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

GUJARAT MEDICAL JOURNAL
INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH
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HEALTH SCHEME
Chairman
Dr. Navneet K. Patel — Ahmedabad

STATE PRESIDENT AND HON. STATE SECRETARY'S MESSAGE

Dear colleagues,

"Cry as hard as you want to

But just make sure that when you stop crying you will never cry again for the same reason !!!!!"

Every tragedy or mishap makes us cry. But at the same time all tragedies & mishaps teach us some lessons.

Recently we had devastating floods in Uttarakhand state. The floods have shattered everybody-physically,psychologically,socially & financially. A lot has been said and written about the ecological imbalance, manmade crises & interference with nature for commercial purpose. It is a subject of debate & let us leave that to experts.

But our prime concern at this juncture should be to help the affected people of Uttarakhand.

IMA HQ has taken an initiative & started a relief fund. An amount has already been sent to Uttarakhand as a relief immediately after the disaster.

Our Gujarat State Branch has also started **IMA GSB Relief Fund.** We appeal all IMA members to donate handsomely for this cause. We, at state level, will collect the funds & will send that to IMA HQ.

The Disaster Management Cell of IMA HQ has also come in action

and started its operations. IMA's Uttarakhand state branch is also doing some exemplary relief work.

After initial rescue & relief operations, doctors' role will be very vital to prevent epidemics. We, the doctors will also have to treat the psychological trauma,depression,phobias etc. inflicted by this tragic disaster. Once again I appeal all IMA members to contribute generously.

Another important issue is Membership Drive. Motivate your friends to become members of IMA so that they can take advantage of various schemes of IMA. Explain them the benefits of becoming members of IMA. Also encourage young doctors who have just passed, to become members. The new members can take benefit of new reduced rates of Membership fees.

Be ready for the BIGGEST EVENT of IMA Gujarat State- a state conference GIMACON 2013 which is to be held in Surat on 19th & 20th October this year. The preparations for GIMACON 2013 are going on at a large scale in full swing. The entire Organizing Committee is working very hard to make this event a success.

We assure you that, this conference will be the most memorable event for all of you. We are sure you all will cherish the memories of Surti Hospitality for a long long time. So enroll your names as Delegates as early as possible,so that necessary arrangements for you can be made in time.

Before signing off, A PEARL.....

"Blessed are those who can give without remembering and take without forgetting..."

Your's Truly,

Dr. Pragnesh Joshi
(President, G.S.B. I.M.A.)

Dr. Bipin M. Patel
(Hon. State Secy., G.S.B. I.M.A.)

I.M.A. NATIONAL SOCIAL SECURITY SCHEME

DFC No.18 was circulated to all the members.

Last date of payment was 15/05/2013.

Those members who have not yet paid the same, send the amount with penalty ₹ 200/- **before 31/08/2013** by cheque

Dr. Kirti M. Patel
Chairman

Dr. Yogendra S. Modi
Hon. Secretary

* * * * *

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

AFAC No.15 was circulated to all the members.

Last date of payment was 30/06/2013.

Those members who have not yet paid the same, send the amount with penalty ₹ 100/- **before 31/08/2013** by cheque

Dr. Navnit Patel
Chairman

Dr. Abhay Dikshit
Hon. Secretary

* * * * *

I.M.A. G.S.B. RELIEF FUND

I.M.A. TALAJA BRANCH	₹	25,850/-
I.M.A. PALITANA BRANCH	₹	11,111/-

DISCLAIMER

Opinions in the various articles are those of the authors and do not reflect the views of Indian Medical Association, Gujarat State Branch. The appearance of advertisement is not a guarantee or endorsement of the product or the claims made for the product by the manufacturer.

COLLEGE OF GENERAL PRACTITIONERS, G.S.B. I.M.A.

(Reported by Dr. Kirit C. Gadhavi; Director, Dr. Lalit I. Nayak; Hon. Secretary and Dr. Vasant Patel; Hon. Jt. Secretary)

Ahmedabad Medical Association organized C.M.E. programme in collaboration with College of G.P. Gujarat State Branch, I.M.A.

Function with attended by Dr. Kirit C. Gadhavi, Director, College of G.P., G.S.B. I.M.A., Dr. Lalit I. Nayak, Hon. Secretary, College of G.P., G.S.B. I.M.A. and Dr. Vasant B. Patel, Hon. Joint Secretary College of G.P. I.M.A. G.S.B. Dr. Kirit R. Sanghavi, Dr. Ashok D. Kanodia, Dr. Abhay Dixit Office Bearers of G.S.B. I.M.A. were present.

Programme was well attended by doctor of A.M.A. branch, Speaker from various part of country Dr. Vishal Marwah from Mumbai, Dr. Raman Kumar from Delhi & Dr. Chakravarty Mazumdar from Bangalore shared their views for changing in our practice which enhance the knowledge & skill of any doctor and about upcoming revolution that is online medical consulting

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OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Manubhai R. Parmar

(22/07/1955 - 20/07/2013)

Age : 58 Years
Qualification : M.B.B.S.
Name of Branch : Bharuch

- Vice President : Gujarat State Branch - 2008-09, 2012-13

* * * * *

Dr. Fonseca Nicholas Leo

(07/08/1925 - 24/05/2013)

Age : 88 Years
Qualification : M.B.B.S.
Name of Branch : Ahmedabad

We pray almighty God their his soul may rest in eternal peace.

NEW LIFE MEMBERS

I.M.A. GUJARAT STATE BRANCH

We welcome our new members

L_M_No.	NAME	BRANCH
LM/22542	Dr. Gnadhi Saurin Pradipbhai	Surat
LM/22543	Dr. Khatri Bhavik Yogeshkumar	Gandhidham
LM/22544	Dr. Vala Gaurav Pradipbhai	Morbi
LM/22545	Dr. Kharadi Pramod Titasbhai	Rajpipla
LM/22546	Dr. Menat Kalpana Jashwantbhai	Rajpipla
LM/22547	Dr. Shah Shreyas Chinubhai	Rajpipla
LM/22548	Dr. Jhala Kumarpalsinh H.	Surendranagar
LM/22549	Dr. Bhagat Rajkumar Chandulal	Rajpipla
LM/22550	Dr. Deshmukh Darshana C.	Rajpipla
LM/22551	Dr. Jhala Dushyantsinh H.	Surendranagar
LM/22552	Dr. Gohil Kirtirajsinh L.	Bharuch
LM/22553	Dr. Patel Dhaval Hemchandra	Patan
LM/22554	Dr. Gadhavi Pradip Babubhai	Palanpur
LM/22555	Dr. Shah Himanshu Pravinchandra	Palanpur
LM/22556	Dr. Arya Deepika Shivdayal	Vadodara
LM/22557	Dr. Patel Arpan Piyushbhai	Vadodara
LM/22558	Dr. Thakkar Tejas Chandrakant	Vadodara
LM/22559	Dr. Dey Saurabh Hirenkumar	Vadodara
LM/22560	Dr. Shaikh Maksud Kaiyumbhai	Vadodara
LM/22561	Dr. Shaikh Lubnabanu Maksud	Vadodara
LM/22562	Dr. Pandya Jaimin Mahehsbhai	Vadodara
LM/22563	Dr. Pandya Megha Jaimin	Vadodara
LM/22564	Dr. Oza Nupur Kiranbhai	Anand
LM/22565	Dr. Kanani Vijay Jivrajbhai	Bhavnagar
LM/22566	Dr. Chaudhari Jagdish S.	Bhavnagar

LM/22567	Dr. Karbhari Mohammad Aslam M.	Himatnagar
LM/22568	Dr. Nimavat Kapil Bhikhubhai	Jetpur
LM/22569	Dr. Karoliya Hiren Jasmatbhai	Morbi
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LM/22573	Dr. Khatri Ankit Nayankumar	Visnagar
LM/22574	Dr. Patel Kalpesh Devjibhai	Surat
LM/22575	Dr. Italiya Dilip Babubhai	Surat
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LM/22582	Dr. Maitry Rakesh Markamday	Jasdan
LM/22583	Dr. Thakkar Hitesh Dineshchand	Anjar-Kutch
LM/22584	Dr. Shah Viral Subhashchandra	Patan
LM/22585	Dr. Patel Devang Viththalbhai	Jetpur
LM/22586	Dr. Raval Munindra Anilkumar	Visnagar
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LM/22588	Dr. Shah Rupesh Bharatbhai	Gandhinagar
LM/22589	Dr. Patel Bhavna Chanakyakumar	Gandhinagar
LM/22590	Dr. Solanki Ketan Punamchand	Gandhinagar
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LM/22596	Dr. Daxini Arvind Bhupendra	Surat
LM/22597	Dr. Pandey Arvind Santkumar	Surat

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LM/22618	Dr. Jadav Vipashyana Jayant	Ahmedabad
LM/22619	Dr. Shah Ami Rohitkumar	Ahmedabad
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LM/22621	Dr. Soni Janak Bhavarlal	Ahmedabad
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LM/22623	Dr. Vyas Rakesh Kumar	Ahmedabad
LM/22624	Dr. Vadodaria Saraju B.	Ahmedabad
LM/22625	Dr. Vadodara Gurpreet Kaur	Ahmedabad
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LM/22635	Dr. Shah Haard Rajeshbhai	Ahmedabad
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LM/22643	Dr. Roy Dhara Bhavesh	Ahmedabad
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LM/22645	Dr. Mehta Vishal Indravadan	Valsad
LM/22646	Dr. Patel Bharatkumar Kantilal	Deesa
LM/22647	Dr. Modi Rahulkumar Baldevbhai	Mansa
LM/22648	Dr. Patel Mayur Arvindkumar	Borsad
LM/22649	Dr. Doshi Tejas Mahendrabhai	Jamnagar
LM/22650	Dr. Mistry Rusva Atulbhai	Jamnagar
LM/22651	Dr. Vachhani Ashvin Dayalal	Surat
LM/22652	Dr. Patel Rakesh Manjibhai	Surat
LM/22653	Dr. Kakadia Mukesh Manjibhai	Surat
LM/22654	Dr. Chaudharu Rakesh Kumar	Surat
LM/22655	Dr. Sharma Neeta M.	Surat
LM/22656	Dr. Chopra Manik	Surat
LM/22657	Dr. Arora Anju	Surat
LM/22658	Dr. Virani Shamsuddin J.	Surat
LM/22659	Dr. Virani Bijal Shamsuddin	Surat

CONGRATULATIONS

GUJARAT STATE S.S.C. BOARD

ANUJ PARIMALBHAI GANDHI

Percentile Rank : 99.99 (A1)
Date of Birth : 30/06/1997
School : Sun & Sky English School, Surendranagar
Hobby : Reading, Cricket
Line of Interest : Medical
Father Name : Dr. Parimal D. Gandhi
Mother Name : Dr. Pallaviben P. Gandhi

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PRACHI NIMSHKUMAR VYAS

Percentile Rank : 99.99 (A1)
Date of Birth : 13/03/1998
School : Sagar Vidhyalay, Nava Naroda
Hobby : Reading
Line of Interest : Medical
Father Name : Dr. Nimeshkumar Vyas
Mother Name : Dr. Nilaben N. Vyas

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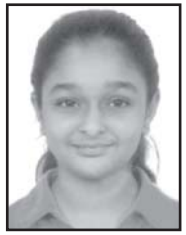

ANSHUMALEE YOGESHBHAI PATEL

Percentile Rank : 99.99 (A1)
Date of Birth : 17/01/1998
School : Shree Narayan Guru Vidhyalay
Hobby : Photography, Novel, Reading
Line of Interest : Medical
Father Name : Dr. Yogesh G. Patel
Mother Name : Dr. Gita Y. Patel

* * * * *

JEET JANAKBHAI PATEL

Percentile Rank : 99.99 (A1)
Date of Birth : 05/12/1997
School : L.M.P. Reva Experimental School, Bilimora
Hobby : Music, Cricket
Line of Interest : Medical
Father Name : Dr. Janak C. Patel
Mother Name : Dr. Archna J. Patel

JAHNVI TEJASBHAI DAVE

Percentile Rank : 99.98 (A1)
Date of Birth : 03/12/1997
School : C. N. Vidhyalay, Ambawadi
Hobby : Tennis, Volley Ball, Painting
Line of Interest : Medical
Father Name : Dr. Tejas Dave
Mother Name : Dr. Jigna T. Dave

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KUNJ ARUNBHAI GOR

Percentile Rank : 99.91 (A1)
Date of Birth : 20/10/1997
School : St. Xaviers, Adipur, Kutchh.
Hobby : Swimming, Cricket
Line of Interest : Medical
Father Name : Dr. Arun Gor
Mother Name : Dr. Alpa Gor

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PARANSHI JIGEESHBHAI DESAI

Percentile Rank : 99.84 (A1)
Date of Birth : 26/08/1998
School : H. B. Kapadia School.
Hobby : Reading, Social Work
Line of Interest : Medical
Father Name : Dr. Jigeesh N. Desai
Mother Name : Dr. Tamanna J. Desai

* * * * *

PRARTHANA VIVEKBHAI MEHTA

Percentile Rank : 99.81 (A1)
Date of Birth : 18/01/1998
School : Diwan Ballubhai Mahyamik School,Kakaria
Hobby : Reading & Tennis
Line of Interest : Medical
Father Name : Vivekbhai Mehta
Mother Name : Dr. Sonal V. Mehta

GUJARAT STATE C.B.S.C. BOARD

MANSI BIMAL SHAH

Date of Birth : 27/08/1995
School : Vastrapur Kendriya Vidhyalay, Vastrapur
Hobby : Drawing, Computer, Travelling
Line of Interest : Medical
Father Name : Dr. Bimal J. Shah
Mother Name : Dr. Beena B Shah

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GUJARAT STATE H.S.C. BOARD

PRANJAL NITINBHAI SHUKLA

Percentile Rank : 99.88 (A1)
Date of Birth : 18/11/1995
School : Bharatiya Vidya Bhavan, Bharuch.
Hobby : Music, Computer, Cricket
Line of Interest : Medical
Father Name : Dr. Nitin Vishnuprasad Shukla
Mother Name : Dr. Trupti Nitinbhai Shukla

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COMMUNITY SERVICE

GANDHIDHAM

02/06/2013 Blood donation Camp with SEVA bharti (RSS). 83 bottles were collected

08/06/2013 Blood Donation Camp with Gandhidham Automobile Dealers' Association (90 donors)

24/06/2013 Blood Donation Camp at Adani Power, Mundra (353 donors)

30/06/2013 Pentioner General Health Check up camp at SBI by Dr. Shreenath Goswami and Dr. Jignesh Mehta, more than 120 patients were benefitted

30/06/2013 Doctors' day celebration at Rotary Hall,

JETPUR

23/06/2013 A Medical Diagnostic Camp for Police Department. In that camp total 66 patients were examined

MORBI

08/06/2013 Blood pressure and diabetes detection camp. 116 patients took benefit with free medicines to all

16/06/2013 Celebration of Father's Day with 'Save Girl Child' programme

PALANPUR

07/04/2013 Celebrated 'World Health Day'

10/05/2013 Medical Camp at Police Head Quarter 350 patients were benefitted by Diagnoses & Medicine.

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BRANCH ACTIVITY

AMRELI

13/07/2013 "Management of intra cranial Hemorrhage" by Dr. Sanjay Teelala

"Joint Replacement present scenario" by Dr. Pareen Kantesaria

BHAVNAGAR

26/06/2013 "Symposium on Absorb Stent" by Dr. Siddharth Mukerjee and Dr. Sanjivkumar Bhatia

30/06/2013 "How to modify mode of practice" by Dr. Rajesh Teli

"Stress management in Doctors" by Dr. Anish Chandarana

GANDHIDHAM

01/06/2013 "Surviving sepsis" guideline by Dr. Rajesh Mishra

15/06/2013 "Recent trends in management of sepsis" by Dr. Chirag Natravadia

"Management of COPD" by Dr. Bhavin Gor

29/06/2013 "Rational use of Antibiotics" by Dr. Jayant Mehta

"Myths and misconceptions about cancer" by Dr. Jignesh Meva

JETPUR

26/06/2013 "Management of Anaemia" by Dr. M.V. Pansuria

"Laboratory Diagnosis of Anaemia" by Dr. G.G. Bhanderi and Dr. B.K. Koyani

11/07/2013 "Updates on Ulcerative Colitis" by Dr. P.M. Kamani

KALOL

02/07/2013 "Endoscopic Lumber Disc Surgery under L.A." (A day care procedure) by Dr. Tushar G. Shah

"Psychiatric disorder in children & adolescence" by Dr. Param Shukla

16/07/2013 "Management of Liver Cancer" by Dr. K. S. Patel

"Overview of Metabolic" by Dr. Atul J. Shah

MORBI

07/06/2013 "Current trends in Cosmetic surgery" by Dr. Chintan Patel

"Recent advances in treatment of varicose veins & DVT" by Dr. Mohal Banker

18/06/2013 "Infertility – An Overview" by Dr. Hetal Modha

"ART (Assisted Reproductive Technique) Simplified" by Dr. Dipesh Sorathia

28/06/2013 "What is best for your patients going for CABG" by Dr. Anil Jain

Newer Frontiers in Interventional Cardiology

(1) Rotablator (2) IVUS and (3) Fractional Flow Reserve by Dr. Joyal Shah

PALANPUR

12/04/2013 "Chronic Kidney disease" by Dr. Jatin Kothari

"Acute Kidney injury" by Dr. Jayesh Modi

18/04/2013 "Breast Cancer & Mammography" by Dr. Mihir Pandya

"Management of Breast Cancer" by Dr. Bhavna Parikh

01/05/2013 "Recent advances in management of vitamin D3 deficiency" by Dr. Parag shah

"Prevention & Management of Osteoporosis & bone Densitometry" by Dr Parag Shah

"Various penile deformities" by Dr. Ashvin Gami

13/06/2013 "Management of Pancreatitis" by Dr. Sunil Narang

"Useful tips in emergency" by Dr. H.K. Panchal

PORBANDAR

20/04/2013 "Osteoarthritis Knew M/M" by Dr. Nitin Budhdev

"Clinical Approaches for Chronic Pain M/M" by Dr. Tejas Soni

25/04/2013 "DVT-Diagnosis & management" by Dr. Kinjal Bhatt

29/06/2013 "IVF in Detail" by Dr. Darshan V. Sureja

13/07/2013 "Managing Hypertension" by Dr. Mihir P. Tanna

RAJKOT

11/05/2013 "Newer advances in Joint replacement surgery" by Dr. Dimple Parekh and Dr. Nitin Buddhdev

29/06/2013 "An update on cardiac surgery" by Dr. Anil Jain & Dr. Rajan Mody

WANKANER

20/07/2013 "Pneumococcal disease & its prevention in Adult" by Dr. Jayant Mehta

"Pneumococcal disease & its prevention in Pediatrics age group" by Dr. Trupti Vaishnani

Family Planning Centre, I.M.A. Gujarat State Branch

Respected Members,

Indian Medical Association, Gujarat State Branch runs 9 Urban Health Centers in the different wards of Ahmedabad City.

These Centres performed various activities during the month of June- 2013 in addition to their routine work. These are as under :

01-06-2013 to 30-06-2013 : Intra domestic house to house survey by the centers of Ahmedabad.

16-06-2013 to 18-06-2013 : Migratory Polio by the centers of Ahmedabad.

20-06-2013, 29-06-2013 : Medical Camp (Khokhra) Total Patients : 73, 128

26-06-2013 : Medical Camp (Ambawadi) Total Patients : 75

27-06-2013 : Medical Camp (Wadaj) Total Patients : 52

Rander - Surat : Vitamin 'A' Solution - 20 Children, Iron : 500 tablets & Calcium - 500 tablets, were distributed.

Nanpura - Surat : Vitamin 'A' Solution - 50 Children, Iron : 4000 tablets & Calcium - 2500 tablets, were distributed.

The total number of patients registered in the OPD & Family planning activities of Various Centers is as Follows :

June - 2013

No.	Name of Center		New Case	Old Case	Total Case
(1)	Ambawadi	(Jamalpur Ward)	920	540	1460
(2)	Behrampura	(Sardarnagar Ward)	1041	198	1239
(3)	Bapunagar	(Potalia Ward)	1730	575	2305
(4)	Dariyapur	(Isanpur Ward)	1103	165	1268
(5)	Gomtipur	(Saijpur Ward)	1733	486	2219
(6)	Khokhra	(Amraiwadi Ward)	2256	458	2714
(7)	New Mental	(Kubernagar Ward)	752	123	875
(8)	Raikhad	(Stadium Ward)	399	598	997
(9)	Wadaj	(Junawadaj Ward)	750	158	908
(10)	Khambhat		—	—	—
(11)	Junagadh		----	----	----
(12)	Rander-Surat		----	----	----
(13)	Nanpur-Surat		----	----	----
(14)	Rajkot		360	295	655

No.	Name of Center	Female Sterilisation	Male Sterilisation	Copper-T	Condoms	Ocpills
(1)	Ambawadi (Jamalpur Ward)	22	—	49	8400	778
(2)	Behrampura (Sardarnagar Ward)	26	---	45	10600	1160
(3)	Bapunagar (Potalia Ward)	36	02	51	13160	75 Users
(4)	Dariyapur (Isanpur Ward)	50	—	75	15750	621
(5)	Gomtipur (Saijpur Ward)	29	---	40	1315	181 Pkt
(6)	Khokhra (Amraiwadi Ward)	29	---	53	10000	142
(7)	New Mental (Kubernagar Ward)	16	---	28	9520	374 Pkt
(8)	Raikhad (Stadium Ward)	24	01	35	9600	912 Pkt
(9)	Wadaj (Junawadaj Ward)	26	—	37	20000	1164
(10)	Khambhat	---	—	14	1000	13
(11)	Junagadh	08	—	35	1500	215
(12)	Rander-Surat	27	—	35	1500	60 Pkt
(13)	Nanpura-Surat	30	—	101	2000	100 Pkt
(14)	Rajkot	15	---	101	---	---

ATTENTION PLEASE !!

The office has received back News bulletins of the following members from Postal department with note as "Left", "Insufficient address" etc. The concerned member / friends are requested to inform the office immediately with change of address, L.M. No. & Local Branch.

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LM/07716	Dr. Chhaya Rekha P.	Ahmedabad
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LM/09851	Dr. Desai Dipen Mahendrabhai	Ahmedabad
LM/09852	Dr. Desai Ava Dipenbhai	Ahmedabad
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LM/10760	Dr. Shah Monali L.	Ahmedabad
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65th Annual Conference

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH

Gimacon-2013 Surat

Host : Indian Medical Association, Surat

Theme : "Building Bridges to Better Health"

7 Credit Hours By GMC

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ASIAN HEART INSTITUTE




Date : Sat. & Sun.
19th - 20th October 2013

Pre Conference Workshop
Fri. 18th October 2013

Venues
Gandhi Smruti Bhavan &
Jeevan Bharti High School
Nanpura, Surat

Conference Secretariat
Netrang Eye Hospital & Laser Centre
246, 2nd Floor, Shankheshwar Complex,
Opp. Raymond Showroom, Majuragate,
Surat-395 002 Ph.: 0261 2464314
Cell : 098240 58309
Email : drnitinkgarg@yahoo.com
hariharswati@gmail.com

65th Annual Conference

INDIAN MEDICAL ASSOCIATION

Gimacon-2013 Surat
19th - 20th Oct. 2013

Pre Conference Workshop : Fri. 18th Oct.-2013

Host : Indian Medical Association, Surat

Surat beckons you...

Dear Sir / Madam,

It is our pleasure to welcome you to the GIMACON 2013, 65th Annual Conference of Indian Medical Association, Gujarat State Branch hosted by Indian Medical Association, Surat. The venues of the conference are Gandhi Smruti Bhavan & Jeevan Bharti High School, Nanpura, Surat.

We are all excited about annual event of the IMA GSB. We aim to provide you the latest information about the enhancing health care with a balance between clinical and transactional research. It will be an opportunity for interaction and learning amongst a wide spectrum of health professionals, who have specialised in their respective fields. It is during this event that participants of all ages from different places will come together to develop friendship network and exchange useful knowledge under one roof. We have also planned to arrange short scientific papers, poster presentations, quiz competitions, along with the interesting programmes for the spouse during these days.

We are happy to announce that Gujarat Medical Council has granted 7 (Seven) credit hours, for this conference.

We hope that through this scientific deliberations, we will be able to fulfill the needs of the Family Physicians as well as Consultants to update their knowledge so that they can use them in daily clinical practice.

Please ensure your early registration and accommodation by contacting GIMACON-2013 office bearers.

Awaiting to greet you at the GIMACON-2013 at Surat.

With warm regards... ... ...

President, IMA GSB & Executive Chairman **Dr Pragnesh Joshi**	*Organising Chairman* **Dr Vinod Shah**	*Org. Secretaries* **Dr Nitin K Garg** **Dr Prashant Desai**
Hon. Sec. IMA GSB **Dr Bipin Patel**	*Chairman Reception Comm.* **Dr Nirmal Choraria**	
President, IMA, Surat **Dr. Bhupesh Chawda**	*Hon. Secretary, IMA, Surat* **Dr. Digant Shastri**	

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REGISTRATION FORM

Full Name (Block letters) : _____ _____ _____
Surname Name Fathers'/Husbands' Name

Qualification : _____ Branch of IMA : _____

Mailing Address : _____

_____

City : _____ State : _____ Pin : | | | | | | |

Phone : STD Code_____ (O)_____ (Mob.)_____

E-mail : _____

Medical Council Reg. No. _____ Conf. Reg. No. : _____

Accompanying Persons :

S.N.	Full Name	Relation	Age	Gender	₹
1					
2					

Registration Fees **PATRON : ₹ 11,000/-** || **RC MEMBER : ₹ 3,000/-**

Date up to	IMA Member	Non IMA Member	Accomp. Person	Students up to Internee
30-09-2013	₹ 1000/-	₹ 1500/-	₹ 800/-	₹ 800/-
10-10-2013	₹ 1200/-	₹ 1800/-	₹ 800/-	₹ 1000/-
Spot (Kit not guaranteed)	₹ 1500/-	₹ 2000/-	₹ 1000/-	₹ 1200/-

Note : (1) Accompanying person is not entitled for kit. (2) Medical students must have to submit college authority letter. (3) Registration from 11-10-2013 onward will be considered as Spot.

Bank :	Branch :
Registration : ₹	Cheque / DD No.
Accom. Person : ₹	Date :
Total ₹ : In words	

All payment in cheque/DD drawn in favour of "**GIMACON-2013**" Payable at Surat.
Please send registration form to **Conference Secretariat : Netrang Eye Hospital & Laser Centre**
246, 2nd Floor, Shankheshwar Complex, Opp. Raymond Showroom, Majura Gate, Surat-395 002.
Cell : 098240 58309 Email : drnitinkgarg@yahoo.com, hariharswati@gmail.com

65th Annual Conference

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Gimacon-2013 Surat
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TARIFF OF DIFFERENT HOTELS

HOTEL	Distance from Station	Deluxe		Super Deluxe		Royal	
		Single	Double	Single	Double	Single	Double
Lords Plaza	0.5 km	3000	3500	5500	6000	8000	8000
Embassy Hotel	Opp. Rly. Sta.	1400	1800	2000	2400	3000	3500
Hotel Balwas'	0.5 km	1500	1500	2200	2200	2500	2500
Hotel Alfa	0.25 km	1100	1300	1300	1500	2000	2200
Hotel Citizen	0.5 km	950	1100	1200	1400	1800	1800
Hotel Apex	0.5 km	1900	2200	2200	2500	2500	2800
Best Western	Opp. Rly. Sta.	2400	2700	3000	3300	3500	4000
Hotel Galaxy	0.5 km	1300	1600	1500	1800	1900	2800
The Grand Bhagwati	8.00 km	7500		8000		20000	

IMA Guest Houses in different parts of the State - for IMA Members

State	Address of Guest House	Conact Person & Contact Datails	Tariff
A.P. Bhimavaram	IMA Building, Motupallivari Street, Bhimavaram	M-09885284231 Fax : 08816-234231	Rs. 100/-, 150/- per day Single A/C - 400/-
A.P. Hyderabad	IMA Building, Near Esamia Bazar, Hyderabad (AP)	Tele.:(040) 24656378 hydcityima@yahoo.co.uk Fax : (040) 24738197	Double A/C-600/- (12 room) Double A/C-500/- (8 rooms)
Assam Barpeta Road	Tourist Lauge Bareta Road, Dist. Bareta, Assam-781315	Dr. Kankan Goswami, M-9435025239	Rs. 400/- per room (5 rooms)
Assam Tezpur	IMA Guest House, 1st Floor, IMA House, Tezpur-784001 Tinsukia, Chinarapatti,	Dr. H.K. Borah M-9435081697	4 AC Rooms @ Rs. 750/- per room
Assam Tinsukia	SBI Main Branch, Tinsukia- 786125	Dr. Phanindra Saikia M-09435134550	Rs. 250/- per room (2 rooms)
Bihar Patna	IMA Bldg, Dr. A.K.Nsinha Path S-E of Gandhi Maidan Patna-4	Tele.: 0612-2321542 info@imabihar.org Fax : 0612-2321542	Double bedded 100/-
Bihar Samastipur	IMA Bhawan, Opp. KHE Inter College Kashipur, Samastipur-848101	Mr. Rakesh Roshan M-09431245533 Tele.:06274-224094	Rs. 250/- per person, 2 bedded (4 Rooms)
Chandigarh	IMA House, Sector - 35 chandigarh	Tele.: 0172-2602595 singh_zora@yahoo.co.in Fax : 0172-2602595	A/C room Rs. 600/-, Cooler Rs. 350/-, Non A/C Rs.350/-
Chhatishgarh Durg	IMA Building, IMA Chowk, Opp Dhamdhanaka, Overbirdge, Durg	M-09424107891 Tele.: 0788-2320291 Fax : 0788-2326767 23370009.8819.868,0473,	4th floor 350/- Per Bed+LT.
Delhi IMA HQ.	IMA House, Indraprastha Marg. New Delhi - 110002	0492,8424, imabuiding@gmail.com Fax : (011-23379470, 23378680)	5Th Floor 500/- Per Bed + Lt + Breakfast & bed Tea

IMA Guest Houses in different parts of the State - for IMA Members

State	Address of Guest House	Conact Person & Contact Datails	Tariff
Gujarat Ahmedabad	3rd Floor, AMA House Opp, H.K.College, Ashram Road, Ahmedabad-9	Tele.:079-26587370 imagsb@youtele.com Fax : 079-26587370	**AC** **Double bed Rs. 800/-** **Single bed Rs. 500/-** **Dormitory Rs. 300/-**
Karnataka State HQ	IMA House Alur Ventakta Rao Road, Bangalore-560018, Karnataka	Hony. Secretary Tele. : 080-26800409; 26703255 Fax : 080-26703255 M. : 9008828303 E-mail : imaksb@bsnl.in	Single Bed : 250/- Double : 400/- A/C Delux : 700/- Suite : 800/- Extra bed : 150/- No
Karnataka Tumkur	IMA House, Town Hall Circle, Tumkur : 572102	Tele. : 0816-2251966 M. : 9844190463	Single Bed : 200/- Double Bed : 300/- No
Karnataka Shimoga	IMA House, Mc. Gann Hospital Compound, Shimoga.	Tele. : 08182-224622 M. : 9448421951 E-mail : doc_vishwanath@hotmail.com	Single Bed Double Bed No
Karnataka Chitradurga	IMA House, Opp. Dist. Hospital, Chitradurga-577501	Tele. : 08194-228485 M. : 9972328698	Single Bed : 50/- Double Bed : 100/- No
Karnataka Arsikere	IMA House, Behind Sai Natha Temple, J.C. Hospital Compound, Arsikere-573103	M. : 9448997377 E-mail : hareeshkv@yahoo.com chancheku@gmail.com	Single Bed : 100/- No
Kerala Thiruva'puram	IMA State Headquarters, Anayara. Thiruvananthpuram-695029	Tele.:0471-2741144 imaksb@yahoo.co.in Fax : (0471) 2741155 Dr. Radhamony M.,	Ac, Rs. 600/-, Non AC Rs. 400/-Dormitory - 100/ Yes
Kerala Kottarakara	IMA House, Bubby Kottarakara Road P.O. Kotarakaro, Dist. Kollam	Hony.Secretary M-9447801337 Tele.: 0474-2454066 drradhymony@yahoo.co.in Fax : 0474 - 2454066	Rs. 400/- Per Day

IMA Guest Houses in different parts of the State - for IMA Members

State	Address of Guest House	Conact Person & Contact Datails	Tariff
MP Gwalior	Gwalior	M. : 9827062860 E-mail : ima_gwalior@yahoo.in	One double bedded Rs. 500/- per day
MP Indore	I.M.A Bhawan. Dr. S.K. Mukharji IMA Parisar M.O.G. Lines, Indore-452002	Tele.:0731 - 2787988 imacon2008@gmail.com Fax : 0731-2787988	Rs. 350/- Day
MP Jabalpur	IMA House, Medical Road Wright Town, Jabalpur - 482002	Tele.:0761-2404940,4005715 imajabalpur@yahoo.co.in Fax : 0761-4005715	Rs. 100/-
MP Ratlam	Subhedara IMA House Rajendra Nagar, Ratlam	Tele. : 07412-231737 pkghate@yahoo.com Tele.:(022) 23543255,	Rs. 150/-
Maharastra Mumbai	IMA House, IMA Chowk, 16 Keshav rao Khadye Marg Haji Ali, Mumbai-400034	ima_mumbail@rediffmail.com, ma_mumbai@mtnl.net.in Fax : (022) 23545510	Rs. 500/-
Maharastra Mumbai West	IMA Building, J.R.Mhtre Marg JVPD Scheme Bhehind chandan cinema Juhu, Mumbai - 400049	Tele.:022-26206517,26254368 imamumbaiwest@yahoo.com Fax : 022-26254368	Rs. 1200/- + 10.30%
Maharastra Nagpur	IMA House North Ambbazari Road Nagpur-440010, IMA Berhampur	Tele.: (0712) 2550777,2522421 imacon2007@gmail.com Fax : 0712-2550777	AC Rs. 340/-
Orissa Berhampur	M.K.C.G Medical College Campus Berhampur - 760004	Tele.: (0680) 2200227 kkp1000@hotmail.com	Rs. 300/-
Orissa Cuttack	IMA House Medical Road Ranihat cuttack-753007	Tele.:(0671) 2121125 imaorissa@imaorissa.com Fax : (0671) 2413060	Rs. 350/-

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Rajasthan Ajmer	Infront of Jhawahar Lal Nehru Hospital, Ajmer MBS Hospital Campus,	M - 9414300220	Rs. 400/- for 24 hours (2 Rooms) Rs. 600/- for 24 hours
Rajasthan Jaipur	Balsissh (22), Godham Circle, Sardar Patel Marg, Jaipur	M - 094142-40898	
Rajasthan Kota	Nayapura Kota	M - 09414179558 Sindur Gardens,	(2 rooms) Pallar (AC Single Bedded) -
Tamil Nadu State HQ Chennai	423 Kilpauk Garden Road Kilpauk, Chennai-10	Tele.: (044-26443055)	Rs. 200/-
Tamilnadu Chennai	**TN State PPLS Building** House No. 11 & 12, Sankara Heritate Apts., Super Tank, Chelpetr, Chennai-600031, TN	Tele. : 2215457; 2212720; 2215467 (f) Dr. T. Sadagopan M. : 09843034878 E-mail : schemestnsb.vellore@gmail.com	Double bedded A/C. Rs. 700/- Single occpancy of double bedded A/c. : Rs. 600/- No
Tamilnadu Salem	12, Saradha College Road, New Five Road, Salem-636004	Tele. : 2248033 M. : 9443263342	Three double bedded room : Rs. 250/- No
U.P. Banaras	IMA Bulding Chetganj Varanasi - 221001	Mr. Babbloo M -09415336602 Tele.:0542-2403194, 2419797 Fax : 0542-2403194	Rs. 350-/- AC Rs. 300/- Non Ac
U.P. Bareilly	IMA Bhawan, 110, Civil Lines Bareilly	Mr. Karan, M-09410498049 Tel:0581-2511716 raveesh.ely@gmail.com	Rs. 1000/-perday+10.3 Tax, No. of rooms 4 NO
U.P. Lucknow	IMA Bhawan River Bank colony Lucknow	M-9.41541e+009 Tele.:0522 2626440 Fax : 0522-2626440	AC - Rs. 500/- 2 Dormatory Rs. 200/-
West Bengal State Office	11/3 Dr. Biresh Guha Street Kolkata-17	Tele.: 033-22810758 imabengalstate@yahoo.co.in Fax : 033-22810758	One AC Dormatary for 6
West Bengal JIMA Building	53, Creek Row, Kolkata - 700014	Tele.: 033-22378092, 22366437 J-ima@vsnl.net	Single deluxe - 600/- Double deluxe - 1000/- Double A/C - 800/- Triple bed - 1200/- Dormitory non a/c - 200/-

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INDIAN MEDICAL ASSOCIATION
GUJARAT STATE BRANCH

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Email: imagsb@youtele.com & imagsb@gmail.com

Rate of Advertisement

Revised rates of advertisement in journal & bulletin effective from 1st September, 2012

	POSITION OF ADVT.	JOURNAL		BULLETIN	
		FOR MEMBERS	*FOR NON-MEMEBRS*	*FOR MEMBERS*	*FOR NON-MEMEBRS*
A	Inside FullPage	RS. 7,000-00	RS. 8,000-00	RS.6,000-00	RS. 7,000-00
B	Inside Full Page (Multi Colour)	RS.14,000-00	RS.17,000-00	RS.10,000-00	RS.13,000-00
C	Half Page	RS.3,500-00	RS.4,000-00	RS.3,000-00	RS.3,500-00
D	Quarter Page	RS.2,000-00	RS.2,500-00	RS.1,500-00	RS.2,000-00

- The size of Bulletin Full page 120 x 190 mm, Half Page 120 x 85 mm and Quarter Page 60 x 85 mm.
- The size of Journal Full page 190 x 250 mm, Half Page 190 x 125 mm and Quarter Page 85 x 125 mm.
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SCIENTIFIC UPDATE

Acute and Chronic Pancreatitis

Pancreatitis, which is most generally described as any inflammation of the pancreas, is a serious condition that manifests in either acute or chronic forms. Chronic pancreatitis results from irreversible scarring of the pancreas, resulting from prolonged inflammation. Six major etiologies for chronic pancreatitis have been identified: toxic/ metabolic, idiopathic, genetic, autoimmune, recurrent and severe acute pancreatitis, and obstruction. The most common symptom associated with chronic pancreatitis is pain localized to the upper-to-middle abdomen, along with food malabsorption, and eventual development of diabetes. Treatment strategies for acute pancreatitis include fasting and short-term intravenous feeding, fluid therapy, and pain management with narcotics for severe pain or nonsteroidal anti-inflammatories for milder cases. Patients with chronic disease and symptoms require further care to address digestive issues and the possible development of diabetes. Dietary restrictions are recommended, along with enzyme replacement and vitamin supplementation. More definitive outcomes may be achieved with surgical or endoscopic methods, depending on the role of the pancreatic ducts in the manifestation of disease.

Incidence and Pathophysiology

Acute pancreatitis has a sudden onset and short duration, whereas chronic pancreatitis develops gradually and worsens over time, resulting in permanent organ damage.

Epidemiology

The incidence of chronic pancreatitis has not been well studied. One reason for the lack of epidemiological data has been the difficulty in achieving a generalized consensus on the classification and diagnosis of chronic pancreatitis, making it difficult to compare between studies.

Some patients experience recurrent acute pancreatitis, a condition which may be difficult to distinguish from early-stage chronic pancreatitis. The incidence of recurrent acute pancreatitis is not well defined, but has been estimated to be up to 15% among patients who experienced a first acute pancreatitis attack.

One study reported an incidence of recurrent acute pancreatitis of 10.9% in patients who experienced a first attack, with 6.4% going on to develop chronic pancreatitis.

The incidence of chronic pancreatitis is highest between 40 and 60 years of age, with a higher rate of occurrence in the male population. Differences in the occurrence of pancreatitis between males and females are likely due to different frequencies of various pancreatitis risk factors associated with each gender. Women have a predilection for the development of gallstones, and therefore, are more likely to develop gallstone-associated pancreatitis. Conversely, men are more likely to have alcohol-induced pancreatitis.

The most common symptom associated with pancreatitis is pain localized to the upper-to-middle abdomen. Patients often report that their pain radiates to the back. Acute pancreatitis is often associated with nausea or vomiting, and the pain may worsen immediately following a meal.

Because chronic pancreatitis results in abnormal or diminished pancreatic function, patients may also experience issues related to food malabsorption. Malabsorption is primarily related to a diminished ability to secrete enough pancreatic enzymes to properly digest fats, because pancreatic lipase is the primary pathway of fat digestion. This leads to steatorrhea, bloating, indigestion, dyspepsia, and diarrhea.

The pancreas is a key component in the regulation of blood sugar levels, and the development of diabetes mellitus is a major complication resulting from chronic pancreatitis or severe acute necrotizing pancreatitis. Pancreatitis directly causes diabetes as a result of inflammation-induced damage to islet cells, the insulin-producing cells of the pancreas.

Acute pancreatitis inflammation can also lead to pancreatic cell death, or pancreatic necrosis. Often, this necrotized tissue becomes infected, a condition referred to as infected necrosis. Pancreatic necrosis may lead to the development of pancreatic pseudocysts or tissue abscess, common complications associated with pancreatitis.

Pathophysiology

Together, alcohol abuse and gallstones account for over 80% of all cases of acute pancreatitis.

One study calculated the estimated annual risk of developing pancreatitis was 0.05–0.2% among patients with gallstones, and further determined that small gallstones were associated with the highest risk.

Anatomical abnormalities or pancreatic trauma may also contribute to the development of acute pancreatitis.

Metabolic disorders such as hypercalcemia and hypertriglyceridemia are also risk factors for acute pancreatitis. Other acute pancreatitis risk factors include exposure to specific medications or toxins and infection.

Chronic pancreatitis can be broadly categorized into 3 etiologies: alcohol abuse, idiopathic, and other. Alcohol abuse is the primary cause of chronic pancreatitis, accounting for approximately 70–80% of all cases.

The TIGAR-O classification system, first proposed in 2001, identifies 6 major etiologies for chronic pancreatitis: toxic/metabolic (T), idiopathic (I), genetic (G), autoimmune (A), recurrent and severe acute pancreatitis (R), and obstruction (O).

Chronic pancreatitis causes irreversible scarring of the pancreas, resulting from prolonged inflammation. The most accepted hypothesis regarding the pathogenesis of chronic pancreatitis is the sentinel acute pancreatitis event (SAPE) hypothesis, in which an initial insult or injury to the pancreas results in acute pancreatitis.

A migration of stellate cells and inflammatory reactions subsequently occurs. Repeated and prolonged pancreatic inflammation leads to the accumulation of collagen and matrix proteins. Cytokines such as tumor growth factor beta (TGFb) cause fibrosis and scarring of the pancreatic tissue, which can result in decreased pancreatic function

Early recognition of acute pancreatitis is a crucial step to allow for proper treatment and the optimal therapeutic outcome. A diagnosis of acute pancreatitis is based on the presence of 2 of the following 3 criteria:

(1) characteristic abdominal pain; (2) elevated [≥ 3 times the upper limit of normal (ULN)] levels of serum amylase and/or lipase; or (3) characteristic findings on a computed tomography (CT) scan.

Elevated levels of serum trypsinogen, an enzyme secreted only by the pancreas, is a valuable tool when diagnosing acute pancreatitis. Normal levels of this enzyme in patients who present with other symptoms characteristic of acute pancreatitis indicates that these symptoms are likely due to another condition.

In industrialized countries, the majority of acute pancreatitis cases are due to either gallstones (38%) or alcohol use (36%).

However, several other factors may be responsible for the development of acute pancreatitis, including complications following endoscopic retrograde cholangiopancreatography (ERCP), metabolic causes (such as hypertriglyceridemia or hypercalcemia), physical causes (such as a pancreatic mass), and the use of certain medications (including hydrochlorothiazide and azathioprine).

The etiology cannot be determined in approximately 20% of patients; these patients are therefore diagnosed with idiopathic acute pancreatitis.

Treatment Options for Acute Pancreatitis

Fasting and Short-term Intravenous Feeding

Following the positive outcomes of several clinical studies, nutritional support is now considered a critical part of the treatment of patients with severe acute pancreatitis. The choice for administering nutritional support is between either enteral administration or total parenteral nutrition (TPN).

A randomized trial that compared jejunal tube feeding versus oral feeding reported that while both methods were beneficial, jejunal tube feeding was associated with a lower incidence of pain,

A randomized study of 50 patients with severe acute pancreatitis showed that nasogastric feeding resulted in improved control of blood glucose levels, although these patients also experienced a higher number of complications.

Fluid Resuscitation

Fluid therapy has been found to play a critical role in improving the outcomes of patients with acute pancreatitis, and is a component of the supportive care recommended in the American College of Gastroenterology (ACG) Practice Guidelines.

Aggressive fluid resuscitation is an important treatment to counteract the hypovolemia that may accompany acute pancreatitis. Hypovolemia has a negative effect on the microcirculation within the pancreas, and can lead to

further complications including hemoconcentration (hematocrit ≥ 44), tachycardia, hypotension, scant urine output, and prerenal azotemia.

Reduced volume can also result in organ failure, which is responsible for many of the early deaths attributed to acute pancreatitis. Aggressive fluid

resuscitation can also be used to minimize ischemia and reperfusion injury, thereby preventing organ failure.

Although not established through clinical study, the general consensus of the amount of fluids to be administered is 250–300 cc/hour.

The success of fluid therapy is determined by monitoring vital signs and urine output, as well as a drop in hematocrit levels within 24 hours.

Pain Management

Abdominal pain is one of the chief symptoms of acute pancreatitis, and can range from mild discomfort to severe pain depending on the severity of disease. Alleviation of this pain is an essential step in the management of acute pancreatitis. Parenteral narcotics are generally administered for severe acute pancreatitis.

The parenteral narcotics used in this setting include meperidine, morphine, fentanyl, and hydromorphone, among others. According to the ACG Practice Guidelines, there is no evidence to suggest the superiority of one drug over another.

The amount and fre-quency with which these agents are administered should be closely monitored. Nonsteroidal anti-inflammatory drugs (NSAIDs) are alternatively used as disease symptoms improve and patients are weaned off narcotic therapy.

Antibiotic Therapy

The danger of patients with acute pancreatitis developing associated infection has led to the use of antibiotics as prophylactic therapy to prevent infected necrosis.

The widespread use of antibiotics in this setting is largely based on a Cochrane review of 4 randomized trials which found that prophylactic intravenous antibiotics could reduce mortality and incidence of pancreatic sepsis.

If an infection is suspected, antibiotic therapy can be initiated and a pancreatic fine needle aspiration performed for bacteriology; treatment is then halted if an infection is not confirmed.

Otherwise, treatment should continue for 14 days.

Octreotide

Octreotide, a synthetic version of the naturally occurring peptide hormone somatostatin, has been explored as a possible treatment for acute

pancreatitis. Somatostatin is a potent inhibitor of pancreatic exocrine secretion, and thus reduces or suppresses the pancreatic response to food intake.

This ability to allow the pancreas to “rest” is the primary rationale for its use in the treatment of acute pancreatitis. The half-life of somatostatin is very short (2–3 minutes), greatly limiting its therapeutic potential.

However, octreotide must also be administered several times daily in order to attain therapeutic levels; thus longer-acting formulations of octreotide requiring once-monthly administration have also been developed.

A high dose of octreotide (200 mg 3 times daily) is typically used to treat patients with severe acute pancreatitis.

However, an analysis of both the intent-to-treat and evaluable populations showed no significant difference in patient outcomes, including the mortality rate, complication rate, pain duration, need for surgical intervention, or duration of hospital stay. The study investigators concluded that octreotide had no benefit in the treatment of acute pancreatitis. More recently, a meta-analysis suggested that while octreotide and somatostatin offered no benefit in the treatment of mild acute pancreatitis, they reduced the mortality rate among patients with severe disease.

Therefore, there is currently no conclusive clinical trial evidence to support the use of either somatostatin or octreotide in the treatment of acute pancreatitis.

Investigational Therapies

Although the pathophysiology of acute pancreatitis has not been clearly established, it is thought that reactive oxygen free radicals may play a central role. Reactive oxygen free radicals such as superoxide anions, hydrogen peroxide, and hydroxyl free radicals have been shown to be produced during a pancreatitis episode, and patients with pancreatitis have higher free radical activity.

Based on this evidence, antioxidants have been explored as a possible therapeutic agent in acute pancreatitis. Antioxidants have been shown to be partially effective in experimental models of acute pancreatitis.

However, to date antioxidants have only been investigated in the clinical setting to a limited extent, and require further testing in well-designed clinical trials.

Treating acute pancreatitis

There is no specific treatment for acute pancreatitis, but for most people, the condition gets better on its own within a week.

In severe cases, complications can develop that require specific additional treatment. In these cases, recovery may take much longer and the condition can be fatal.

Fluids

Your body can become dehydrated during an episode of acute pancreatitis, so fluids will be provided through a tube connected to one of your veins. This is known as intravenous fluid (IV).

In severe cases of acute pancreatitis, IV fluids can help prevent a serious problem called hypovolemic shock, which occurs when a drop in your fluid levels causes a reduction in the volume of blood in your body.

Nutritional support

Although the diet of many people with mild acute pancreatitis is not restricted, some people are advised not to eat. This is because trying to digest solid food could place too much strain on your pancreas.

Depending on the severity of the condition, you may not be able to eat solid foods for a few days or longer.

If you need to avoid solid food, a feeding tube may be used to provide your body with nutrients. This is known as enteral feeding and it often involves using a tube that's inserted into your stomach through your nose (nasogastric tube).

Oxygen

To ensure that your vital organs have enough oxygen, it will usually be supplied through tubes into your nose. The tubes can then be removed after a few days once it is clear your condition is improving.

In severe cases, ventilation equipment may also be used to assist with your breathing.

Painkillers

Acute pancreatitis often causes severe abdominal (tummy) pain, so strong painkilling medication will probably be required, such as morphine.

Some of the painkillers used can make you feel very drowsy.

Treating the underlying cause

Once the condition is under control, the underlying cause may need to be treated. Treatments for the most common causes of acute pancreatitis - gallstones and alcohol consumption - are outlined below.

Gallstones

If a gallstone is responsible for the pancreatitis, you may need to have a procedure called endoscopic retrograde cholangiopancreatography (ERCP), or your gallbladder may need to be removed.

Gallbladder removal surgery may be done while you are in hospital or it may be planned for a number of weeks in the future.

An ERCP procedure is an alternative treatment for gallstones. It involves using a narrow, flexible tube (known as an endoscope), which has a camera on one end. An ultrasound scan will be used to guide the endoscope into your digestive system and surgical instruments will be passed down the endoscope so the gallstone can be removed.

Alcohol consumption

Everyone who has had acute pancreatitis should avoid alcohol completely for at least six months, whatever the cause of the condition. This is because alcohol can cause further damage to the pancreas during your recovery.

Investigations and diagnosis

- Acute pancreatitis is diagnosed clinically but requires CT evaluation to differentiate mild acute pancreatitis from severe necrotic pancreatitis.

CT is an important common initial assessment tool for acute pancreatitis. Imaging is indicated during the initial presentation if:

- the diagnosis of acute pancreatitis is uncertain
- there is abdominal distension and tenderness, fever>102, or leukocytosis
- there is a Ranson score > 3 or APACHE score > 8
- there is no improvement after 72 hours of conservative medical therapy
- there has been an acute change in status: fever, pain, or shock

Magnetic resonance imaging

While computed tomography is considered the gold standard in diagnostic imaging for acute pancreatitis,[12] magnetic resonance imaging (MRI) has become increasingly valuable as a tool for the visualization of the pancreas, particularly of pancreatic fluid collections and necrotized debris.[13] Additional utility of MRI includes its indication for imaging of patients with an allergy to CT's contrast material, and an overall greater sensitivity to hemorrhage, vascular complications, pseudoaneurysms, and venous thrombosis.[14]

Another advantage of MRI is its utilization of magnetic resonance cholangiopancreatography (MRCP) sequences. MRCP provides useful information regarding the etiology of acute pancreatitis, i.e., the presence of tiny biliary stones (choledocholithiasis or cholelithiasis) and duct anomalies.[13] Clinical trials indicate that MRCP can be as effective a diagnostic tool for acute pancreatitis with biliary etiology as endoscopic retrograde cholangiopancreatography, but with the benefits of being less invasive and causing fewer complications.

Treatment

Pain control

Originally it was thought that analgesia should not be provided by morphine because it may cause spasm of the sphincter of Oddi and worsen the pain, so the drug of choice was meperidine. However, due to lack of efficacy and risk of toxicity of meperidine, more recent studies have found morphine the analgesic of choice.] Meperidine may still be used by some practitioners in more minor cases, or where morphine is contraindicated.

Bowel rest

In the management of acute pancreatitis, the treatment is to stop feeding the patient, giving him or her nothing by mouth, giving intravenous fluids to prevent dehydration, and sufficient pain control. As the pancreas is stimulated to secrete enzymes by the presence of food in the stomach, having no food pass through the system allows the pancreas to rest.[*citation needed*] Approximately 20% of patients have a relapse of pain during acute pancreatitis. Approximately 75% of relapses occur within 48 hours of oral refeeding.

Nutritional support

Recently, there has been a shift in the management paradigm from TPN (total parenteral nutrition) to early, post-pyloric enteral feeding (in which a feeding

tube is endoscopically or radiographically introduced to the third portion of the duodenum). The advantage of enteral feeding is that it is more physiological, prevents gut mucosal atrophy, and is free from the side effects of TPN (such as fungemia). The additional advantages of post-pyloric feeding are the inverse relationship of pancreatic exocrine secretions and distance of nutrient delivery from the pylorus, as well as reduced risk of aspiration.

ERCP

Early **ERCP** (endoscopic retrograde cholangiopancreatography), performed within 24 to 72 hours of presentation, is known to reduce morbidity and mortality.[34] The indications for early ERCP are as follows :

- Clinical deterioration or lack of improvement after 24 hours
- Detection of common bile duct stones or dilated intrahepatic or extrahepatic ducts on CT abdomen

The disadvantages of ERCP are as follows :

- ERCP precipitates pancreatitis, and can introduce infection to sterile pancreatitis
- The inherent risks of ERCP i.e. bleeding

It is worth noting that ERCP itself can be a cause of pancreatitis.

Surgery

Surgery is indicated for (i) infected pancreatic necrosis and (ii) diagnostic uncertainty and (iii) complications. The most common cause of death in acute pancreatitis is secondary infection. Infection is diagnosed based on 2 criteria

- Gas bubbles on CT scan (present in 20 to 50% of infected necrosis)
- Positive bacterial culture on FNA (fine needle aspiration, usually CT or US guided) of the pancreas.

Complications

Complications can be systemic or locoregional.

- Systemic complications include ARDS, multiple organ dysfunction syndrome, DIC, hypocalcemia (from fat saponification), hyperglycemia and insulin dependent diabetes mellitus (from pancreatic insulin-producing beta cell damage)

- Locoregional complications include pancreatic pseudocyst (Most common, occurring in up to 25% of all cases) and phlegmon / abscess formation, splenic artery pseudoaneurysms, hemorrhage from erosions into splenic artery and vein, thrombosis of the splenic vein, superior mesenteric vein and portal veins (in descending order of frequency), duodenal obstruction, common bile duct obstruction, prog ression to chronic pancreatitis

Management

Medical management of mild acute pancreatitis is relatively straightforward; however, patients with severe acute pancreatitis require intensive care.

Initial supportive care includes the following:

- Fluid resuscitation[4]
- Nutritional support

Antibiotic therapy is employed as follows:

- Antibiotics (usually of the imipenem class) should be used in any case of pancreatitis complicated by infected pancreatic necrosis but should not be given routinely for fever, especially early
- Antibiotic prophylaxis in severe pancreatitis is controversial; routine use of antibiotics as prophylaxis against infection in severe acute pancreatitis is not currently recommended

Surgical intervention (open or minimally invasive) is indicated when an anatomic complication amenable to a mechanical solution is present. Procedures appropriate for specific conditions involving pancreatitis include the following:

- Gallstone pancreatitis: Cholecystectomy
- Pancreatic duct disruption: Image-guided percutaneous placement of a drainage tube into the fluid collection[5]; stent or tube placement via ERCP; in refractory cases, distal pancreatectomy or a Whipple procedure
- Pseudocysts: None necessary in most cases; for large or symptomatic pseudocysts, percutaneous aspiration, endoscopic transpapillary or transmural techniques, or surgical management
- Infected pancreatic necrosis: Image-guided aspiration;

necrosectomy

- Pancreatic abscess: Percutaneous catheter drainage and antibiotics; if no response, surgical debridement and drainage

Pathophysiology

Normal pancreatic function

The pancreas is a gland located in the upper posterior abdomen. It is responsible for insulin production (endocrine pancreas) and the manufacture and secretion of digestive enzymes (exocrine pancreas) leading to carbohydrate, fat, and protein metabolism. Approximately 80% of the gross weight of the pancreas supports exocrine function, and the remaining 20% is involved with endocrine function. The focus of this article is on the exocrine function of the pancreas.

The pancreas accounts for only 0.1% of total body weight but has 13 times the protein-producing capacity of the liver and the reticuloendothelial system combined, which together make up 4% of total body weight. Digestive enzymes are produced within the pancreatic acinar cells, packaged into storage vesicles called zymogens, and then released via the pancreatic ductal cells into the pancreatic duct, where they are secreted into the small intestine to begin the metabolic process.

In normal pancreatic function, up to 15 different types of digestive enzymes are manufactured in the rough endoplasmic reticulum, targeted in the Golgi apparatus and packaged into zymogens as proenzymes. When a meal is ingested, the vagal nerves, vasoactive intestinal polypeptide (VIP), gastrin-releasing peptide (GRP), secretin, cholecystokinin (CCK), and encephalins stimulate release of these proenzymes into the pancreatic duct.

The proenzymes travel to the brush border of the duodenum, where trypsinogen, the proenzyme for trypsin, is activated via hydrolysis of an N-terminal hexapeptide fragment by the brush border enzyme enterokinase. Trypsin then facilitates the conversion of the other proenzymes to their active forms.

A feedback mechanism exists to limit pancreatic enzyme activation after appropriate metabolism has occurred. It is hypothesized that elevated levels of trypsin, having become unbound from digesting food, lead to decreased CCK and secretin levels, thus limiting further pancreatic secretion.

Because premature activation of pancreatic enzymes within the pancreas

leads to organ injury and pancreatitis, several mechanisms exist to limit this occurrence. First, proteins are translated into the inactive proenzymes. Later, posttranslational modification of the Golgi cells allows their segregation into the unique subcellular zymogen compartments. The proenzymes are packaged in a paracrystalline arrangement with protease inhibitors.

Zymogen granules have an acidic pH and a low calcium concentration, which are factors that guard against premature activation until after secretion has occurred and extracellular factors have triggered the activation cascade. Under various conditions, disruption of these protective mechanisms may occur, resulting in intracellular enzyme activation and pancreatic autodigestion leading to acute pancreatitis.

Pathogenesis of acute pancreatitis

Acute pancreatitis may occur when factors involved in maintaining cellular homeostasis are out of balance. The initiating event may be anything that injures the acinar cell and impairs the secretion of zymogen granules; examples include alcohol use, gallstones, and certain drugs.

At present, it is unclear exactly what pathophysiologic event triggers the onset of acute pancreatitis. It is believed, however, that both extracellular factors (eg, neural and vascular response) and intracellular factors (eg, intracellular digestive enzyme activation, increased calcium signaling, and heat shock protein activation) play a role. In addition, acute pancreatitis can develop when ductal cell injury leads to delayed or absent enzymatic secretion, as with the *CFTR* gene mutation.

Once a cellular injury pattern has been initiated, cellular membrane trafficking becomes chaotic, with the following deleterious effects:

- Lysosomal and zymogen granule compartments fuse, enabling activation of trypsinogen to trypsin
- Intracellular trypsin triggers the entire zymogen activation cascade
- Secretory vesicles are extruded across the basolateral membrane into the interstitium, where molecular fragments act as chemoattractants for inflammatory cells

Activated neutrophils then exacerbate the problem by releasing superoxide (the respiratory burst) or proteolytic enzymes (cathepsins B, D, and G;

collagenase; and elastase). Finally, macrophages release cytokines that further mediate local (and, in severe cases, systemic) inflammatory responses. The early mediators defined to date are tumor necrosis factor-alpha (TNF-α), interleukin (IL)-6, and IL-8.

These mediators of inflammation cause an increased pancreatic vascular permeability, leading to hemorrhage, edema, and eventually pancreatic necrosis. As the mediators are excreted into the circulation, systemic complications can arise, such as bacteremia due to gut flora translocation, acute respiratory distress syndrome (ARDS), pleural effusions, gastrointestinal (GI) hemorrhage, and renal failure.

The systemic inflammatory response syndrome (SIRS) can also develop, leading to the development of systemic shock. Eventually, the mediators of inflammation can become so overwhelming to the body that hemodynamic instability and death ensue.

SCIENTIFIC UPDATE

Approach to common psychiatric illnesses in OPD practice – common pitfalls . A view from the trenches.

Various epidemiological studies done in India for mental illnesses , reflects a very frightening and alarming scenario. 20%of adult population in the community suffers from one or another mental illnesses . In children and adolescent population prevalence rate is 16.5%. In the 6-14 years of age group approximately four crore children require professional help. Prevalence rate for all psychiatric illness in general population is 9.5 to 370/1000 population . Economic cost of treating psychiatric patients is , 10000 crore, if we take 200/1000 population prevalence rate and modest figure of 500rs/month expense . Apart from these figures increase in invisible mental problems like suicide , suicidal attempts aggression and violence , widespread substance use (addictions) , marital disharmony and divorce etc . Against this we have only 6500 qualified psychiatrist and even less clinical psychologist and counselors . The number of psychiatrist is 23% less than what our country needs .

(Source – Indian psychiatric epidemiological studies learning from the past –Indian journal of psychiatry year January 2010. Author – Suresh Badamath and Ravindra Shrinivas Raju.)

Against this backdrop,it is well known that most common psychiatric illnesses encountered in office practice of family physician , physicians, surgeons , pediatrician are all types of anxiety disorders and depressive disorders . My attempt in this article will be to empower you in treating them better .We are going in a landmine , where our conventional weapons of diagnosis are useless .No lab , no X rays , no scans or sonography . Your only unconventional weapon is listening .At the end of the day you will have the satisfaction of having managed your patients just like your near and dear ones !!.This will be a gold standard for ideal treatment.

The most common psychiatric illness in this list is Depression , the incidence is 20-30% incidence and it comes in various disguises. It takes away a lot of your time , energy and is a big financial drain on our health care delivery system .The classical signs of depression are sadness of mood , crying spells , decrease in appetite , insomnia ,suicidal ideas etc .What you see may be quite different.

Depression in children --- many parents often refuse to believe that the child is depressed .Children may present with deterioration in school performance, temper tantrums , increased aggression and violence ,lying , stealing ,running away from home , substance abuse (tobacco , alcohol) ,various types of phobias , antisocial behaviour school refusal etc.

There may be other co-morbid psychiatric problem like learning disability (TARE ZAMIN PAR), secondary enuresis , encopresis , phobias etc etc .Since parents are extremely reluctant to meet the psychiatrist .First point of contact is family physician or pediatricians.

DO'S AND DON'T'S FOR MANAGING CHILDREN.

Do's –

1) Minimum basic medical workup.
2) Listen to them with empathy .
3) Remove guilt from parents .
4) Involve the important people in the children's life like teachers whom they like and supportive friends.
5) For children older than 6 years the choice of antidepressant drugs is similar to that of adults.However the dosage should be adjusted according to their weight.
6) Use conventional , old , time tested drugs like tri-cyclic compounds .Avoid fancy new agents with which you are not familiar .The key here is “Adequate dose for sufficiently long time for minimum 4-6 wks .
7) This is one population, where I have no hesitation in advocating use of qualified counsellors and clinical psychologist.

DONT'S—

1) Telling the parent that the child will out grow it .
2) Avoid corporal punishments which can humiliate the child and damage the child's self – esteem.
3) Sending them to hostel- correctional facility!!!.
4) Changing your medicine every few days and using combinations .

Presentations seen in adult and middle aged population – The disguises are

We Asian people have limited vocabulary, so to express our emotional anguish, we somatize!!!.So the disguises are :

1) Multiple physical complaints (more than one systems) vague in nature, constantly changing .
2) No correlation with anatomy and physiology.
3) Signs and symptoms not described in our text book s eg – burning sensation all over body .
4) Pre dominant c/o pain – unmeasurable changing , out of proportion and not responding to conventional analgesic and anti inflammatory .sometimes even aggravated by it .
5) Patient coming with fat files with all medical workup – basically normal in nature.
6) They will do anything , going to faith healers , sooth Sayers, alternative system of medicine ,but not psychiatrist .They would rather prefer to die, than seeing a psychiatrist . !!
7) Sudden increase in substance abuse (addiction).
8) Request for unnecessary surgeries and complete health checkups.
9) Presenting with psycho—sexual dysfunction like diminished desire, early ejaculation ,erectile dysfunction .
10) Presenting with hysterical conversion reactions .
11) Ending up in medical emergency rooms with suicidal intent or even serious attempts .

DO'S AND DON'T'S.

DO'S – a) listen to them with empathy and avoid unnecessary investigations. If at all needed , just go for a basic minimum medical workup with TSH.

b) Explain them that this disorder is due to chemical imbalance in brain , which unfortunately today we cant measure !!!

c) Use antidepressants drugs in adequate dose for sufficiently long time i.e. 4-6 weeks

d) The dictum here is to start low and go slow go up to optimum dose . Master one or two drugs from each different group . Explain common side effects , because that is what patient is going to experience first .

DON'T'S a) Telling them that it is all in mind and giving them a long list of medicines with 2-3 tonics .Is this what you do with your own family members ?

b) Threatening that if patient don't behave they will be forced to refer the patient to psychiatrist

c) Not communicating with patients and writing in small letter just for medico legal benefits “Reference to psychiatrist which patient can neither read nor understand “

d) Changing antidepressants every few days, changing the brand name , frequent follow ups and not warning them about common side effects .

The next common disorder is various types of anxiety disorders like panic disorders , hysterical conversion reactions , phobias , somatization disorder , psychogenic pain disorder , hypochondriasis , obsessive compulsive disorder, generalized anxiety disorder .We will only deal with common problems coming to you .These disorders may come alone or as a co-morbidity with your other medical surgical problems.

We all know common signs and symptoms of anxiety and have experienced it at some time or the other.

Psychic s/s –Excessive thinking , sleep disturbances , irritability, undue worries, decreased concentration , restlessness, feeling of impending doom .

Physical s/s –gabhrahman , palpitations , difficulty in breathing, motor restlessness, increased frequency of urine , chest discomfort etc.

In panic disorders,the level of anxiety is extremly high ,lasting for a few minutes to 45 minutes . Patient lives and dies thousand times and usually by the time they reach the doctor they are symptom free.

Patient learns to avoid that situation if it is related to a specific place .

Hypochondriasis : Here patient has irrational and obsessive fixation to some bodily illness like cardiac phobias , cancer phobias , HIV fear and so on .In all anxiety disorders the central theme is “Out of proportion “apprehension , fear or bodily complaints .

Do's and Don'ts for managing anxiety disorders :

Do's 1) Reassurance and proper scientific explanation like role of sympathetic and parasympathetic imbalance

2) Rule out alcohol and other substance abuse disorders and intoxication .

3) R/o thyroid disorders , hypoglycemia and also pheochromocytoma if B.P is abnormally high .

4) Use SSRI group of drugs like flouxetine sertraline , esitalopram , paroxetine , fluvoxamine etc in adequate dosage for sufficiently long time .

5) Avoid benzodiazepine , but initially you might need it. As as far as possible never use them for more than 4-6 wks .

6) Prefer long acting benzodiazepines like clonazepam , chlordizepoxide , diazepam etc .

7) Use sos dispersible clonazepam freely so future avoidance behaviour can be controlled .

8) Promote Non pharmacological measures like exercise,meditation , pranayam and life style changes .

DON'T'S : – a) Telling them you don't have anything and it is all in your mind.

b) Writing in illegible words at the corner of a case papers in small letters.

"Reference to psychiatrist "and giving them a long list of investigations , medical workup and lots of medicines.

c) Using alprazolam for more than few days , In fact it is better to avoid .Its short half like maker ,it is an ideal drug of abuse, if used unchecked .

d) Avoid invasive cardiac or other workups and rare investigation to rule out rare medical illnesses.

Last but not the least is hysterical conversion reaction or hys or for some people even malingering , which needs special mention here, Because this illness comes with sudden , dramatic emergency presentation .It needs a different management approach. As the name indicates conversion means Psychic signs and symptoms are converted in physical signs and symptoms

Common profile – a) Acute sudden dramatic onset

b) Young age , female preponderance

c) s/s more in presence of relatives

d) No h/o of known medical illness to explain the s/s .

e) H/o of secondary gains – some recent stress or desire to get something out of environment

f) Can mimic any neurological illness

g) There is a la - Bella indifference –apparent lack of anxiety .

These patients commonly presents as :

1) convulsion
2) unconsciousness or fainting spells .
3) Hemiplegia –paraplegia
4) Aphonia
5) Blindness
6) Anaesthesia.

APPROACH TO INDIVIDUAL PRESENTATION :

1) Convulsion – We have to differentiate it from actual seizure disorder . so don't rush .Dont label seizure disorder in a hurry , because you will inflict a punishment to take medication for a very long time which is 3—5 years unnecessarily .

2) Take a good history from some eye witness.

3) Ask for video clipping of actual episode if no eyewitness is available .In hysterical convulsion , pre-monitory aura may be present or absent . no night attacks , no h/o tongue bite or loss of spinchter control . no typical tonic and clonic spams , lasts longer , no post ictal confusion or sequelelike headache , vomiting , body ache , EEG is frequently recommended but not conclusive and its abnormality doesn't prove or rule out epilepsy .

4) Hysterical unconsciousness or fainting spells – here patient responds to painful stimuli , all reflexes are WNL, no focal deficit .R/O syncopal attacks when in doubt .

5) Hemiplegia – no known medical illness to explain , no anatomical or physiological correlation for level of lesion .Reflexes are normal , no focal deficit .

Hoovers contalateral leg sign is positive i.e put palm of your hand against sole of the patients paralysed limb, and ask him to raise healthy limb .In the process you will experience counter pressure from the "paralysed limb", if it is hysterical hemiplegia .Another method is to give slow I.V lorazepam and you will see dramatic relief in hysterical hemiplegia .

Hysterical Aphonia – Sudden , dramatic loss of speech , One simple test to clinch the diagnosis .Ask the patient to write –If she/he can write easily it is aphonia .

Paraplegia –No h/o of known medical illness or injury , no spinchter disturbances , no focal deficits ,reflexes, sensory system WNL , all neurological investigations are normal.

Blindness : a) One simple test – try and poke your finger unobserved .Pt will close the eyes if it is hysterical .

b) Pt will walk without bumping in furnitures , corneal and pupillary reflexes are normal.

R/O cortical blindness by ECG – visually evoked potential will be disturbed .

Hysterical anaesthsia: Doesn't correlate with sensory distribution , anesthesia according to patients own imagination .

One test available :

a) Fold his /her hand behind the back with fingers on both hand s interlocked and test the sensations.This will confuse the patient and when you test sensations , he/she will make blunders !!!.Now treatment

TREATMENT -DO'S AND DON'T'S

DO'S

1) judicious use of anxiolytic and antidepressants , when you suspect depression or patient is above the age of age 30.
2) Benzodiazepines for a short period and only long half like substances like diazepam,chlordizepoxide and clonazepam .
3) Use of aversion therapy judiciously in absence of relatives for e.g Ryle's tube in unconscious patient .
4) Cut down secondary gains by sending relative out .
5) Mention possibility of surgical intervention with a straight face , if medications don't work .
6) Try giving a placebo injection in absence of relative with a strong suggestion and mention the threat of surgical intervention ,if the injection fails .Thus combining the technique of strong suggestion and aversion to provide the patient space for a face saving solution .

DONT'S -- a) Any organic label in a hurry e.g epilepsy

b) Humiliation and insult – label malingerer .

c) Sympathy rather than empathy.

d) IV fluids , extensive workups , multiple referrals to superspecialist and long hospitalization .Pt learns more from it to maintain a SICK ROLE!!!

We psychiatrists are poor cousins of medical fraternity , divorced from medicine so patients would rather die , than come to us .

In this situation all my esteemed medical collegues must learn to manage the population , other wise the likely scenario would be

1) Patients going to alternative system of medicine , faith healers , sooth sayers and giving our allopathic system bad name .
2) Repeated unnecessary admission , unnecessary medical workup , are a burden to health care delivery system , taking us away from attending more deserving seriously ill patients .
3) Poorly treated or half heartedly treated depression becoming resistant depression just like resistant T.B .
4) Use of short acting Benzodiazepine sold by chemist without prescription creating iatrogenic drug dependence
5) Undiagnosed or ignored co - morbid psychiatric illness in surgical patients leading to delayed recovery ,out of proportion expectations and sometimes even a medicolegal case .
7) Poor communication leading to doctor shopping .
8) Secondary complication of hospitalization like hospital infection .

When to refer this patient to Psychiatrist

1) Patients with suicidal ideas intent or attempt must be seen by psychiatrist.
2) Presence of psychotic features like hallucinations .Delusions or lack of insight
3) Co – morbid psychiatric problems like Depression with medical illness , depression with substance abuse .
4) Known mentally ill patient undergoing major surgery .
5) Psychiatric illness with other stressful life events who will need counseling and psychotherapy.
6) Poor response and psychotropic drug in 4-6 weeks time , when given in sufficient dosage or
7) Chronic refractory cases .
8) Hospitalized patient where psychiatric intervention is easy .
9) Poor tolerance for psychtropic drugs .

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