doctors have studied. "**He shall live because of me."(jeevishyathi Mayaivasi).**

It is said that at birth, your life was a plain canvas. Your potential is the colors. Your choices are the strokes on the canvas. At death, this canvas will either be a treasured masterpiece, or an unnoticed scribbling. On judgment day you will be judged as to how good a painter you were in painting your life.

In a book 'Outlyers' the author writes how passion and zest for life brings great results. He says extraordinary people are extraordinary just because they did everything with extraordinary passion. Most of the people have become great not just because they had extra-ordinary intellectual or physical capacity, but they, spent more time on their talent/ ability. We have examples of late Dr. Abdhul kalam, Madam Curie, Mother Theresa, St. Francis of Assisi, St. Francis Xavier, Steve Job and Bill gates etc

So growing old means to continue living our lives to the fullest with the awareness that our life is a gift from God and living this life fruitfully and meaningfully would be our gift to God. Henri Neuwen, a catholic priest and a writer asked this question to himself: "Is my growing old making me any closer to Christ? Am I only getting older or am I getting Godly?

To live meaningful life we should establish a certain harmony between material and spiritual; between body and soul. We are about to conclude the year of Consecrated Life and right now we are in the jubilee year of Mercy. Our holy father Pope Francis invites us all to be merciful like our heavenly Father. He spoke to the seminarians on July 6, 2013: saying "To be joyful witness of the Gospel one must be authentic and coherent".

One of the serious challenges Sister Doctors might face is to balance your work/duty/obligations as doctors with your spirituality and religiosity. The importance of our communion with God through prayer is a constant sustaining power for all the faithful, particularly for the religious and priests.

Watterson Lowe says: "Nobody grows old by merely living a number of years. People grow old by deserting their ideals. Years wrinkle the face but to give up enthusiasm wrinkles the soul."

If you continue to work and to absorb the beauty in the world around you, you will find that age does not necessarily mean getting old. He ended his presidential address by imparting his Episcopal blessing to all the Sister Doctors.

Sr. Dr. Hilda the treasurer of SDFI proposed a vote of thanks to all gathered for gracing the occasion with their precious presence. As a sign of our gratitude a memento was given to all the dignitaries. Sr. Dr. Hilda thanked Montfort brothers for their constant help, Rev. Fr. Maria Stephan for the media coverage and SABS postulants for their prayer dance. The inaugural session ended with praise and thanks to God.

The Inaugural Mass was offered by Rt. Rev. Arch Bishop Leo Cornelio and concelebrated with Rev. Fr. Thomas Chacko SVD, Rev. Fr. Kurian Kachappilly CMI, Rev. Fr. Biju Paliath, Rev. Fr. Antonious Toppo and Rev. Fr. Tomi IMS, Sr. Dr. Rose Mary thanked the Bishop and priests with mementos.

Post lunch session

AGBM business session was started with a warm welcome by Sr. Dr. Lucian, the National President to all the SDFI members.

Sr. Dr. Liza FSLG, national secretary presented the report of 2015-2016. Sr. Dr. Prema Devaraj SND proposed and Sr. Dr. Vida seconded it. It was followed by the report of the treasurer Sr.Dr.Hilda which was proposed by Sr. Dr. Lucy SND and seconded by Sr. Dr. Fracisulu JMJ.

Sr. Dr. Lucian addressed the general body and explained the achievements and problems faced by our forum. She congratulated the Tamil Nadu region for their selfless service during the flood in

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Chennai. She informed us about the disaster fund formed by SDFI with the help of Medical Mission Sisters. SDFI could work with CHAI for the flood relief works. She expressed her happiness for the work we could do for the flood victims. Tamil Nadu region was appreciated for their selfless service, courage and compassion.

She also explained the status of FCRA., which is under inspection all over the country. We also discussed about the possibilities of having an office at SJMCH.

Following which the group dispersed for the regional meeting and tea.

The regional reports were read. Kerala region report was read by Sr. Dr. Mercy SABS, Andhra Pradesh region by Sr. Dr. francisulu JMJ on behalf of Sr. Dr. Annie JMJ. Tamil Nadu region by Sr. Dr. Martina SJC, Western region by Sr. Dr. Beena UMI, Northern region by Sr. Dr. Jyoti Serrao, Central region by Sr. Dr. Alphy OSF, and Karnataka region by Sr. Dr. Vida. Sr. Dr. Lucian appreciated all the good works done by Sister Doctors in various parts of India very specially underserved areas. She thanked God for the courage and compassion with which Sister Doctors are serving the Lord the Divine healer. She thanked all the regional presidents and secretaries for their selfless service and for finding time amidst their busy schedule.

We also remembered Sr. Dr. Perpetua SAL of St. Ann's of AP region who served the Lord following His mandate of healing and spreading the message of His Compassion and healing. She was suffering from leukemia and went for her heavenly abode in Oct.2015. A 2 minutes silence was observed in remembrance of her. May her soul rest in peace.

The election proceedings began with a prayer invoking the Holy Spirit for guidance. The doors were shut and attendance was taken. Total numbers of Sister Doctors present were 114. The nominees for president's post were Sr. Dr. Beena UMI, Sr. Dr. Rose Mary CFMSS, Sr. Dr. Liza FSLG, Sr. Dr. Hilda , Sr. Dr. Prema, Sr. Dr. Vida, Sr. Dr. Martina, Sr. Dr. Alphy OSF and Sr. Dr. Alphonse Mary who was absent.

Except Sr. Dr. Beena and Liza rest all of them withdrew and Sr. Dr. Beena UMI won the election by 65votes. Sr. Dr. Liza FSLG was unanimously elected as a secretary and Sr. Dr. Vida was unanimously elected as treasurer.

Sr. Dr. Lucian congratulated and welcomed the new team with flowers and wished them all success for the coming years. She thanked Sr. Dr. Liza and Sr. Dr. Hilda for their cooperation and support for the past three years as a secretary and treasurer. She also thanked Cyril the SDFI

coordinator for his selfless service and presented him a gift as a token of our love and appreciation.

Sr. Dr. Liza congratulated Sr. Dr. Lucian for completing her six years of tenure as a President successfully and thanked her for her selfless service rendered to SDFI. Indeed she has done her best for the forum. Sr. Dr. Hilda and Sr. Dr. Liza presented her a gift as a token of our love and appreciation for her service for SDFI. All of us thanked God for the new team and outgoing team in one voice by singing thank you thank you Jesus.

After the dinner there was a mind refreshing entertainment programme by students from Asha Niketen Higher Secondary school for the deaf, and by the seminarians from SVD and Passionate Seminary. It was a mind blowing performance. All are enjoyed very well.

The day ended with a good musical note in the heart and mind of every one.

Day II - 30th Jan (Saturday)

The day started by the participating in the Holy Eucharist by Rev. Fr. Mathew V.C, Vicar General of Arch diocese of Bhopal.

CME-1

At 8.30 am, Dr. Rajesh Sethi MD (Medicine), graduated with Fellowship in Cardiology presently working in Asha Niketan Hospital, Bhopal began the CME on review of common approaches to various cardiac diseases. Sr. Dr. Archana UMI, introduced him and Sr. Dr. Shoba welcomed him with a sapling. Sr. Dr. Martina thanked him and Sr. Dr. Little Flower handed over to him a memento.

CME-2

Sr. Dr. Sally John, MD (Psychology) spoke and highlighted the Common psychiatric problems in old age. She was introduced by Sr. Dr. Bindhu George, welcomed by Sr. Dr. Alphy OSF with a sapling. Sr. Dr. Amulya thanked her for very informative session and Sr. Dr. Reena handed over the memento to Sr. Dr. Sally.

CME-3

The session on common eye disease and their prevention and management was enlightened by Dr. Prakash Aggarwal, MD, DNBE(Ophthalmic). He is Assistant professor of Ophthalmology, people's college of Medical Sciences, Bhopal.

He was introduced by Sr. Dr. Alphy OSF and welcomed by Sr. Dr. Beena with a sapling. It was an informative and practical session. Sr. Dr. Malti thanked him and Sr. Dr. Ashreena handed him a memento as a token of our gratitude.

A day worth to be remembered where all felt one and were filled with joy and happiness. At the picnic all were excited and amnesia set in forgetting that we are Doctors. The boating in the Lake of Bhopal was

so exciting the young and old could not but swing their body in music and danced to the beat. The Peoples world was another exciting place where everyone enjoyed the beautiful national international monuments and excitement park. It was very relaxing moments of our life. All returned to pastoral center with refreshed mind and body.

Day III January 31(Sunday)

Sunday dawned and all proceeded to implore God's grace by participating in the Holy Eucharist celebrated by Rev. Fr. Godwin Vagus SVD. Sisters from Sr. Dr. Alphy OSF's community added the melody to the Holy Mass.

The senior stars of SDFI were invited to grace the beginning of the day. It was a heart touching hour when they shared their rich experiences to the youngsters. All the young stars of the elderly gave their message from their heart. The take home message from the senior to juniors were " Commitment to Jesus and the church, Faithfulness to the vows, Total surrender to God, Good communication with empathy, To clad ourselves with Obedience and Humility, Encourage and support the Juniors and nurses. Abstain from anger and pride, and to be rooted in Jesus". Sr. Dr. Lucian, National President honored Sr. Dr. Prema SND for winning the award for the excellent contribution for RNTCP by CBCI - CARD at New Delhi in June 2015.

CME IV by Dr. Sushil Jindal MD (Medicine), DM (Endocrine) was on Endocrine system and its Disorders. Sr. Dr. Alphy OSF introduced the speaker and Sr. Dr. Cross Mary welcomed him with a sapling. It was a very informative session. Sr. Dr. Dhannya S.J thanked him and Sr. Dr. Arogya Mary handed a memento as a token of our appreciation for him.

A short evaluation was done. Sr. Dr. Lucian appreciated and Thanked LOC for praiseworthy arrangement for AGBM and their selfless service.

She specially thanked Sr. Dr. Alphy OSF for her leadership and her community for their whole hearted support. Sr. Dr. Alphy OSF brought the whole diocese to SDFI. We honored them with a shawl. Sr. Dr. Lucian also thanked Sr. Dr. Liza FSLG and Sr. Dr. Hilda UFC handed a gift as a token of her gratitude and love.

Everyone in one note of gratitude applauded the Local Organizing Committee. Sister Doctors departed for their own destination rejuvenated and refreshed in spirit and body.

A loving good bye to meet again was resounding in the whole of Pastoral center.

Sr. Dr. Liza. FSLG
National Secretary

Sr. Dr. Beena UMI
National President.

NORTHERN REGION REGIONAL MEETING REPORT 2015 -16.

DATE: 25th August, 2015

VENUE: Holy Family Hospital , Okhla, Delhi.

The annual regional meeting of SDFI northern region was held at Holy Family Hospital Okhla, Delhi ,on 25th August, 2015. Twelve sister doctors from U.P, U.K., Rajastan, Punjab and Delhi were present for this meeting. About 16 – 18 members were supposed to attend this meeting but due to Dengue epidemic in this region, either sister doctors were the victims or other doctors had contracted Dengue in their hospitals because of which they were unable to attend the meeting.

The theme for this meeting was ' Growing older gracefully 'and ' RNTCP'.

The resource persons were Fr. Joe Mannath SDB, the National Secretary of the CRI and Sr. Prabha Varghese H.C. the Executive Director of CBCI- CARD.

The meeting began with a short prayer and a hymn to the Holy Spirit. Sr. Dr Rose Mary who is the president of the northern region welcomed all the participants. Sr. Dr. Melba briefly shared about the challenges sister doctors face in the hospital and in the community. She shared how gracefully one can grow over the years sitting her own example. She encouraged all saying the we have other sisters in the community who support, encourage and back us up when we face problems and difficulties, which indeed is a blessing. As we grow older we need to learn to be humble and gracefully hand over our positions to the younger ones and take the back seat which will give us freedom, peace and joy. She concluded saying that Jesus is our strength and miracle worker and we need to learn to trust in Him.

Sr. Dr. Rose Mary briefly introduced Fr. Joe Mannath SDB to the participants. We were indeed privileged to have him as our resource person.

Fr. Joe Mannath SDB enlightened us about how to grow old gracefully with power point presentations based on many of the following inputs:

Seven rules to be happy are: **Wake up**: When we wake up, we decide to have a good day.

Dress up: put on a smile which is inexpensive way. **Shut up**: say nice things to others and to learn to listen.

Stand up: for what we believe. **Look up:** to the Lord. **Reach up:** for something higher.

Lift up: the needs of others. Specially those who suffer alone than we do.

Life is a precious gift of God. Hence lets us not sleep off life.

We are also called to keep our five areas ever alive.

Body: To keep our body healthy, we need to eat healthy diet, exercise thrice a week, keeping oneself and surroundings clean, sleeping at regular time, avoiding addictions to food, alcohol, tobacco, drugs, T.V., internet & gossip.

Mind: Read & learn new things, exercise one's mind, learning to learn which will help in memory, concentration, reading, writing and time management.

Emotions: Learn the art of happiness; tackle negative emotions like anger, sadness, fear, jealousy and hurts. If handled well we have a great source of energy. Soft skills matter more than hard skills.

Relationships: Those who relate well are happier and healthier. Build up younger people, seek the honest feedback, not to speak ill of others and finally the best gift we can give to others is peace.

Spirit: Count your blessings, cultivate personal prayer, and face one's death which will help us to live better. Faith gives us core beliefs. There is no problem that God cannot solve. I don't know what awaits me in my future but I know who waits for me in my future. In the heart of God there is always a place for me.

These five areas are not equal. They are increasing in depth and strength.

He also told us that while facing death one goes through fear, anger, denial, remorse, more fear and more anger and finally acceptance. Let us not have regrets in later life.

He shared with us his experience of lessons from doctors who were compassionate and put God first in life. When one starts the day with prayer he/she is led to the bedside of the patient who needs them.

The climax of the day was the meaningful **Eucharistic celebration** by Fr. Joe Mannath SDB. Who made the celebration alive, active and participatory by power point presentation and sharing. **The message was God is in charge, He is alive, He has conquered death, He goes before me.**

Vote of thanks to Fr. Joe Mannath SDB, was given by Sr. Dr. Jyothie serrao SAP and Sr. Dr. Melba presented the memento.

Post lunch session was conducted by Sr. Prabha H.C. She was introduced by Sr. Dr. Shiny Daniel. Sr.Prabha shared her concern about nonparticipation of catholic doctors in the meetings before making the policies. When the meeting is called in a short notice , doctors from different denominations and religion take lot of interest and reach for these meetings from different parts of the country. But hardly any catholic doctor takes part in these meetings. Policies or bills will affect all of us and hence we need to wake up and raise our voices and give our opinions. We need to think of the wider interest. Sr. Dr Rose Mary president of northern region and Sr. Dr. Liza,

national SDFI secretary volunteered to take part in these meetings and do the needful.

She also enlightened us about RNTCP. She said that, we are missing about 3 million TB cases globally and in India about one million cases are not reported.

Before concluding she gave us the check list of gracefully growing old.

Sr. Dr. Sandra UMI thanked Sr. Prabha H.C. for her sharing and presenting a bag to all the participants. Sr Judit SD presented the memento.

Sr .Dr. Jessy Maria CMC expressed her gratitude to Sr. Dr. Rose Mary, on behalf of all the participants for arranging the meeting.

Sr. Dr. Rose Mary thanked Fr. George , the Director of Holy Family Hospital for his generosity, various arrangements with minute details and for sponsoring all the expenses of the day for the sister doctors. She also thanked all the staff of the Holy Family Hospital for their generous help and availability even though it was a holiday for them.

All dispersed to their communities with renewed vigour and zeal.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL

Northern region members gathered at Pastoral centre Bhopal. The next regional meeting would be at Kota- Rajasthan on 3rd Sunday of August, 2016.

The theme was not decided.

The national AGBM venue was suggested as Kerala.

The Theme extending the care for the elderly.

Action Plan for 2016-17

Shrada and Sandwana programme of CHAI to be started in the region.

Sr. Dr. Rose Mary,
President, Northern Region

Sr. Dr. Jyothie Serrao SAP
Secretary, Northern Region

SDFI CENTRAL REGION MEETING

SDFI Central Region meeting was held on 22nd & 23rd August, 2015 at Pastoral Centre, Jabalpur, Madhya Pradesh. Only Sr. Alphy and Sr. Archana could come for both the gatherings. The Central Region being too vast, our Sister Doctors may be finding it hard to make two long travels to attend both regional and national meetings.

Even as the Central Region covers a vast area and we are unable to meet as much as we wanted, we try to contribute to SDFI in whatever way possible. One can offer only five loaves and two fish, but Jesus is the one who multiplies it, and we believe in His power.

The regional meeting in Jabalpur started at 7:30 am with a small prayer. We had holy mass celebrated by Fr. Sibi Joseph, Vice-principal of St. Aloysius Senior Secondary School (Sadhar, Jabalpur) and Youth Director for Jabalpur Diocese. On aging gracefully he said: when one is closer to God, one would feel younger. He prayed for God's blessing that we may have enough wisdom, prudence and knowledge to achieve this goal.

Dr. Ashish Dhingra gave us a lecture, highlighting updated knowledge in diabetes management. Fr. Kurian Kachappilly, Provincial of CMI Bhopal Province, enlightened us with his talk on "Doctors without Frontiers." His talk helped us to ponder over the following points: (1) Whether the Gospel is truly the "handbook" for our daily living and decision making? (2) Is Jesus really our greatest love, as we promised he would be when we professed our vows? (3) Do we share Jesus' own compassion?

After lunch, we had an outing sponsored by one of our well-wishers and a high tea sponsored by Sr. Alphy's convent. In the evening we evaluated our day's programmes. We requested all to come to Bhopal for the 22nd AGBM, as it was going to be held at a place in our region. After dinner, most of us departed for our respective places. We had a very good day of relaxation and togetherness.

At the regional meeting held alongside AGBM in Bhopal, Sr. Shobha was elected the new Secretary of Central Region. Regarding next AGBM, we suggested Mumbai as the venue and proposed for the topic either "emergency care in rural set-up" or a relevant theme related to the Year of Mercy.

Our Achievements:-

1. Sr. Teena Francis attended relief camp in Nepal for 2 weeks (12-28/05/2015).
2. Sr. Shobhana received Mary Glory award from St. John's.
3. Sr. Prema Devaraj received national award for the best DMC (District Microscopy Centre).
4. Srs. Prema Devraj, Anisheela, Ancily, Jyothi Kerketta and Jisa David involved in anemia eradication programme. Srs. Prema Devraj, Ancily and Jyoti were active in the programme for sexual and reproductive health for rural women and adolescents.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL

Central region members gathered at Pastoral centre Bhopal. The next regional meeting would be at Bhopal in the month of August, 2016.

The national AGBM venue was suggested as Mumbai.

The Theme Extending the care for the elderly.

Sr. Alphy OSF
President of Central Region

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

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Minutes of the SDFI - Western Regional Meeting

Date: 5th & 6th September, 2015

Venue: Holy Family Hospital, Bandra, Mumbai.

On 5th & 6th September, 2015, SDFI Western Region was held at Bandra, Holy Family Hospital. A total of thirty-five participants were present, of which, fifteen were Sister-Doctors. The air was filled with joy and enthusiasm, as we greeted each other and shared our experiences. We were privileged to have Rev. Fr. Joe Mannath, Secretary – National CRI, as our Resource person.

The meeting commenced with a prayer. Sr. Dr. Beena welcomed all the participants with a warm welcome-address. Rev. Fr. Joe Mannath was welcomed by Sr. Dr. Annette with a bouquet of flowers.

Fr. Joe inspired us with his lively session on the role of consecrated women in healing ministry. A special emphasis was laid on consecrated life, as this year has been dedicated to "The Consecrated Life". He urged each one of us to be a tangible expression of God's love and compassion, through our kind and generous service towards all, especially towards the sick, whom we are taking care of. The group was dispersed at 1:00 p.m. for lunch-break. Everyone enjoyed the delicious menu. The post-lunch session was livelier, as Fr. Joe started with few jokes. He made a power-point presentation on four areas of growth, which is essential for the Religious to grow as integrated person, to live a balanced life. He concluded his session by praying Psalm: 139, through a video presentation.

Sr. Dr. Sally John proposed the vote of thanks. She thanked Rev. Fr. Joe Mannath for taking time out from his busy schedule, to enlighten us. Sr. Dr. Roshni honoured him, in a traditional Indian way, with a shawl.

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Sr. Dr. Sally also thanked the Ursuline Sisters, particularly, Sr. Dr. Beena, for the beautiful arrangements. The meeting concluded on a joyful note, where everyone found time to chit-chat with each other.

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

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL

Western region members gathered at Pastoral centre Bhopal. The next regional meeting would be at St. Pius College on Month of September, 2016.

The national AGBM venue was suggested as Kerala.

The Theme Extending the care for the elderly.

Sr. Dr. Ashreena Miranda,
President,
Western Region.

REPORT OF A.P. REGIONAL SDFI MEET 2015 ON 30TH AUGUST 2015 AT ST. JOSEPH'S GENERAL HOSPITAL, GUNTUR

The Day started with Jubilation and excitement welcoming the Sister Doctors from different parts of A.P. Region.

Meeting started at 09:30 A.M. with a meaningful prayer led by Sr. Catherine, ASMI. Sr. Dr. Annie welcomed the gathering and each one introduced themselves. She highlighted some points on Healthy living and how to take care of our bodies. In the welcome address Sr. Dr. Annie talked about consecrated life – Response to God's call.

1. It is a call to be Human (2) A call to be happy (3) A call to be Holy.

To be Human means to accept oneself, to be authentic and true to oneself. To Trust in God and His unconditional Love and Mercy. To throw oneself into His hand come what may. To belong - a sense of being part of a community, parish, village, nation, world and cosmos.

A Call to be Happy a fully Human person is a happy person. Other points to make us joyful - a sense of gratitude for everything – an ability to live in the present moment - a readiness to let go of our attachments.

A call to be Holy – Our broken world needs consecrated persons who are authentically Human, deeply Happy and truly Holy.

In the midst of World's darkness and brokenness, division and violence , we religious remind everyone that God loves us so much, that he gave his only Son not to condemn, but to save us and lead us by His Holy Spirit to the fullness of life and love.

At 10:30 A.M. we had an input session by Dr. Phani Kumar M.D, Consultant Physician, Asst. Professor of Medicine, NRI Medical College and Hospital, Mangalagiri, Guntur. He was welcomed with a bouquet by Sr. Dr. Marietta. He spoke on Metabolic Syndrome X, Insulin Resistant Syndrome. It is associated with increased risk of CVD and DM. Hypertriglyceridemia is a marker of Insulin Resistance. Over Weight and obesity, sedentary life and aging are high risk for Insulin Resistance. He was given a Memento by Sr. Ippolitta.

At 11:30 A.M. we had Holy Mass by Fr. Amalnadhan, S.J., Director of Retreat Centre, Nambur. He spoke on spiritual aspect of Healing Ministry. We had a meaningful Eucharist, praying for Healing Ministry. Sr.

Dr. Pioreena proposed vote of thanks thanking Fr. Amalnathan for the mass and the community sisters for the arrangements.

After a delicious lunch we went to St. Joseph's Nature Cure Centre, Kakani. There we had some sharing about some of the problems faced by the Sister Doctors. It is suggested to take professional protection through IMA, so that any problem arises, we can approach through IMA.

Sr. Dr. Jayaratna Bala JMJ, The Director of the Center explained to the Sister Doctors about the natural treatment given there like Colon Therapy, Cerajam, steam and mud baths, through all this treatment body is cleansed both internally and externally. Sr. Dr. Sujatha JMJ , Naturopathy Doctor was also in that centre ; since recently she has completed her Degree will join the SDFI. Some patients gave testimony, about their good improvement naturopathy treatment where all other doctors have not given any hope. We had dry fruits, carrot laddu and herbal tea.

All the Sister Doctors felt happy to see the Nature Cure Centre. The whole day program was well appreciated and we bid farewell.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL

Andhra Pradesh regional members gathered in the hall at the pastural center Bhopal at 4pm.There were 12 Sister Doctors present. Sr. Dr. Annie.JMJ reelected as the regional president, Sr. Dr. Innamma was elected as the secretary.

Regional activities 2015 :- Anaemia detection programme, Adolescent health tips for School Children were conducted.

Activities for 2016-17:-

Theme:- Caring for the elderly/ Infertility-PCOD

Venu:- Hyderabad

Activites-

- Sradha – Detection of HT/DM
- Santhwana- Helping the poor families for health insurance..
- Anaemia detection & treatment to be continued.

National AGBM Venu – Goa/ Bombay

Theme - Cancer prevalence.

Sr. Dr. Annie.JMJ,
President,
Andhra Pradesh Region.

REPORT OF ANNUAL REGIONAL MEETING OF KARNATAKA SISTER DOCTORS FORUM

The annual regional meeting of Karnataka sister doctors forum was held on 19th and 20th September 2015 at Sadbhavana Bangalore. A good number of sister doctors attended and participated actively.

The meeting began at 10.00 a.m. with an audio visual prayer conducted by Sr. Dr. Lenita d Souza which put us in right perspective to begin the meeting. The president Sr. Dr. Vida olivera welcomed the participants as well as the resource person Rev. Fr. Sylvester OCD who spoke on the origin of the consecrated life and its relevance today in the church for humanity. There was an interactive session after his talk. This was followed by tea break at 11.30 a.m.

At 12 noon there was the Eucharistic celebration after which lunch followed and a short siesta.

After noon was set aside for an outing. At 2.p.m. all the members set out for sightseeing and relaxation. We visited St. Mary's Basilica first and with her blessing went forward to see the Jawaharlal memorial Planetarium. The show on Solar Planet was very interesting and educative. From there we entered the India Gandhi memorial dancing fountain. The dancing water fountain show was thrilling and relaxing. At 8.p.m. the group returned to Sadbhavana for dinner and rest.

The second day on 20th the day began with Eucharistic celebration at 8.a.m. followed by breakfast. The input session started at 10.a.m. with the resource person Dr. Jeethu John M.D. from St. John's medical college hospital, speaking on the topic Emerging Diseases such as H1N1, Dengue, Malaria and chickengunia. It was a very informative session and the members had plenty of doubts to clear.

After the CME session there was a short tea break after which was the sharing session wherein all the sisters shared their work experiences, difficulties and the programmes of the SDFI. The next

venue for the regional meeting was suggested as St. John's medical College hospital since the speakers could be taken from the college according to the topic.

The president thanked all the members for their presence and active participation. With lunch the meeting came to an end at 2 PM.

Sr. Dr. Vida Olivera SCCG,
President,
Karnataka Region.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL:

The members of the region gathered at pastoral center Bhopal. The next regional meeting was planned as

Venue: Mangalore.

Time: 1st week of July.

Theme: Year of Mercy.

CME: Drug abuse & de-addiction.

Action Plan: Health awareness camps at regular intervals.

Health insurance policy.

Next AGBM venue was suggested as Mumbai/ Hyderabad

Theme: Safe guarding the environment for the preservation of health.

CME: Malignancies related to women.

Sr. Dr. Lenita SCCG,
President,
Karnataka Region.

TAMIL NADU SDFI REGIONAL MEET – AUGUST 2015 29TH &30TH

"WHERE THERE ARE RELIGIOUS THERE IS JOY" - POPE FRANCIS

These words were true as we Tamil Nadu sister Doctors gathered together for our annual gathering.

It was special in many ways.

1. Being the year of Consecrated Life.
2. Being the place of nature –Kothagiri.
3. Being the chance of getting credit hours. (We get 3hours)

First in the history of TN - SDFI 30 of us gathered at St. Mary's Convent, Kothagiri for our regional meeting. Thanks to Sr. Emily FMM, the vibrant person of TN-SDFI who did all the arrangements and was there before us to welcome the participants.

After a warm welcome our day began with joyful outing as the morning hours are the only pleasant weather assured to see some places. We visited few view points and SIMS Park at Coonoor. After a sumptuous lunch we began our sessions on Diabetic Neuropathy, Hypertension in Diabetes, Newer drugs in Diabetes presented by Dr. Elizabeth Rani from Kovai, who was excellent, confident and was able to answer all our practical enquiries. We then had the original flavoured tea of the place. After which we just made a short visit to KODA NADU – the estate of Chief Minister Jaya Lalitha – which was breathe taking and wonderful. Evening we had a meaningful Eucharistic celebration by Rev. Fr. Thadeus – Franciscan. After dinner we were still fresh to go ahead with our business meeting and lighter moments together.

The second day all of us enjoyed the chill morning breeze after a good night rest and the day's session was dedicated to reflect on consecrated life. We were blessed to have Rev Fr. Jerry SJ – the barefoot man-. We started the day with the meaningful Holy Eucharist in which we together reflected on 'religious as salt of the earth and light of the world'.

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The next two sessions were thought provoking and challenging as he was sharing deep reflection on how as Doctors and health personnel, we can live more effectively our consecrated life. He slowly took us on journey in to Pope's message for consecrated people, finally he also spoke on few illnesses in our consecrated life as described by Pope Francis, making it relevant for our healing ministry. He challenged us to make a difference in our life as consecrated persons , in our community and in our mission.

Thus, the two days programme ended with loads of reflections, inspirations and determinations. We all departed from the coolness of the hill with Tabore experience like Jesus, to make our ABBA experience alive in our mission.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL:

Tamil Nadu regional members gathered at the pastoral center of Bhopal on 29/01/2016. There were 13 members present.

The next regional meeting would be at Pondy on July 23rd and 24th 2016. The topic would be interpretation of ECG, X-ray and CT scan

Next AGBM venue: Hyderabad.

The topics: Emergency medicine, Pain & Palliative Care and Alternative medicine.

Suggested to have regional whats app group to share the medical informations and updates.

Sr. Dr. Martina SJC,

President,

Tamil Nadu Region.

Minutes of the Regional Meeting - Kerala Region

Date: 22nd&23rd August 2015.

Venue: Pastoral Animation Centre for Studies.

The SDFI Kerala Regional Meeting was held at PACS, Kallettumkara on 22nd and 23rd August 2015. It was a time of joy and excitement along with sharing as 60 sister doctors from different parts of Kerala gathered together. The meeting began at 5.30 pm on 22nd August with a pilgrimage to the tomb of Blessed Mariam Thresia at kuzhikkattusserry. The participants still cherish the sweet memories of the hospitality shown by the Holy Family Sisters.

After supper, at 9 pm, the general session started with a short prayer. Sr. Dr. Ranitta FCC, president of the forum welcomed the gathering and it was followed by the self introduction of the Sr. Doctors. Dr.Ranitta mobilized everybody to attend the SDFI National meeting at Bhopal. At 10pm the members dispersed for personal prayer and rest.

` The second day of the conference commenced with the morning prayer at 6am. At 6.30am Rt. Rev. Dr. Pauly kannookkadan, Bishop of Irinjalakkuda, celebrated the holy mass. His Excellency, the Bishop delivered a message based on LK18:1-8, the parable of the widow and the unjust Judge. Bishop started the sermon quoting the words of Pope Francis. Where consecrated people live together, there abides lasting joy and happiness. Bishop shared that the year of the consecrated coincides with 'the year of mercy' as mercy and joy are two inseparable virtues to be practiced in the life of every Christian. For this the bishop spoke of an anecdote from the life of Bl. Mother Theresa. Malcon Maggaridge, in his personal meeting with mother Theresa said that he won't do any such works like mother, even if he is rewarded with 1000 dollars. Mother replied that even she won't do such works even if she is promised 10,000 dollars. The officer then asked mother what urges her to do such services. Mother replied that the love of the Eucharistic Lord compels her to do all these.

Bishop concluded his sermon with a touching event. Two tourists visited a coffee-stall and ordered for two coffees. Mean while an official came and ordered for a coffee and two coffee- pending. After a while two army officials came and ordered for 2 coffees and 15 coffee-pending. With curiosity the tourists asked the owner of the shop what is meant by coffee-pending? Then the owner asked them to wait for a while. Soon an ugly looking old man came there and asked whether there is any coffee pending. The owner cordially treated the old man and replied that there is of course coffee pending. He enjoyed the coffee and a few minutes later two old ladies came and asked the same question. The owner welcomed and gave them coffee. The owner asked the tourists whether everything is clear to them and they answered yes. It was a poor country where such practices existed to help the poor and needy. Likewise, there should be a place in our hearts for the poor, the sick and the needy .The paternal blessings and thought provoking message delivered by the bishop was really inspirational to welcome a vibrant tomorrow in the healing ministry of all the doctor sisters. This was followed by breakfast.

The Inaugural session was at 9.30am.Sr.Dr.Ranitta FCC, president of the forum welcomed all the dignitaries with her usual cordial words. Quoting Pope Francis she told that there are two categories of

doctors. The first Group of doctors is busy with all kinds of studies and experimentations. The second type of doctors is very committed and they are always with patients extending all possible services to the patients.The latter Type of doctors are very vigilant and act like doctors on the warfront. The question is where are we? To which group do we sister doctors belong?

Pleasing approach and warm personal contact is very important in the healing profession. Sr. Ranitta expressed her gratitude to God almighty for the blessings showered on each and every member as all are living a noble call.

Rev .Fr .Sunil Chiriyamkandath, CHAI (K) president and JMMC Hospital Assistant Director inaugurated the Programme by lighting the lamp. Father told that whenever KCBC meet, the bishops always share that we have all kinds of health forums like –nurses forum, doctors forum, sister doctors forum and CHAI. What is important is good co-ordination to make it a powerful church ministry. KCBC health commission chairman Rt. Rev. Dr. Jacob Manathodath also stressed on making all forums a joint venture .Though Catholics form only1 ½ % of total Indian population, the bed strength of catholic hospitals is 10% and it is really commendable. Our sisters, doctors, and Paramedical professionals are very strong. How far they are efficient in their respective professional spheres is to be discussed/ considered. Our Problem is that we like to work in isolation and we compartmentalize patients saying my patient, my hospital, my congregation etc. India may be the youngest country in the world by 2020. But our youth are addicted to Junk food, which will make them unhealthy and sick. It is necessary to take steps to lead them out of this tendency.

Our services should have practical dimensions. We should find out the felt need of our society and must plan our activities accordingly.

Sr. Ranjana CHF, Provincial of Pavanatma province, Irinjalakkuda delivered the Valedictory address. She quoted Pope Francis who always exhorts and preach is the gospel of encounter. Sister Doctors wield divine ministry. They are called and consecrated to be protectors of life. They are called to give gospel based proclamation through their ministry. The glory and nobility of the ministry lies in generating new faith and hope in all the patients they encounter. There should be an over flow of mercy in the encounter between a doctor and his patient. When we pray the Rosary there is always an encounter. For example in the joyful mysteries we see five different encounters. Similarly each patient should feel joy and relief after each encounter.

Rev. Dr. Joji Kallingal, Director, PACS, delivered the Presidential address. Church renders great service and she has great vision about all her ministries. Our ministry and services are sacraments and these sacraments lead to redemption. In all our encounters we should manifest our saviour. Only then our ministry will become relevant and meaningful. Any person can buy medicine from a medical store, but the consultation with a doctor is very relevant and the dealings and words of the doctor can work miracles in the patients.When we succeed in imparting Jesus to others and follow Jesus' teachings, then our hospitals will become mission hospitals. Mother Mary's presence radiated and communicated god experience not only to Elizabeth but even to the fruit of her womb.

God the father found Mother Mary worthy to give the Saviour to the world. Today the sister doctors are the ones who give Christ, the saviour to the world. Father's words have great relevance in the modern world where sister doctors have a special role in imparting the love of Jesus, the great healer.

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Sr.Dr.Lilian talked on the vision and mission of the SDFI. She emphasized on holistic healing and for this we have to be missionaries with true spirit. Sr.Dr.Mercy proposed vote of thanks.The Inaugural Session was followed by the scientific session on menopausal symptoms and management by Dr.sareena Gilvas Professor and Head of OBG, Jubilee mission Medical college hospital. After the coffee break there was a session on RNTCP. The two days conference came to an end with the vote of thanks and lunch. Participant bid good bye to all to meet again for the SDFI, National Conference at Bhopal.

Sr. Dr. Ranita FCC,
President,
Kerala Region.

REGIONAL MEETING AT PASTORAL CENTER, BHOPAL:

The regional meeting started with a silent prayer. There were 32 members present. Since the president, secretary and treasurer completed their terms of three years there was election for these posts. Sr.Dr. Betty Jose SH was elected as the regional president, Sr.Dr. Reeja FCC was elected as the secretary, and Sr.Dr.Elsy Lukose SH was elected as the treasurer.

After the discussion the Venue & Theme for the next AGBM was suggested as

Venue: Mumbai/ Calcutta

Theme: Sister Doctors – Ambassadors of Divine Mercy.

The regional meeting

Venue: Thalassery / Kannur

Date: 20th & 21 st August.

Theme was not decided.

There was a suggestion to have the AGBM in August / September due to the specialty med. Conferences are in January/ February.

Sr. Dr. Betty Jose SH,
President,
Kerala Region.

APPROACH TO COMMON CARDIAC DISEASES

DR RAJESH SETHI. MD(MEDICINE),
FELLOWSHIP IN NON INVASIVE CARDIOLOGY,
EX JR CONSULTANT ESCORTS HEART INSTITUTE,
NEW DELHI

CHEST PAIN

- MOST COMMON EXPRESSION OF CAD
- MI UNRECOGNISED IN 12 %
- MI NOT A/W CHEST PAIN IN 25%
- IS IT CARDIAC OR NON CARDIAC?

IF CARDIAC,IS IT DUE TO-

- CAD
- PERICARDITIS
- AORTIC DISSECTION
- PULMONARY EMOLISM
- MVP
- HCM

IF CAD,IS IT D/T

- AMI
- UA/NSTEMI
- STABLE ANGINA
- VASOSPASTIC ANGINA
- MIXED ANGINA

IF NON CARDIAC ,IS IT -

- ESOPHAGEAL:GERD,SPASM,POST VOMITING
- MUSCULOSKELETAL:COSTOCHONDRITIS,OA OF SPINE
- HYPERVENTILATION
- AC PEPTIC ULCER
- AC PANCREATITIS
- AC CHOLECYSTITIS
- LUNG D/S:PNEUMOTHORAX,PNEUMONIA,PL EFF

EVALUATION OF CHEST PAIN

- **ONSET**:SUDDEN:MI,AORTIC DISSECTION GRADUAL:ANGINA
- **SITE AND RADIATION**:COMMONEST IN IHD IS SUBSTERNAL.LT ARM RADIATION IS COMMONEST.EPIGASTRIC IS CONFUSED WITH APD
- **DURATION**:INTERVENTION IF <12 HR,RECANALISATION WITH SK 75%IN 1 ST HR 40%IN 6HR.STABLE ANGINA NEVER >30 MIN. UA/AMI >30 MIN.NON CARDIAC IF FOR DAYS.TLX IF NO PAIN BUT <4 HRS

EVALUATION OF CHEST PAIN

- **CHARACTER OF PAIN**: HEAVINESS,CHOAKING,ACIDIY,BURNING,CONSTRICION,UNEASINESS
- **SEVERITY**:UNRELIABLE
- **RELATION TO PHYSIOLOGICAL ACIVITY**:MOST VALUABLE.INCREASES WITH EFFORT,LAG IN ANGINA NOT IN MUSCULAR.INCR WIH COLD,EMOTION,DREAM,STOOL,FEVER,SUPINE

EVALUATION OF CHEST PAIN

- **CLINICAL SITUATIONS PRECIPITAING ANGINA**: 1.**NBA**:SYMPATHOMIMEICS,ALPHA 2 STIMULANTS,STEROIDS ,NITRATES IN HCM,MVP,REFLEX TACHY

2.**CAD**:ASPIRIN D/T BLEED

3:**HTN**:HYDRALAZINE,NIFEDIPINE

4.**HYPOTHYROIDISM**.THYROXIN

5.**JOINT D/S**:NSAID,STEROIDS

6 **ULCER**:DECREASED ABS OF ANTIANGINALS

7DEPRESSION:TCA CAUSE ARRHYTHMIA AND HTN

ANGINA RELIEVING FACTORS

- REST
- NTG
- SITTING/STANDING
- BELCHING
- WALK THROUGH

EVALUATION OF CHEST PAIN

REST PAIN

- UA/NSTEMI
- MI
- PRINZEMATAL ANGINA
- MIXED ANGINA

EVALUATION OF CHEST PAIN

NOCTURNAL PAIN

- ASS LVF
- VASOSPASM
- LT MAIN D/S
- MIXED ANGINA
- SEV AR
- ACCEL HTN
- IS A CONTRAINDICATION FOR TMT

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EVLUATION OF CHEST PAIN

- **ACCOMPANYING SYMPT**:

1 **DYSPNOEA**:LVF,ANGINA,DIASTOILC DYSFUNC

2 **SYNCOPE**:MI,ARRHYTHMIA,PE,TAMPONADE, PNEUMOTHORAX,PERICARDITIS,HCM,UGI BLEED

3**VOMITINGS**:IWMI,ASPRIN,MORPHINE,MYOCARDIAL RUPTURE

EVALUATION OF CAD

PAINLESS MI:

- ELDERLY,DM,GA,LVF WHEN DYSPNOEA IS MAIN, FAILURE TO RECOGNISE

CAD

- **SYMPT OF ASS D/S** :

APD:D/D FOR CAD,CI FOR TLX

SORE THROAT:STK CI IN STREPTOCOCCAL INF

BA:D/D IS LVF,B BLOCKERS ARE CI,ALLERGY TO STK LIKELY

HTN:DRUGS,CI TO TLX

RECENT CVA:CI TO TLX

DM:HYPOGL CAN PRECIPITATE ANGINA

CAD

- **ANGINA**: GOLDMAN'S ACTIVITY SCALE

CLASS I:NO LIMITATION INCL CLIMBING STAIRS

CLASS II:SLIGHT LIMITATION OF ORDINARY ACT, CLIMBING 2 STAIRS DOES NOT CAUSE ANGINA

CLASS III:MARKED LIMITATION OF ORDINARY ACT

CLIMBING 1-2 STAIRS CAUSES ANGINA

CLASS IV:AT REST AND EVEN ON SLIGHT EXERTION

CAD

- **DIAGNOSIS OF STABLE CAD**

EXERCISE ECG- 45-50% SENS,85-90%SPECIFIC

STEC/DSE-80-85% SENS,80-88%SPECIFIC

SPECT-73-92%SENS,63-82%SPECIFIC

VASODILATOR SPECT-67-94%SENS,75-84%SPECIFIC

CTA-95-99%SENS,64-83%SPECIFIC

CAD

- **UA**:CRESCENDO ANGINA ON PRE EXISTING CHR STABLE ANGINA

  ANGINA AT REST OR MIN EXERTION

  ANGINA PECTORIS ACUTE ONSET (< I MONTH)

CLASSIFICATION:A)**SEVERITY**:1 NO EPISODE IN LAST 2 MONTHS,2EPISODE IN LAST 1 MONTHS BUT NOT IN 48 HRS,3 EPISODE OF REST PAIN IN 48 HRS B)**CLINICAL** 1 SECONDARY,2 PRIMARY, 3POST IFARCT C)**T/T** 1NO RX,2ON STD RX,ON IV RX

CAD

- **NON ACS CAUSES OF RAISED TROPONIN LEVELS:**

RENAL DYSFUNCTOIN
CHF
PE
AORTIC DISSECTION
MYOCARDITIS
POST CPR
BURNS
SEPSIS
HYPERTENSIVE CRISIS
SAH
RHABDOMYOLYSIS

PERICARDITIS

- SUBSTERNAL,SHOULDER,PARASTERNAL,EPIGASTRIC
- RADIATION TO ARM IS RARE
- O/E RUB,FEVER,SIGNS OF EFFUSION OR TAMPONADE
- USUALLY D/T SYSTEMIC D/S
- CAUSES OF PER EFF-

DRUGS
INFECTIONS
UREMIA
AD
HYPOTHYROID
MALIGNANCY
POST MI
RH FEVER
SLE,RA,AS,WEGNERS,SCLERODERMA

PULMONARY EMBOLISM

- PLEURITIC PAIN IN AXILLA OR INTERSCAPULAR REGION
- DYSPNOEA IS A CARDINAL FEATURE
- CENTRAL CYANOSIS
- TACHYCARDIA IS A RULE
- HYPOTENSION,INCREASED JVP,DRY LUNGS
- BRADY RULES PUT PE
- **D DIMER**-HIGH NEG VALUE>99%.IF NORMAL ,STOP WORKUP

IF HIGH, IMAGING FOR CONFIRMATION

- **RX**-NORMOTENSIV+NORMAL RV-ANTICOAG

NORMOTENSIVE+RV HYPOKINESIA-INDIVIDUALISE RX
HYPOTENSIVE-ANTICOAGULATION+TLX/EMBOLECTOMY

AORTIC DISSECTION

LOOK FOR IT WHEN

- RIPPING,TEARING PAIN OVER BACK RADIATING TO ARTERY INVOLVED
- MARFANS,HTN ARE PREDISPOSING FACTORS
- ASSYMETRIC PULSE
- ACUTE AR
- PERICARDIAL RUB/TAMPONADE
- MI IF CORONARIES INV
- AC ABD PAIN (MESENTRIC INV)
- MEDIASTINAL WIDENING ON XRAY
- 90% ARE DISTAL,ANTICOAGULATION IS CI

AORTIC DISSECTION

- HIGH RISK CONDNS+HIGH RISK SYMPT+HIGH RISK FINDINGS

IF HIGH RISK (2>2 risk factors)-SX REF
IF INTERMEDIATE(1 risk factor)-ECG&XRAY IF NOT S/O ALTERNATE DIAGNOSIS-TEE/CT/MR

- IF AD-DECREASE HR<60 BPM,DECREASE BP<120, CONTROL PAIN

IF DISSECTION WITH HYPOTENSION/SHOCK-EXPEDITE SX M/M,I/V FLUIDS TO KEEP MAP 70 MM HG,R/O TAMPONADE,AR

MVP

- ATYPICAL CHEST PAIN
- YOUNG ,TALL AND LEAN PT
- CLICK WITH LATE SYS MURMUR
- ST CHANGES IN INF AND LATERAL LEADS
- ECHO IS DIAGNOSTIC
- DETERIORATES WITH NITRATES

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NON CARDIAC CAUSES OF CHEST PAIN

- ESOPHAGEAL:10-25% ADMS, INCR BY SWALLOWING,GERD,DELAYED RESP TO NITRATES,DECR WITH ANTACIDS,NO RELATION WITH EFFORT
- SIMULATIONS WITH ANGINA:RELIEVED WITH NITRATES,PROVOKED BY FOOD,NOCTURNAL PAIN

APPROACH TO PT WITH CHEST PAIN

- HISTORY OF RISK FACTORS
- **AC CH PAIN WITH ABN ECG:**I/ LINE,RHYTHM,IF MI ASPIRIN,TICAGRELOR/PRASUGREL/CLOPIDOGREL,BB,CCB,ACE I,NITRATES,O2,HEPARIN,GPIIb /IIIa INHIBITORS,TLX/PCI
- **AC CH PAIN WITH NO E/O MI:**HEPARIN,ASPIRIN, CLOPIDOGREL,BETA BLOCKERS,CCB,NITRATES,ACE I
- **ATYPICAL CHEST PAIN:**OBSERVATION
- **NON CARDIAC** : APD,PANCREATITIS,CHOLECYSTITIS ,PNEUMOTHORAX, ESOPHAGEAL SPASM

STEMI

- **PRIMARY PCI-**IF FMC TO DEVICE TIME<90 MIN AT PCI CAPABLE CENTRE AND <120 MIN IF NON PCI CAPABLE CENTRE
- **INDICATIONS-**

ISCHAEMIC SYMPTOMS<12 HRS

ISCHAEMIC SYMPTOMS<12 HRS WITH CONTRAIND TO TLX IRRESPECTIVE OF TIME DELAY FROM FMC

CARDIOGENIC SHOCK/CHF IRRESPECTIVE OF TIME DELAY

ONGOING ISCHAEMIA 12-24 HRS

STEMI

- **FIBRINOLYSIS**-IF >120 MIN DELAY FROM FMC TO PCI
- **INDICATIONS**

ISCHAEMIC SYMPTOMS<12 HRS

ONGOING ISCHAEMIA 12-24 HRS

- **AGENTS-**

TENECTEPLASE 85% PATENCY,MOST FIBRIN SPECIFIC

RETEPLASE 84%

ALTEPLASE73-84%

STK-NON FIBRIN SPECIFIC.,ANTIGENIC.60-68% PATENCY

STEMI

- **CONTRAIDICATIONS TO TLX-**

ABSOLUTE_

ANY PRIOR ICH

KNOWN STRUCTURAL CARIOVASCULAR MALFORMATION (AV)

MALIGNANT INTRACRANIAL NEOPLASM

ISCHAEMIC STROKE 3 MONTHS(EXCEPT <4.5 HRS)

SUSPECTED AD

ACTIVE BLEEDING DIATHESIS

INTRACRANIAL SX WITHIN 2 MONTHS

FOR SK ,IF USED WITHIN 6 MONTHS

UNCONTROLLED HTN DESPITE RX

STEMI

- **CONTRAINDICATIONS TO TLX**

RELATIVE-

ORAL ANTICOAGULANT RX

PREGNANCY

ANY MAJOR SX <3 WEEKS

BP >180/110 AT PRESENTATION

STROKE >3 MONTHS

ACTIVE PEPTIC ULCER

IC PATHOLOGY EXCEPT ABSOLUTE CI

TRAUMATIC /PROLONGED CPR >10 MIN

APPROACH TO PT WITH CHEST PAIN

- CHEST PAIN WITH N CORONARIES: VASOSPASM,MICROVASCULAR,SLOW FLOW
- NO TMT IF :REST PAIN IN LAST 1 WEEK
- IF CLASS III ANGINA OR MORE

APPROACH TO PT WITH CHEST PAIN

- **DECISIONS:**
- 1 **STABLE ANGINA** 1-2,MILD POSITIVE OR NEGATIVE:MEDICAL RX
- **2ANGINA CL3-4,TVD,NLV**: SX HAS 92%5 YR SURVIVAL,74% SURVIVAL ON MED RX
- **3TVD,LVD,ANGINA**:SX HAS 82% 5YR SURVIVAL, 52% SURVIVAL ON MED RX
- **4ASYMPTOMATIC POST MI:**MORTALITY 3-4%AFTER 5 YR WITH BOTH SX,MED RX
- **5LT MAIN D/S** >50% ASMPT: SX

PRACTICAL IMPLICATIONS

- AC CH PAIN:,P AND BP AND ECG,LATER ASK FOR RECORDS
- NOCTURNAL PAIN WITH NORMAL ECG:ADMIT
- ANT CH PAIN 1ST TIME IN LIFE:CAD
- NORMAL ECG DOES NOT R/O CAD
- AC MI:TLX/INTERVETION
- PAIN POST TLX:INTERVENTION
- NO TMT IF REST PAIN IN LAST 1 WEEK
- PAIN POST PTCA/CABG SIMILAR TO EARLIER:ISCHAEMIA
- ATYPICAL PAIN POSITIVE TMT:FALSE POSITIVE
- TYPICAL PAIN NEG TMT:FALSE NEGATIVE

DYSPNOEA

- **CAUSES**:

CARDIAC

PULMONARY

ANEMIA

OBESITY

HYSTERICAL

MALIGNEING

DYSPNOEA EVALUATION

- IS IT DYSPNOEA
- IS IT CARDIAC?PULMONARY
- IF CARDIAC,GRADE
- DURATION
- ON RX OR NOT
- ASSOCIATED SYMPTOMS

CONDITIONS SIMULATING DYSPNOEA

- ANGINA EQUIVALENT
- KUSUMAUL'S RESPIRATION (RENAL,DKA)
- HYPERVENTILATION:ANXIETY,MALIGNERING,PULMONARY EMB,DRUGS LIKE BB ASPIRIN,PREGNANCY,FEVER,SEPSIS
- DEPRESSION

IF LVF WITH NORMAL SENSORIUM,RULES OUT HYPOTENSION,HYPOXIA

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DYSPNOEA WITH DROWSINESS

- 1 **KUSSUMAUL'S** :DKA,RENAL FAILURE,METHYL ALCOHOL POISONING
- 2**LVF**:HYPOGLYCEMIA,MORPHINE USE,HYPOTENSION,HYPOXIA
- 3 **CNS DISEASES:**HYPERTENSIVE ENCEPHALOPATHY,EMBOLIC STROKE

FACTORS FAVOURING PULMONARY CAUSE OF DYSPNOEA

- COUGH
- WHEEZING
- FEVER
- PLEURAL PAIN
- SEASONAL VARIATION
- PROGRESSIVE OVER YEARS
- RESPONSE TO BRONCHODILATORS
- RESPONSE TO O2
- DEEP CYANOSIS
- NO E/O CAD

FACTORS FAVOURING CARDIAC CAUSE OF DYSPNOEA

- PND/ORTHOPNEA
- ASS SYMPT OF HEART DISEASE
- BROWN FROTHY SPUTUM
- RAPID PROGRESSION OF SYMPTOMS
- NO CYANOSIS WITH DYSPNOEA
- RESPONSE TO DIURESIS
- E/O HEART DISEASE ON EXAMINATION
- CHEYNE STOKES BREATHING

GRADING OF DYSPNOEA

- I SEV UNACOUSTOMED EXERCISE CAUSES DYSPNOEA .PVP <12 MM HG
- II MODERATE EXERTION CAUSES DYSPNOEA. PVP 12-18 MM HG
- III MILD EXERTION CAUSES DYSPNOEA. PVP 19-24 MM HG
- IV DYSPNOEA AT REST .PVP >25 MM HG

PND

- **C/S:** INCR VEINOUS RETURN,INCR RV OUTPUT, DECREASED LV CONTRACTILITY IN SLEEP, DREAMS,ARRHYTHMIA
- **CONDITIONS SIMULATING PND:**

OSAS
ANGINA EQUIVALENT
GERD
OBESITY
POST NASAL DRIP
ASTHMA (NOCTURNAL)
ANXIETY
PULMONARY EMBOLI

ORTHOPNEA

- **CAUSES:**

LVF
COAD
DIAPHRAGMATIC PARALYSIS
LARGE ASCITES

IMPORTANCE OF DURATION OF DYSPNOEA

- IF >5 YRS PND,ORTHOPNEA –MS LIKELY,

AV D/S AND CAD UNLIKELY AS PT'S SURVIVE < 3YRS

RVF DEVELOPS EARLY IN RV DISEASE,LATE IN MV DISEASE

IF DYSPNOEA >18 MONTHS IN AR-SX HAS POOR OUTCOME

DRUGS AFFECTING DYSPNOEA

- **BB:AGGREVATE** NBA,LVF,DEPR

RELIEVE ANXIETY,ANGINA EQUIVALENT

- **BRONCHODILATORS:AGGREVATE** ANXIETY,ARRHYTHMIA,MS,ANGINA

RELIEVE BRONCHOSPASM

- **NITRATES:AGGREVATE** HOCM,MVP

RELIEVE ANGINA,LVF,ESOPHAGIAL SPASM

- **DIGOXIN:AGGREVATE** HCM,ANGINA

RELIEVE MS,LVF

- **DIURETICS:AGGREVATE** PE,P EFF,COAD

RELIEVE LVF,RENAL

- **STEROIDS:AGGREVATE** CHF,RENAL

RELIEVE BRONCHOSPASM

DYSPNOEA IN CLINICAL STATES

- **CAD**

ANGINA EQUIVALENT
LVF-ISCHAEMIA,VALVULAR,CHD,ARRHYTHMIA
PULMONARY EMBOLISM
B B IND BRONCHOSPASM
ASSOCIATED COAD
HYPOGLYCEMIA
DKA

LVF MEANS EF<40%
LVF WITH EF>40% -VALVULAR,ANEMIA,VSD
LVF COMMON WITH AWMI
DYSPNOEA WITH IWMI:A/W PWMI,MR,OLD AWMI,VSD,PE,ASS DCM
DYSPNOEA WITH MI 4 YR SURVIVAL <50%
DYSPNOEA WITH EF 50% 4 YR SURVIVAL 80%

DYSPNOEA IN CLINICAL STATES

- **VALVULAR DISEASE**

MS :IF DYSPNOEA >5 YR MS

IF >3 YR AV D/S UNLIKELY

RH FEVER:LATENT PERIOD >3 YR

NO DYSPNOEA WITH RVF-TS

AS:SURVIVAL 2-3 YR WITH ANGINA,SYNCOPE

1.5 YRS WITH DYSPNOEA

DYSPNOEA WITH MILD AS- ASS CAD,ASS MS,HCM

DYSPNOEA IN CLINICAL STATES

- **VALVULAR DISEASE**

MR :PALPITATION IS GEN 1ST SYMPT

DYSPNOEA IS LATE

PVH IN MR: ASS MS,ASS LVD,ARRHYTHMIA,SEV MR WITH NON COMPLIANT LA

RAPID DYSPNOEA IN MR:IE,RUPTURE OF CHORDAE,ARRHYTHMIA,CAD,RECUR RH FEVER

DYSPNOEA>2 YRS-POOR OUTCOME OF SX

DYSPNOEA CL II-SX

AVOID DIURETICS & LANOXIN :MASK DYSPNOEA AND LVD

DYSPNOEA IN CLINICAL STATES

- **VALVULAR DISEASES**

AR: DYSPNOEA IS LATE PRESENTATION
RAPID DYSPNOEA IN AR:
ASS MV D/S
LVD
ARRHYTHMIA
RECUR RH FEVER
HTN
IE

CLAS II DYSPNOEA IS AN INDICATION FOR SX
IF DYSPNOEA S <2 YRS-GOOD RESULT OF SX
SOME PTS IMPROVE OF EFFORT AS HR INCR,AR DECR,LATER LVD CAUSES DYSPNOEA

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SYNCOPE

- **MECHANISM**:DECR CBF CENTRAL AO PRESSURE <60 MM HG,DECR ENERGY SUBSTRATES RBS<40,PAO2<60
- **CAUSES**:

1 VASOVAGAL
2 CARDIOVASCULAR
3METABOLIC,DRUGS
4CNS D/S
5 UNKNOWN

VASOVAGAL SYNCOPE

- COMMONEST C/S
- PRODROME FEW SEC TO MIN,EVENT LASTS<1 MIN,ADJUSTS TO SURROUNDING IN SECONDS
- CAUSES:

1VASOVAGAL PHENOMENON
MICTURITION
COUGHING
LAUGHING
SWALLOWING
DEFAECATION
SITUATIONAL
CAROTID HYPERSENSITIVITY
ACUTE PAIN
2POSTURAL
3HYPERVENTILATION
4PSYCHOGENIC

CVS SYNCOPE

- 13% OF SYNCOPES
- ARRHYTHMIAS 80%
- **CAUSES:**

1 ARRHYTHMIAS:
A)**BRADY**-SICK SINUS,CHB, HYPOKALEMIA,RAISED ICH,DRUGS, MYOCARDITIS,ISCHAEMIC
B)**TACHY**:VENTRICULAR,SUPRAVENTRCULAR
CONDITIONS PREDISPOSING TO ARRHYTHMIA: CAD,CHF,HYPOKALEMIA,HYPERKALEMIA,INCR QTc,CKD,CAROTID HYPERSENSITIVITY, TUMORS,EMOTIONS,VALVULAR D/S

CVS SYNCOPE CAUSES CONTD

2STRUCTURAL HEART D/S:
SEV AS
HCM
TAMPONADE
PE
MYOCARDITIS
TOF,EISSENMENGER
SEV PS
PPH

CVS CAUSES OF SYNCOPE CONTD

- **VT** :25%OF ALL SYNCOPE,39%OF CVS SYNCOPE

NO PRODROME (DIFF FROM VASOVAGAL)
HAVE UNDERLYING HEART D/S

- **SVT**:LESS COMMON (8% OF CVS SYNCOPE)

CAUSES IN SVT:
A UNDERLYING HEART DISEASE(AS,HCM,CAD,PS, RCM)
B RATE>200 BPM
C PRE EXCITATION

CVS CAUSES OF SYNCOPE CONTD

- **BRADYARRHYTHMIAS**:31% OF CVS SYNCOPE

CHB &SSS COMMONEST
IF PALPITATION,NORMAL,SYNCOPE:SSS
SSS CAUSING SYNCOPE;MECHANISMS-
1SEV BRADY,2 CHB,3 SINUS ARREST,4 SVT WITH RVR, 5 SVT-VT 6 BB OR VERAPAMIL
CHB CAUSING SYNCOPE-
1RBBB *1st DEGREE HB
2RBBB*LAHB
3LBBB*Ist DEGREE HB
4MOBITZ TYPE II
5ALTERNATING BBB

NON ARRHYTHMIC CAUSES OF CV SYNCOPE

- **1 AS:**COMMONEST

A) SEV AS B)ARRHYTHMA C)ASS CAD D)HCM

- 2 **CAD**:A)ARRHYTHMIAS B)ISCHAEMIA C) PARA SYMPATHETIC EXCESSIN IWMI D)DRUGS-DILATORS,DIURETICS,ARRHYTHMIAS D/T DRUGS E)PE F)TAMPONADE

IF SYNCOPE WITH AMI R/O ICH BEFORE TLX

- NITRATE SYNCOPE
- **HTN AND SYNCOPE:**A)POSTURAL D/T DRUGS B)HT ENCEPHALOPATHY C)ICH D)PHAEOCHROMOCYTOMA
- **SYNCOPE IN MS:**RARE EVEN IF SEVERE. A)LA MYXOMA B)ARRHYTHMIA C)SEV PHT D)PE E)THROMBUS F)ASS AS G)ASS CAD

NEUROLOGICAL CAUSES OF SYNCOPE

- EPILLEPSY IS COMMONEST
- **DISEASES MIMICKING SYNCOPE:**

EPILLEPSY
NARCOLEPSY
TIA
SAH
BASILAR MIGRAINE
BULBAR SYNCOPE
BRAIN TUMORS
PN

DIFFERENCES BETWEEN SEIZURE AND SYNCOPE

- SEIZURE:

AURA
ABRUPT LOC
SENSORY HALLUCINATION
DEJAVU
EMOTIONAL STRESS
CONFUSIONAL STATE
MOTOR AUTOMATISM
PROLONGED AMNESIA
H/O CVA,INJURY,ALCOHOL WITHDRAWAL,MALIGNANCY
RECURRENT SYNCOPE IN YOUNG

SIMILARITIES BETWEEN SYNCOPE AND SEIZURE

- BLACK OUT
- GIDDINESS
- NAUSEA
- SWEATING
- WEAKNESS
- YAWNING
- SIGHING
- PALLOR

NEUROLOGICAL CAUSES OF SYNCOPE

- **CAROTID D/S:** B/L CAROTID D/S AND AS BOTH CAUSE MURMURS IN CAROTIDS,MURMUR IN AS IS BETTER ON PRECORDIUM
- **VBI**:AGE >65 YRS,ATAXIA,DYSARTHRIA,

CAUSES:ATHEROSCLEROSIS,SPONDYLOSIS,SUBCLAVIAN STEEL

- **SAH**:ALTERED SENSORIUM,NECK RIGIDITY,

NEUROLOGICAL SIGN

- HTN WITH ECG CHANGES ,CONFUSION WITH CAD
- HTN WIH BRADY D/T ICH,CONFUSION WITH BRADY

NEUROLOGICAL CAUSES OF SYNCOPE

- **ICH**:ALTERED SENSORIUM IS A RULE
- **PN**:DIABETIC,ALCOHOL,GBS,DRUGS,AMYLOID OSIS,NEURALGIAS
- **METABOLIC**:HYPOGLYCEMIA,HYPOTENSION, ALCOHOL,INCR QTc

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INTRA ABDOMINAL CAUSES OF SYNCOPE

- **UGI BLEED**
- **INCREASED VAGAL REFLEX**-VOMITING,MICTURITION,AC PAIN,ENDOSCOPY
- **PERFORATION**
- **BLUNT TRAUMA**
- **AC PANCREATITIS**
- **LIVER ABSCESS** RUPTURE INTO PLEURA AND PERICARDIUM

MISLEADINGS D/T UGI BLEED:A)POST SYNCOPE BP INCREASES,B)LACK OF ABD PAIN,C)500 ML LOSS WITHOUT MALENA AND HEMATEMESIS D)CHEST DISCOMFORT e)ECG CHANGES

HISTORY IN SYNCOPE

- 75%DIAGNOSIS
- **BACKGROUND:**

1)DM-HYPOGLYCEMIA,CAD,CVA,TIA,POSTURAL GIDDINESS
2)HTN-POSTURAL D/T DRUGS,ENCEPHALOPATHY,CVA,CAD
3)ALOHOLISM-INTOXICATION,NEUROPATHY
4)CAD
5)POST OP-PE,POSTURAL
6) DEAF PT-INCREASED QTc
7)ULCER-BLEED,PERFORATION
8)PAINFUL SITUATION-VASOVAGAL
9)H/O FALL-SDH

- **RELATION TO PHYSIOLOGICAL ACT-**

1)EXERTIONAL-AS,HCM,TAKAYASU'S
2)UPPER LIMB EXERCISE-SUBCLAVIAN STEEL
3)COUGH
4)MICTURITION
5)NECK MOVTS-CAROTID HYPERSENSITIVITY

EXAMINATION OF PT WITH SYNCOPE

- DROWSY-SUGARS,ALC,ICH
- BP-HYPOTENSION,ENCEPHALOPATHY
- PULSE-ARRHYTHMIA,VAGAL
- TONGUE-EPILLEPSY
- BRUIT
- MURMUR
- CLICK
- RUB
- LEG VEINS-DVT,PE
- STOOL TEST-BLEED

DIAGNOSTIC TESTING IN SYNCOPE

- RBS
- HB
- NA/K
- HCO3-DECREASED IN EPILLEPSY
- ABG-PE HAS DECREASED O2
- ENZYMES-ISCHAEMIA
- ECG-RHYTHM,RATE,QTc,HYPOKALEMIA AND HYPERKALEMIA
- HOLTER 15% YEILD
- ECHO
- EPS
- NEURO INV

PALPITAION

EVALUATION-

- IS IT PALPITATION OR SOME OTHER SYMPT
- DID IT PRECEDE OR FOLLOW KNOWLEDGE OF HEART DISEASE(PSYCHOLOGICAL IF LATTER)
- PERSISTENT (AF,VOL OVERLOAD) OR PAROXYSMAL (ARRHYTHMIA)
- NATURE OF PALPITATION
- ASSOCIATED SYMPT
- EXTRACARDIAC CAUSE OF PALPITATION
- DRUGS CAUSING PALPITATION

PALPITAION

- **DISEASES MISTAKEN FOR PALPITATION:**

1)CAD
2)INTERNAL HG(TACHAYCARDIA)
3)AC PANCREATITIS
4)PE

- MV/TV D/S:SV ARRHYTHMIA
- WPW:RE ENTRANT SV ARRHYTHMIA, DIGOXIN IS CONTRAINDICATED

PALPITATION :CAUSES

- **CARDIAC CAUSES:A)INTRINSIS D/S**

REGURGITANT LEISIONS
LT TO RT SHUNT
HYPERKINETIC HEART D/S
PHT
PPI
B)**ARRHYTHMIAS**-
PAT-RAPID,REGULAR
AF:RAPID,IRREGULAR,AFL WITH VARYING BLOCKS
CHB:BRADY
VE-NORMAL RATE WITH OCC IRREGULARITY
SSS-PALPITAION-NORMAL-SYNCOPE

PALPITATION CAUSES

- **NON CARDIAC CAUSES**:

HYPERDYNAMIC STATES-
A)ANAEMIA,B)THYROTOXICOSIS,
C)FEVER,D)ANXIETY, E)AV FISTULA,
F)PHAEOCHROMOCYTOMA

DRUGS-
VASODILATORS,TCA,SYMPATHOMIMETICS

DIAPHRAGMATIC FLUTTER

PALPITATION CLUE TO DIAGNOSIS

- **CAD**-ARRHYTHMIA,CONDUCTION DIST
- **CHF**-DIG TOX,HYPOKALEMIA D/T DIURETICS, AF,VF
- **MVP**-SV ARRHYTHMIA,VENTRICULAR
- **ANTIARRHYTHMIC RX-QTc**
- **DIURETICS**-HYPOKALEMIA,LVD
- **DEPRESSION**-TCA,INCR QT
- **THYROTOXICOSIS**-AF WIH FVR
- **PRE EXCITATION**-RE ENTRANT SVT,AF WITH WIDE QRS.DIGOXIN IS CONTRAINDICATED
- **MV D/S-AF**.DIGOXIN IS CHOICE
- **HCM/AS/PS**
- **DIABETIC**-MI,HYPOGLYCEMIA
- **NBA**-DRUG INDUCED
- **HYPERTENSION**-VASODILATOR,PHAEOCHROMOCYTOMA

ASSOCIATED SYMPTOM WITH PALPITATION

- **SYNCOPE**-SERIOUS ARRHYTHMIA , HYPOGLYCEMIA,PHAEOCHROMOCYTOMA
- **DYSPNOEA**-IF PRECEDES PALPITATION-LVF PRECIPITATING ARRHYTHMIA/BA/PEWITH ARRHYTHMIA

IF FOLLOWS PALPITATION-PALPITTION RESULTING IN CHF
IF DYSPOEA WITH PALPITATION-INTRINSIC HEART DISEASE

- **IF CHEST PAIN:CAD**
- **POLYUREA**-PAT
- **SWEATING**-ANXIETY/HYPOTENSION WITH ARRHYTHMIA/ANGINA,AMI/HYPOGLYCEMIA
- **DIAORRHEA**-THYROTOXICOSIS,IBS,HYPOKALEMIA

PALPITATION IN VALVULAR DISEASES

- USUALLY A FEATURE OF REGURGITATNT LEISIONS
- LATE IN STENOTIC LESIONS
- **MS WITH AF-**

CHR MS IN YOUNG
INCREASED EMBOLISM
TEE TO R/O THROMBUS
IND FOR BMV/SX
AF –R/O MS

- **MILD MS WITH AF-**

ASSOCIATED ASD,THYROTOXICOSIS,PREEXCITATION,PE,SSS

PALPITATION WITH HTN

- DRUGS
- PHAEOCHROMOCYTOMA
- HYPOKALEMIA
- HYPERTHYROIDISM
- ASSOCIATED CAD

ASYMPTOMATIC PATIENT

- PHYSICALLY INACTIVE PATIENTS
- DENIAL OF SYMPTOMS
- FAILURE TO RECOGNISE THE SYMPTOM
- DRUG MASKING THE DISEASE
- REALLY ASYMPTOMATIC PATIENT
- ASYMPTOMATIC PATIENT WITH MILD DISEASE
- ASYMPTOMATIC PT WITH SEVERE DISEASE

ASYMPTOMATIC PATIENT WHERE SX IS INDICATED

- **CAD-LMCA>50%**

TVD WITH LVD

- **VALVULAR HEAR DISEASE**

LVD WITH SEV MR/AR
SEVERE AS(CONTROVERSIAL)
SEVERE MS

- **CONGENITAL**

ALL LT TO RT SHUNT (>2:1)
MOD TO SEV PS
SEV AS
SEVERE CO A
ALL CYANOTIC DISEASES

POTENTIALLY SERIOUS ASYMPTOMATIC D/S

- SEV HT
- SEV PAH
- SEV AS
- SEV CAD WITH LT MAIN D/S
- INTRACARDIAC TUMORS
- AORTIC ANEURYSMS
- CORONARY VASOSPASM
- INTRACRANIAL ANEURYSM

ASYMPTOMTIC PT

- NO DEFINITIVE INDICATION FOR SX IN ASYMPTOMATIC PATIENT EXCEPT FOR THE INDICATIONS LISTED EARLIER
- ABSENCE OF SYMPTOMS IS UNLIKELY WITH SEVERE MS BUT COMMON WITH OTHER VALVULAR DISEASES
- COMMONEST CAUSE OF DEATH IN ASYMPTOMATIC AS IS SX

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

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Minimizing Medico legal Problems In Obstetrics And Gynecology

Introduction

The godly image of the doctors is gradually fading into oblivion people claim 'health for money' and hence cases of medical litigations are on the rise.

A professional liability survey conducted in USA in 2006, by the American college of obstetricians and gynecologists (ACOG) revealed that 89 percent fellows had been sued during their careers. There was an average of 2.6 claims per obstetrician. Sixty two percent of obstetrics-gynecology claims were from obstetrics.[1] ACOG professional liability survey revealed 62 percent American obstetricians stopped their practice before 55 years and 31 percent dared to continue beyond 45 years.[2]

Inspite of the best intention and care, mishaps sometimes do happen but can certainly be minimized by adopting certain safety measures.

Prevention starts at the primary level – against the complaint being filed in the first place. The next level is preventing the doctor from being negligent and limiting financial compensation if any.

WAYS TO MINIMIZE MEDICAL LITIGATIONS[3]

Awareness of medico legal problems

Doctors must be aware about the potential areas of litigation and the various happening in the medico legal arena. They should be aware of the changes in laws that may influence their practice.

Medical Ethics

(Code Of Medical Ethics 2002)

A thorough knowledge is of medical ethics is essential for all medical professionals. It is useful in improving practice methods and should be include in the medical curriculum.

Good Interpersonal Relationship And Clear Communication

A suspicious patient who has no faith in her physician is a potential litigant. A good personal rapport with the patient and her relatives can prevent filing a suit, even if any mishap happens.

The patient must not be given false guarantees and needs to understand what to expect from the treatment. The doctor and other care providers must be polite and courteous their sympathy towards the patient.

Proper counseling

Counseling is exchange of information and views in a language best understood by the patient. Discussion involves the patient and her relatives in the decision-making process, after providing them with the knowledge of the treatment offered. Risk and complications of the procedures and prognosis of the disease need to be explained. Good counseling instills enormous confidence and faith. It helps to remove fear and misconceptions that may exist in the mind of the patient.

Counseling is advocated before any gynecological and obstetric procedures like

Antenatal fetal monitoring and labor monitoring: Indication; medications used and side effects; induction and augmentation of labor.

Cesarean section: clear indication for the same; comparison with a normal delivery; short and long-term risks involved for the mother and baby. *Prenatal screening and diagnosis*: indications; risk of fetal loss or adverse outcome; benefits vs. risks.

Adolescent health problem: counseling of patient and guardian; the social picture of adolescent health hazards.

Contraception: temporary/ permanent and hormone replacement therapy: indications for use; accompanying risks; compliance issues; short and long-term risks.

MTP *procedures*: medical vs. surgical; risks involved; failure rates; slight chance of ectopic pregnancy.

Endoscopy: indications; comparison with open surgery; conversion if required; specific risks involved.

Hysterectomy: indication; toute; conservation of ovaries; side effects of treatment.

Gynecological: mode of treatment; prognosis; side effects of treatment.

Counseling is discussed in detail in chapter 35.

Informed consent

After proper counseling an informed consent is to be taken.

It is a written agreement signed by the patient in the presence of a witness authorizing the doctor to perform the said investigation or medical / surgical management.

Consent should be obtained in a non-coerced maneer, written in the language best understood by the patient, avoiding medical jargon. It should be understood by the patient and her relatives.

An informed consent should contain the following.

A. Nature, limitations , consequences and risks of management.
B. Risks involved in anesthesia and allied procedures
C. Alternative mode of treatment that may be considered.

More importance should be given especially in cases of minors or mentally disturbed people where the guardian signs the consent form.

Standard Medical Service

Improving infrastructure

There is no substitute for a good quality service. One cannot guarantee the quality of service where the infrastructure is not up to the mark. Doctors are often victimized by the miserable standards of hospitals and this leads to manhandling and harassment, which is not infrequent in India. Facilities available in an institution should be displayed. Health authorities should set norms for the health sector as a whole. A minimum standard of care must be maintained in all hospitals, clinics and nursing homes.

Quality of care

The quality of service should not be compromised. Adequate consultant supervision especially in the obstetric wards helps in early diagnosis and intervention whenever necessary. Active pre and postoperative management is essential.

Adequate training

Medical education

Doctors must have MCI recognized training for practicing medicine. Prescription heads should depict the true qualifications, designation, training and experience of the particular doctor. Certain mistakes performed by less qualified personnel may be considered unpardonable when performed by specialists.

A doctor is expected to have a "reasonably skillful behaviour" adopting the "ordinary skills" and must practice with at least "ordinary care". He can only be sued if it is proved that he was negligent in his duty and did not offer the required medical care necessary and the patient suffered actual damage for which he was responsible. Training of paramedical staffs and midwives who come in direct contact with patients is also essential for maintaining proper standard medical service.

CMEs

All doctors must be updated with the fast changing scenario of the medical field. Regular CMEs and workshops need to be attended to acquire necessary knowledge and modify clinical care. This also promotes fellowship within the fraternity and prevents doctors from degrading their colleagues.

Audits

Morbidity and mortality audits should be done on a regular basis in institutions.

Regular meeting of staff and analysis of their work is very important for improving medical care, (for details please refer to chapter 36).

Second opinion or referral

If required or suggested by the patient in a specific case, the doctor should not feel humiliated to consult another medical practitioner for a second opinion. Timely referral if the need arises should be arranged and kept in mind.

Documentation and record keeping

It must be remembered that documentation is a part of medical training and one must make it a habit. This will not only facilitate research and review but is perhaps the most vital factor in fighting malpractice suits. Proper case documentations can protect a doctor from litigation.

Records must include the following:

- History and physical examination findings of the patient.
- Drug allergies and allergies and chronic medication if any
- Plan of management
- Date and time of interventions done
- Operative / investigation notes
- Records of discussion with patient / relatives at each visit
- Note to be kept of patients not following instructions
- Records should be preserved for a period of at least three years
- Records must not be forged as this amounts to criminal offence

Risk management

Risk management is a process for improving the safety and quality of care through reporting, analyzing and learning from adverse incidents involving patients.

Risk management involves the development of strategies to

- Prevent or limit health risk to the patient
  Recognition of practices giving rise to poor clinical outcomes
  Monitoring standards of care by clinical audit
  Need for modification of guidelines
  Continuing medical education / training
  Improve future practice
  Opportunity to have individualized review of care
  Opportunity to question practice and receive explanations
  Improve quality of care
- Reduce legal risk to the care provider
  To reduce chance of a claim
  To control costs of a claim should be made
  Risk management not primarily about avoiding or mitigating claims but rather a tool for improving the quality of care. risk management is elaborated in chapter 38.

Public awareness program and health education

In an era of tremendous advances in sciences and technology, public expectation is very high and devistion from the normal outcome gets the party agitated. A perfect outcome of any disease does not only depend on the physician but also depends on the patient, party and community. There is lack of health education and sometimes people come to the doctor in late and irreversible stages of the disease. Sometimes they may not disclose knowledge of pre existing diseases or drug intake. This could be of great consequences.

So public awareness program, which include health awareness, is of utmost importance. In this regard professional bodies and media should play an important role.

Professional indemnity insurance

All professional doctors must cover themselves under medical indemnity **insurance to protect themselves against malpractice claims. It is useful to know a member of the company well who will be easily approachable if the need arises. Annual premium must be paid in time to prevent the policy from lapsing for further information on medical indemnity please refer to chapter 40.**

Course after litigation

If a doctor sued, he should immediately contact the insurance company and draft a reply to the letter. It must contain all possible points in his defense as subsequent points during hearing may be rejected.

Points to be covered

1. Qualification and training of the doctor.
2. Infrastructure of the hospital or clinic with back up support.
3. Any facts if suppressed by the patient or her relatives e.g. previous medical disorders or treatments.
4. Copy of written or informed consent where risks and complications have been explained.
5. Circumstantial evidence in support of mishap like lack of facilities may be highlighted.
6. Proof of duty care and medical services offered.
7. Treatment of patient from other doctors and different specialties as and when required.

What to do if a doctor gets used is discussed in detail in chapter 44.

CONCLUSION

Medical profession is always exposed to the threat of litigation. But practicing defensive medical is not the solution. It hampers professional confidence and brings about a sense of dissatisfaction among patients.

The most important aspects of preventing litigations are:

- Generalized improvement of health care infrastructure including health education to the community

- Adoption of every possible precaution and professional updating by health care personnel.

  Doctors Cannot avoid mishaps inspite of their sincere intentions but a good doctor-patient relationship and a sympathetic attitude towards the patient and her relatives will go a long was preventing the doctor from being dragged to the court.

REFERENCES

1. Chervenak JL. Overview of professional liability. Clin perinatal, Jun 2007;34(2):227-32.
2. Sue scheible the patriot ledger copyright 2005.
3. National confidential enquiry into patient outcome death (NCEPOD) (www.ncepod.org.uk/reports.htm).

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Common Eye Diseases

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Red Eyes

- Peripapillary
- Circumcorneal

Peripapillary congestion

- Conjunctival Disesase
- Lid problem
- Fornix

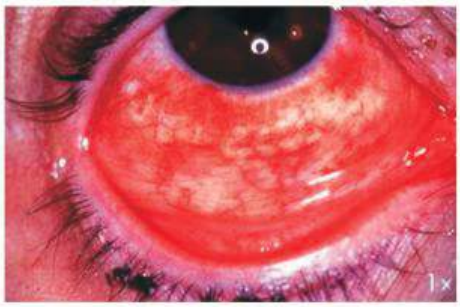
❑Innocuous
❑Can be treated at primary care level

Circumcorneal congestion

- **Corneal Disease**
- **Anterior chamber**
- **Iris / Uveitis**
- **Glaucoma**

❑**Serious**
❑**Needs detailed evaluation**
❑**Slit lamp examination**

Conjunctivitis



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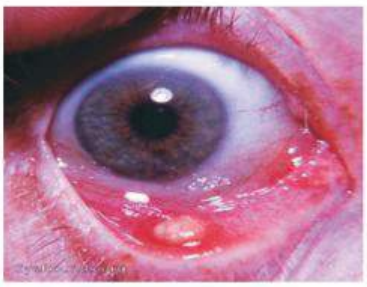
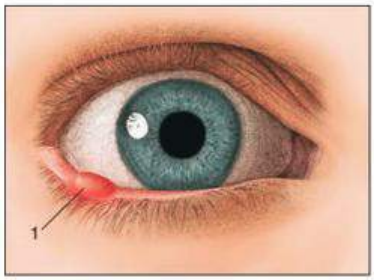
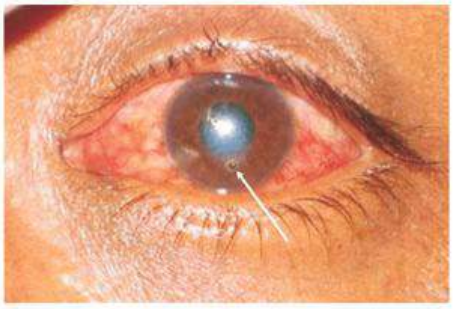
Internal hordeleum



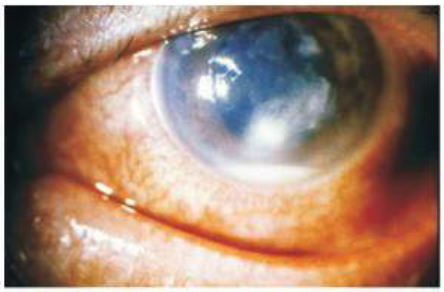
Stye



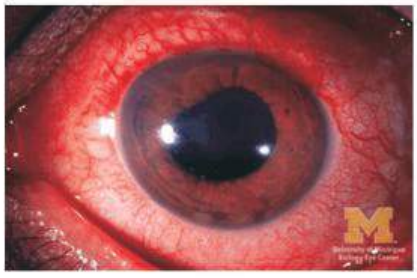
Foreign Body



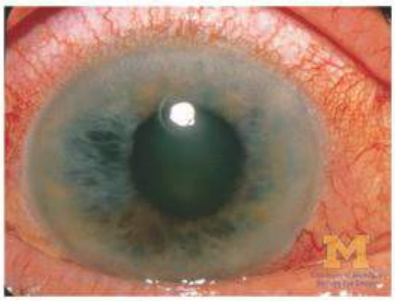
Corneal Ulcer



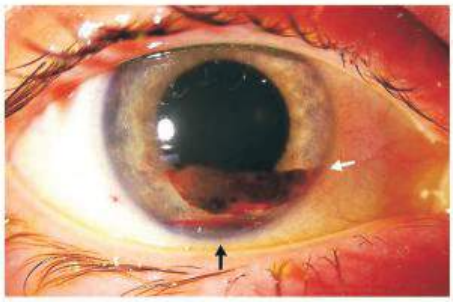
Uveitis



Angle closure Glaucoma



Trauma



When to refer

- **If vision is decreased**
- **Circumcorneal congestion**
- **Problem is recurrent**
- **Photophobia is present**
- **If problem persists inspite of conservative Mx**

Dry Eyes

- Symptoms
- Dryness
- Itching
- Foreign Body sensation
- Eyestrain,

- Treatment
- Lubricants
- Mild steroids
- Life style modification

Diabetes & The Eye

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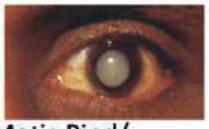
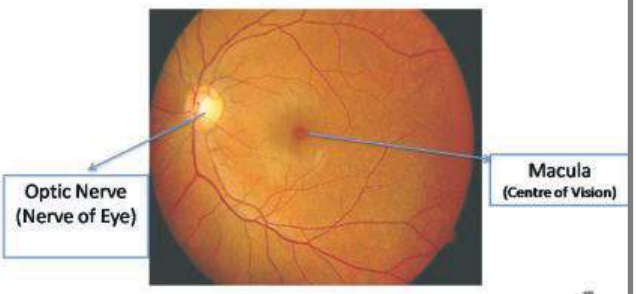
How Does It Affects The Eye

- Frequent Change of Glasses



- Early Formation of Cataract (Motia Bind/ Safed Motia) and HARD cataracts
- DIABETIC RETINOPATHY

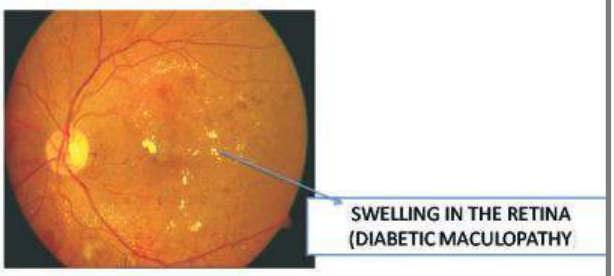
Normal Retina



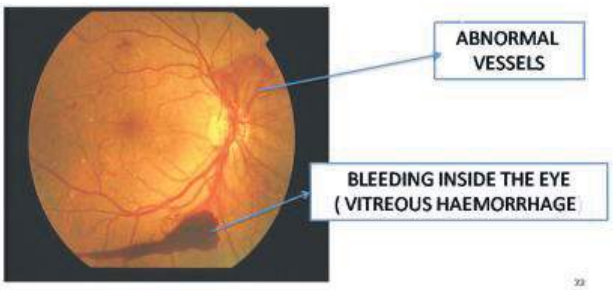
What is Diabetic Retinopathy???

- Affects Normal Delicate Blood Vessels of the eye
  - Leakage of Fluid at the centre of vision (Macular Edema)
- Formation of Abnormal Blood Vessels
  - Bleeding inside the eye

Leaking Normal Vessels



Abnormal Vessels



Why is it important?

- Diabetic Retinopathy is the leading cause of blindness
- 2nd Most common complication of DM
- Most of the pts will have D.R after 10 yrs

Symptoms

Blurred Vision- Swelling or bleeding in the eye can cause blurred vision

Vision Loss- If retina is damaged, vision can be lost permanently.

THERE MAY BE NO SYMPTOMS IN EARLY STAGES

Is it important for physicians?

- First contact – physicians
- Screening helps to prevent Permanent Vision loss
- Just as important as preventing MI or Foot care

What to do?

- Counsel for complications
- Explain importance of screening – FP, ECG, Foot care etc
- Refer for Fundus Photo as per protocol

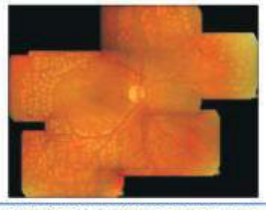
When to check for diabetic retinopathy

- Type 1 DM- Refer at 5 years after onset
- Type 2 DM- At onset/diagnosis of disease

Yearly Fundus Photograph

Most patients start having some retinal damage at 5-10 years after onset of ds

Fundus Camera



DIGITAL PHOTOGRAPH OF RETINA

Fundus Examination: "When"?

- 1st Examination :
  - Type I : 5yr. After onset or at Puberty
  - Type II : Immediately after diagnosis
- Minimal follow-up:
  - Annually If normal at first examination
  - If abnormal at 1st examination, early visits required

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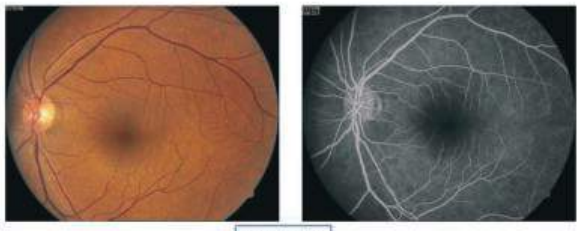
What Other Tests Can be Done?

Fundus flourescin Angiography

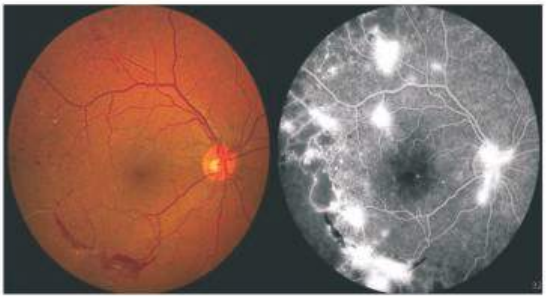
OCT

Normal Angiogram



No Leakage

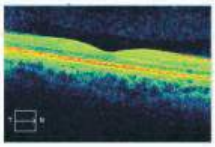
Leaking Blood Vessels

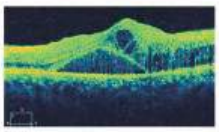


Optical Coherence Tomography

- Optical coherence tomography (OCT) gives a cross section of the retina and shows the amount of swelling present
- CT SCAN OF THE RETINA

OCT



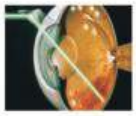


- Cross –sectional view of the retina
- Qualitative and quantitative analysis of ME

Multidisciplinary Approach

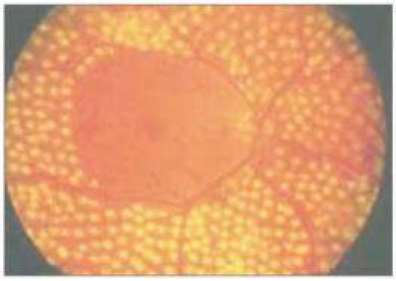
- Control of Diabetes
- Control of Systemic Co-morbidities
  - Blood Pressure
  - Kidney Status
  - Heart Status
  - Brain Status

LASER

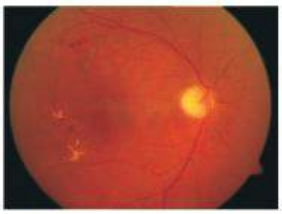


- Special Laser used to seal any weak blood vessels in the eye and prevent them from leaking.
- The laser treatment helps maintain eyesight but may not reverse the vision loss

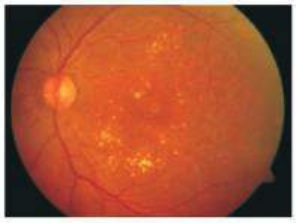
Pan Retinal Photocoagulation (PRP)



Macular Lasers



Focal Photocoagulation



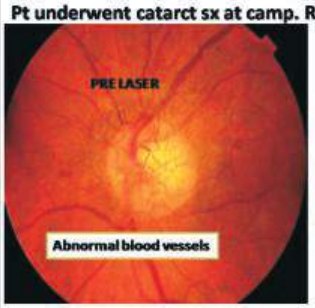
Macular Grid

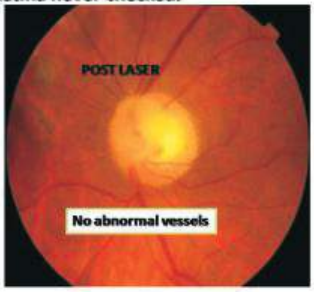
56 yr old man with 8 year h/o DM. Poor Vision Right eye

PRE LASER

POST LASER
Decrease in swelling

62 year lady with h/o DM since 9 years.
Pt underwent catarct sx at camp. Retina never checked.





Adjunctive Treatment Intravitreal Injections

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Agents

Steroid-Triamcinolone

Bevacizumab

Ranibizumab

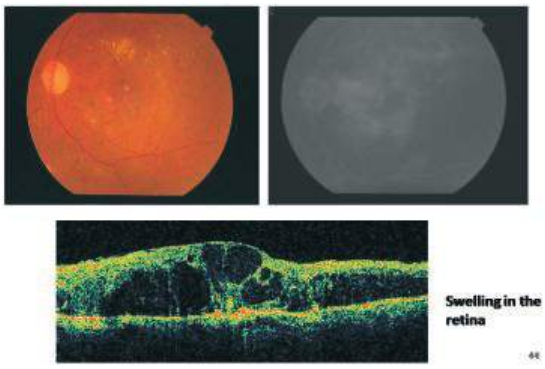
ANTI VEGF AGENTS

Intravitreal Implants

- Illuvien (Alimera)
  – Life 18-36 m

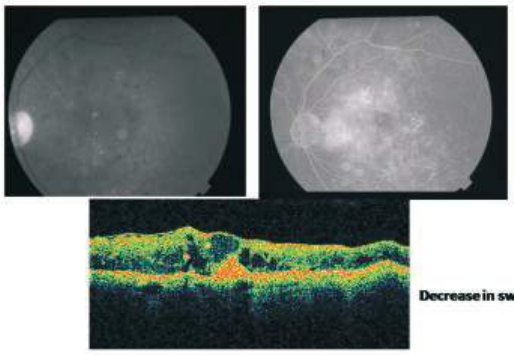
- Ozurdex (Allergan)
  - Life upto 6 m

Pre Injection & LASER



Swelling in the retina

Post Injection & LASER

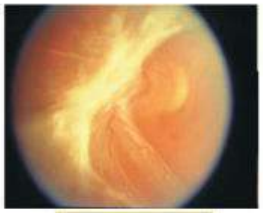


Decrease in swelling

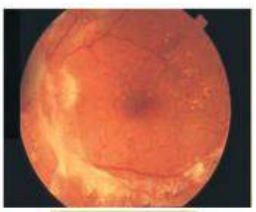
Surgical Treatment

- Bleeding Inside Eye (Vitreous Hemorrhage)
- Shifting of retina from its postion (Tractional/ Combined Retinal Detachment)
- Swelling not responsive to medical treatment

In advanced cases surgery called VITRECTOMY may be needed to clear the blood and scar tissue from the eye



BEFORE VITRECTOMY



AFTER VITRECTOMY

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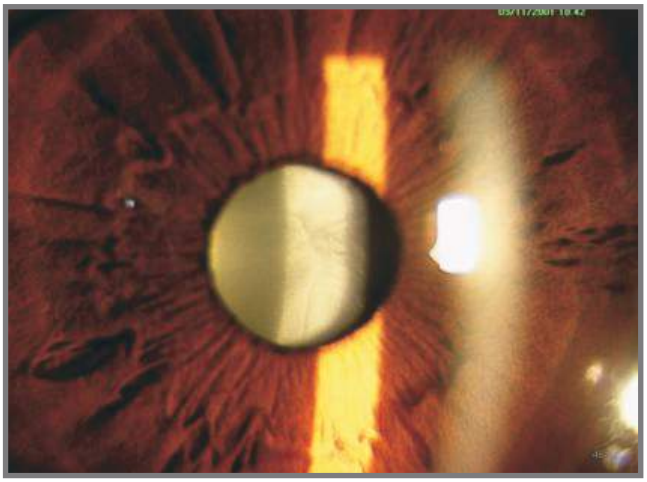
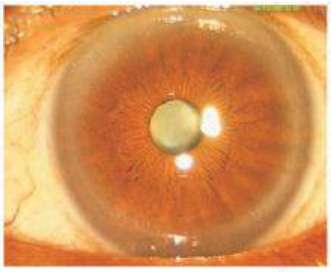


Cataract

- Age related
- Needs treatment when daily routine activity is not possible
- Maturation concept is not valid
- Surgery done by Phaco (laser) technique is best.

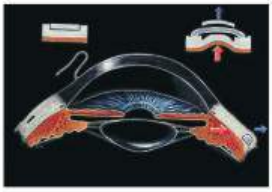


Cataract

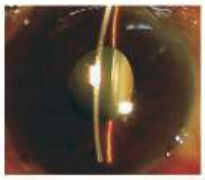
Technique:

Old: Manual removal of entire lens through large incision called SICS

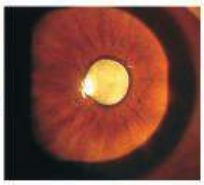
New: Phaco (laser) technique. Nucleus broken into small pieces and removed through machine



Cataract

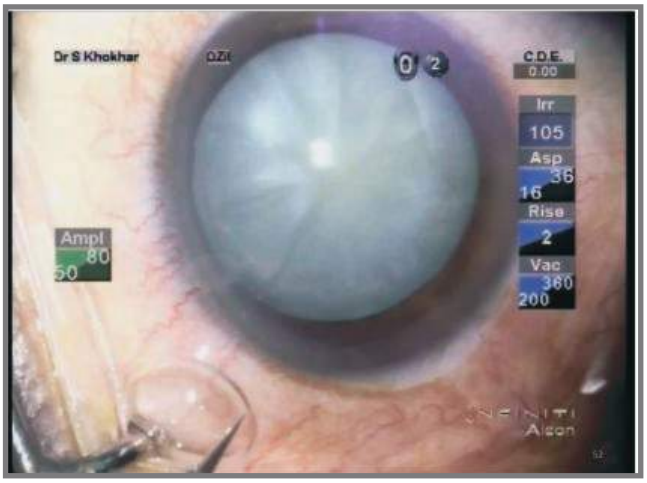


Immature

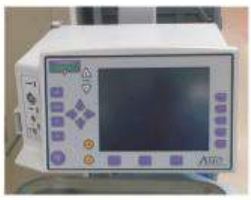


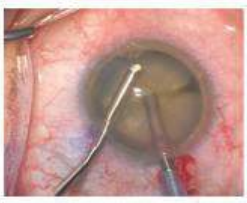
Mature

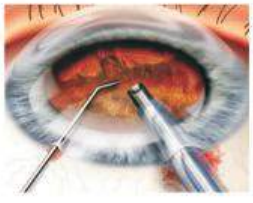
Hypermature

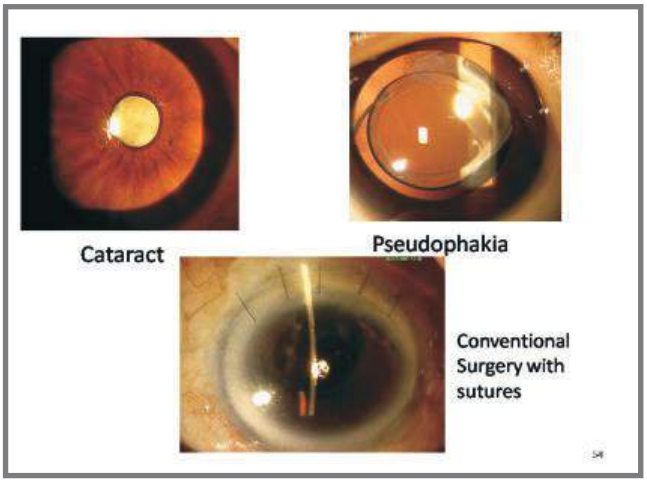


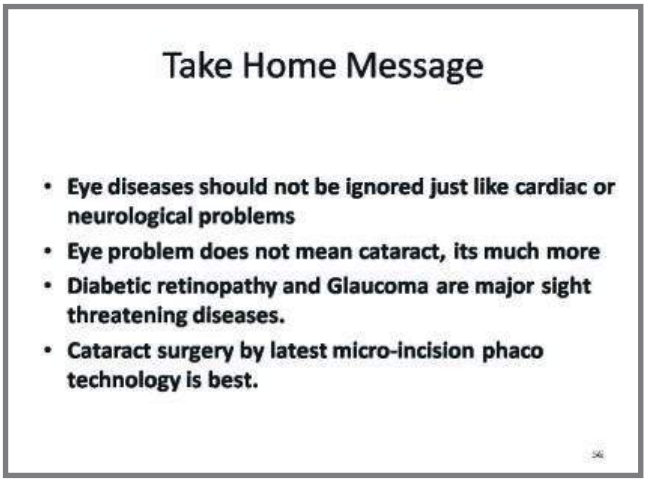
Phaco Technique











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

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Email: sisdocindia@gmail.com

HUMAN TRAFFICKING

Definition

Human trafficking is the trade of humans, most commonly for the purpose of sexual slavery, forced labor, or commercial sexual exploitation for the trafficker or others. This may encompass providing a spouse in the context of forced marriage, or the extraction of organs or tissues, including for surrogacy and ova removal.

Human Trafficking is defined as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Human trafficking can occur within a country or trans-nationally. Human trafficking is a crime against the person because of the violation of the victim's rights.

Human trafficking generated an estimated $7 billion to $9.5 billion per annum as of 2004. Human trafficking is thought to be one of the fastest-growing activities of trans-national criminal organizations. Human trafficking is condemned as a violation of human rights by international conventions.

In 2008, the United Nations estimated nearly 2.5 million people from 127 different countries, 98 transit countries and were being trafficked into 137 destination countries around the world. The average cost of a human trafficking victim today is USD $90.

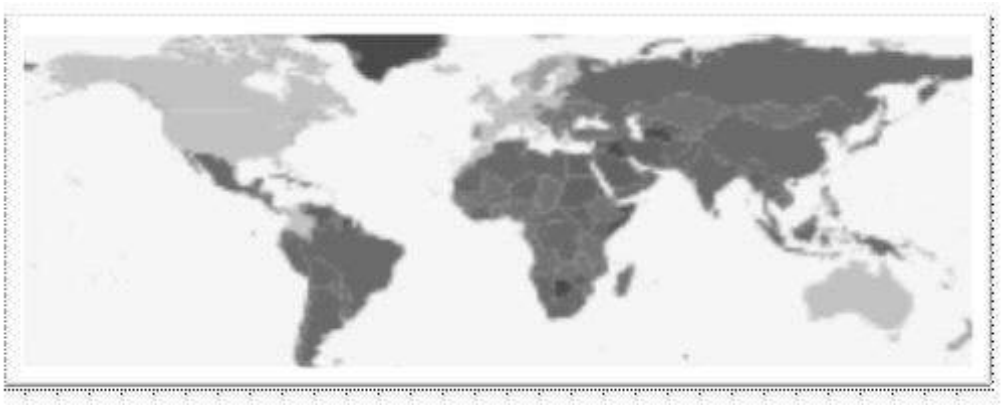
The International Organization for Migration (IOM), the single largest global provider of services to victims of trafficking, reports receiving an increasing number of cases in which victims were subjected to forced labour.

Child labour is a form of work that is likely to be hazardous to the physical, mental, spiritual, moral, or social development of children and can interfere with their education. Sub-Saharan Africa is the region with the highest incidence of child labour, while the largest numbers of child-workers are found in Asia and the Pacific.

General

A schematic showing global human trafficking from countries of origin and destination

Very High/ High/ Medium/ Low/ Very Low/ Not Reported.



A world map showing the legislative situation in different countries to prevent female trafficking as of 2009 according to *Woman Stats Project*.

* **Gray** – No data;
* **Green** – Trafficking is illegal and rare;
* **Yellow** – Trafficking is illegal but problems still exist**;**
* **Purple** – Trafficking is illegal but still practiced;
* **Blue** – Trafficking is limitedly illegal and is practiced;
* **Red** – Trafficking is not illegal and is commonly practiced.

National statistics

- A growing pattern of trafficking in child prostitutes from Nepal.
- A bout 5000 to 7000 between the age of 10-18 are trafficked to India each year.
- NGOs estimate more than 12,000 and more women and children are rafficked into the country annually from neighbouring countries.
- 200,000Nepali girls are in prostitution in India
- 20% of the child prostitutes in India come from Bangladesh and Nepal.
- HIGH SUPPLY & DEMAND ZONE
- Andhra Pradesh, Tamil Naidu & Karnataka - Souh
- Maharashtra - West
- Uttar Pradesh - North
- West Bengal, Orissa, Jharkhand - East

Other States like Assam, Meghalaya, Bihar, Delhi, Goa, Gujarat, Madhya Pradesh, Pondicherry and Rajasthan also are supply zones.

Many tribal girls from Chotanagpur belt in Bihar, Orissa, West Bengal and Jharkhand have migrated or are being trafficked to the Indian cities for the purpose of domestic labour.

How traffickers control their victims

It is important to traffickers that their victims are cooperative when doing business. Sometimes they are drugged, remove documents, prevent the victims from learning the language isolation, moving them from place to place, threatening them, and accommodating them in a way that they will become homeless if they leave. By moving victims from place to place, they are unable to become familiar with their surroundings. So the victims become helpless, and have no chance of escaping from their traffickers.

The UN Office on Drugs and Crime(UNODC) has further assisted many non-governmental organizationsin their fight against human trafficking. It encourages campaign with NGO Caritas Migrant to raise human-trafficking awareness.

The united Nations Global Initiative to Fight Human Trafficking(UN.GIFT) was conceived to promote the global fight on human trafficking, was launched inMarch 2007 by UNODC. UN.GIFT works with all stakeholders —governments, business, academia, civil society and the media —to support each other's work, create new partnerships, and develop effective tools to fight human trafficking.

The Global Initiative is based on a simple principle: human trafficking is a crime of such magnitude and atrocity that it cannot be dealt with successfully by any government alone. This global problem requires a global, multi-stakeholder strategy that builds on national efforts throughout the world. (To pave the way for this strategy, stakeholders must coordinate efforts already underway, increase knowledge and awareness, provide technical assistance, promote effective rights-based responses, build capacity of state and non-state stakeholders, foster partnerships for joint action, and above all, ensure that everybody takes responsibility for this fight.)

In carrying out its mission, UN.GIFT will increase the knowledge and awareness on human trafficking, promote effective right-based responses, build capacity of state and non-state actors, and foster partnerships for joint action against human trafficking.

As of November 2015, 169 countries have ratified the United Nations Trafficking in Persons Protocol, of which UNODC is theguardian. Significant progress has been made in terms of legislation: as of 2012, 83 per cent of countries had a law criminalizing trafficking in persons in accordance with the Protocol.

India Anti Human Trafficking Portal

In India, the trafficking in prsons for commercial sexual exploitation, forced labor, forced marriages and domestic servitude is considered an organized crime. The Government of India applies the Criminal Law (Amendment) Act 2013, active from February 3, 2013, as well as Section 370 d 370A IPC, which defines human trafficking and "provides stringent punishment for human trafficking of children for exploitation in any form including physical exploitationor

any form of sexual exploitation, slavery, servitude or the forc removal of organs.

Shri R.P.N.Singh, India's Minister of State for Home Affairs, launched a government web portal, the Anti Human Trafficking Portal, on February 20, 2014. The official statement explained that the objective of the on-line resource is for the "sharing of information across all stakeholders, States/UTS [Union Territories and civil society organizations for effective implementation of Anti Human Trafficking measures. (The ky aims of the portal are:

- Aid in the tracking of cases with inter-state ramifications.
- Provide comprehensive information on legislation, statistics, court judgements, United Nations Conventions, details of trafficked people and traffickers and rescue success stories.
- Provide connection to "Track child", the National Portal on Missing Children that is operational in many states.)

The Anti-trafficking Policy Index

The '3P Anti-trafficking Policy Index' measures the effectiveness of government policies fight human trafficking based on an evaluation of policy requirements prescribed by the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (2000).

On November 4, 2010, U.N. ecretary-Generalan Ki-moonlaunched the united Nations Voluntary Trust Fund for Victims of Trafficking in Personsto provide humanitarian legal and financial aid to victims of human trafficking with the aim of increasng the number of those rescued and supported, and broadening the extent of assistance they receive.

In December 2012, UNODC published the new edition of the Global Report on Trafficking in Persons. It has revealed that 27 per cent of all victims of humantrafficking officially detected globally between 2007 and 2010 are children.

The Global Report recorded victims of 136 different nationalities detected in 118 countries between 2007 and 2010.

Anti-trafficking initiatives.-- one of the organizations taking the most active part in the anti-trafficking is the United Nations.

Religious declaration

In 2014, for the first time in history major leaders of many religions –Catholic, Buddhist, Anglican, Hindu, Jewish, and Muslim, met to sign a shared commitment gainst modern-day slaverythe declaration they signed calls for the elimination of slavery and human trafficking by the year 2020.

Structural factors:- A complex set of factors fuel sex trafficking, including overty unemployment, social norms that discriminate against women, commercial demand for sex, institutional challenges, and globalization

The Has a Name is a play about written by Andrew Koomanin 2009. It is about the Trafficking of childreninto exual slaveryand was inspired by the deaths of 54 people in the anonghuman-trafficking incident

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What can we do ? Go to www.stopthetraffik. Org

1. Sign a Global Declaration Card
2. Persuade your company/community/ church to join Stop The Traffik Coalition.
3. Buy a bag of freedom keys.
4. Be creative, stage an event.
5. Spread the word.
6. Pray.

Public Awareness Programme and rally on Human Trafficking conducted by staff of Holy Cross Hospital, Sanjeevani Foundation, staff and students of various schools of Kalyan, Dt. Thane, Maharashtra on 10-12-2015.




Sr. Dr. Roshni Neerakal.
Holy Cross Hospital,
Karnik Road,
Kalyan- 421301, T. Thane, MS.

XXII CME & AGBM - PHOTO GALLERY

Inaugural Mass

Prayer Song

Prayer Dance

Lighting The Lamp

Presenting Memento

Inaugural Session

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Inaugural speach
Rev. Fr. Tomi Thomas,
Director General, CHAI

Felicitation
Rev. Sr. Jenova OSF,
Provincial Superior,
OSF congregation, Bhopal

Felicitation
Rev. Fr. Kurian Kachappilly CMI,
Provincial, St. Paul's province,
Bhopal

Felicitation
Dr. Sanjay Gupta,
President, IMA,
Madhya Pradesh State.

Felicitation
Rev. Fr. Varghese , principal,
Higher Secondary School,
Bhopal.

Presidential Address
Most Rev. Leo Cornelio SVD,
Arch Bishop of Bhopal.

Dr. Rajesh Sethi MD,
Addressing the Sister Doctors...

Sr. Dr. Sally John MD,
Talking to the Sister Doctors...

Dr. Prakash Aggarwal MD,
talking to the Participants...

Dr. Sushil Jindal MD,
giving a lecture...

Presenting Memento

A Million Thanks
to
Local Organizing Committee .

Visit to Lake of Bhopal and Peoples world

Sr. Dr. Lucian SCC handing over the Trust Deed to the President elect, Sr. Dr. Beena UMI.

Sr. Dr. Lucian SCC handing over the Accounts to the new treasurer, Sr. Dr. Vida Olivera. SCCG.

Sister Doctors in natural calamities

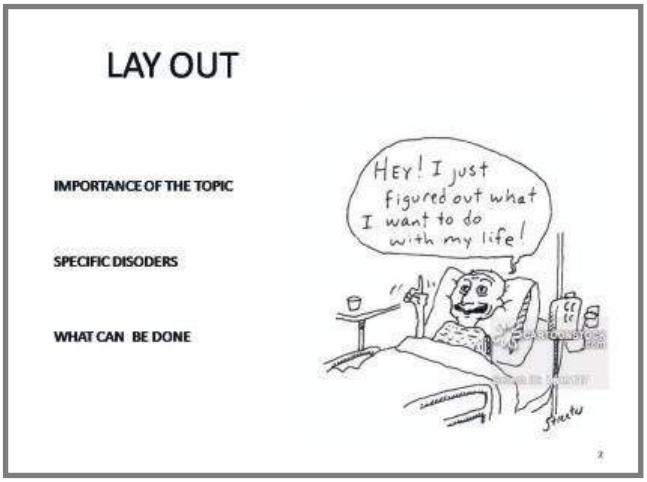
Sr. Dr. Alphonsa Mary FIHM, and Sr. Dr. Jacquline FMM at Flood Relief camp, Chennai.

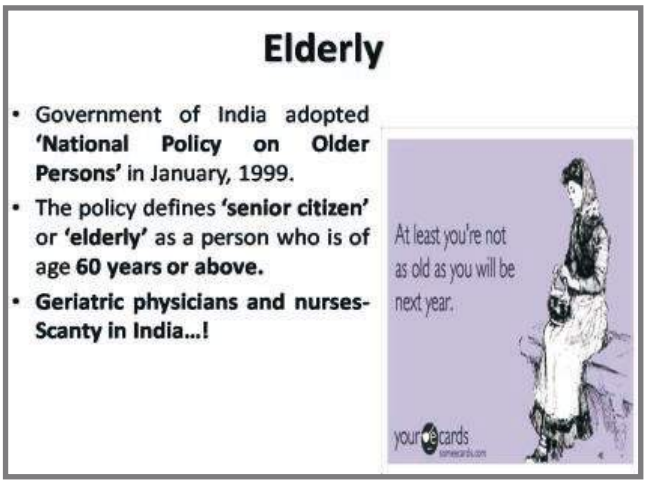
Our Sister Doctors in Flood Relief Camp, Chennai.

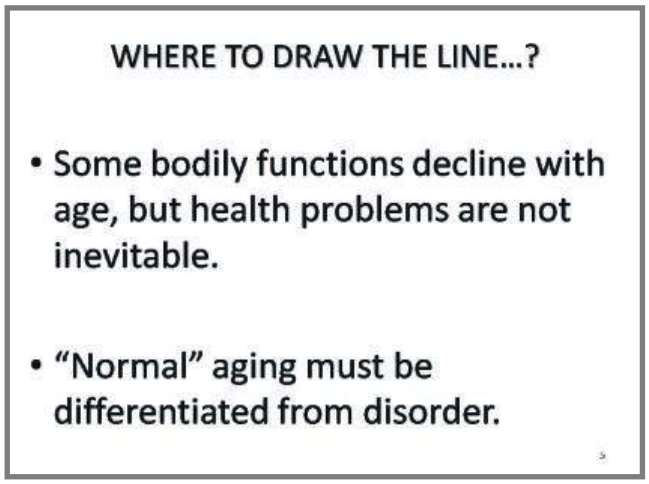
Common Mental Illnesses in the Elderly

Sr. Dr. Sally John SJB MD

(Psychology)







Myths Associated with Aging

- Pathology is a normative aspect of aging.
  - Depression.
  - Cognitive impairment.
  - Confusion is normal and just a part of getting older.
- Any sign of cognitive impairment must be dementia.
- Ongoing grief and pain is an expected part of old age.
- Mental illness is a product of taking tension

The Aging Brain

- Structural Changes
- Neurochemical Changes
- Changes in Cognitive and Motor Abilities

Structural Changes Associated with Brain Aging

- Decline of brain weight
- Neuron loss
- Neuronal atrophy
- Synaptic loss
- Pruning of dendritic trees
- White matter changes
- Gliosis

Neurochemical Changes in Aging

- **marked changes in dopaminergic neurons**
- **decrease in the levels of markers of the cholinergic system**

Changes in Motor Abilities

- **Gait slowing**
- **Reaction time slowing**
- **Balance changes (vestibular, sensory, motor, and brain)**

Changes in Cognitive Abilities

- Mental speed
  Executive function
- Long-term memory is most affected by aging. Retrieval is less efficient; the elderly need more cues
- Concentration - less in older adults

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The million dollar question

Are the behavioral changes part of normal changes of aging or symptoms of an undetected mental illness....??

Problems with detecting Mental Illness

- Psychiatric conditions –Present differently in the elderly
- Physical Symptoms are reported more often than Psychiatric symptoms

Problems with detecting Mental Illness

- Erroneously perceived as a normal part of aging process by clinicians.
- Co-morbid with other medical conditions.
- Can be result of multiple medications

Prevalence of Mental Illnesses

Nearly 20 percent of persons older Than age 65 years have diagnosable psychiatric symptoms.

RISK FACTORS

- Physical disability
- Long-term illness (e.g., heart disease or cancer)
- Physical illnesses that can affect thought, memory, and emotion (e.g. thyroid or adrenal disease)
- Change of environment, like moving into assisted living
- Illness or loss of a loved one
- Medication interactions
- Alcohol or substance abuse
- Poor diet or malnutrition

Medical Co-morbidities

Medical Co-morbidities

- Chronic Obstructive Pulmonary Disease (Anxiety, Delirium, Depression).
- Diabetes Type I & II (Depression, Delirium)
- Parkinson Disease (Depression, Cognitive Impairment, Delirium, Psychosis)
- Huntington's Disease ,Multiple Sclerosis (Depression, Delirium, Psychosis)
- Stroke (Depression, Delirium, Psychosis, Cognitive Impairment/Dementia)
- Urinary Tract Infections (Delirium)

Medical Co-morbidities

- Cancer, Thyroid conditions (Depression, Psychosis)
- Nutritional Deficiencies, Vitamin B 12 Deficiency (Delirium, Depression)
- Hearing or Vision loss (Depression, Psychosis)
- Loss of mobility due to fractures, chronic pain or arthritis (Depression, Delirium)

Drugs and Psychiatric illnesses

Drug Class	Indication	Side Effects
Analgesics	Pain	Delirium
Anticonvulsants	Tremors	Delirium, Dementia
Corticosteroids	Inflammation	Hallucinations, depression, mania , delirium, Anxiety
Anti-Parkinson's Medications	Parkinson's Disease	Psychosis, delirium, depression
Interferon-A	Antiviral Medication	Depression, Delirium

Drugs and Psychiatric illnesses

Drug Class	Indication	Side Effects
Antihistamines: Diphenhydramine (Benadryl) sold OTC	Allergies	Delirium, Visual Hallucinations
Antihypertensive	Hypertension	Depression, Hallucinations

the '3 D's' in Older Adults

Depression

Dementia

Delirium

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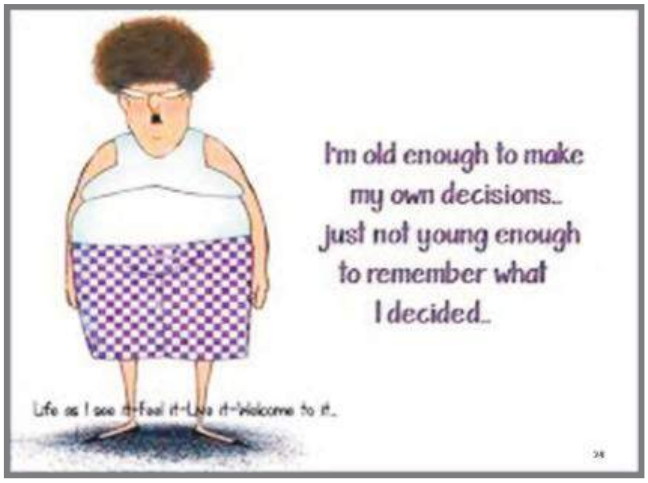


Overlapping symptoms

- –Confusion
- –Apathy/Anhedonia
- –Emotional Lability
- –Irritability
- –Lack of concentration
- –Memory Problems
- –Appetite Changes/Eating Problems

DEPRESSION

Depression and Older Adults

- Depression is the most common mood disorder
- Nearly 20-30 % of elderly suffer from a mood disorder
- 20% of depressed patient endure a chronic course with no remission
- Co-morbidity is high
- Older adults may be more willing to consult with their primary care physician than with a mental health professional

Societal Impacts of Depression

- 4th leading contributor to global burden of disease.
- Expected to be 2nd only to Ischemic Heart Disease worldwide and 1st in developed nations by 2020

28

- Depression amplifies the negative impact of other medical conditions.
- Co-morbid with alcohol and substanc violence

Societal Impacts of Depression (cont.)

- 15-20% of depressed patients end their lives by suicide
- 80% receive some benefit from treatment, but less than half receive treatment

DSM –IV-TR Criteria for Major Depressive Disorder

(APA, 2000)

- **Five (or more)** of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1)depressed mood or (2) loss of interest or pleasure.
  - Depressed Mood (most of the day/everyday)
  - Loss of interest or pleasure (anhedonia)
  - Significant weight change (more than 5% in a month) or significant appetite disturbance nearly every day

DSM –IV-TR Criteria for Major Depressive Disorder (APA, 2000)

- Sleep problems nearly every day (insomnia/hypersomnia)
- Psychomotor agitation/retardation nearly every day
- Chronic fatigue/loss of energy nearly everyday
- Excessive feelings of worthlessness/guilt nearly everyday
- Diminished ability to think or concentrate nearly everyday
- Recurrent thoughts of death/dying/suicidal ideation

Depression in Older Adults

- Predominance of reported somatic rather than emotional complaints
  - Pain (head, stomach, back), fatigue, sleep problems, appetite.
- Reported cognitive/memory problems.
- Higher rates of psychotic symptom
  - Delusions or Hallucinations

Risk Factors

- **Female**
- **Unmarried**
- **Co-morbidity**
- **Chronic financial strain**
- **Family history of depressive illness**
- **Lack of social support**

Depression and Dementia

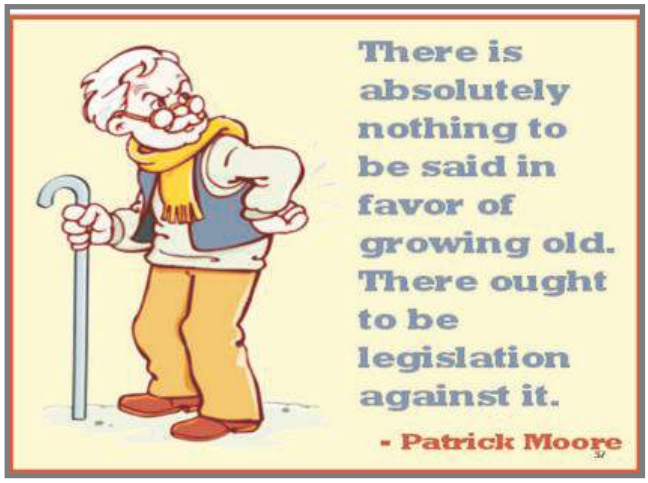
- **Symptoms of depression often precede cognitive decline in older adults**
- **Monitoring for cognitive decline is crucial in depressed elders- Pseudo dementia**
- **Greater risk for nursing home placement and death**

Acute and/or Chronic Pain

- **Arthritis, fractures, diabetes, rheumatic diseases, lower back pain).**
- **Pain can severely limit older adults participation in several activities and social relationships leading to depression**
- **Older adults may be reluctant to discuss pain and assessment of pain remains a challenge.**

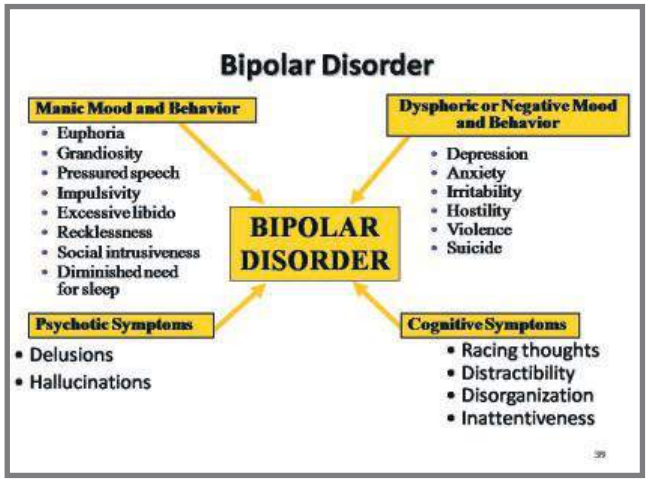
Impact of Pain on Functioning

- Pain threshold decreases with age.
- Persistent pain is associated with
  - –Depression
  - –Impaired cognitive function
  - –Impaired physical function
  - –Sleep disturbance
  - –Agitation
  - –Decreased socialization.



The MOOD DISORDER Spectrum

- Dysthymia.....
- Single Major Dpressive Episode (MDE)
- Chronic MDE....
- Atypical MDD....
- Recurrent MDD....
- Bipolar Disorder

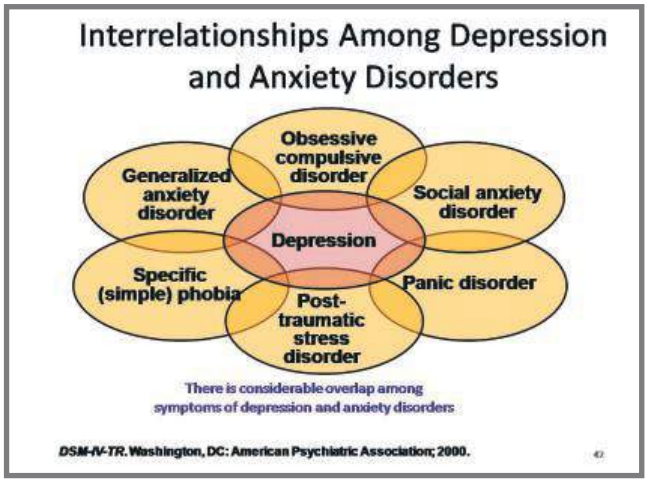


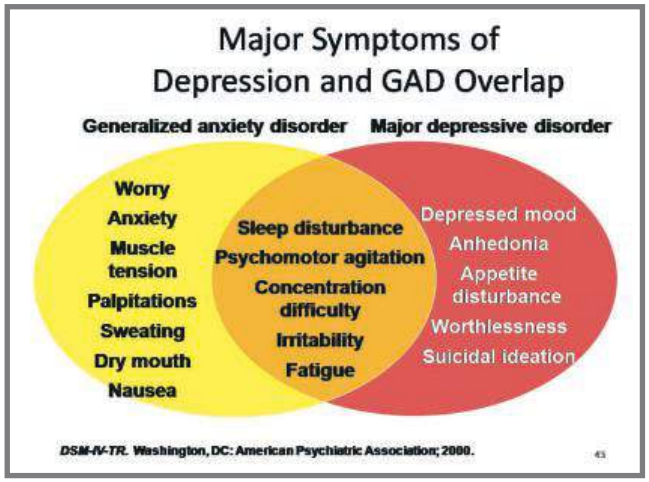
Bipolar Disorders

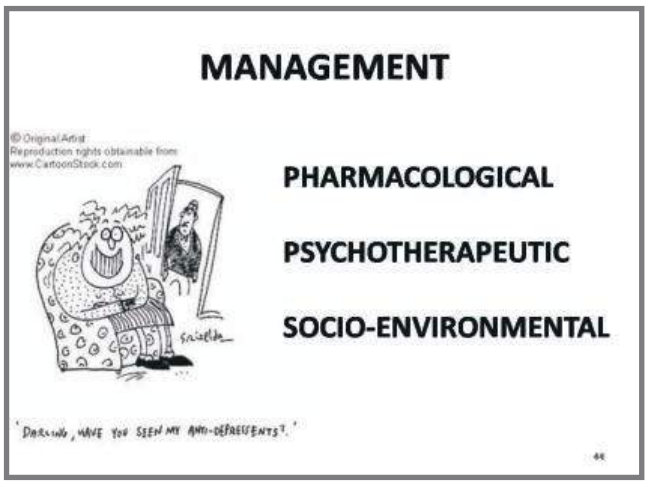
- May present with mixed, manic, dysphoric or agitated states
- More likely to have irritability, treatment resistance, higher mortality rate
- Develop dementia at a higher rate than elderly without bipolar illness

Anxiety Disorders

- Usually begins in early or early or middle adulthood but may appear after age 60
- Prevalence rate: 5 -11 but with the elderly - up to 20% with 37% co-morbidity with depression, dementia and medical illnesses such as CHF, CAD, diabetes

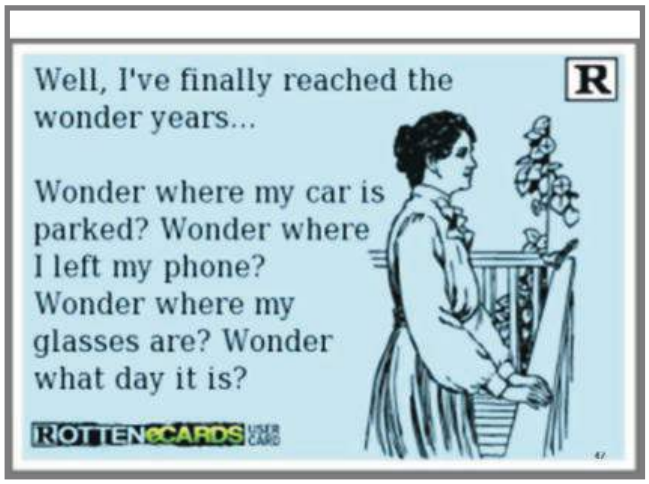

Interrelationships Among Depression and Anxiety Disorders
Obsessive compulsive disorder
Generalized anxiety disorder
Social anxiety disorder
Depression
Specific (simple) phobia
Panic disorder
Post-traumatic stress disorder
There is considerable overlap among symptoms of depression and anxiety disorders
DSM-IV-TR. Washington, DC: American Psychiatric Association; 2000.


Major Symptoms of Depression and GAD Overlap
Generalized anxiety disorder
Major depressive disorder
Worry
Anxiety
Muscle tension
Palpitations
Sweating
Dry mouth
Nausea
Sleep disturbance
Psychomotor agitation
Concentration difficulty
Irritability
Fatigue
Depressed mood
Anhedonia
Appetite disturbance
Worthlessness
Suicidal ideation
DSM-IV-TR. Washington, DC: American Psychiatric Association; 2000.


MANAGEMENT
PHARMACOLOGICAL
PSYCHOTHERAPEUTIC
SOCIO-ENVIRONMENTAL
'Darling, have you seen my anti-depressants?'


MANAGEMENT
• SSRI- Sertraline, Escitalopram, Fluoxetine
• TCA- Mostly not preferred
• SNRI- Mirtazepine, Duloxetine
• Other Newer Antidepressants
• CBT
• Supportive Psychotherapy
• Behavioural and Life style modifications


MANAGEMENT
• In case of BIPOLAR DISORDER, treat with MOOD STABILIZERS like Lithium, Valproate and Carbazepine
• For acute stage use ANTIPSYCHOTICS like Haloperidol,Trifluperazine Olanzapine, Risperidone, and Chrorpromazine


Well, I've finally reached the wonder years...
Wonder where my car is parked? Wonder where I left my phone? Wonder where my glasses are? Wonder what day it is?
R
ROTTENeCARDS

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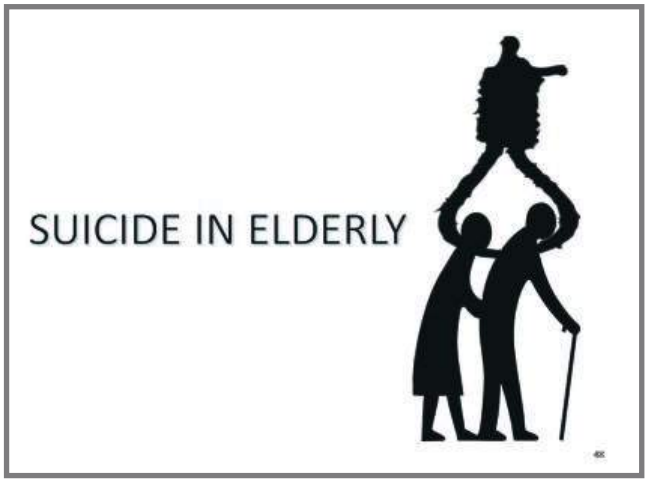

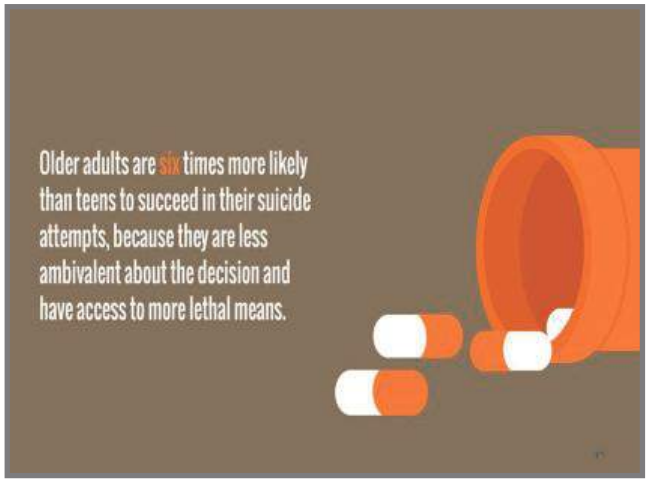

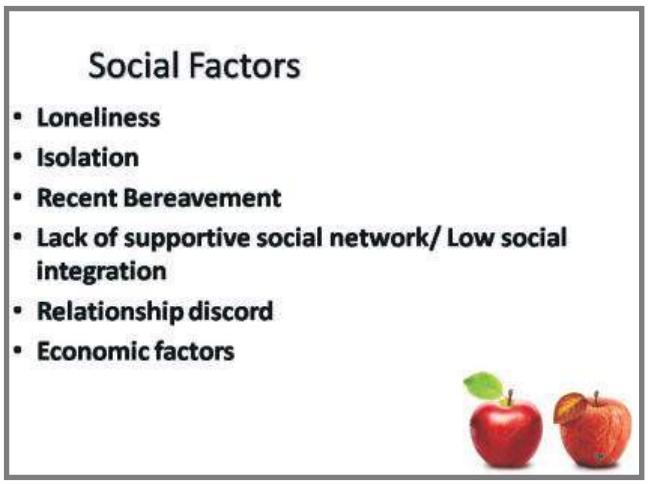

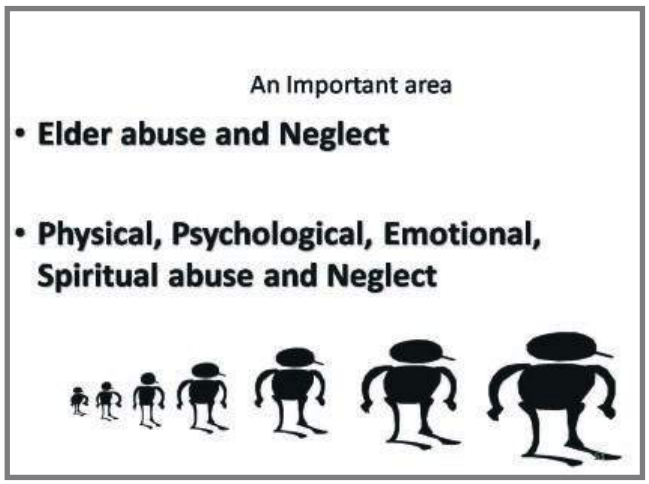

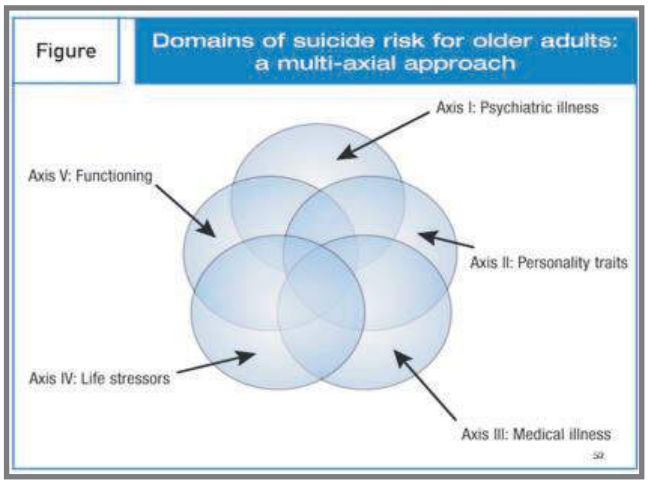

Physical Illness

- Epilepsy
- Parkinson's disease
- Strokes
- Multiple sclerosis
- Huntington's chorea
- Head injury
- Peptic ulcer
- Rheumatoid arthritis
- Cancer
- Thyroid disorders
- Diabetes

Assessment tool for suicide risk:

S- Male Sex
A- Age (young/elderly)
D- Depression
P- Previous attempts
E- ETOH
R- Reality testing (Impaired)
S- Social support (lack of)
O- Organized plan
N- No spouse
S- Sickness

Management

- Improving Resilience/Coping skills

➢ Goal – To enhance protective factors

➢ Reduce risk factors

➢ Cognitive Behavior Therapy model

(Lapierre, Dubé, Bouffard, & Alain, 2007).

MANAGEMENT

1. Early identification and treatment of depression
2. Improved awareness among treating physicians
3. Improved mental health services
4. Restriction/Monitoring
5. Helpline services

Psychotic symptoms

- Sudden/ Late onset
- Behavioral disturbances
- Delusions and hallucinations
- Irrelevant talking
- KEEP A HIGH SUSPECICON FOR ORGANICITY

Sleep Disturbances in the Elderly

Prevalence of Insomnia by age group*:

Age 18-34 – 14%
Age 35-49 – 15%
Age 50-64 – 20%
Age 65-79 – 25%

*Mellinger GD et al. Arch Gen Psychiatry 1985;42:225-232.

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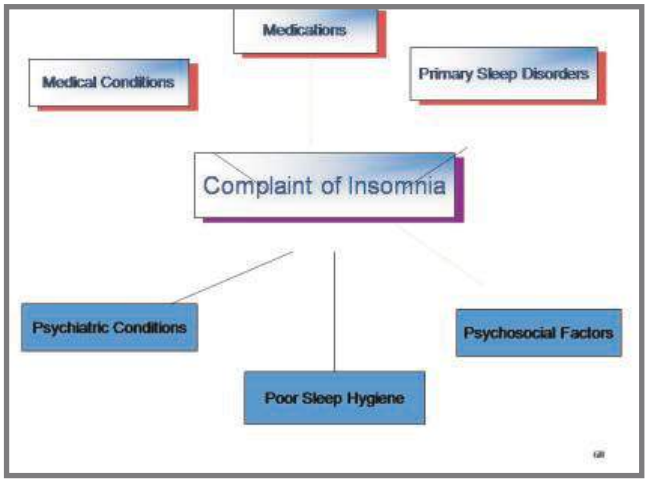


Examples of 'Legal' Drugs That Cause Insomnia

- **Alcohol**
- Decongestants
- CNS stimulants
- Stimulating antidepressants
- Beta-blockers
- Diuretics
- Thyroid hormones
- Bronchodilators
- **Nicotine**
- Calcium channel blockers
- **Caffeine**
- Corticosteriods
- CNS Depressants
- Quinidine
- Anticonvulsants
- Antiparkinsonian agents

Medical Condition

- CV disease
- Pulmonary Disease e.g. COPD
- GERD
- Renal failure
- Parkinsonism
- Chronic Pain
- Nocturia

Psychiatric Condition

- Depression
- Anxiety
- Dementia – circadian rhythm disruption with pronounced fragmentation of sleep-wake pattern
- Substance Abuse

Improving Sleep Complaints

- Treat underlying depression (up to 80%), anxiety disorder, schizophrenia
- Treat related sleep disorders (i.e. obstructive sleep apnea with CPAP/weight loss)
- Treat underlying Medical and Neurological D/O
- 'Manage' medication(s)
- Limit alcohol
- Behavioral interventions -GOOD SLEEP HYGIENE

Clinical Presentation in the Elderly with an Alcohol/SA Problem

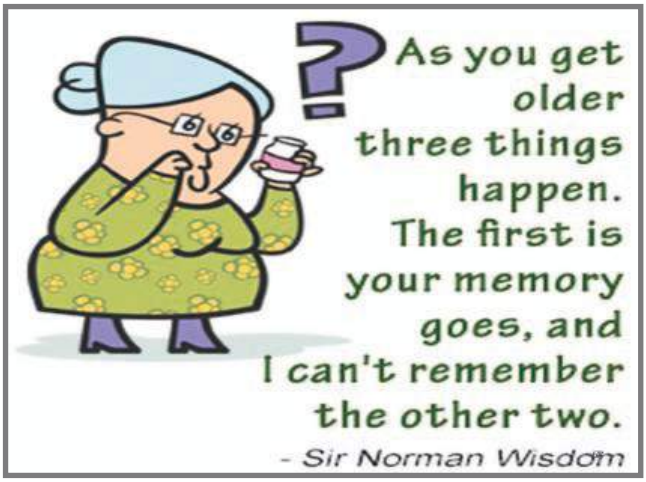
- Do NOT present as: substance seeking behavior such as characterized by crime, manipulative, and antisocial behavior
- Presentations vary but may include: marital discord, falls, confusion, poor personal hygiene, depression, anxiety, sleep complaints, malnutrition, delirium, dementia

Other 'Illegal' Substances of Abuse

- Marijuana
- Cocaine
- Amphetamines
- Hallucinogens/NMDA
- Phencyclidine
- .....
- Few statistics available for the elderly; many addicts die before they reach an older age because of overdoses, deterioration in health/health consequences/premature death and death due to violence

OTC and Prescription Use/Misuse

- Laxatives
- Antihistamines
- OTC stimulants and herbals
- Antibiotics
- BZDs/Meprobomate - for sedation or anxiety
- Analgesics/opioids



Dementia

- 2nd most common cause of disability among people aged 65 and older (second only to arthritis)

VIDEO

Neuropsychiatric Clusters in Dementia

- Apathy: withdrawn, lack of interest, a motivation
- Depression: sad, tearful, hopeless, low self-esteem, anxiety, guilt
- Aggression: aggressive resistance, physical aggression, verbal aggression
- Agitation: walking aimlessly, pacing, trailing, restlessness, repetitive actions, dressing/undressing, sleep disturbance
- Psychosis: hallucinations, delusions, misidentifications

TYPES of Dementia

- **Alzheimer's Dementia** (Most common):
  - Genetic linkage (especially for early onset)
  - Amyloid plaques & Neurofibrillary tangles
  - Brain atrophy
  - Insidious onset and persistent, gradual progression
- **Vascular Dementia** (8-30% of dementia cases):
  - Multi subtypes
  - Multiple strokes/infarcts/TIA's/Single strategic strokes
  - Small vessel Ischemic Changes
  - White matter lesions
  - Rapid onset and variable, stepwise progr

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294.1x Dementia, Alzheimer's Type (APA, 2000)

A. The development of multiple cognitive deficits manifested by both:

1) Memory impairment (impaired ability to learn new information or to recall previously learned information)
2) One (or more) of the following cognitive disturbances:
   a) Aphasia (language disturbance)
   b) Apraxia (impaired ability to carry out motor activities despite intact motor function
   c) Agnosia (failure to recognize or identify objects despite intact sensory function).
   d) Disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

Dementia: Statistics

DAT (Dementia of Alzheimer's Type)

VIDEO

Incidence:

5-8% .....over age 65

15-20%.....over age 75

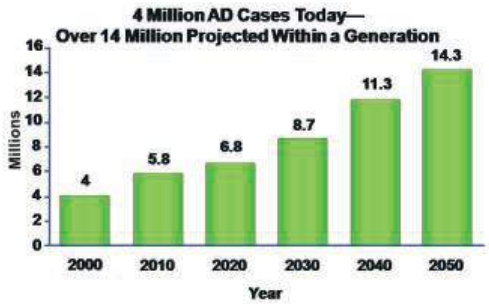
25-50+%.....over age 85

Women > Men (1.2-1.5 to 1.0)

If trends continue, population with DAT will quadruple within the next 50 years.....

New Cases/Year=360,000=40 new cases/hour

Projected Prevalence of Alzheimer's Disease (AD)



(Other) Dementias.....

-Vascular Dementias are estimated to account for 15% of all dementias

-Dementia with Lewy Bodies* estimated to account for 7-26%

-Parkinson's Disease: dementia occurs in 20-60% of PD patients (20% DAT)

(Other) Dementias.....

-Pick's Disease/FTD

-Huntington's Disease

-Creutzfeldt-Jakob disease

-Associated with long term use of alcohol

Other Causes of Dementia

Adapted from: Aging Successfully(2003). 8(3): p.12

- **Drugs**
- **Emotional**
- **Metabolic**
- **Eyes and ears impaired**
- **Normal Pressure Hydrocephalus**
- **Tumors & Lesions**
- **Infection**
- **Anemia (Vit. B-12/Folate deficiency**

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Mild Cognitive Impairment (MCI)

- MCI (mild cognitive impairment): Not of sufficient severity to qualify for a diagnosis of dementia
- Impairment in memory or other areas of cognitive functioning usually noticeable to them or to those around them
- Performance on 'memory or cognitive' tests are usually below that expected for their age and education

MCI
Prevalence Rate in the Community

- Normal aging → MCI → early DAT
- Prevalence rate for >60 years of age: 3%
- Prevalence rate for >75 years of age: 15%
- Annual conversion rate to DAT: 6-25%/year

MANAGEMENT

- Early Detection and intervention
- Behavioural and medical management
- Prevention
- Caregiver management

DELIRIUM

Delirium
(APA, 2000)

- A serious, time-limited condition with a sudden onset and short/fluctuating course marked by impaired or altered consciousness and cognition.
- Difficulty thinking clearly or perceiving the world around them.
- Incoherent speech, confusion, memory impairment, disorientation.

Delirium
(APA, 2000)

- Symptoms can include Hyper-arousal (overly alert/agitated) &/OR hypo-arousal (sleepy/groggy)
- Can be a sign of a serious medical condition that can lead to brain damage or death.
- Multiple causes including: surgery, infection, medication, nutritional deficiencies(B-12), alcohol/drugs, head trauma, chemotherapy or environmental changes.

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DSM-IV-TR Criteria for Delirium

(APA, 2000)

293.0 Delirium due to a General Medical Condition

A. Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus sustain or shift attention.

B. A change in cognition (i.e. memory deficit, disorientation, language disturbance) or the development of perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia.

C. Disturbance develops over a short period of time (hours to days) and tends to fluctuate during the course of the day.

D. Evidence from history, physical examination or lab findings that the disturbance is caused by the direct physiological consequences of a general medical condition.

DSM-IV-TR Criteria for Delirium

(APA, 2000)

Substance-Induced Delirium:

Evidence that either:

(1) Sx's found in A & B developed during substance intoxication, or

(2) Medication use is etiologically related to the disturbance.

Substance-Withdrawal Delirium:

Evidence that sx's from criteria A & B developed during, or shortly after, a withdrawal syndrome.

Epidemiology of Delirium

- **Delirium often presents in primary care settings and is often incorrectly diagnosed as dementia or other disorders**
- **Prevalence in older hospital patients 10-26% .**
  - **14% in ER patients**
  - **31-80% in ICU**
- **As high as 1% in community dwelling older adults**
- **Post surgery delirium range from 5-52%**
- **Patients with delirium have longer hospital stays, higher mortality- 30-40%**

Causes of Delirium

Adapted from: Aging Successfully (2003). 8(3): p.12

- Drugs
- Emotional
- Low O2(anemia, Myo. Infarc., Stroke, PE)
- Ictal
- Retention of urine and feces
- Infection
- Undernutrition/Vitamin Deficiency
- Metabolic
- Subdural

Etiology of Delirium

- **Drugs:** Antidepressants; Antipsychotics; Sedatives & Narcotics; Antiparkinsonians; Anticholinergics; Alcohol/Street Drugs (hallucinogens)
- **Illnesses/Infections**: Urinary Tract infections; Staph infection; HIV related; Sepsis; Pneumonia
- **Metabolic**: Liver/Kidney failure; Glycemic imbalance
- **Pulmonary**: Congestive heart failure; COPD; Anemia; Shock; Hypoxemia.

Etiology of Delirium

(Hooyman & Kavik, 2008; Zarit & Zarit, 2007)

- **Environmental:** Sensory deprivation or overload; stress; head trauma; pain; physical restraint use; intensive care treatment; nutritional deficiencies (B-12; dehydration).
- **Surgery:** Major (heart surgery/bypass; hip replacement); minor (cataracts).
- **Neurological:** Stroke; subdural hematoma; cancer; seizures; encephalitis/brain infection.

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Management

- Needs emergency care
- Evaluate and treat the underlying cause
- Adequate hydration
- Reduced stimulation
- Restrain if need be
- IV Benzodiazepines/ Antipsychotics
- 24 hr closer monitoring

Conclusion

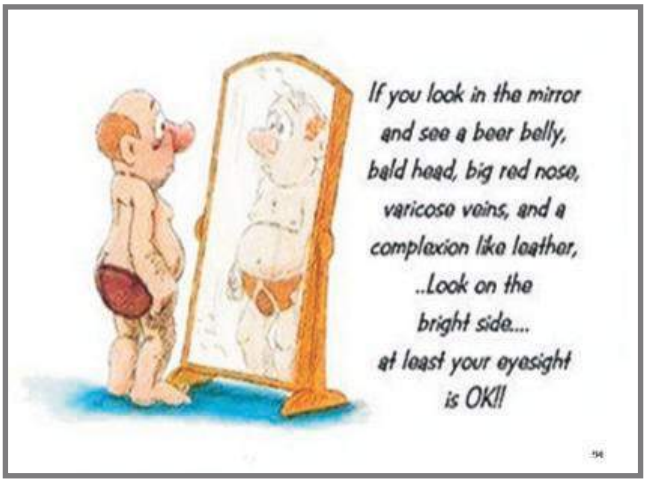
- Spend time understanding the perspective of elder patients and explore all areas completely.
- Challenge misperceptions and stigma – Pathology is not a normative part of aging.
- Routinely screen for depression, suicide and substance use.
- Be vigilant for Dementia, delirium.
- Adopt a bio-psycho-social framework toward assessment and treatment.

CONCLUSION

- Continually explore and reflect on views of older adults.
- Be respectful to your patient. Don't talk down or show irritation
- Speak directly to older adults and not to caregivers unless indicated.
- Do not assume older adults will tell you if something is wrong without asking. Ask directly.
- Educate and utilize caregivers as appropriate

Take home message

- Psychiatric disorders needing intervention is high in elderly
- Recognize that psychiatric and medical symptoms can mimic, overlap, interact, and impact each other.
- Keep a high suspicion/alert in order to detect
- Early detection and intervention can reduce morbidity and mortality
- Managing the above will have a bearing on improving the quality of life of our ELDERLY PATIENTS



RESILIENCE OF A SISTER DOCTOR

Dear Friends,

I would like to share with you the event that had kept me shattered but helped me learn more and experience God's strength and protection.

Mrs. Shamama, 25years old PRIMI booked with me since the gravindex test was positive. She was diagnosed to have huge hemorrhagic cyst at 12 weeks of pregnancy and underwent ovarian cystectomy safely at 14 weeks. She was a regular and compliant patient. She was diagnosed to have hypertension of pregnancy since 26 weeks of gestation and she was comfortably managed with T. Alpha Dopa. At 40 weeks of gestation she was posted for elective cesarean section in view of CPD (Cephalo Pelvic Disproportion) and delivered to alive baby boy weighing 3kg.

In view of her increase BMI she was started on prophylactic LMWH (Low Molecular Weight Heparin) to avoid DVT (Deep Vein Thrombosis). Post-operative stay at hospital was uneventful. Her Blood Pressure recordings were within normal limits that she did not need any anti-hypertensive drugs. She was discharged on happy note but in 2 days she returned to the hospital with the complaint of headache, when diagnosed to have the BP of 140/100mmHg. She was admitted and treated with MgSo4 and anti-hypertensive. All her vitals were normal and had no complaints. Patient was comfortable on night rounds.

At 2.30am early morning I was woken up with a startling call saying that the patient had no pulse and no breathing. So I rushed to the ward and shifted her to the ICU and connected her soon to the ventilator after CPR. Then I called for cardiologist and neurologist after seeing the trace of pulse and effort of breathing again. Cardiologist had ruled out the possibilities of pulmonary embolism and the neurologist couldn't rule out the impending brain stem dysfunction. She was shifted to higher centers, but none can get her saved. After a week of life on ventilator she finally slipped into God's hands.

I was broken and I nearly felt like fleeing away from my duties. I spent deeper moments with the Lord for strength and courage. Dear Friends I am very blunt to analyze this tragedy with you so to learn from each event specially that which shakes us.

If a mother of PIH after her delivery though appears to be normotensive, better to put her on anti-hypertensive drugs and follow her up very closely. May be we have forgotten to use the skill of fundoscopy which is the small window of what is happening within the brain. We learn from each incident that happens to us.

With limited resources in most of our rural village hospitals, let us use our skills and expertise diligently and carefully. In spite of all our best efforts and equipment we can still see the patients slipping away from our hands. But it takes courage to be a healer of God's Mercy. With the strength of Jesus and the support of my dear sisters and friends I rise up again to take the next step to care for the next patient still a better way.

Sr. Dr. Anne Joyce SMMI
St. Mary's Hospital,
Arisipalayam,
Salem,
Tamil Nadu – 636009

☺ FOR THE PEACE OF MIND ☺

Life is long and full of challenges. Most of these challenges are internal and depend on how WE CHOOSE to accept and interpret them. Here are some points that, if followed, will guarantee a better life – one that brings with it true peace of mind.

SO TAKE A SEAT, RELAX and READ THROUGH these slowly and reflectively.

☺ **DO NOT INTERFERE IN OTHER'S BUSINESS UNLESS ASKED:**

Most of us create our own problems by too often interfering in the affairs of others unnecessarily. We do so because we have convinced ourselves that our way is the best way and our logic is the perfect logic and we must direct others. The fact is – no two human beings can think or act in exactly the same way. Mind your own business and you will have your peace.

☺ **FORGIVE AND FORGET:**

This is the most powerful aid when it comes to Peace of Mind. We often develop ill feelings towards those who insult or harm us. We nurture grievances which in turn results in our loss of sleep, development of stomach ulcers, high blood pressure etc. Life is too short to waste on such trifles, FORGIVE and FORGET and move on. Also learn to forgive yourself and not only be forgiven by others. Love flourishes in GIVING and FORGIVING.

☺ **DO NOT CRAVE FOR RECOGNITION:**

The world is with lots of selfish people. They seldom praise anybody without selfish motives. They may praise you today because you are in power but as soon as you are out of power, they will forget your contributions and achievements and will start finding faults in you. So do your duties ethically and sincerely.

☺ **DO NOT SUCCUMB TO ENVY AND JEALOUSY:**

We all have experienced how envy can disturb our peace of mind. You know that you work hard but sometimes others get promotions while you do not. There are several examples like this in everyday life. Should you be envious?.... No. Remember everybody's life is shaped by his or her destiny. Nothing will be gained by blaming others for your misfortune. Jealousy will not get you anywhere; it will only take away your peace of mind.

☺ **ENDURE WHAT CANNOT BE CURED:**

This is the best way to turn a disadvantage into an advantage. Every day we face numerous inconveniences, ailments, irritations and accidents that are beyond our control. If we cannot

control them or change them, we must learn to put up with these things. Believe in yourself and you will gain in terms of patience, inner strength and will power.

☺ **DO NOT BITE OFF MORE THAN YOU CAN CHEW:**

We often tend to take on more responsibilities than we are capable of carrying out. This is done to satisfy our ego. Know your limitations. You cannot gain peace of mind by expanding your external activities. Try to make time for prayer, introspection and meditation. If you earnestly meditate half an hour every day, your mind will become peaceful during the remaining 23-and a-half hours which in turn would increase your efficiency and you will be able to produce better results in less time.

☺ **NEVER LEAVE YOUR MIND VACANT:**

An empty mind is the devil's workshop. Keep your mind occupied with something positive and worthy. Follow a hobby actively, do something that holds your interest. Your hobby, social work or charity work can give you a lot of fulfillment and achievement.

☺ **DO NOT PROCRASTINATE AND NEVER FORGET:**

Do not waste a lot of time wondering," should I or shouldn't I". You can never plan enough because you cannot anticipate all the future happenings. Value your time and do the things that need to be done in time. Sitting back and worrying will lead to nothing. Learn from mistakes but do not brood over the past unduly.

☺ **LET GO OFF NEEDING EVERYBODY TO LIKE YOU:**

Everyone doesn't need to like you and some people won't, no matter what you do. Don't take things what others say about you too seriously/ personally. What they think and say is a reflection of them and not you.

☺ **WHO WE ARE:**

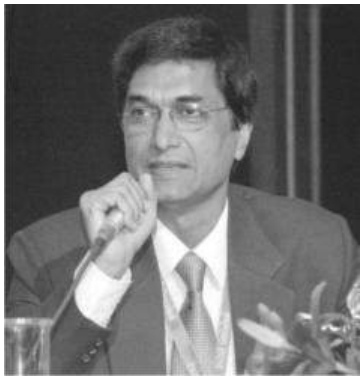
Our background and circumstances might have influenced who we are but we are primarily responsible for who we are.

☺ **And finally DO NOT FORGET:**

WHATEVER HAPPENED WAS DESTINED TO HAPPEN ONLY THAT WAY. WHY CRY OVER THE SPILLED MILK?

Sr. Dr. Liza Tom CSS,
Bharat Mata Hospital,
Muri, Ranchi dist.,
Jharkhand

Endocrine Diseases in Elderly



Dr. Sushil Jindal
MD, DM (Endocrinology)
Professor of Medicine
PCMS, Bhopal

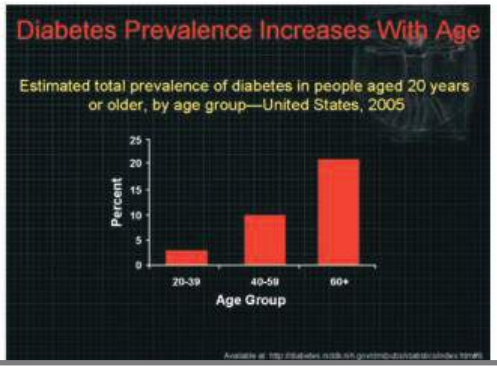
Introduction

- With increasing life expectancy geriatric population is increasing
- Aging population has profound medical implications
- By year 2050, there are estimated to be 324 million senior citizens (60+) in India
- Health needs and diseases of elderly are different from younger ones
- Metabolic and endocrine diseases, degenerative disorders and malignancies are major contributors to health problems in elderly

Common endocrine disorders In elderly

- Diabetes
- Thyroid disorders – hypo, hyper, malignancies
- Osteoporosis
- Cushing's – mostly exogenous

Diabetes in old age



Age-Related Factors That May Affect Diabetes Control

- Altered senses
- Difficulties in preparing/eating food
- Decreased mobility/exercise
- Altered renal/hepatic function
- Altered circulation
- Co-morbidities
- Polypharmacy
- Social changes

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Common Comorbidities In Older Adults: Diseases and Geriatric Conditions

HRS, representative of 35 million people ≥65, 2004

Index Condition (%)	*Weighted* Prevalence (%) of Other Conditions Among Respondents Having Index Condition						
	CAD	CHF	Diabetes	UI	Falls	≥1 Other	≥2 Other
CAD (8.7)		17%	29%	29%	34%	67%	30%
CHF (4.8)	58%		37%	37%	43%	87%	56%
Diabetes (19.4)	24%	9%		28%	29%	57%	23%
UI (25.0)	19%	7%	22%		37%	58%	20%
Falls (23.2)	23%	9%	24%	39%		64%	23%

Lee et al, JAGS 2009:57:511

Signs of Hypoglycemia in the Frail Elderly

- Confusion, disorientation
- Poor concentration and coordination
- Drowsiness
- Weakness
- Altered behavior, aggression
- Falls
- Myocardial infarction
- Seizures
- Stroke
- Coma, death

Risk Factors For Insulin-Induced Hypoglycemia in Elderly Patients With Diabetes

- Decreased awareness of hypoglycemia symptoms
- Delayed insulin clearance, erratic insulin absorption
  - Renal failure
  - Insulin injection in hypertrophic sites
- Decreased endogenous glucose production
  - Severe liver disease
  - Alcohol (ethanol) ingestion
  - Renal disease

Chelliah A et al. *Drugs Aging*. 2004;21(8):511-530

Patient characteristics	Rationale	FBS or Preprandial BS	HS Glucose	A1c	Blood pressure	Lipids
Healthy few co-morbidities, intact cognition and functional status	Longer remaining life expectancy	90-130	90-150	<7.5	140/80	Statin. Unless contraindicated or not tolerated
Complex/ intermediate health status, CVD or several chronic illnesses, mild to moderate CI	Intermediate remaining life expectancy, High treatment burden, fall risk, hypoglycemia vulnerability	90-150	100-180	8	140/80	Statin. Unless contraindicated or not tolerated
Very Complex/ poor health (LTC) or numerous illnesses or mod-severe CI or 2+ADLs deficits	Limited remaining life expectancy, makes benefit uncertain	100-180	110-200	<8.5	150/90	Consider likelihood of benefit (secondary primary) prevention

Diabetes in the Elderly Checklist

- ❑**ASSESS** for level of functional dependency (frailty)
- ❑**INDIVIDUALIZE** glycemic targets based on the above (A1C ≤8.5% for **frail** elderly) but if otherwise healthy, use the **same** targets as younger people
- ❑**AVOID** hypoglycemia in cognitive impairment
- ❑**SELECT** treatment therapy carefully
  - ❑Caution with sulfonylureas or thiazolidinediones
  - ❑Basal analogues instead of NPH or human 30/70 insulin
  - ❑Premixed insulins instead of mixing insulins separately
- ❑**GIVE regular diets** instead of "diabetic diets" or nutritional formulas in nursing homes

Consider A1C 7.5-8.5% if ...

- Limited life expectancy
- High level of functional dependency
- Extensive coronary artery disease at high risk of ischemic events
- Multiple co-morbidities
- History of recurrent severe hypoglycemia
- Hypoglycemia unawareness
- Longstanding diabetes for whom is it difficult to achieve an A1C ≤7%, despite effective doses of multiple antihyperglycemic agents, including intensified basal-bolus insulin therapy

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Add an agent best suited to the individual (agents listed in alphabetical order):

Class	Relative A1C lowering	Hypo-glycemia	Weight	Other therapeutic considerations	Cost
Alpha-glucosidase inhibitor (acarbose)	↓	Rare	neutral to ↓	Improved postprandial control, GI side effects	$$
Incretin agents: DPP-4 Inhibitors	↓↓	Rare	neutral to ↓	• May use detemir or glargine instead of NPH or human 30/70 for less hypos • Premixed insulins and prefilled insulin pens instead of mixing insulin to reduce dosing errors	
GLP-1 receptor agonists	↓↓ to ↓↓↓	Rare	↓↓		
Insulin	↓↓↓	Yes	↑↑		
Insulin secretagogue: Meglitinide	↓↓	Yes	↑	• CAUTION in the elderly • Initial dose = HALF of usual dose • Avoid glyburide • Use gliclazide, gliclazide MR, glimepiride, nateglinide or repaglinide instead	
Sulfonylurea	↓↓	Yes	↑		
SGLT2 inhibitors	↓↓ to ↓↓↓	Rare	↓↓	• CAUTION with renal dysfunction	
Thiazolidinediones	↓↓	Rare	↑↑	• CAUTION in the elderly • Increased risk of fractures • Increased risk of heart failure	
Weight loss agent (orlistat)	↓	None	↓	GI side effects	$$$

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Thyroid disorders in elderly

Hypothyroidism

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Case Report

- 85 y gentleman c/o gen. weakness, forgetfulness, loss of taste, bodyache, constipation, unsteady gait, no desire for going to morning walk & progressive deafness
- Symptoms attributed to old age, routine labs normal, symptomatic Rx offered - no relief.
- Looking after administration of a clinical lab, he himself decides to go for TFT
- FT4 0.45 (N=0.7-1.8), TSH 69.6 (N=0.2-5.0)
- LT4 started, all symptoms gradually disappeared

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Case report

- 74 years old woman c/o severe constipation - enemas
- She remains withdrawn and depressed – put on antidepressants by her physician
- Voice has become hoarse and face puffy – KFT ordered
- She c/o muscle aches and joint pains – NSAIDs
- C/o DOE and vague chest pain – 2D Echo ordered – pericardial effusion
- She falls asleep while watching TV with loud snoring
- T3 88, T4 1.8, TSH > 150
- LT4 started 25 micgm/day and gradually increased to 100/day
- Patient is back to her normal life in one month

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Learning points

- Hypothyroidism is fairly common in old age
- Hypoguisia, cognitive dysfunction, loss of hearing and cerebellar ataxia are common with PHT in old age
- All elderly patients with vague symptoms should be screened for hypothyroidism
- Elderly patients need less dose of LT4 (1.2 micgm/kg BW rather than 1.6 micgm/Kg BW)
- Dose should be build up very gradually - 12.5-25 micgm every second week
- AF and CHF are very common with overdose in elderly patients – need more frequent monitoring.

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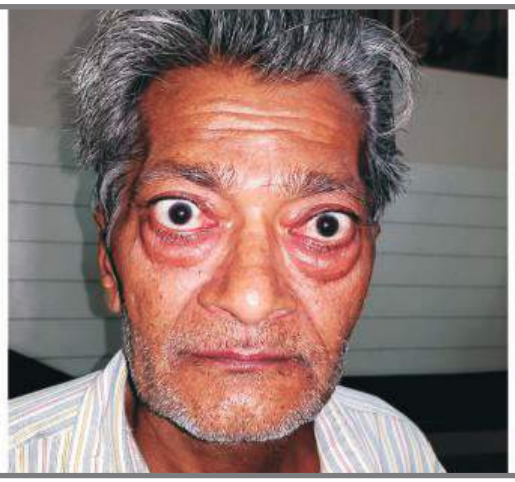
Thyrotoxicosis: causes

- Grave's Disease
- Toxic MNG
- Solitary toxic adenoma
- Over treatment with thyroxin
- Thyroiditis



Thyrotoxicosis: symptoms & signs in elderly

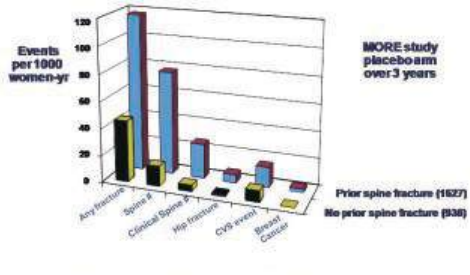
- Classical symptoms & signs may be absent or masked by other diseases/drugs
- Weight loss is prominent
- AF, CHF more common
- Apathetic thyrotoxicosis – anorexia, apathy, depression
- Increased fracture risk due to osteoporosis
- Proximal myopathy
- T3 toxicosis more common – isolated T3 rise with suppressed TSH
- Treatment remains same – antithyroid drugs, RAI, surgery should be avoided

Thyroid malignancy

- Any thyroid nodule appearing in old age should be considered malignant
- FNAC at a good center is must
- In most cases prognosis is good
- Treatment is total thyroidectomy followed by RAI therapy

Osteoporosis

Osteoporotic fractures, Cardiovascular events & Breast cancer in osteoporotic postmenopausal women



from Silverman et al, 2004 J Am Geriatr Soc 52:1543-8

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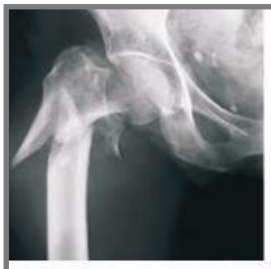
Background

- The problem
  - Osteoporosis is common
  - Over 50% of women and 30-45% of men over age 50 have osteopenia/osteoporosis
  - White woman over age 50: 50 % lifetime risk of osteoporotic fracture, 25% risk vertebral fracture, 15% risk of hip fracture
  - Man over age 60 has 25% risk osteoporotic #
  - 70% over age 80 have osteoporosis



You're not looking at a hip fracture, you're looking at a death sentence.

- ***Each year, one in three persons over the age of 65 will take a serious tumble that may land them in hospital with a broken hip.***
- ***One in three of those who do break their hip will die within a year.***
- ***Two thirds will experience dementia-like symptoms.***
- ***Most will never see home again.***

Methods to evaluate for osteoporosis

- Quantitative Ultrasonography
- Quantitative computed tomography
- Dual Energy X-ray Absorptiometry (DEXA)
  - ?"gold standard"
  - Measurements vary by site
  - Heel and forearm: easy but less reliable (outcome of interest is fracture of vertebra or hip!)
  - Hip site: best correlation with future risk hip fracture
  - Vertebral spine: predict vertebral fractures; risk of falsely HIGH scores if underlying OA/osteophytes

Calcium Intake Recommendations

Life Stage Group	Estimated Requirement (mg/day)	Recommended Dietary Allowance (mg/day)	Upper Level Intake (mg/day)
Infants 6 to 12 months	*	*	1,500
4–8 years old	800	1,000	2,500
14–18 years old	1,100	1,300	3,000
31–50 years old	800	1,000	2,500
51–70 year-old female	1,000	1,200	2,000

* For infants, adequate intake is 200 mg/day for 0 to 6 months of age and 260 mg/day for 6 to 12 months of age.

Vitamin D Intake Recommendations

Life Stage Group	Estimated Avg Requirement (IU/day)	Allowance (IRecommended Dietary U/day)	Upper Level Intake (IU/day)
Infants 6 to 12 months	*	*	1,500
4–8 years old	400	600	3,000
14–18 years old	400	600	4,000
31–50 years old	400	600	4,000
51–70-year-old female	400	600	4,000

* For infants, adequate intake is 400 IU/day for 0 to 6 months of age and 400 IU/day for 6 to 12 months of age.

Institute of Medicine. Dietary Reference Intakes for Calcium and Vitamin D: Report Brief. Washington, DC: IOM, 2010. Available at: http://www.iom.edu/Reports/2010/Dietary-Reference-Intakes-for-Calcium-and-Vitamin-D.aspx. Accessed September 13, 2013.

FDA-Approved Therapeutic Options

Prevention	Treatment
Estrogen	Calcitonin
Alendronate Risedronate Ibandronate Zoledronic acid Raloxifene	PTH (teriparatide) Denosumab

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Estrogen Treatment (ET)

- Several approved oral and transdermal preparations
- Treats symptoms of estrogen deficiency
- Skeletal effects:
  - Decrease in biochemical markers of 50% to 60%
  - 2-year BMD increase of 4% to 6% at hip and spine
  - Decreased incidence of vertebral and hip fractures (34%) after 5 years in the Women's Health Initiative (WHI)
  - Effects in women with osteoporosis have not been evaluated in randomized controlled trials
- Concern about adverse effects
- Long-term use not recommended

Rossouw JE, et al. Writing Group for the Women's Health Initiative Investigators. *JAMA*. 2002;288:321-333.

Raloxifene

- Raloxifene (60 mg daily)
- Skeletal effects:
  - Decrease in biochemical markers of 30%
  - 3-year BMD increases of 2% to 3% at hip and spine
  - Decreased incidence of vertebral fractures (30% to 50%) in women with pre-existing vertebral fractures or low bone density. No effect on nonvertebral or hip fractures has been observed
- Extra-skeletal effects: reduction in invasive breast cancer

Ettinger B, et al. *JAMA*. 1999;282:637-645.

Raloxifene

- Adverse effects
  - Hot flashes
  - 2- to 3-fold increased risk of venous thromboembolic events
  - No increased risk of stroke, but *Black Box Warning* for increased risk of death following stroke
  - Leg cramps

Sontag A, Wan X, Krege JH. *Curr Med Res Opin*. 2010;26:71-76.

Calcitonin

- Calcitonin (200 units daily by nasal spray)
- Skeletal effects:
  - Decrease in biochemical markers of 20%
  - Small effect (1% to 2%) on bone density in spine
  - Reduced incidence of vertebral fractures (36%) in women with pre-existing vertebral fractures
  - No effect on nonvertebral or hip fractures has been observed
- Adverse effects
  - Nasal stuffiness
  - Possible increased cancer risk

Chesnut CH 3d, et al. *Am J Med*. 2000;109:267-276. http://effectivehealthcare.ahrq.gov/slides/?pageaction=displaySlides&tk=49&dpg=9&scroll=314. Accessed: September 13, 2013. European Medicines Agency. Press release. July 20, 2012. Available at: http://www.ema.europa.eu/docs/en_GB/document_library/Press_release/2012/07/WC500130122.pdf. Accessed: September 13, 2013.

Bisphosphonates

Alendronate, Risedronate, Ibandronate, and Zoledronic Acid

- Alendronate: 10 mg daily (tablet) or 70 mg weekly (tablet or liquid) for treatment, 5 mg daily or 35 mg weekly for prevention
- Risedronate: 5 mg daily or 35 mg weekly (tablet); 150 mg monthly (tablet)
- Ibandronate: 150 mg monthly by tablet; 3 mg intravenously over 15 to 30 seconds every 3 months
- Zoledronic acid: 5 mg by intravenous infusion over a minimum of 15 minutes once every year for treatment—and every other year for prevention

National Osteoporosis Foundation. *Clinician's Guide to Prevention and Treatment of Osteoporosis.* Washington, DC: National Osteoporosis Foundation; 2013. Available at: http://www.nof.org/hcp/clinicians-guide. Accessed September 13, 2013.

2012 Jun 25;172(12):930-6

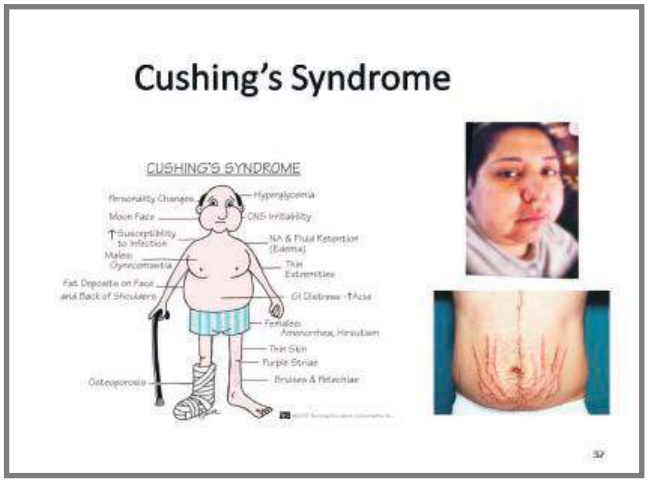
Treatment: Summary

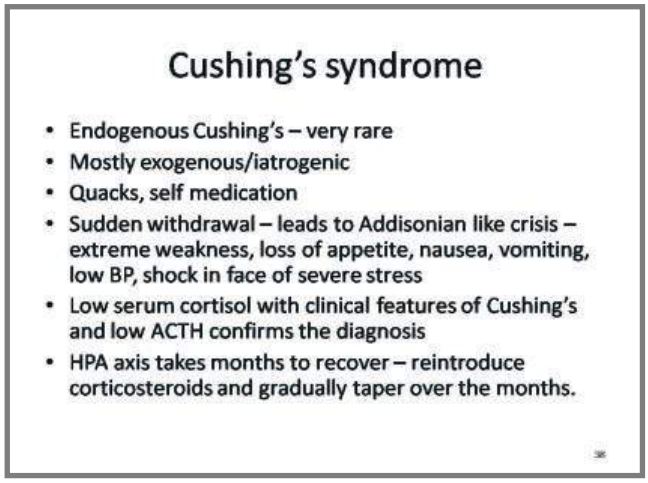
Safe and effective therapies are available

Antiresorptive agents
- Prevent bone loss and preserve architecture
- Improve quality of bone
- Reduce the risk of vertebral fractures (all agents)
- Alendronate, risedronate, zoledronic acid, and denosumab proved to reduce the risk of nonvertebral and hip fractures

Anabolic agent: rhPTH [1-34] (teriparatide)
- Increases bone density and size
- Improves quality of bone
- Reduces the risk of vertebral and nonvertebral fractures

Patient factors determine the most appropriate drug to use





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

CONTACT US

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AWARDS – WE ARE PROUD OF YOU!

Hearty Congratulations…!

Sr. Dr. Betty Jose SH, President of IAP, Wayanad Branch receives the best Branch Award.

Sr. Dr. Emily Susai FMM & Sr. Dr. Betty Jose SH receiving the Best Doctors Award at the Doctor's Day Celebration on 1st July, 2016.

Sr. Dr. Annie Sheela CTC receiving POPE FRANCIS KARUNYA AWARD FROM KERALA LATIN CATHOLIC ASSOCIAN (KLCA) on 9th February, 2016.

TRIBUTE TO SR. DR. PERPETUA SAL

Death has once again laid its icy hands on the family of St. Ann as Sr. Perpetua was carried to the bosom of the Lord, her beloved. The long journey of our dear Sister became still at 10.40 a.m on 10th November 2015. Gently her soul flew away to the heavenly bliss…Though standing around her…no farewell words were spoken, no chance to say good bye, as she went away from our presence, our hearts ache in sadness, and secret tears still flow.

Sr. Perpetua was born on 9th October 1940 in Chengalam, Kanjirapally Diocese, Kerala. She was the fifth among the 7 children of Mr. Philip and Annamma. Being brought up in a traditional Catholic family she developed a desire to belong to the Lord totally. She joined the Society of St. Ann, Luzern in the year 1957. She made her First Commitment on 6th June 1962 and perpetual profession on 6th June 1965. She did her MBBS from St. John's medical college Bangalore, second batch and her post-graduation in Obstetrics and Gynecology at King George Hospital Visakhapatnam. As an expert Obstetrician and Gynecologist she rendered her service in our various institutions. She did counselling studies in Philippines for one year. She was president of CHAAP for one term and was an active member of CRI.

Sr. Perpetua touched the lives of the patients with her loving and caring approach revealing the Divine healer, Jesus. She was a person deeply rooted in prayer having a special devotion and love for the Eucharistic Lord and she used to be with the Eucharistic Lord for hours and hours every day; sitting in silence and solitude she drew strength from the Lord. Almost for the past two decades she was fully engaged in enlightening the people with her knowledge and God experiences going far and wide giving seminars and talks to the people of different walk of life.

Sr. Perpetua was enjoying fairly good health until she was diagnosed as having Chronic Lymphocytic Leukemia in October, 2014. She was referred to Manipal Hospital Bangalore for further investigations and treatment. On first of November she developed respiratory infection and was brought to St. Ann's Hospital. Investigation showed that she was suffering from severe renal disease. She was seemingly improving but on the ninth day her condition rapidly deteriorated and she was given sacrament of the anointing of the sick. She breathed her last at 10.40 am at Sun Rise hospital, Vijayawada.

May her soul rest in peace!

Sr. Dr. Annie P.A.
St. Joseph's General Hospital
GUNTUR.

HIGHLIGHT OF BHOPAL AGBM

First Sister Doctors Forum organized at Ashaniketan

Bhopal | Our Staff Reporter

The first Sister Doctors Forum of India in central region was organized on Monday at Pastoral Centre, Ashaniketan Campus during the XXII general body meeting and CME programme.

At the inaugural session of the programme, National President of SDFI, Dr. Lucian highlighted the work of SDFI, most of the Sisters and Doctors work in remote rural areas of the country where health facilities are minimal and health personnel are rare and also explained the importance of medical field. She further welcomed all the dignitaries. The inaugural address was given by Director General of CHI, Fr. Tomi Thomas.

IMA president (Madhya Pradesh), Dr. Sanjay Gupta, Fathers Kurian Kachappilly, Ronald Cardoza and Varghese, and Sisters Jenova and Rashmi felicitated all Sisters and Doctors.

Most Rev. Leo Cornelio SVD, Archbishop of Bhopal, gave the presidential address then offered the Holy Mass and blessed the SDFI gathering. Sr. Dr. Alphy OSF, the SDFI Central Region President, and her team took the initiative to conduct this great event at Pastoral Centre, Bhopal. The Madhya Pradesh Medical Council has granted certificate of credit hours to all the delegates who attended the CME (Continuing Medical Education).

-Published at Daily Pioneer News Paper, Bhopal on 2nd February, 2016.

SISTER DOCTORS FORUM OF INDIA

4435, 36, Makhanlal Street, 7 Ansari Road, Darya Ganj
New Delhi - 110 002.

August 8, 2016

Dear esteemed friends and colleagues,

Greetings from SDFI!

I am pleased to inform you that, we have decided to revise and re-edit the SDFI Directory, as it is seven years since we have printed the first SDFI Directory.

We need to add the names of new members in the Directory / delete the names of the deceased members from the Directory. There are also many Sister Doctors who are transferred during this span of seven years. Therefore, we need to add their names too, under the respective regions.

You may send the above details to the following e-mail Id :

2016sdfi@gmail.com

Those of you who do not have email facility, may kindly send the same to me, by post, on the following address, as early as possible :

Sr. Dr. Beena MD,
Holy Family Hospital,
St. Andrew's Road,
Bandra West,
Mumbai-400 050,
MAHARASHTRA.

Thanking you, in advance, for your kind co-operation.

With warm regards.

Beena.

Sr. Dr. Beena
President - SDFI

SISTER DOCTORS FORUM OF INDIA

4435, 36, Makhanla Street, 7, Ansari Road, Darya Ganj,
New Delhi – 110 002

LIFE MEMBERSHIP REGISTRATION FORM

PHOTO

Name *:

Congregation Abbreviation *:

Congregation Name *:

Qualification *: Specialization *:

Member type *:

Date of Birth *:

Contact Address *:

Phone No *: Mobile No *:

Primary E-mail *: Secondary E-mail:

Designation *:

First Profession Year *:

Province Address *:

Province Phone No: Province Mobile No:

Name of the College: Year of Passing *:

MCI Reg No*: / State*: Medical Council Reg No*:

OFFICE USE ONLY

Reg No * : Region:

ID Card:

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PARTICIPANTS OF 22nd AGBM, SDFI,
29TH, 30TH AND 31ST JANUARY, 2016
PASTORAL CENTER, BHOPAL, MADHYA PRADESH.