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I.M.A.G.S.B. NEWS BULLETIN

GUJARAT MEDICAL JOURNAL
INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH

Vol-19 AUGUST-2024 Issue-08

Estd. On 2-3-1945
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PRESENTING THE FIRST EVER STUDY FROM INDIA ON CARCINOMA ENDOMETRIUM

SURGICOPATHOLOGICAL OUTCOMES AND SURVIVAL IN CARCINOMA BODY UTERUS: A RETROSPECTIVE ANALYSIS OF CASES MANAGED BY LAPAROSCOPIC STAGING SURGERY IN INDIAN WOMEN

Objectives: The context of this article is based on two main titles those being Gynecologic Oncology and Minimal invasive surgery. **The aim of this study was to report the laparoscopic management of a series of cases of endometrial carcinoma managed by laparoscopic surgical staging in Indian women.**

Materials and Methods: This study was conducted in a private hospital (referral minimally invasive gynecological center). This was a retrospective study (Canadian Task Force Classification II-3). Eighty-eight cases of clinically early-stage endometrial carcinoma staged by laparoscopic surgery and treated as per final surgicopathological staging. All patients underwent laparoscopic surgical staging of endometrial carcinoma, followed by adjuvant therapy when needed. Data were retrieved regarding surgical and pathological outcomes. Recurrence-free and overall survival durations were measured at follow-up. Survival analysis was calculated using Kaplan–Meier survival analysis.

Results: The median age of presentation was 56 years, whereas the median body mass index was 28.3 kg/m2. Endometroid variety was the most commonly diagnosed histopathology. There were no intraoperative complications reported. The median blood loss was 100 cc, and the median intraoperative time was 174 min. There were a total of 5 recurrences (5.6%). The outcome of this study was comparable to studies conducted in Caucasian population. **The predicted 5-year survival rate according to Kaplan–Meier survival analysis is 95.45%, which is comparable to Caucasian studies.**

Conclusion: Laparoscopic management of early-stage endometrial carcinoma is a standard practice worldwide. However, there is still a paucity of data from the Indian subcontinent regarding the outcomes of laparoscopic surgery in endometrial carcinoma. The Asian perspective has been highlighted by a number of studies from China and Japan. **To our knowledge, this study is the first from India to analyze the surgicopathological outcomes following laparoscopic surgery in endometrial carcinoma.** The outcome of this study was comparable to studies conducted in Caucasian population.

Eva Endoscopy Training Institute
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QR Code for Entire Article

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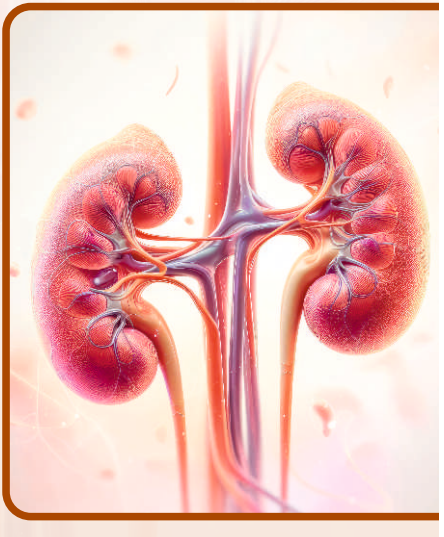

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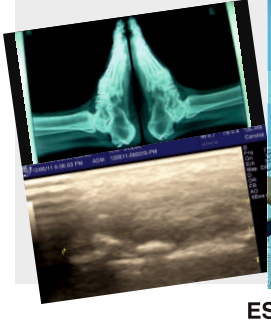
PUMP BUMP

- PUMP BUMP (Haglund Deformity), Tendo Achilles Tendinopathy (insertional and noninsertional) are a group of disorders which cause Achillodynia.
- Diagnosis is done with X Rays and USG.
- When conservative treatment fails local steroid injections are avoided due to risk of tendon rupture. Shoes modification may not work and ambulation is painful.Chronic pain and disability causes frustration and depression.
- Surgery is demanding with long term rehabilitation and complications are dreaded
- Orthotripsy can cause inflammatory modulation , repair and regeneration of tissues leading to pain free ambulation and activities without any brace. Eccentric loading exercises can accentuate the healing process with better outcomes



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STATE PRESIDENT'S MESSAGE

Dear IMA Friends,

'This time it is a Rajkot'

On the behalf of the IMA-GSB & organizing team of GIMACON-24, I welcome you all this wonderful conference GIMACON-2024 hosted by IMA Rajkot Branch.

As we all are aware that the annual conference of IMA GSB it own importance. We will be installing the New team of IMA GSB under leadership of president elect. Dr. Mehul Shah.

Lot many Business meetings important decision, direction, pending matters of various schemes of IMA GSB will be taken & issues will be debated.

As I am from Rajkot, It gives me immense pleasure & pride to in invite you all in this conference. It will be a 2 days academic festival where in stalwarts from various corners of India will deliver their scientific deliberations & share there experience with us to update our knowledge.

I am assure you of traditional hospitality of "કાઠીયાવાડ" by serving you a mouth watering dishes and last but not least, to make you relax & rejuvenate we plan internationally recognize "Bollywood Night" on Saturday Night 19th Oct 2024. Friends join us with your family to this lifetime memorable event.

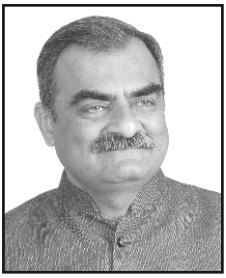
Please search for **'GIMACON-24'** Website on Google.

See you in Rajkot.

Be Healthy, Be Blessed.

Dr. Bharat M. Kakadia
President, G.S.B., I.M.A.

HON. STATE SECRETARY'S MESSAGE



IMA Gujarat Angry:
A Call for Unity and Protection

In the wake of the tragic and horrific killing of a lady doctor in a Kolkata hospital, the Indian Medical Association (IMA) has made a firm and united call for justice. The IMA condemns this act of violence in the strongest terms and is resolute in its demand for the protection of healthcare workers across the nation.

The IMA stands united in its demand for a Central Protection Law to safeguard all healthcare workers. Our hospitals, where lives are saved daily, must be declared safe zones, free from any threats or violence. It is imperative that these spaces remain sanctuaries where doctors and healthcare workers can work without fear.

We also demand fast-track trials for the perpetrators of such heinous crimes & exemplary punishment to set a strong precedent that violence against healthcare workers will not be tolerated. Additionally, the IMA calls for adequate compensation for the bereaved family, recognizing the immense loss and hardship they now face.

The strength of our profession lies not just in our knowledge or skills but in our unity. Doctors across the nation have come

together in an unprecedented show of solidarity, reinforcing the message that we stand as one, undivided and determined to protect our fraternity. Every local branch of the IMA Gujarat has played a crucial role in amplifying this cause, proving that when doctors unite, we are an unstoppable force. Together, we will continue to advocate for our rights, uphold our dignity, and ensure that the safety of every healthcare worker is paramount. Our unity is our greatest shield, and with it, we will bring about the change that is desperately needed.

The IMA Gujarat extends its heartfelt thanks to all doctors and members of the IMA's local branches for their unwavering solidarity and support during this difficult time. It is through this collective strength that we will overcome this crisis. Together, we stand as one—unified and resolute in our pursuit of justice.

This solidarity is just the beginning of our collective effort to secure justice for our Kolkata colleague who lost her life & to advocate for the safety of all healthcare professionals. Our strength and unity will drive the change we need.

Unity is our strength. Let us continue to support one another and remain steadfast in our mission to protect those who dedicate their lives to saving others.

Dr. Mehul J. Shah
Hon. State Secy., G.S.B.,I.M.A.

INDIAN MEDICAL ASSOCIATION (HQs.)
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To,

All State Presidents & Secretaries of IMA

All Local Branch Presidents & Secretaries of IMA

Dear Doctor,

Greetings from Indian Medical Association HQs.

IMA HQs. is declaring a campaign on 1) Violence on doctors and hospitals, 2) Criminal prosecution of doctors. All the state and local branches are directed to gear up for the campaign as envisaged.

1. Central Law on Violence

We are passing through difficult times in practising the profession. The ambience in our hospitals is one of fear and mistrust. The violence on doctors and hospitals has reached epidemic proportions.

The Central Government had initiated a Bill on violence on doctors and hospitals. It was even put up for public comments. However, the Bill is yet to be introduced in the Parliament.

The Government protected the doctors from mindless violence during Covid by amending the Epidemic Diseases Act of 1897 which is not in force now.

A central law in statute on attacks on doctors and hospitals will be a deterrent and would strengthen the state legislations in 23 states. Hardly any conviction has happened in these states inspite of the state legislation.

IMA demands a Central Law on violence on doctors and hospitals

2. Criminal prosecution of doctors

Mindless criminal prosecution has resulted in harassment of doctors and practice of defensive medicine. There is a legitimate case for exempting the professional service of doctors from criminal prosecution. It is the responsibility of the Government to provide a safe and amiable atmosphere for doctors to practise their profession without fear of criminal prosecution.

The criminal liability of medical negligence is of controversial legality.

To establish criminal liability, it is important to ascertain whether the intent to cause harm (mens rea) existed. In cases of criminal medical negligence, the intention to cause harm has been replaced by gross negligence. Gross negligence has not been defined in the BNS.

The concept of mens rea has to be applied in letter and spirit. Absence of mens rea in a case of a medical accident is too evident to be ignored. The unique and distinct nature of medical negligence as different from a crime is evident even at the stage of defining the crime.

IMA stands by its policy that in the absence of mens rea (criminal intent) doctors can be held responsible only in civil law (Law of Torts) Accordingly IMA is committed to work towards exempting the doctors from criminal prosecution.

Section 106 of Bharatiya Nyay Sanhita (BNS)

(1) Whoever causes death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to five years, and shall also be liable to fine; and if such act is done by a registered medical practitioner while performing medical procedure, he shall be punished with imprisonment of either description for a term which may extend to two years, and shall also be liable to fine.

Section 26 of Bharatiya Nyay Sanhita (BNS)

Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm.

Illustration,

A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint. but not intending to cause Z's death. and intending. in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence.

IMA demands application of section 26 in cases of alleged criminal negligence. IMA demands to exempt the medical profession from criminal prosecution.

With kind regards

Dr. R V Asokan
National President

Dr. Anilkumar J Nayak
Honorary Secretary Geneal

(IMA-News)

INDIAN MEDICAL ASSOCIATION (HQS)

Pricing of drugs and medical devices (23rd July 2024)

Rational

- More than two-thirds (65%) of all healthcare payments are borne out-of-pocket (OOP) in India, of which 70% is reported to be attributable to drugs.
- Public Health Foundation of India (PHFI), in their report in 2018, Out-of-pcket (OOP) health expenses drove 55 million Indians to poverty in 2017, and of these, 38 million (69%) were impoverished by expenditure on drugs alone,
- Out of the total pharmaceutical expenditure incurred by households, 18% is for in-patient treatment while 82% is for out-patient care. These figures suggest that the cost of pharmaceuticals is an important area for policy intervention.

Regulations: Issues

- Access and Availability of the quality drugs is the prime concerns.
- Transparency in process.
- Constant updates on Technological Advancements.
- Balancing Affordability and Industry Viability.
- Reduction in drug R&D investments resulting in the introduction of fewer new molecules per year.

Improving Drug Affordability

- Strengthening Price Control Mechanisms.
- Promoting Generic Drugs by strengthening the regulatory mechanism to monitor the efficacy and quality of Generics.
- Boosting Domestic Production by reducing dependence on imported API (Active Pharmaceutical Ingredients).

Current Status

- As per (NPPP-2012), the prices of drugs under NLEM are to be fixed by the Government by adopting the simple average price of all the brands having market share of 1 per cent of the total market turnover.
- Pharma firms are allowed to increase the price of non-essential drugs by 10% annually.
- A new drug developed in India and granted patent under Indian law will be exempted for 5 eyars. Companies discovering new process or a new delivery system are also eligible.

Fallacy

- Any average taken out of the prices of the leading brands would lead to high ceiling price for any medicine in comparison to earlier cost based ceiling mechanism.
- Government has allowed price rises of even controlled medicines depending on Wholesale Price Index (WPI). WPI has no relation in determining cost of medicines.

GST on Drugs and Medical Devices

- GST on HEalth is taxation on illness. Taxing the sick for falling ill is illegitimate.
- Medicines and medicinal devices are charged three slabs of GSt viz. 5% 12% and 18%
  a) Life saving equipments (ventilators, monitors, anaesthesia equipments) @12%
  b) Batteries of all life saving equipments @28%
  c) X-Ray machines, ultrasound machines and sugar testing strips @18%
  d) Repair and maintenance of medical equipments @ 18-28%
  e) Drugs, oxygen and disposables @ 12%
  f) health insurance @ 18% GST.

Medical Devices: Regulation and Control

- Medical Devices are primarily imported:
  (I) A lack of high-eng technology, and
  (ii) Poor availability of raw materials.
- Importing is cheaper than manufacturing domestically because of a low import duty, and a 12% GST on manufactured goods.
- Reduce the excise duty on importing machinery used for setting up manufacturing plants.
- Country has only 18 certified Medical Device Testing Labs.
- Indian medical Association can play a role in establishing quality norms.
- Bureau of Indian Standards can harmonise Indian Standards with globally accepted quality stands for medical devices.
- Medical devices are regulated as drugs under the Drugs and Cosmetics Act, 1940. The Medical Devices Rules, 2017 and NMDP 2023 contain provisions regulating medical devices.

Medical Devices : Regulation and Control

- formulating a separate legislation for medical devices is a step forward.
- CDSCO in its current form is incapable of effectively regulating the medical devices industry.
- Upskilling of the regulator is required..
- NPPA Monitors the price of non-essential medical devices and allows an annual inrease of 10% in prices.

- Medical devices that are required for critical care be scheduled and listed under the National List of Essential Medicines.
  I) pricing be bsed on the cost and quality considerations.
  ii) AMC/CMC shuold be rationalized as well as standardized.
  iii) Ministry continue with price exemptions until an ecosystem for innovation and R&D is built.
  iv) The Product Linked Incentive Scheme (PLI Scheme) has to be extended to more products and more states.
- Trade margin Rationalisation Policy is expected to address arbitrary pricing by importers.

IMA Opinion

- Pharma prices do not reflect their production cost. Prices are for the branding. Fix prices as per manufacturing cost.
- Antibiotics are a priority are for intervention. Public sector production and Pool procurement (like in TB) is crucial. Such an intervention will not only keep the prices low but also contain AMR.
- Revive Public Sector Pharma and Vaccine Companies. Price to be fixed on the basis of manufacturing cost.
- Ensure quality of medicines for generic drugs to gain the confidence of doctors and patients.
- No GST on Medicines and Medical equipments.

IMA Opinion

One drug, One price also known as the "one molecule, on MRP approach, aims to standardize the pricing of drugs with the same chemical composition, regardless of the company manufacturing them, This policy ensures the all brands of a drug with the same active ingredient and same standards of manufacture are sold at the same price.

Ban differential pricing : Government should ban differential pricing of a drung under different brand names (generic generic, trade generic or branded generic) by one company. (one chemical drug, one company, one price).

The following require capping of prices:

- Coronary Balloons.
- Catheters and Stents for Neuro Intervention. Neuro intervention Catheters, Stents and Balloons are exorbitantly priced and average intervention for Stoke costs >₹7,00,000.
- Catheters and Stents for Peripheral Artery Intervention. Many patients land up with amputation without intervention.
- Online sale of medicines should be banned.

(IMA-News)

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NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI
FIRST APPEAL NO. 587 OF 2023

(Against the Order dated 15/02/2023 in Complaint No. 10/2010 of the State Commission Madhya Pradesh)

1. V.C. RAWAT & 3 ORS.
   S/O SHRI PRABHU DAYALJI, AGED 79 YEAR, R/O 13-HIG A, VIDYA NAGAR , HOSHANGABAD ROAD BHOPAL
2. SHISHIR RAWAT A
   S/O SHRI V.C. RAWAT AGED 50 YEARS R/O 13-HIG A, VIDYA NAGAR, HOSHANGABAD ROAD BHOPAL
3. SUMIT RAWAT
   S/O SHRI V.C. RAWAT AGED 48 YEARS R/O 13-HIG A, VIDYA NAGAR, HOHANGABAD ROAD BHOPAL
4. SACHIN
   S/O SHRI V.C. RAWAT, AGED 33 YEAR5S, R/O 13-HIG A, VIDYA NAGAR, HOSHANGABAD ROAD BHOPAL ..... Appellant(s)

Versus

1. AKSHAYA HOSPITAL & ANR.
   RISHI NAGAR CHAR IMLI BHOPAL
2. UNITED INDIA INSURANCE CO. LTD
   CITY BRANCH OFFICE NO 3, 131/11, ZONE-2, M.P. NAGAR BHOPAL .....Respondent(s)

BEFORE:
HON'BLE MR. JUSTICE RAM SURAT RAM MAURYA,PRESIDING MEMBER
HON'BLE BHARATKUMAR PANDYA, MEMBER

FOR THE APPELLANT	:	MR. ARUN SINGH TOMAR, ADVOCATE MR. VIKAS UPADHYAY, ADVOCATE
FOR THE RESPONDENT	:	FOR THE RESPONDENT-1 : MR. DEEPESH JOSHI, ADVOCATE
	:	MR. AMUL GUPTA, ADVOCATE
	:	MR. DEEPAK C. ADVOCATE
FOR THE RESPONDENT-2	:	MS. SWETA SINHA, ADVOCATE

Dated : 26 June 2024

ORDER

1. Heard Mr. Arun Singh Tomar, Advocate, for the appellants, Mr. Deepesh Joshi, Advocate, for respondent-1 and Ms. Sweta Sinha, Advocate, for respondent-2.
2. Above appeal has been filed against the order of State Consumer Disputes Redressal Commission, Madhya Pradesh, dated 15.02.2023, dismissing CC/10/2010 filed by the appellants.
3. V.C. Rawat, Shishir Rawat, Sumit Rawat and Sachin Rawat (the appellants) filed CC/10/2010, for directing the respondents to pay (i) Rs.60/- lakhs with interest @18% per annum from 01.04.2009 till the date of realisation, as the compensation; (ii) litigation costs; and (iii) any other relief which is deemed fit and proper in the facts and circumstances of the case.
4. The complainants stated that V.C. Rawat is husband and Shishir Rawat, Sumit Rawat and Sachin Rawat are sons of the deceased Smt. Rama Rawat. Smt. Rama Rawat, aged about 63 years (for short the patient) did Post Graduation in (i) Sociology, (ii) Drawing & Painting and (iii) Music and was on Singer's List of All India Radio, Bhopal. She was an active member of IAS Officers Wives Association Club, Vanita Samaj Ladies Club, Anand Vihar and Vidya Nagar Colony Club. The patient was a regular morning walker and did not ever have angina chest pain. Her post retirement life was sailing happily and smoothly. V.C. Rawat along with the patient went for a stroll at about 18:00 hours on 31.03.2009. On returning home, the patient complained uneasiness and discomfort. Dr. S.K. Parashar, Additional Director, Central Government Health Scheme (CGHS), Office and Dispensary at Jahagirabad, Bhopal, resides at a distance of 1000 feet from the house of the complainants.

   As V.C. Rawat was a life member of the CGHS, he requested Dr. S.K. Parashar on telephone to examine the patient. Dr. S.K. Parashar, however, without examining the patient, asked V.C. Rawat to take the patient to Akshaya Hospital, which was an empaneled hospital of the CGHS. After meal, V.C. Rawat took the patient to Akshaya Hospital, reaching there at 20:30 hours on 31.03.2009. The patient was admitted to Intensive Care Unit (ICU) Ward straightway prior to completing documentation. While, the patient was on the bed in ICU, ECG wire terminals were attached to her body and ECG was done at 21:31 hours on 31.03.2009. Dr. Amit Singh MD was monitoring the ECG. The attendants handed over a list of medicines to V.C. Rawat, be brought from the medical store at the basement. When V.C. Rawat was returning with medicines to the lift, Dr. P.C. Manoria, Cardiologist came out of the lift. V.C.

Rawat requested him to examine the patient in ICU. Although he nodded but did not turn up to examine the patient. When V.C. Rawat came to ICU with medicines, he found that the patient was being attended by Dr. Gupta, a very junior MBBS doctor and two homoeopathy assistants namely Rajesh Panderiya BHMS and Vinod Kumar BHMS. By inserting a drip needle into wrist, they were transfusing saline liquid to the patient. They informed V.C. Rawat that the ECG of the patient did not show any alarming condition. Later on V.C. Rawat learnt that they had also transfused NTG injection to the patient. In ICU ward, there were 8 to 10 ICU cabins in semicircular situation and the attending doctors and staffs were located in center of it. V.C. Rawat inquired from the attendants that when the senior doctors namely Dr. Anil Gupta and Dr. Deepak Chaturvedi would examine the patient. They informed that the senior doctors would not come in night and would be available at 8:00 AM on the next morning. There is no need for them to come, as the young doctor Gupta (Junior) was also MBBS. Beside this, one Dr. Amit Singh was doing central monitoring of ECG. They again assured V.C. Rawat that there was no emergent condition of the patient, which 05/08/2024, 13:26 about:blank about:blank 2/10 required immediate examination by the senior doctor. V.C. Rawat asked for phone numbers of the senior doctors but the staff did not provide phone numbers of the senior doctors. The patient suffered from headache, sleeplessness and vomiting sensation, which was informed to the attending doctors by V.C. Rawat. The patient was pressing for going to the home but V.C. Rawat consoled her by saying that they would go to home in morning. Even in night, no senior doctor visited the hospital. The attendant did second ECG at 00:22 hours on 01.04.2009 and V.C. Rawat informed that the ECG did not show any alarming condition, B.P. was 130/90 m. Hg and the patient was sleeping, then he relaxed and waited outside the ICU. At 3:00 hours on 01.04.2009, V.C. Rawat heard a lot of commotion. Rajesh Panderiya came outside ICU and called V.C. Rawat to get up as “auntie was not waking up”. They were trying oxygen breathing etc. Immediately thereafter, the junior doctor declared that the patient had expired due to sudden heard attack. The applicant was stupefied as he was not informed that the patient had any symptom prior to heart attack. V.C. Rawat asked to call the senior doctors, namely Dr. Anil Gupta, Dr. P.C. Chaturvedi and Dr. P.C. Manoria. Dr. Pankaj Manoria son of Dr. P.C. Manoria, a junior doctor came to the hospital at 3:30 hours on 01.04.2009 and repeated same thing that the death had occurred due to sudden heart attack. The Directors of the hospital came in morning at 6:00 hours. V.C. Rawat

met them in their chamber and they too repeated same reason of sudden heart attack. On insistence, unsigned copies of treatment papers and 'death certificate', signed by Dr. Amit Singh MD were given. In 'death certificate' cause of death was mentioned as 'Acute Coronary Syndrome, Cardiac Arrest, Cardiac Pulmonary Arrest". On the request of V.C. Rawat, the dead body was sent to his home at 7:00 hours in ambulance. On the request, two signed copies of the treatment papers were given on 15.04.2009 bearing the date 31.03.2009. The complainants returned one copy of the treatment papers on 15.04.2009 and requested to mention the name and qualification of the person, who had signed it but same document was again sent through speed post, which was received on 18.05.2009. In the treatment papers dated 31.03.2009, name of the Physician In-charge was mentioned as Dr. Anil Gupta, M.D., BP as 170/110, pulse 76/m, No chest pain. The medicines prescribed are mentioned as NTG 25 mg @8 drops/minute, T. Cardace 5 mg OD, T. Betaloc 25 mg BD and Lenoxin (dejoxin). ECGs at 21:31 hrs dated 31.03.2009 and 00:22 hrs on 01.04.2009 showed normal sinus rhythm. Right Bundle Branch Blockage mentioned is not a lethal condition and existed in her ECG of January, 2005 as well. The pathological report showed CKMB was normal 18.4 U/L well within the 0-25 U/L normal range, Serum Urea, Creatinine Sodium, Potassium were normal.

At 10:30 PM on 31.03.2009, BP 150/100. Dose of antihypertensive NTG was increased to 10 drops/mt. At 00:30 hours on 01.04.2009, BP was 130/90 and NTG continued to 10 drops/mt. At 1:30 hours on 01.04.2009, BP was 120/90 and at 2:00 hours 118/70. NTG drop continued. At 2:30 hours, sudden cardiac arrest, no respiration, no response, BP not recordable, Atropine and adrenaline administered. Recording from "1:30 hours to 2:30 hours" was on the right hand space of the same papers, which is space for writing treatment, which is clear manipulated entry. Pages-1 to 3 are in different handwriting and pages 4, 5, 6, 7 and 8 are in different handwriting, which is said to be of Technical Assistant. The entries are made on 01.04.2009 at 3:15 hours, 4:10 hours, 3:00 hours, 2:10 hours, 2:18 hours, 2:30 hours, 00:30 hours. At the bottom of page 4, 2:30 AM, the last line was written and cut "Patient certify at 2:30 AM". The anomalies, mismatch and manipulation in the record are apparent. After death of the patient, the case was discussed with Dr. Pankaj Manoria son of Dr. P.C. Manoria at 3:15 AM. At 4:10 AM, the case was discussed with Dr. P.C. Manoria but what was the need and outcome of the

discussion is not mentioned. As per the record, the NTG drip was not 05/08/2024, 13:26 about:blank about:blank 3/10 removed till the end, which was removed at 6:00 on 01.04.2009. The overwriting of the date as 01.04.2009 is apparent. The case history of the patient was not noted. Akshaya Hospital claims to be “An Exclusive Heart & Multi Specialty Centre” and the patient was admitted in ICU and diagnosed with Acute Coronary Syndrome. The patient remained there for 6 hours but the hospital could not arrange for examination of the patient by its Heart Specialists. Admission papers shows that the patient was admitted under Dr. Anil Gupta but he also did not visit the hospital this period. Six hours crucial period to save the life of the patient was wasted. The hospital was not equipped with the instruments for constantly recording BP of the patient. The hospital has employed Homeopath Technician as the attendants in ICU, who administered NTG to the patient although they had no qualification to use this modern medicine. While transfusing NTG, recording of BP of the patient at every short interval was required. From the record, it is proved that BP was not recorded after 00:30 hours on 01.04.2009 till the death of the patient. Neither infusion pump nor even micro drip set was used to control NTG drip. Infusion of NTG is highly risky procedure but 'informed consent' has not been obtained. The rate of NTG infusion is the criteria to control BP and requires very frequent BP measurement and fine adjustment of NTG drops. When BP of the patient came down to 130/90 at 00:30 hours, NTG drip should have been removed or drastically reduced, to avoid any further fall of BP and tachycardia (increase in pulse rate due to fall of BP), an hyperfusion of coronary artery and danger of coronary arrest. “Unstable Angina” has been mentioned as a diagnosis. The patient was in ICU. Then a cardiologist should have examined her which was not done. The attendant doctor did not record medical history or the condition of the patient at the time of admission. Infusion of NTG is high risk procedure, which is required to be used by a specialist trained doctor but it was used by a junior doctor to the patient. Although high risk procedure of infusion of NTG was followed but the complainant was neither informed in this respect nor 'informed consent' was obtained from him. On the other hand, the complainant was informed that it was a saline drip and there was no mention of NTG injection in it. Many anti-hypertensives, in combination were given to the deceased just to treat mild hypertension, namely VTG, Bet-loc, Cardiac although there was no chest pain and ECG did not show any symptom of cardiac disrythmias. In blood test report also cholesterol and CKMB were

normal, which show that there was no ischaemia. In 'death certificate' cause of death was mentioned as 'Acute Coronary Syndrome, Cardiac Arrest, Cardiac Pulmonary Arrest", which are contrary to ECG report. On these allegations, the complaint was filed on 05.04.2010.

5. Akshaya Hospital (respondent-1) filed its written reply and contested the complaint. Akshaya Hospital (the hospital) stated that it was a reputed hospital in Bhopal, having fullfledged ICCU for last 20 years. All the paramedical staffs of the hospital are trained. The hospital had 17 ICCU & CCU beds fully equipped with state of art gadgets. The hospital was providing 24 hours service with at least one post graduate doctor. Smt. Rama Rawat, aged about 63 years (the patient) visited the hospital on 31.03.2009 at 21:15 hours. Instead of vesting time in paper work, the patient was directly admitted to ICCU, where she was attended by a senior doctor namely Dr. Amit Singh, MD (Medicine) (who did MD from Gandhi Medical College, Bhopal, in 2007 and thereafter worked as Senior Resident Doctor in Hamidia Hospital, Cardiology Department, Bhopal). The patient was subjected to all preliminary check-up viz. general examination, blood pressure, pulse rate, blood test, ECG etc. between 21:15 to 21:31 hours. ECG at 21:31 hours showed Sinus tachycardia with ST segment depression and Right Bundle Brach Block suggestive of unstable angina. Her ECG 05/08/2024, 13:26 about:blank about:blank 4/10 was done by Dr. Amit Singh, who informed the condition of the patient to V.C. Rawat. At the time of paper work relating to admission of the patient, V.C. Rawat inquired about the Directors of the hospital and he was informed that they were not available. Dr. P.C. Manoria was not associated with the hospital rather he was running an independent Heart Care Centre at the third floor of the hospital building. It is denied that V.C. Rawat was informed that saline only was being transfused to the patient. In the prescription slip Nitro Glycerine (NTG) was written in bold letter. List of medicine, supplied to V.C. Rawat, mentioned NTG. The patient was transfused saline, NTG with Dextrose. Dr. Amit Singh, a senior doctor was attending the patient as such other senior doctors namely Dr. Anil Gupta and Dr. Deepak Chaturvedi were not required to be called. There was no junior doctor Gupta MBBS, ever associated with the hospital. Dr. Amit Singh attended the patient from the time of her admission till her death with the assistance of trained medical staff of the hospital. Phone numbers of Dr. Anil Gupta and Dr. Deepak Chaturvedi was mentioned over the Files, Latter Pads and Discharge Tickets etc. It is denied that the staff did not provide phone numbers of Dr. Anil Gupta and Dr. Deepak Chaturvedi.

Second ECG was done at 00:21 hours on 01.04.2009, which showed settling changes as heart rate settled down from 106 beats per minutes to 75 beats per minute, pulse rate of 62/min and ST segment became isoelectric. BP became normal, ECG changes reverted towards normal and the patient went to sleep, as admitted by V.C. Rawat. In fact as the patient had Bradycardia (slowing of heart rate), which followed by cardiac arrest at 2:05 hours on 01.04.2009. Dr. Amit Singh and medical staff immediately started all resuscitative measure. V.C. Rawat was also informed immediately. In spite of best efforts of Dr. Amit Singh, the patient died at 2:30 hours, however on the request of V.C. Rawat, CPR was continued for 30 minutes more and on of insistence of V.C. Rawat, Dr. Amit Singh consulted Dr. Pankaj Manoria and Dr. Dr. P.C. Manoria on telephone. The patient had history of uncontrolled DM-2, uncontrolled Hypertension, and RBBB from 6-7 years. Sudden cardiac arrest was due to well-known complication in case of Acute Coronary Syndrome. Acute Coronary Syndrome refers to a spectrum of clinical presentations ranging from those for ST-segment elevation myocardial infarction (Stemi) to presentation found in

non-ST-segment elevation myocardial infarction (NSTEMIN) or in unstable angina. In terms of pathology ACS is almost always associated with rupture of an atherosclerotic plaque and partial or complete thrombosis of the infarct-related artery. It is denied that the deceased never had symptoms of heart attack. The patient was admitted in the hospital after 3:15 hours of start of first symptom with classical signs and ECG changes of acute coronary syndrome, which clearly suggested that the patient had a problem associated with her heart. ECG report dated 31.03.2009 at 21:31 hours clearly confirms the said diagnosis. There were two bundles of electric conduction in heart though a patient with one bundle bock has a chance of developing cardiac arrest in Acute Coronary Syndrome. CPK MB usually rises in six hours after cardiac injury. It is a routine in a hospital to repeat CPK MB after 12 hours, if initial report is normal. CPK MB will not rise in angina pectoris and even in Acute Coronary Syndrome in initial six hours. The patient was treated with NTG Cardace Betaloc, along with low molecular weight heparin, loading dese of Aspirin & Clopidogrel, Plectropic doses of Statin & Anxiolytic to control High Blood Pressure and Acute Coronary Syndrome. Cardace along with lowering BP also improves endothelial dysfunction. The patient was started NTG at the rate 4.16 micro gms/minute and then up titrated up to 8.33 micro

gms/minute. NTG was given through a PVC conduit (bottle & IV set) which absorbs NTG, making effective NTG dose much less than what was going on with additional security attached namely DialO-Flow, which is standard practice in the hospital to infuse NTG and other sensitive drugs.

Last recorded BP of the patient at 2:00 hours on 01.04.2009 was 118/70. The patient was already on Betaloc and Betablockers could not be withdrawn suddenly as it may precipitate heart attack. Lomorin was not given to the patient. It was Lomorin-a low molecular weight heparin, a standard treatment for Acute Coronary Syndrome was given. At the time of admission, the patient had BP of 170/110 and RBG was 193 mg%, both were grossly on higher side-suggestive of inadequate treatment, the patient was receiving in the past prior to her admission in the hospital. Photostat copies of the medical documents were supplied to V.C. Rawat on 01.04.2009, after one hour of the death of the patient. Page No.1 is a Treatment Sheet. Monitoring notes of vital signs, when the patient was alive was put on Page No.2 (back of treatment sheet was used for recording vital signs). There was no tampering in medical records. It may be a mistake ut not tampering. V.C. Rawat V.C. Rawat sent his son on 02.04.2009 afternoon for obtaining signed copies of the documents, which were supplied to him. During talks, the son of V.C. Rawat informed that the patient had episode of burning in chest and ghabrahat off and on for last six months, for which, she used to take Alprax or Zolfresh. He also informed that during this period, no ECG, TMT or Angiography was done. The complainants have deliberately concealed medical history of the patient. Although signed copies of medical records supplied to the son of V.C. Rawat on 02.04.2009, it were again demanded on 15.04.2009. There is no deficiency in service on the part of the hospital. The complaint is liable to be dismissed.

6. United India Insurance Company Limited (OP-2) filed its written reply and stated that as the patient had died due 'cardiac arrest' as such liability of insurance company was not attracted.

7. State Commission sent the papers relating to treatment of the patient in the hospital to Gandhi Medical College, Bhopal and sought for its expert opinion. A Medical Board consisting of Dr. T.N. Dubey, Dr. B.S. Yadav and Dr. Ajay Sharma submitted its report dated 15.07.2009 holding that the patient was monitored well and no negligence was committed by the hospital. The complainants filed Rejoinder, Affidavits of Evidence of Dr. D.K. Satpathy, Dr. Ashok Gupta, P.P. Agrawal and V.C. Rawat and documentary evidence

including Expert Opinion of Dr. D.K. Satpathy. Opposite party-1 filed Affidavit of Evidence of Dr. Deepak Chaturvedi, Dr. R.K. Singh, Dr. Ajay Sharma and Dr. T.N. Dubey and documentary evidence including Expert Opinion of Dr. R.K. Singh. The complainants cross-examined Dr. T.N. Dubey, Chairman of Medical Board. Dr. Amit Singh filed his Affidavit before Medical Board. Both the parties filed their written synopsis.

8. State Commission, after hearing the parties, vide judgment dated 15.02.2023, held that the complainants, in paragraph-9 of the complaint have admitted that the patient was suffering from Right Bundle Branch Blockage since January, 2005. Dr. D.K. Satpathy does not know what was nominal volume of Toroponim and could not read the report of echocardiographs therefore his expert opinion and affidavit were not worth reliable. Otherwise also, he was not a cardiologist. Expert opinion of Dr. R.K. Singh, Cardiologist Chirayu Hospital Bhopal and the opinion of Medical Board dated 15.07.2009 did not find any negligence in treatment of the patient. Although the complainants cross-examined these witnesses at length but nothing adverse has come. Neither deficiency in service on the part of the hospital nor negligence in treatment of the patient was proved. On these findings, the complaint was dismissed. Hence this appeal has been filed.

9. We have considered the arguments of the parties and examined the record. In paragraph-12 of the complaint, the complainants alleged following deficiency in service, namely (i) Akshaya Hospital claims to be "An Exclusive Heart & Multi Specialty Centre". The patient was admitted in ICU, diagnosed with Acute Coronary Syndrome and remained there for 6 hours but the hospital could not arrange for examination of the patient by its Heart Specialists. (ii) Admission papers shows that the patient was admitted under Dr. Anil Gupta but he also did not visit the hospital during this period. Six hours crucial period to save the life of the patient was vested. (iii) The hospital was not equipped with the instruments for constantly recording BP of the patient. (iv) The hospital has employed Homeopath Technician as the attendants in ICU, who administered NTG to the patient although they had no qualification to use modern medicine. (v) While transfusing NTG, recording of BP of the patient at every short interval was required. From the record, it is proved that BP was not recorded after 00:30 hours on 01.04.2009 till the death of the patient. (vi) Neither infusion pump nor even micro drip set was used to control NTG drip. Infusion of NTG is highly risky procedure but 'informed consent' has not been

obtained. (vii) The rate of NTG infusion is the criteria to control BP and requires very frequent BP measurement and fine adjustment of NTG drops. When BP of the patient came down to 130/90 at 00:30 hours, NTG drip should have been removed or drastically reduced, to avoid any further fall of BP and tachycardia (increase in pulse rate due to fall of BP), an hyperfusion of coronary artery and danger of coronary arrest. "Unstable Angina" has been mentioned as a diagnosis. (viii) The attendant doctor did not record medical history or the condition of the patient at the time of admission. Infusion of NTG is high risk procedure, which is required to be used by a specialist doctor but it was used by a junior doctor to the patient.

10. Akshaya Hospital (OP-1) in its written reply stated that it was a reputed hospital in Bhopal, having full-fledged ICCU for last 20 years. The hospital had 17 ICCU & CCU beds fully equipped with state of art gadgets. The hospital was providing 24 hours service with at least one post graduate doctor. All the paramedical staffs of the hospital are trained. NTG was given to the patient through a PVC conduit (bottle & IV set) which absorbs NTG, making effective NTG dose much less than what was going on with additional security attached namely Dial-O-Flow, which is standard practice in the hospital to infuse NTG and other sensitive drugs. Dr. Deepak Chaturvedi, the Director of the OP-1 filed his Affidavit of Evidence and proved above fact. It is admitted that the hospital was empaneled under Central Government Health Scheme, which prima facie proves that the hospital was equipped with all necessary instrument to treat a patient, including heart patient. The complainants have not applied for inspection of the hospital by any Local Commissioner and the affidavit of Dr. Deepak Chaturvedi, remained un-rebutted. Therefore, it cannot be said that the hospital was not equipped with necessary medical instrument to treat a heart patient. The allegations in this respect are not proved.

11. The complainants, in paragraph-12 of the complaint, has been stated that they would have refused to get the deceased treated in the hospital if they had known that the deceased would be treated by a junior doctor and homeopaths and not by the competent qualified senior doctor. In paragraph-6 of the complaint, they stated that V.C. Rawat inquired from the attendants that when the senior doctors namely Dr. Anil Gupta and Dr. Deepak Chaturvedi would examine the patient. They informed that the senior doctors would not come in night and would be available at 8:00 AM on the next

morning. There is no need for them to come, as the young doctor Gupta (Junior) was also MBBS. Beside this, one Dr. Amit Singh was doing central monitoring of ECG. Dr. Amit Singh, in his Affidavit, has stated that he was on night duty at Akshaya Hospital on 31.03.2009 and attended the patient from the time of her admission at 9:30 PM on 31.03.2009 till her death at 3:00 AM on 01.04.2009. Treatments and investigations were advised and written by him. The vital signs, pulse, BP etc. were written by Vinod and Rajesh under his supervision and advice, working as Technical Assistant in the hospital.

The Medical Board found that all the treatment papers/prescriptions were signed by Dr. Amit Singh. From the statement in paragraph-6 of the complaint and other evidence on record, it is proved that Dr. Amit Singh, MD (Medicine) was attending the patient from the time of her admission in the hospital and V.C. Rawat was informed that Dr. Anil Gupta and Dr. Deepak Chaturvedi would come to hospital at 8:00 am in next morning. V.C. Rawat did not make any inquiry about examining the patient by Dr. P.C. Manoria, from the attendants. He was satisfied with Dr. Amit Singh, MD (Medicine) and did not withdraw the patient from the hospital. Had the patient attended by alleged doctor Gupta (Junior), MBBS, Rajesh Panderiya BHMS and Vinod Kumar BHMS, he would have certainly withdrawn the patient from the hospital.

12. Now the question arises for consideration as to whether Dr. Amit Singh, MD (Medicine) was competent for ICU duty in the hospital?. Dr. T.N. Dubey, Chairman of the Medical Board, in cross-examination, stated that in ICU, the treating doctor present should be MD Medicine. Medical Council of India did not prescribe that MD doctor present in ICU should have intensive course. Every MD Medicine is competent to treat patient in ICU. It is true that Homeopath doctors are not trained in allopathic medicine and for this reason a Homeopath cannot treat a patient by himself with allopathic medicine but they can supervise the vitals of the patient like any other paramedical staff. The appellants have not produced any contrary guidelines of Medical Council of India. From above evidence, it is proved that Dr. Amit Singh, MD (Medicine) was In-charge of ICU of the hospital at the time of admission of the patient in hospital on 31.03.2009 at 21:15 hours. Dr. Amit Singh, MD (Medicine) attended the patient, advised investigation and treatment of the patient. Homeopaths merely noted the vitals of the patient. All these facts were in the knowledge of V.C. Rawat. Dr. Amit Singh, MD (Medicine) was competent to treat the patient in ICU. Although the Admission papers were on the letter

head of Dr. Anil Gupta but V.C. Rawat was informed that he would come at 8:00 hours on next morning.

13. The complainants have alleged that the attendant doctor did not record medical history or the condition of the patient at the time of admission. But in expert opinion, Dr. D.K. Satpathy has noted that in admission sheet, history of the patient was noted "known case of D.M. & Hypertension & Osteoporosis". Complained at the time of admission:- Burning sensation of the chest, ghabrahat, Perspiration with coldness of upper and lower limb. Nausea with headache. Vertigo. Vitals were noted as P-76 min, BP-170/110 mm/hg. Allegation in this respect is not proved.

14. Other allegations have been made that (i) Infusion of NTG is highly risky procedure but 'informed consent' has not been obtained. (ii) Infusion of NTG is high risk procedure, which is required to be used by a specialist trained doctor but it was used by a junior doctor to the patient. (iii) The rate of NTG infusion is the criteria to control BP and requires very frequent BP measurement and fine adjustment of NTG drops. (iv) While transfusing NTG, recording of BP of the patient at every short interval was required. From the record, it is proved that BP was not recorded after 00:30 hours on 01.04.2009 till the death of the patient. (v) When BP of the patient came down to 130/90 at 00:30 hours, NTG drip should have been removed or drastically reduced, to avoid any further fall of BP and tachycardia (increase in pulse rate due to fall of BP), an hyperfusion of coronary artery and danger of coronary arrest.

OP-1 in its reply stated that at the time of admission, the patient had BP of 170/110 and RBG was 193 mg%, both were grossly on higher side. The patient was started NTG at the rate 4.16 micro gms/minute and then up titrated up to 8.33 micro gms/minute. NTG was given through a PVC conduit (bottle & IV set) which absorbs NTG, making effective NTG dose much less than what was going on with additional security attached namely Dial-OFlow, which is standard practice in the hospital to infuse NTG and other sensitive drugs. Last recorded BP of the patient at 2:00 hours on 01.04.2009 was 118/70. The patient was already on Betaloc and Betablockers, NGT could not be withdrawn suddenly as it may precipitate heart attack. Lomorin was not given to the patient. It was Lomorin-a low molecular weight heparin, a standard treatment for Acute Coronary Syndrome was given. The patient never went into hypotension. NTG cannot produce hypotension and death within a span of 10 minutes.

The patient was subjected to all preliminary check-up viz. general examination, blood pressure, pulse rate, blood test, ECG etc. between 21:15 to 21:31 hours. ECG at 21:31 hours showed Sinus tachycardia with ST segment depression and Right Bundle Brach Block suggestive of unstable angina. At the time of admission, the patient had BP of 170/110 and RBG was 193 mg%, both were on higher side. The patient was started NTG at the rate 4.16 micro gms/minute and then up titrated up to 8.33 micro gms/minute. Second ECG was done at 00:21 hours on 01.04.2009, which showed settling changes as heart rate settled down from 106 beats per minutes to 75 beats per minute, pulse rate of 62/min and ST segment became isoelectric. BP became normal, ECG changes reverted towards normal and the patient went to sleep. Last recorded BP of the patient at 2:00 hours on 01.04.2009 was 118/70. The patient was already on Betaloc and Betablockers could not be withdrawn suddenly as it may precipitate heart attack. Lomorin was not given to the patient. It was Lomorin-a low molecular weight heparin, a standard treatment for Acute Coronary Syndrome was given. NTG was given through a PVC conduit (bottle & IV set) which absorbs NTG, making effective NTG dose much less than what was going on with additional security attached namely Dial-O-Flow, which is standard practice in the hospital to infuse NTG and other sensitive drugs. Last recorded BP of the patient at 2:00 hours on 01.04.2009 was 118/70. Medical Board did not find any negligence in transfusing NTG. NTG is life-saving drug, which required monitoring of vital of the patient during its infusion. From the record, it is proved that monitoring of vital was done on some interval. Even Dr. D.K. Satpathy has not stated that excess dose of NTG was transfused.

ORDER

In view of aforesaid discussions, we do not find any ground to interfere with the order of State Commission. The appeal has no merit and is dismissed.

.....J

RAM SURAT RAM MAURYA

PRESIDING MEMBER

.....

BHARATKUMAR PANDYA

MEMBER

HEALTH SCHEME; G.S.B. I.M.A.

UNIQUE SCHEME

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SINGLE MEMBERSHIP DUAL BENEFIT

- ON SINGLE MEMBERSHIP, BOTH THE MEMBER AS WELL AS HIS/HER SPOUSE CAN GET BENEFIT IN THE SCHEME.
- MEMBER CAN GET BENEFITS FROM HEALTH SCHEME AS WELL AS FROM MEDICAL INSURANCE.

DISEASES COVERED

- HEART DISEASE *BYPASS, ANGIOPLASTY, VALVULAR HEART, PACE MAKER IMPLANT.)
- KIDNEY DISEASE (HEMODIALYSIS, RENAL TRANSPLANT, RENAL ANGIOPLASTY)
- CANCER-SURGICAL, RADIOTHERAPY, CHEMOTHERAPY
- JOIN T REPLACEMENT (TOTAL KNEE AND HIP JOINTS)
- BRAIN TUMOR

- CEREBRAL/BRAIN HEMORRHAGE
- ORGAN TRANSPLANT
  (LIVER, LUNG, KIDNEY & HEART TRANSPLANT ONLY)

PHONE NO. 9313570725

healthschemeimagsb@gmail.com | +079 26585430
(02:00 PM - 06:30 PM)

DISCOUNTED FEES SCHEDULE

AGE GROUP	ADMISSION FEES (Rs.)	ANNUAL SUBCRIPTION FEES (Rs.)	ANNUAL MEMBERSHIP FEES (Rs.)	TOTAL	GST 18%	ADVANCE F.A.C. (Rs.)	TOTAL (Rs.)
Below age of 35 Yrs	0	50	50	100	18	7500	7618
Between 35-45 Yrs	750	50	50	850	153	7500	8503
Between 46-55 Yrs	1250	50	50	1350	243	7500	9093

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH
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PHONE : (079) 265 87 370 Email: imagsb@gmail.com

Ref No. A-11/HFC/LM/2024-2025 **Date: 18-3-2024**

Dear Branch Secretary

I hope that this circular finds you in the best of health and spirit. In continuation of our circular **A-11/HFC/LM/2024-2025,** further tabulated information is given below for the revision of fees effective from **1/4/2024.** Local branch share to be collected extra as per individual branch decision/resolution.

If the Local Branch does not have GST number, then sent the following amount to IMA GSB.

Category	Total Fees	Branch Share	GST. Amt. (18%)	To be Sent to GSB IMA including Admission Fee
Single Life	12330-00	840-00	2219-00	13709-00
Couple Life	18201-00	1280-00	3276-00	20197-00

If the Local Branch has GST number, then sent the following amount to IMA GSB. Kindly send challan copy of GST paid to IMA GSB.

For Single Life Member -	**Rs. 11490-00**
For Couple Life Member -	**Rs. 16921-00**

Membership Fees by a Cheque / DD. drawn in favour of **" G.S.B. I.M.A.".**

The above increase of fee Rs. 50.00 in Life Member every year is computed as per the resolution passed in 41st State Council at Nadiad on 12/05/1989.

Yours Sincerely

Dr. Mehul J. Shah
Hon. State Secretary

Redevelopment of IMA HQs. Building
Indraprastha Marg, New Delhi

Dr Ketan Desai
Chief Patron

Dr Anilkumar J. Nayak
HSG, IMA HQs (New Delhi)

Dr. Bharat M. Kakadia
President,
IMA-GSB

Dr. Mehul J. Shah
Hon. State Secretary,
IMA-GSB

Dr. Tushar B. Patel
Treasurer,
IMA-GSBB

APPEAL

"Our Commitment, Our Responsibility"

Let's Rebuild the
IMA Headquarters Building
for Future Generations to Come

IMA NEW BUILDING

32282348231670 6@cnrb

SCAN TO DONATE

In favour of	:	IMA NEW BUILDING
Bank	:	Canara Bank
Account No.	:	110162316706
IFCS Code	:	CNRB0019067
Branch	:	C R Building, Delhi

Income Tax Rebate u/s 80G

Redevelopment of IMA HQs. Building Fund Our Esteemed Donor's

Dr. Narendra M. Patel
Ahmedabad
Rs. 2,00,000/-

Dr. Girdhar Patel
Palanpur
Rs. 2,00,000/-

Dr. Y. T. Patel
Mehsana
Rs. 1,11,111/-

* * * * *

IMA team met with Union Health Minister Shri J.P. Nadda, Shri Apurva Chandra, Secretary (Health & Family Welfare, GoI), and Dr. Atul Goel (Director General, DGHS, GoI). During the meeting, a memorandum was submitted demanding to declare hospitals across the country as safe zones, a central law against violence and NMC to bring in security stipulations for recognition of medical colleges.

* * * * *

CME IMA Himatnagar Branch

State Working Committee Meeting, Ahmedabad

PPS Zonal Educative Seminar IMA Mehsana Branch

* * * * *

CME IMA Rajkot Branch

CME of Continuing Medical Education

Blood Donation Camp

CME IMA Amreli Branch

* * * * *

IMA Bhavnagar Branch

Blood Donation Camp

Mega Tree Plantation Mission

Cultural Day Celebration

* * * * *

IMA Deesa Branch

CME

HPV Vaccination Camp

CME IMA Kalol Branch

* * * * *

Blood Donation Camp IMA Mahuva Branch

* * * * *

IMA Mehsana Branch

CME

YOGA Day Celebration

IMA Morbi Branch

Cultural Festival Rhythm-2024

CME

* * * * *

CME IMA Palitana Branch

* * * * *

IMA Vadodara Branch

Annual Cultural & Sports Festival, Bharuch

Dr. V. G. Patel Oration

Table Tennis Tournament

YOGA Day Celebration

GIMACON 2024

Hosted by Indian Medical Association, Rajkot

...Let's Talk Health

76TH ANNUAL CONFERENCE OF IMA GUJARAT STATE

The Reasons

WHY YOU MUST ATTEND

this conference.....

- ✓ Update on Life style Health challenges
- ✓ Brilliant faculties
- ✓ Extraordinary venue
- ✓ Superb time management
- ✓ Extravagant entertainment program
- ✓ Mouth watering delicious food
- ✓ Perfect proportion of talks, discussion, debates, videos, fellowship & much more...
- ✓ Never before trade exhibitions...

19th & 20th October 2024

Hotel Seasons Rajkot

INVITEE

President IMA GSB
Dr. Bharat Kakadia

Hon. Secretary IMA GSB
Dr. Mehul Shah

Vice President IMA GSB Rajkot Zone
Dr. Bhavesh Sachde

Org. Chairman Gimacon 2024
Dr. Atul Pandya

Org. Secretary (Chief)
Dr. Chetan Lalseta

Org. Secretary (Event)
Dr. Paras D. Shah

Org. Secretary (Scientific)
Dr. Sanjay Bhatt

President IMA Rajkot
Dr. Kant Jogani

Hon. Secretary IMA Rajkot
Dr. Amish Mehta

Gimacon 2024

76th ANNUAL CONFERENCE OF IMA GUJARAT STATE
Hosted by Indian Medical Association, Rajkot

19th & 20th OCTOBER 2024

REGISTRATION FORM

Full Name (in capital letters) :	
Qualification :	
Address :	
City :	State : / Pincode :
GMC/MCI Registration No. :	
IMA Branch :	IMA Membership No. :
E-mail :	Mobile :

REGISTRATION CHARGES

CATEGORY	UPTO 31-08- 2024	01-09-2024 to 30-09- 2024	01-10-2024 to 15-10-2024	After 15-10-2024 (Spot)***
Patron	₹ 30000 As Donation	₹ 30000 As Donation		
RC Member	₹ 6500 + GST	₹ 7000 + GST		
Delegate (IMA Member)	₹ 4000 + GST	₹ 4500 + GST	₹ 6000 + GST	₹ 6000 + GST
Delegate (Non IMA Member)	₹ 5000 + GST	₹ 5500 + GST	₹ 6500 + GST	₹ 6500 + GST
Medical Student** (UG or PG)	₹ 2500 + GST	₹ 3000 + GST	₹ 3500 + GST	₹ 4000 + GST
Corporate Delegate (Non Doctor)	₹ 8000 + GST	₹ 8500 + GST	₹ 9000 + GST	₹ 9000 + GST
Accompanying Person*	₹ 2500 + GST	₹ 3000 + GST	₹ 3500 + GST	₹ 3500 + GST

*6 Years & Above
**Letter From Head of the Department/Dean Will be Must.
***Conference Kits will not be given to Spot registrations

Mode of payment : Cash ☐ Cheque ☐ UPI ☐ NEFT ☐ RTGS ☐ Details :

BANK DETAILS

Account Name : INDIAN MEDICAL ASSOCIATION
Account Number : 331005000567
Bank Name : ICICI BANK
IFSC Code : ICIC0003310
Account type : CURRENT ACCOUNT
UPI ID : MSINDIANMEDICALASSOCIATION.eazypay@icici

SCAN TO REGISTER

OFFICE USE ONLY

Form Number

Date of Registration

Conference Secretariat : Dr. Chetan Lalseta
Shraddha Hospital, Shri Giriraj Hospital Marg, Amarnath Main Road, Off, 150 Feet Ring Road, Rajkot, Gujarat 360005
98251 99585 gimacon2024@gmail.com www.gimacon2024.com

SHYAM UROSURGICAL HOSPITAL

4th floor, Viva Complex, Opposite. Parimal Garden,
Above RBL Bank, Ellisbridge, Ahmedabad-380006.

Dr. Kandarp Parikh

(Mch., D.N.B. (Urology)
Chairman: Shyam Urosurgical Hospital
Endourologist and Robotic Surgeon

Professional Positions:

- **President**: Urology Society of India, West Zone
- **President**: Ahmedabad Urology Society
- **Founder**: Secretary, Gujarat Urology Association
- **Invited Faculty in Endourology for International & National Conferences:**
  World Endourology Conference: Mumbai, Amsterdam, Taipe, Munich, London, France, Abudhabi, Korea
- **European Urology Association (EUA):** Copenhagen, Amsterdam,
- **International Alliance of Urolithiasis:** India, China, London
- **Experts in Stone Diseases (ESD):** South Africa, Dubai, Shanghai, Athens
- **Society International Urology (SIU):** Abudhabi, Montreal Canada, Dubai, New Delhi
- **Urology Association of Asia (UAA):** Dubai, Bali

National Conferences

Hyderabad, Ranchi, Kolhapur, Bhopal, Chandigarh, Bangalore, Vadodara, Goa, Ahmedabad, Pondicherry, Mehsana, Ahmedabad, Agra, Gauhati, Pune, Manipal, Nadiad, Surat, Srinagar

Director Department of urology: Marengo CIMS Ahmedabad

SHYAM UROSURGICAL HOSPITAL

One Stop Station for Advance Urology Care

Facilities Available

Endoscopy treatment of Kidney stones/ Ureteric stones/ Prostate/ Urethra & Bladder (PCNL/ RIRS/ Laser Prostatectomy)

Minimal invasive therapy for BPH

- Urolift
- REZUM

Robotic & Laparoscopic Urosurgeries

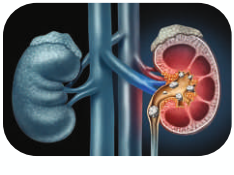
Kidney, Adrenal, Urinary Bladder, Prostate cancer Surgery

Speciality Clinic

- Urinary Incontinence clinic
- Stone Prevention clinic
- Prostate disease awareness clinic
- Infertility & Impotence clinic

Advantages of Flexible Ureteroscopy (RIRS)

- Best Minimal Invasive surgery option for Renal stone up to **2 CM**. in size
- Cutting edge technology for kidney, ureteric stones & diseases
- Advantages: **No cut, No pain, No bleeding**
- Only 24 hrs. hospitalization



SHYAM UROSURGICAL HOSPITAL
4th Floor, Viva Complex, Above RBL Bank,
Opp. Parimal Garden, Ahmedabad-380006.
Ph: (079) 26469846, 40033892 (M) 9824047767
E-mail: drkandarp@shyamurousrgical.com
Website: drkandarpparikh.com

Scientific Update

Epilepsy: Advanced Diagnostics and Treatment Modalities

Epilepsy is a chronic, non-communicable brain disease affecting approximately 50 million people worldwide, with higher incidence rates in developing countries due to factors like neuro-infections, road traffic accidents, and hypoxic brain insults. Seizures, caused by excessive electrical discharges in brain cells, can be focal (originating from a specific brain area) or generalized (involving both cerebral hemispheres).

Identifying the type of seizure is important since focal seizures are often more resistant to medications, but may offer a chance at seizure freedom if the focus can be precisely localized.

Advances in Diagnostic Tools:

1. **Video EEG** This technique combines EEG and video recording to help identify seizure semiology, localize seizure activity to specific brain regions, and distinguish between true seizures and pseudo-seizures. The video EEG captures patient's paroxysmal events and the simultaneous EEG recording helps to classify whether the events are true or nonepileptic. The machine also captures the audio during the recording which helps in the evaluation of the patient's speech and language during the seizure event. VEEG identifies electrical signals from the brain of the patient during events which were previously labelled as supernatural events. During presurgical evaluation, antiseizure medications are tapered in a controlled environment under the supervision of doctors to precipitate habitual seizures occurring at home. This helps us in localizing and lateralising the seizure onset to a particular lobe or hemisphere.
2. **MRI Brain:** Standard MRI may miss lesions causing seizures. The HARNESS Epilepsy protocol on a 3T MRI machine, including volumetric T1 and FLAIR images with adjusted parameters, significantly improves neuroimaging diagnostic accuracy.
3. **MRI Brain Post-Processing:** Extracted MRI images undergo mathematical processing to enhance lesion detection sensitivity. Volumetric calculations, especially for the hippocampus aid in identifying conditions like mesial temporal sclerosis, a common and remedial cause of focal seizures.
4. **Digital PET Scan:** This scan identifies brain areas of hypometabolism indicative of seizure foci. A brain-specific PET scan reduces radiation exposure and cost compared to whole-body scans.

5. **PET-MRI Co-Registration:** PET scan data is superimposed on MRI images using specialized software to pinpoint the exact brain structures associated with hypometabolic areas.

Treatment Modalities-Medical Therapy

The bedrock of epilepsy treatment is prevention of seizures, and the complications of seizures, thereby improving the overall quality of life (QoL). The medical management includes administration of a variety of anti-seizure medications (ASMs). In selected cases, it may include immunomodulation by corticosteroids and/or steroid sparing long-term immunomodulation. Based on the phenotype and nature of epilepsy, we can tailor the medical management to individual cases. This forms the basis of precision medicine, where we offer therapeutics based on the genotypic correlation.

Treatment Modalities-Surgical Therapy

The main aim and principle of epilepsy surgery is to identify and disconnect or resect, the presumed, localized epileptogenic focus/lesion (Epileptogenic zone) with minimal or no risk of unacceptable neurological deficits. It's a QoL surgery. After an exhaustive workup, this is performed if the benefits of surgery significantly outweigh the risks and morbidity. It should also be acceptable to the patient, family, and the caregivers-stakeholders. With the latest neurosurgical infrastructure, expertise, and teamwork, the surgical outcomes are gettingmore and more satisfactory.

Usually, resective surgeries carry significantly high seizure control rates as compared to disconnection procedures. Palliative procedures like callosotomy and VNS (Vagal Nerve Stimulation) are performed to reduce seizure burden in patients with non-localizing epilepsy.

Advances in Neurosurgical tools:

1. **Neuro Navigation:** This very high-precision GPS-like system assists in precisely locating seizure-causing areas for surgical resection or radiofrequency ablation. This can significantly minimise the surgical opening, time and morbidity. With advanced imaging fusion and integrated Ultrasound scanner, we can have a real-time picture of the surgical field, which significantly ameliorates the need for intra-op MRI.
2. **Electrocorticography (ECoG):** Performed intra-operatively, ECOG records EEG activity directly from brain surface and depth areas. This has a high level of sensitivity and specificity for locating the focus and checking the adequacy

of surgical resection. This will significantly reduce necessity for re-surgery, in case of a sub-optimal outcome.

3. **Radio Frequency Ablation (RFA):** Neurosurgical technique where the lesion/focus identified as epileptogenic can be ablated using a radio frequency probe. It can be done with the help of a neuro navigation system or stereotactic frame, through burr hole surgery. This is a minimally invasive technique to treat difficult to access, and small lesions causing intractable epilepsy.
4. **Awake Surgery:** This is one of the most challenging task for the operating surgeon, anesthesiologists, as well as the patient. In case of an eloquent area resection, the patient remains awake under local anesthesia. The patient's motor power, language, attention span, and memory are continuously tested by special techniques, which will guide the surgeon to tailor resection and avoid a neurological deficit. avoid a neurological deficit.

Additional Techniques:

Other advanced techniques include Ictal and Interictal SPECT, stereo-EEG (SEEG), Magnetoencephalography (MEG), and Electrical Source Imaging (ESI), which are available for complex cases.

Implications for Patient Care:

Drug Resistant Epilepsy is a challenging condition that often requires life-longmedication, impacting patients' quality of life. Previously, patients needed to travel abroad or to specialized centers in Southern India for treatment of medically refractory epilepsy.

However, with the local availability of these advanced diagnostic tools and neurosurgical techniques, there is now hope for seizure-freedomand drug-freedom, significantly improving patient QoL.

General practitioners and physicians play a crucial role in recognizing epilepsy and referring patients for these advanced diagnostic evaluations and treatments, ensuring better management and quality of life for those affected by this condition.

Dr. Gopal Shah MCh Neurosurgery
Dr. Rutul Shah DM Neurology, Epileptologist.
Dr. Abhishek Gohel DM Neurology, Epileptologist.

Neuroscience department, K D Hospital, Ahmedabad

SOCIAL SECURITY SCHEME; G.S.B. I.M.A.

UNIQUE SCHEME

Be a Member

Application Form Scan Here

Approved Amendments From 24/02/2024,

- The benefit of the above scheme can be availed only after three year of membership who became member of the scheme during 50 to 60 years of age.
- **A member above the age of 50 years and below the age of 60 years having a continuous membership of Gujarat State Branch of IMA atleast of 3 years on the day of joining the scheme.**
- **Every live and retired Members of this scheme shall have to pay Rs. 1500/- (Rupees : One Thousand Five Hundred Only) as Brotherhood Fraternity Contribution (BFC) yearly .**
- A member above the age of sixty years is not eligible to become a member.

FEE SCHEDULE :

	Admission Fee	18% GST	Advanced Fraternity Contribution	Annual Subscription	Total
UP To 30 Years	Rs. 1000/-	180/-	Rs. 3000/-	Rs. 1/-	Rs. 4181/-
31 To 40 Years	Rs. 2000/-	360/-	Rs. 3000/-	Rs. 1/-	Rs. 5361/-
41 To 50 Years	Rs. 3000/-	540/-	Rs. 3000/-	Rs. 1/-	Rs. 6541/-
51 To 55 Years	Rs. 10000/-	1800/-	Rs. 3000/-	Rs. 1/-	Rs. 14801/-
56 To 60 Years	Rs. 20000/-	3600/-	Rs. 3000/-	Rs. 1/-	Rs. 26601/-

Office : 3rd Floor, "A.M.A. House", Opp. H. K. College,
Ashram Road, Ahmedabad - 380 009.
Phone : 079-26580690 E-mail : sssgsbima@gmail.com

FAMILY WELFARE SCHEME; G.S.B. I.M.A.

UNIQUE SCHEME

Application Form Scan Here

Be a Member

- **Approved Amendments From 24/02/2024,**
- Any life member of Gujarat State Branch of I.M.A is eligible to become the member this Family Welfare Scheme GSB IMA (FWS GSB IMA). **There is no prerequisite to be a member of SSS GSB IMA Scheme**.
- Any member aged between **50 to 60 years having three (03) years of continuous life membership of Gujarat State Branch of IMA** is eligible to become the member of this scheme Family Welfare Scheme GSB IMA (FWS GSB IMA).
- Benefit of Fraternity Contribution of the scheme for **Members Upto age of 50 years**, is eligible only after Completion of **one year of membership** of **FWS GSB IMA.**
- Benefit of Fraternity Contribution of the scheme for **Members aged between 50 to 60 years,** is eligible only after Completion of **three year of membership** of **FWS GSB IMA.**
- Member above the age of 60 years is not eligible to become a member.

FEE SCHEDULE :

	Advanced Fraternity Contribution	Admission Fee +	18% GST	Total
UP To 35 Years	Rs. 5000/-	Rs. 2000/- +	360/-	Rs. 7360/-
36 To 40 Years	Rs. 5000/-	Rs. 4000/- +	720/-	Rs. 9720/-
41 To 45 Years	Rs. 5000/-	Rs. 6000/- +	1080/-	Rs. 12080/-
46 To 50 Years	Rs. 5000/-	Rs. 7000/- +	1260/-	Rs. 13260/-
51 To 55 Years	Rs. 5000/-	Rs. 10000/- +	1800/-	Rs. 16800/-
56 To 60 Years	Rs. 5000/-	Rs. 20000/- +	3600/-	Rs. 28600/-

Office : 3rd Floor, "A.M.A. House", Opp. H. K. College,
Ashram Road, Ahmedabad - 380 009.
Phone : 079-26580690 E-mail : fwsgsbima@gmail.com

I.M.A. College of General Practitioners

Head Quarters

IMA TN State HQs Building, Doctors Colony, Via Bharathi Nagar 1st Main Road, Off: Mudichur Road, Tambaram (West), Chennai -600 045, Mob: 94426 12138 / 97890 14450

APPLICATION FORM FOR LIFE MEMBERSHIP

(The information will be treated as confidential)

PLEASE WRITE CLEARLY

Application Form Scan Here

1. Name (In Block Letters): Dr. .....
2. S/o, W/o :.....
3. Address (In Block Letters) for: Correspondence:

   Contact No.....Email ID.....

4. Date of Birth: Sex: MALE/FEMALE

5. Qualification(Degrees-**MBBS/MD/MS** & Diplomas)

1. University.....Year.....3. University.....year.....
2. University.....Year.....4. University.....Year.....

6. Registration with.....Medical Council Reg No.....
7. Member of IMA through.....Branch ..... State Branch
8. IMA Life membership No.....
9. Status: General Practice/Specialist Practice/Govt. Service/Teaching Service

I hereby give an undertaking that I shall abide by the rules and regulations of IMA CGP and uphold and promote the aims of the College to the best of my ability.

Signature of the Applicant

FOR OFFICE USE ONLY **SUB-FACULTY IMA CGP**

Forwarded to IMA CGP State Faculty Membership Approved YES/NO

Membership fee remitted

Date.....

HON.SECRETARY LOCAL BRANCH/
HON. SECRETARY SUB-FACULTY, IMA CGP

FOR OFFICE USE ONLY **STATE-FACULTY IMA CGP**

Forwarded to IMA CGP HQs ,Chenna i Membership Approved YES/NO

Membership fee remitted

Date.....

HON. STATE SECRETARY/
HONY. FACULTY SECRETARY, IMA CGP

FOR OFFICE USE ONLY **HEADQUARTERS IMA CGP**

Received on.....Form and Fee Rs..... By Cash/ Cheque / DD / Neft / IMPS/ UPI / No.....Date..... Bank.....

Allotted Membership No.....

Life Membership Certificate dispatched on..... **Life Membership Fee for GP's and Other Specialists**

Rs: 1180 /-)

(DD/Cheque in the Name of "**IMA CGP HQRS**" payable **Chennai**)

HON. SECRETARY
IMA CGP HEADQUARTERS

CONGRATULATIONS

❖ **Dr. M. R. Kanani** **Bhavnagar**

Being appointed Advisory Board Member The National Forensic Science Universtiy (NFSU) under the Ministry of Home Affairs- Government of Indian (MHA-GOI)

* * * * *

OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Chandulal R. Hansalia	20-01-2024	Junagadh
Dr. Thakorebhai N. Patel	22-02-2024	Bardoli
Dr. Madhukar C. Parekh	10-04-2024	Junagadh
Dr. Champaklal C. Shah	28-04-2024	Ahmedabad
Dr. B.S. Agrawal	19-05-2024	Dahod
Dr. Rajendra K. Salvi	20-05-2024	Bharuch
Dr. Vinay Khanapur	21-05-2024	Anand
Dr. Hasmukhbhai M. Shah	22-05-2024	Vadodara
Dr. Rajendra V. Joshi	26-05-2024	Palanpur
Dr. Suryakant I. Patel	28-05-2024	Ahmedabad
Dr. Dineshchandra P. Shah	31-05-2024	Ahmedabad
Dr. Ramesh N. Patel	03-06-2024	Navsari
Dr. Kantivan Goswami	03-06-2024	Gandhinagar
Dr. Vijay S. Mehta	11-06-2024	Surat
Dr. Kiran S. Jagiwala	16-06-2024	Surat
Dr. Arvind C. Gandhi	18-06-2024	Bilimora
Dr. Dilip R. Naik	19-06-2024	Bilimora
Dr. Navnit D. Choksi	19-06-2024	Jamkhambhadia
Dr. Kundankumar Verma	20-06-2024	Ahmedabad
Dr. Madhusudan M. Chauhan	28-06-2024	Jhalod

We pray almighty God that their souls rest in eternal peace.

BRANCH ACTIVITY

BHAVNAGAR

14-06-2024 World Blood Donation Day. Total 68 bottle of blood were collected.

DEESA

20-06-2024 HPV vaccination camp. Total 84 beneficiary taken benefit of this camp.

GANDHIDHAM

1-6 to 30-6-24 Total 11 Blood Donation Camp and 1274 Units of blood were collected.

JETPUR

12-06-2024 CME on "Interesting case presentation" by Dr. Vishal Sadatiya"

"What's new in Neurosurgery" by Dr. Priyank Vasavada.

27-06-2024 "Erectile Dysfunction, Evaluation & Mx." By Dr. Nayan Timbadiya.

17-07-2024 "Cancer Related" by Dr. Vivek Venugopal, Dr. M. B. Minuchandra, Dr. Sujay Rainchwar and Dr. Gautam Makadiya.

26-07-2024 "Oncology" by Dr. Naitik Chhatrala, Dr. Ravindrasinh Raj, Dr. Kartik Kadia and Dr. Vivek Patel.

02-08-2024 "Cosmetic Head and Neck Cancer Surgery" by Dr. Khyati Vasavada

"Oncology in 2024" by Dr. Pooja Tanna.

07-08-2024 "Clinical pearls in endocrinology" by Dr. Kaushal Seth.

"Clinical pearls in neurology" by Dr. Hiral Halani Seth.

KALOL (NG)

03-07-2024 "Cancer Screening Diagnosis, Prevention & Treatment" by Dr. Chirag Shah.

"Difficult Cases in Oncosurgery" by Dr. Shailesh Patel.

24-07-2024 CME on "Latest updates on ART Treatment also Pre Exposure & Post Exposure Prophylaxis" by Dr. Swati Gohel.

"SGPT – 65" by Dr. Pathik Parikh.

MAHUVA

07-07-2024 Blood Donation Camp. Total 51 units were collected.

MEHSANA

19-06-2024 CME On "Lifestyle Beyond Diet and Exercise - Role In Prevention of NCDS (Non Communicable Diseases)" by

Dr. Chirag A. Shah Followed by Question & Answer Session with Dr. N. R. Patel and Dr. Hemant Sogani.

21/22-6-2024 International Yoga day.

23-06-2024 PPC Zonal Seminar.

01-07-2024 Celebrating for National Doctors Day. Following Senior Members felicitate who have served our Association for many years. Dr. J. F. Chaudhary, Dr. S. S. Patel, Dr. Mohanbhai Patel, Dr. Narayanbhai Patel, Dr. N. T. Patel, Dr. Mukesh Chaudhary, Dr. Dipak Rajyaguru, Dr. Javef Shaikh, Dr Rajesh Pandya, Dr. Rajendra Jain, Dr. P. R. Patel, Dr. Vishnubhai Patel, Dr. Dharamsinh Desai, Dr. Anilbhai Patel and Dr. Alpesh Patel.

16-07-2024 "De-Globalisation & the Emergence of Sanatan Economics Model by Dr. Ankit Shah.

24-07-2024 CME on "An Interesting Neurological Cases from My Initial Practice in Mehsana" by Dr. Jay B Chaudhari.

"Neuro intervention in Aneurysm and Acute Ischemic Stroke'' by Dr. Ankit Patel.

14-08-2024 "Infectious Disease".

"Uncommon Presentation of common duo" by

Dr. Mit Dharsandiaya.

"Cracking the bug-the ID way" by Dr. Chintan Kaswala.

MORBI

19-06-2024 CME on "Snippets of Cancer Patients Management" by Dr. Akash Patel.

"Practical Approach for Hematology Diseases" by Dr. Jaikumar Patel.

12-07-2027	"Workstation (Hands on training insulin pen delivery and growth chart interpretation" by Dr. Chetan Dave.
17-07-2024	"Liver transplant scenario in Gujarat: Present & Future" by Dr. Anand Khakhar.
	"Transplant tales: Tackling ICU challenges in acute on chronic & acute liver failure" by Dr. Himanshu Sharma.
19-07-2024	"RF ablation: The path breaking cure for movement disorders" by Dr. Sagar Betai.
	"Interesting cases of Epilepsy" by Dr. Zubin Shah.
22-07-2024	Free OPD checkup camp. Around 25 patients were benefited.

PALITANA

07-07-2024	CME on "Minimal invasive & endoscopic Spine Surgery" by Dr. Ritesh Shah.

RAJKOT

18-06-2024	Blood Donation Camp. More than 100 units of Blood were collected.

VADODARA

04-07-2024	Doctor's Day Celebration.
27-07-2024	Big event of IMA JDN.
19-07-2024	How to protect from Chandipura virus (Sand Fly)?

VIRAMGAM

27-06-2024	CME on "Alcoholic Liver Disease" by Dr. A. K. Gajjar. Total 25 doctors were present.

* * * * *

MATRIMONIAL

1. BRAHMIN GIRL 28 YRS MS OPHTHALMOLOGY
2. JAIN GIRL 28YRS MS, GYNECOLOGIST, SR
3. JAIN GIRL 30 YRS MD DERMAT RICH / AFFLUENT
4. VAISHNAV GIRL 28 YRS MS, GYNECOLOGIST
5. VAISHNAV GIRL 28 YRS MD PEDIATRICS
6. JAIN BOY 30 YRS, MD MEDICINE OWN HOSPITAL
7. BRAHMIN BOY 28 YRS, MD ANESTHESIA
8. BRAHMIN BOY 32 YRS, MS, Dr.NB UROLOGY
9. BRAHMIN BOY 28YRS Dr.NB PERIPHERAL VAS. SURGERY

CONTACT:
99 78 87 00 00

MATRIMONIAL

Ahmedabad based Goswami Doctor Parents invites Matrimonial correspondence from tall, handsome postgraduate superspecialist Doctor, IAS, IPS, MBA Government officers & business man for their 34 year MD Anesthetist beautiful daughter divorcee having short term married life, no issue, 165cm, 58 kg working as specialist in Ahmedabad

CONTACT:
8401308175

MATRIMONIAL

ALLIANCE INVITED FOR OUR DAUGHTER - GUJARATI BRAHMIN DOCTOR, JAN-1995/5'6", CURRENTLY PURSUING FELLOWSHIP IN NICU AT KANSAS CITY - USA. LOOKING FOR WELL-EDUCATED BOY, PREFERABLY DOCTOR PREFERRING TO SETTLE IN US.

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HOW I DO - Transfusion of Blood Products PART – 3

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(All the articles published in past are available at www.shyamhemoncclinic.com/blog/)

Question: In last part, we covered most common points related to platelet transfusion. I was very surprised to know that **SDP AND RDP ARE EQUAL** IN TERMS OF RESPONSE. We also learned 1. For an average adult, **4-6 units of RDP** are required in most cases. Lower number is not sufficient. 2. Platelets should be transfused as free flow i.e. 6 units in about 30 minutes. Much slower will lead to clumping. 3. Highest risk of bacterial infection among all blood products, as they are stored at room temperature. 4. **Blood group does not matter** for platelet transfusion in **adults**. Hence patient can receive platelet from any donor. 5. One SDP is equal to about 6 RDPs. 6. No absolute contraindications for platelet transfusion. 7. Side effects of platelet transfusion, hence use only when necessary. Most patients with only petechiae or few ecchymoses do not need platelet transfusion. 8. Antiplatelet agents **do NOT reduce** platelet number, only reduce their function.

One question raised by our reader is what is the cut off for platelet transfusion?

Answer: Very good question. There is no specific cutoff number when patients must be transfused. But following points will help:

1. In most cases, patients who are actively bleeding should be transfused regardless of the platelet count, until the diagnosis is clear. Since they may have additional coagulopathy, a mechanical reason for bleeding, may have platelet dysfunction due to very active antiplatelet agents (e.g. ticagrelor).
2. For non bleeding patients, it depends on clinical situation. For example, a stable outpatient with no bleeding and a known diagnosis of ITP (immune thrombocytopenic purpura) can be observed without transfusion at practically any platelet count. We have patients with platelet count of **less than 5000** (yes five thousand only) for years. Similarly for aplastic anemia, stable, can be observed without transfusion at below 10,000 as well. Same is true for many chronic conditions with low platelets.
3. For admitted patients with no bleeding, no other risk factors for bleeding, we frequently wait **till 10,000**. With risk factors, target level is higher depending on risk i.e. target could be 20,000 or even 50,000.

Que: Thank you. In the same line, what is the **cut off for red cell transfusion** and what is the ideal product? Packed red cell i.e. PCV or Whole blood or Fresh whole blood?

Ans: Once again very good questions. Briefly, PCV is the standard of care. **Whole blood has no** advantage whatsoever and no role in modern medicine today. Same true for **fresh blood**. In regions where blood bank is not available to make components, it is ok to transfuse whole blood. Whole blood has plasma, platelets etc which are of no use to a patient who needs only red cells. This is additional volume and also more risk of allergic reactions.

Within time frame of expiry of blood products, results are equal. This has been studied and published multiple times. Hence no advantage of fresh blood, whole or PCV.

Regarding cut off for Hb level, wide variation depending on clinical scenario.

1. Stable outpatient with long standing anemia, especially young patients with no cardiorespiratory compromise, can tolerate very low levels. **Such as about 3-4 g as well**. To allow for diagnostic work up first. Most clinicians would have seen young ladies especially, with iron deficiency and Hb of 3-4 g doing household work and nearly asymptomatic. In fact, transfusion for such patients may lead to cardiac overload. They have compensated cardiac overactivity, and hence they cannot take additional burden easily. Giving them high volume of fluids or blood can **precipitate cardiac failure**. Nutritional anemia patients frequently have such compensated anemia, as it develops very slowly. Including iron or b12 or folic acid deficiency mostly.
2. Patients with other blood disorders like MDS, PRCA, etc also tolerate lower Hb well due to chronicity of disease. Individual patients here may need different cut off for transfusion. For example, some may feel very tired at **8 g and some may be very functional at 6 g**. Thalassemia, sickle cell disease etc hemoglobinopathies have different cut offs depending on various criteria.

Cardiac patients may need a higher cut off like 8.

3. Chronic liver disease, renal disease etc patients also tolerate Hb of about 6-8 frequently.
4. Patients admitted with active bleeding need cut off of about 8-9 g (not too high however) regardless of their cardiac status, young age, stable vital signs etc. As bleeding rate can change quickly, safety margin is important. Moreover, GI bleed, retroperitoneal bleed, fracture in thigh, pleural bleed etc can bleed a lot before it is clinically apparent.
5. For other **admitted patients, including in ICU, several studies have shown that Hb cut off of about 7 is sufficient**. And that maintaining higher Hb of 9 or more did not improve oxygenation, overall outcomes, discharge rate etc. Significant overuse of transfusions happens in admitted patients, much more so in ICU. This can lead to more side effects, leading to poorer outcomes, and of course cost.
6. Even for **cardiac surgery, Hb cut off of 7-8** is appropriate as per multiple trials and guidelines.

August 11th, 2024**Dr Chirag A. Shah**; M.D. Oncology/Hematology (USA), 9998084001. Diplomate American Board of Oncology and Hematology. Ahmedabad. drchiragashah@gmail.comwww.shyamhemoncclinic.com

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INTERESTING CASE: Multi-System Langerhans Cell Histiocytosis Presents as Blueberry Muffin Rash

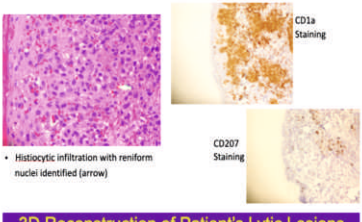
Introduction:

Blueberry muffin rash refers to a congenital rash of hemorrhagic vesiculopustules, resulting from extramedullary hematopoiesis. The differential diagnosis is extensive, including both infectious and noninfectious etiologies.

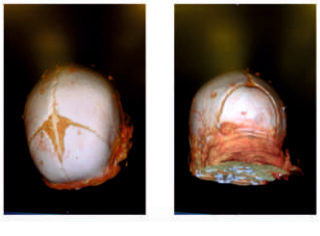
Case Discussion:

14 day old male was transferred to our facility from an outside hospital for fever and congenital rash. Birth history was significant for meconium aspiration and congenital blueberry muffin rash. He was admitted to the NICU for rash/rule out sepsis [?] work up included blood and urine cultures, a course of antibiotics, and TORCH titers, all of which remained negative. Rash had improved and patient was discharged home from NICU.At home, rash worsened and patient became febrile and presented to ER with seizure.

Patient's Biopsy Results



3D Reconstruction of Patient's Lytic Lesions



Work up:

•Thrombocytopenia (76,000), CRP (10.7)

•Infectious Disease - HSV1 and HSV2 DNA PCR, CMV PCR, RPR – negative .CSF culture and latex panel – negative

•Dermatology consulted -Biopsy obtained → Revealed Langerhans Cell Histiocytosis

•Imaging → Skeletal survey (lytic lesions in skull and long bones) , Abdominal Ultrasound, CT scan – scalp soft tissue nodules, pulmonary nodules, hepatosplenomegaly with liver lesions

•Endocrine consulted → Urine osmolality – negative for Diabetes Insipidus

Langerhans Cell Histiocytosis (LCH)

•LCH is rare histiocytic disorder most commonly characterized by single or multiple osteolytic bone lesions with infiltration of histiocytes seen on biopsy with positive CD1a, S100, CD207 antigens.

•This patient was found to have Multi-system Congenital LCH with skin, soft tissue bone, Lymph nodes. lymph nodes, bone marrow, spleen, liver, lung, and GI tract. Treatment for Multisystem LCH includes chemotherapy, which our patient received for 1 year and is now 2 years since treatment completed with no disease activity.

•It is important for physicians to form a broad differential diagnosis and complete a thorough work-up of presenting symptoms, especially blueberry muffin rash as some etiologies are life-threatening and may require interventions such as chemotherapy.

I.M.A.G.S.B. NEWS BULLETIN "Registered under RNI No. GUJ ENG/2006/17132 Published on Last Date of Every Month &
Permitted to post at Ahmedabad PSO on last date of every month under
Registered under Postal Regd. No. GAMC-1561/2022-2024 Valid upto 31-12-2024
License to Post without Prepayment No. PMG/NG/63/2022-2024 Valid upto 31-12-2024

Publication on 31-08-2024

If undelivered
Please Return to :

INDIAN MEDICAL ASSOCIATION
GUJARAT STATE BRANCH
A.M.A., 2nd Floor,
Ashram Road,
Ahmedabad-380 009.

Publisher : Dr. Bipin M. Patel Editor : Dr. Devendra R. Patel
A.M.A. House, 2nd Floor, Opp. H. K. College, Ashram Road, Ahmedabad - 380 009. TELE. 079-26587370
Press : Jay Brahmani Printing Press, 38, Ajay Estate, Dudheshwar, A'bad (M) 99740 65219 E-mail : ashwinprajapati99@gmail.com