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

GUJARAT MEDICAL JOURNAL

INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH

Estd. On 2-3-1945

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(M) 94263 78078

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GUJARAT MEDICAL JOURNAL

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Chairman

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STATE PRESIDENT AND HON. STATE SECRETARY'S MESSAGE

Dear and Respected Colleagues,

We are almost completing 6 months. We will take stalk and plan for future.

We are really glad to know that many members like the idea of donating one hour per week for IMA. We have started taking their voluntary services for the Association. We request the members to be active and take interest in the affairs of IMA especially to the young generation. **You the active IMA members resolve to day** now that out of your own doctor friends you will make **1-2 new active members in IMA from the existing members.** We need new 5 percent members attend at least 80 percent programmes. **Induce participation of inactive members by active members.**

IMA GSB is in a way to form Young Doctors Wing. Dr. Parth Desai has been given the responsibility. We want the involvement of young generation and new ideas. Your suggestions are welcomed. Similarly IMA Gujarat State Branch has planned to form Medical Students Wing. IMA Gujarat State Branch has planned to organize one or two programmes for the interest of the above two groups.

We are nearing 25,000 figure. However registered medical graduates are much more in Gujarat. We need to get all of them with us. Most of the doctors who are not members need to be approached. We all have to make an effort to identify and rope them in.

Along with this, we have to improve our **Pubic Image**. For a better public image, we need to go on multi front and be positive. One such front is public awareness, education and removing general

misconcepts on some topics. Indian Medical Association has identified few of them like IMA Knowledge, Care for Elderly, Aao Gaon Chalen, Disaster Management Cell, Pharmaco Vigilance, Life Style Disease Awareness, T. B. Notification, IMA Road Traffic Accident Awareness, IMA Maternal Mortality rate reduction initiative & IMA Prevention of Blindness in Diabetes etc. I request the local branch secretaries to report the various activities done with regards to the above initiatives.

On 14th June, IMA Gujarat State Branch has organized a very good programme on a less discussed topic – Child Sexual Abuse with the help of IMA HQ and UNICEF. Hon. Secretary General Dr. K. K. Aggarwal, and Hon. Finance Secretary, Dr. R. N. Tandon from IMA HQs were present. It was a day long programmes and members were taking active participation even at 5 p.m. IMA Gujarat State Branch thanks all the members and participants from the various medical colleges not only of Gujarat but from whole western region. IMA HQs appreciated the teamwork of IMA GSB especially of Dr. Mahendra Desai, Dr. Bipinbhai Patel, Dr. Kamlesh Saini & Dr. Parth Desai.

We are planning to start e-bulletin for our members & to reach to the members we require e-mail of the members. I request all of you to update your data & membership information with office.

Team IMA Vadodara is working very hard for GIMACON 2015 to be held on 28-29th November 2015 at Vadodara. You can download the registration form from www.imagsb.com or www.imavadodra.org Be prepare for two days of Mega event of IMA GSB.

Success with people begins with love for people. We are very much impressed by the love and affection receiving from the IMA members and the office bearers of local branches that we are sure to believe **Together we will achieve.**

Dr. Chetan N. Patel
(President, G.S.B.,I.M.A.)

Dr. Jitendra N. Patel
(Hon. State Secy. G.S.B.I.M.A.)

Goals help you channel your energy into action.

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH

Doctor's Day Celebrations

IMA MEGA BLOOD DONATION CAMP

To
The Honorary Secretary/President/ Blood Camp Organizer,
IMA State / Local Branches.

Dear Dr.

Season's Greetings from IMA Head Quarter Team.

DOCTOR'S DAY is celebrated on (Date of Birth & death of **Dr. Bidhan Chandra Roy**) 1st July. He was awarded Bharat Ratna on 4 February 1961.

On the Occasion of DOCTORS DAY, we are requesting all the branches to arrange Blood Donation Camp on **Sunday 28th June**. We have tied up with National blood transfusion council (NBTC) & State Blood Transfusion Council (SBTC) of every state through NACO.

You can get associated with other local NGOs like Rotary Club, Lions club, Religious or Social Organization to arrange camps at different Places like Colleges, Offices, Company, Hall , Railway/Bus Station or IMA premises.

Those arranging Blood Donation Camp would be appropriately felicitated during Annual Function of IMA.

Dr Niranjan Vaidya will be the National Chairman of this Mega Blood Donation Camp. (Mob: +91-9320442122)

Thanking you,

Yours sincerely,

Dr. A. Marthanda Pillai
National President, IMA (HQs)

Dr. K. K. Aggarwal
Hon. Secretary General, IMA (HQs)

Dr. Chetan N. Patel
President, IMA-GSB

Dr. Jitendra N. Patel
Hon. State Secretary, IMA-GSB

ACTIVITY REPORT OF AMACON 2015

AMACON 2015, Annual Conference of Ahmedabad Medical Association was organized on 10th May, 2015 at our own AMA premises. It was attended by more than 300 delegates.

It was a whole day event starting from Registration at 8.00 a.m. to banquet till Mid night.

It was on academic feast. Lectures on different topics were delivered by renowned faculties of respective fields.

Inauguration ceremony was at 11.30 a.m. which was graced by our own beloved Dr. Jitendra B. Patel - Imm. Past President, IMA H.Q.as Chief Guest. He delivered very Inspirational speech. Highlighting the need of hour and emphasizing that medical fraternity is at cross road of change and perception of doctor in society is to be changed.

Along with main conference simultaneously there were papers and posters presentation by post graduate Students of various medical colleges of Ahmedabad. Total 45 papers & posters were presented. Ahmedabad Medical Association has given them platform to present their work as well as to make them aware about AMA & IMA as they are future of medical fraternity.

In the end there was lucky draw and 55 prizes were given.

In the evening there was musical evening with banquet dinner. Food was also Excellent and delegates enjoyed it.

Over all it was a memorable conference and those who had attended, will remember it as a very well planned and organized conference.

Dr. Smitaben B. Shah
President,

Dr. Kamlesh Saini
Hon. Secretary,

Ahmedabad Medical Association

CONGRATULATIONS

❖ **Dr. Sonal B. Patel daughter of Dr. B.I. Patel; Ahmedabad**

Stood first in MS Ophthalmology exam taken by Gujarat University in May, 2015.

❖ **Aditya Vaidya son of Dr. Hiren Vaidya; Surat**

Awarded Third position in 60th National School Games 2014-15 "Chess Tournament 2014-15" on 26-04-2015 to 30-04-2015 at Tamilnadu.

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GUJARAT STATE S.S.C. BOARD

Name : **MASHKARIA SATVIK MEHULBHAI**
Percentile Rank : 99.98% (A1)
Date Of Birth : 29/04/2000
School : Kameshwar Vidyamandir, Ahmedabad
Hobby : Mathematics, Cube Solving, Reading,
Line Of Interest : Research In Mathematics
Father's Name : Dr. Mehul Mashkaria
Mother's Name : Dr. Heena Mashkaria

Name : **SHAH KHUSHBU ARKESHBHAI**
Percentile Rank : 99.98% (A1)
Date Of Birth : 04/06/1999
School : Shivashish School
Line Of Interest : Medical
Hobby : Reading
Father's Name : Dr. Arkesh A. Shah
Mother's Name : Smt. Radha A. Shah

Name : **PATEL HARSHIL AMITBHAI**
Percentile Rank : 99.98% (A1)
Date Of Birth : 17/02/2000
School : M. B. Patel English Medium School,
Hobby : Drawing
Line Of Interest : Medical
Father's Name : Dr. Amitbhai M. Patel
Mother's Name : Dr. Gargi Amitbhai Patel

Name : **DAVE RAJ TEJASBHAI**
Percentile Rank : 99.87% (A1)
Date Of Birth : 31/12/1999
School : Utopia School, S.G. Highway, Ahmedabad
Line Of Interest : Engineering
Hobby : Badminton
Father's Name : Dr. Tejas Dave
Mother's Name : Dr. Jigna Dave

Name : **PATEL MITSU NILESHBHAI**
Percentile Rank : 99.84% (A1)
Date Of Birth : 10/09/1999
School : H.B. Kapadia, Ahmedabad
Hobby : Reading, Music
Line Of Interest : Medical
Father's Name : Dr. Nilesh C. Patel
Mother's Name : Dr. Kinnari N. Patel

Name : **PATEL SHACHI ANILBHAI**
Percentile Rank : 99.81% (A1)
Date Of Birth : 10/06/1999
School : Asia English School
Line Of Interest : Medical
Hobby : Reading, Music
Father's Name : Dr. Anil K. Patel
Mother's Name : Smt. Seema A. Patel

Name : **PATEL MANAN BRIJESHBHAI**
Percentile Rank : 99.79% (A1)
Date Of Birth : 28/12/1999
School : St. Xavier Loyolla
Line Of Interest : Engineering
Hobby : Car Mechanism
Father's Name : Dr. Brijesh A. Patel
Mother's Name : Smt Uloopee B. Patel

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GUJARAT STATE S.S.C. BOARD (CBSE)

Name : CHAWLA LEESHA LAL
Grade : A1
Date Of Birth : 07/04/2000
School : Delhi Public School (Dps), Gandhinagar
Hobby : Reading, Table Tennis,
Father's Name : Dr. Lal Khushaldas Chawla
Mother's Name : Dr. Lata Lal Chawla

GUJARAT STATE H.S.C. BOARD

Name : **GOR KUNJ ARUNBHAI**
Percentile Rank : 99.95% (A1)
Date Of Birth : 20/10/1997
School : St. Xavier's School, Adipur
Line Of Interest : Medical
Hobby : Reading, Swimming
Father's Name : Dr. Arun Gor
Mother's Name : Dr. Alpa A. Gor

Name : **GANDHI ANUJ PARIMALBHAI**
Percentile Rank : 99.93% (A1)
Date Of Birth : 30/06/1997
School : M.K. School, Ahmedabad
Hobby : Cricket, Reading
Line Of Interest : Medical
Father's Name : Dr. Parimal D. Gandhi
Mother's Name : Smt. Pallaviben P. Gandhi

Name : **MISTRY VATSAL HITESHBHAI**
Percentile Rank : 99.87% (A1)
Date Of Birth : 12/04/1997
School : Gyanmanjari School, Bhavnagar
Hobby : Computer
Line Of Interest : Medical
Father's Name : Dr. Mistry Hiteshbhai
Mother's Name : Smt. Mistry Dakshaben Hiteshbhai

Name : **DAVE JAHNVI TEJASBHAI**
Percentile Rank : 99.54% (A1)
Date Of Birth : 03/12/1997
School : C.N.Vidhyalay, Ambawadi, Ahmedabad
Hobby : Tennis, Volley Ball, Drawing
Line Of Interest : Medical
Father's Name : Dr. Tejas Dave
Mother's Name : Dr. Jigna Dave

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GUJARAT STATE H.S.C. BOARD (CBSE)

Name : JAIN DARSHIT RAJENDRABHAI
Grade : A1
Date Of Birth : 10/02/1997
School : Divine Child School, Mehsana
Hobby : Cricket, Swimming
Line Of Interest : Medical
Father's Name : Dr. Jain Rajendra H.
Mother's Name : Smt. Jain Madhuben R.

GUJARAT STATE S.S.C. BOARD

Devansh	Dr. Sandip Shah (Ahmedabad)	98.84% (A2)

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GUJARAT STATE S.S.C. BOARD (CBSE)

Rutika	Dr. Chandresh Vora (Ahmedabad)	(A)

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GUJARAT STATE H.S.C. BOARD

Hardi	Dr. Narendra J. Thakkar (Patan)	99.50 % (A2)
Aashay	Dr. Amish Tank (Ahmedabad)	99.24% (A2)
Vidhi	Dr. Dinesh Modh (Ahmadabad)	98.63% (A2)

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DAYS TO BE OBSERVED

01st July	Doctors Day
11th July	World Population Day
20th July	World Youth Day

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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.

NEW LIFE MEMBERS

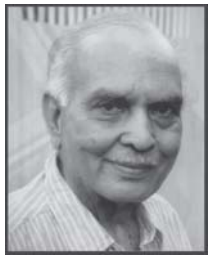
I.M.A. GUJARAT STATE BRANCH

We welcome our new members

L_M_No.	NAME	BRANCH
LM/24455	Dr. Mistry Jay Chandrakantbhai	Bilimora
LM/24456	Dr. Mangukiya Balkrushna I.	Bhavnagar
LM/24457	Dr. Ratho Mitali Vijaysinh	Valsad
LM/24458	Dr. Piprani Vasim Mohammadbhai	Radhanpur
LM/24459	Dr. Zanzmera Saket Niranjan	Surat
LM/24460	Dr. Variya Chetna Ravjibhai	Surat
LM/24461	Dr. Koladiya Nilesh Antubhai	Surat
LM/24462	Dr. Tejani Piyush Rameshbhai	Surat
LM/24463	Dr. Patel Parul Babubhai	Surat
LM/24464	Dr. Agarwal Ruchi Gopalkrishna	Surat
LM/24465	Dr. Gharia Meena Parimalsinh	Surat
LM/24466	Dr. Nayak Mehul Kiritkumar	Mehsana
LM/24467	Dr. Mehta Vikisha Navinchandra	Mehsana
LM/24468	Dr. Shaikh M.Muzaffar F.	Surat
LM/24469	Dr. Yadav Harsh Girishkumar	Rajkot
LM/24470	Dr. Yadav Khushboo Harshbhai	Rajkot
LM/24471	Dr. Morjaria Kartik Sureshbhai	Rajkot
LM/24472	Dr. Rokad Milan Jivrajbhai	Rajkot
LM/24473	Dr. Darji Siddharth Ramanlal	Palanpur
LM/24474	Dr. Gulamali Duraiya Akbarbhai	Dahod
LM/24475	Dr. Shah Darshak Sharadchandra	Anand
LM/24476	Dr. Sheladia Chetan Jerambhai	Surat
LM/24477	Dr. Kumar Kundan Saryoo Prasad	Patan
LM/24478	Dr. Bhutak Laxdeep Ashokkumar	Mahuva
LM/24479	Dr. Raval Jayman Bhupendrabhai	Vadodara

LM/24480	Dr. Nayak Suhani Saumyakumar	Vadodara
LM/24481	Dr. Soni Rishit Jayeshbhai	Vadodara
LM/24482	Dr. Santosh Suman	Vadodara
LM/24483	Dr. Patel Amit Thakorbhai	Vadodara
LM/24484	Dr. Panchal Hitanshu R.	Vadodara
LM/24485	Dr. Panchal Maitri Hitanshu	Vadodara
LM/24486	Dr. Sachchida Nand Sitaram	Amreli
LM/24487	Dr. Chaudhary Chirag Bhagvan	Mehsana
LM/24488	Dr. Ramani Prashant Nitinbhai	Dhoraji
LM/24889	Dr. Lalwani Nisha Shrichand	Bhavnagar
LM/24490	Dr. Singh Ankita Shyamsingh	Nadiad
LM/24491	Dr. Ganvit Ketan Rameshbhai	Navsari
LM/24492	Dr. Chariwala Rohan Arvindbhai	Mandvi
LM/24493	Dr. Parikh Hardik Rashmikant	Ahmedabad
LM/24494	Dr. Patel Mehul Pravinbhai	Ahmedabad
LM/24495	Dr. Kawad Kishor Dhanjibhai	Ahmedabad
LM/24496	Dr. Kawad Pravina Kishorbhai	Ahmedabad
LM/24497	Dr. Shah Aneesh Ajaykumar	Ahmedabad
LM/24498	Dr. Shah Ruchi Aneeshbhai	Ahmedabad
LM/24499	Dr. Shah Kushal Pareshkumar	Ahmedabad
LM/24500	Dr. Patel Tejal Lalitkumar	Ahmedabad
LM/24501	Dr. Thakkar Viral Madhusudan	Ahmedabad
LM/24502	Dr. Karamchandani Jitendra C.	Ahmedabad
LM/24503	Dr. Shah Khanjan Chandrakant	Ahmedabad
LM/24504	Dr. Patel Reeny Bharatbhai	Ahmedabad
LM/24505	Dr. Dhar Shweta Utpalbhai	Ahmedabad
LM/24506	Dr. Solanki Rashesh Prakash	Ahmedabad
LM/24507	Dr. Solanki Rachana Rashesh	Ahmedabad
LM/24508	Dr. Bhambhani Varsha Govardhan	Ahmedabad
LM/24509	Dr. Shah Milap Kamleshbhai	Ahmedabad

OBITUARY



Dr. K. K. Shah

MBBS, MS

(11/01/1933 - 28/05/2015)

Public, Professional and Social Appointments

- National President of Indian Medical Association (1987-88)
- President, Indian Medical Association, Gujarat State Branch (1985-86)
- President, Ahmedabad Medical Association (1981-82)
- He started "Social Security Scheme in Gujarat for Doctors fraternity and their family.
- Recipient of prestigious Dr. B. C. Roy award.
- President of 'HINSA VIRODHAK SANGH' to save animals.
- C. S. Thakkar Orations award, J.D.PCI award, from Ranbaxy Guajrat surgical Association.
- Chairman, Family Welfare Committee.
- Municipal Corporator, Ahmedabad Municipal Corporation, Ahmedabad for 10 years.
- Member Senate, Saurastra University.
- Professor, N.H.L. Medical College.
- President, South Asia Medical Association.
- Founder President of N.S.S.S.

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We send our sympathy & condolence to the bereaved family

Dr. Chandnani Bhagwan G. 09-04-2015 Ahmedabad

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

COMMUNITY SERVICE

ANAND

01-05-2015	Anand Branch has started a section of Drug Alert
05-05-2015	"World Asthma Day "
08-05-2015	"World Thalassemia Day"

BHAVNAGAR

31-05-2015	"World No Tobacco Day" Dr. M. R. Kanani; National Vice-President IMA HQs. has flaged off the oncocyclothone in presence of Dr. P.R. Jha, Dean, Govt. Medical College.

JAMNAGAR

10-05-2015	"World Asthma Day" (7th May) and "World Thalassemia Day" (8th May) It aimed to generate awareness amongst the people that if care is taken Asthama and Thalassemia can be controlled. It also covered the generation of clean city and Swachchh Bharat. For this the rally consisted of specially designed banners and a team of doctors who went on explaining the details to the approaching masses.
12-05-2015	Nursing Day Celebration Aim – To celebrate the Nursing Day Details – IMA Jamnagar offered regular health checkup of the nursing staff by the IMA members and provide them Lab investigations and vaccine for Cervical Cancer cost to cost.
23-05-2015	Health Mela organized by Govt. of Gujarat Health Awareness generation Initiative joined the celebration of Government's launch of health projects
14-06-2015	Blood Donation Camp. Total 80 bottle were collected from medical students and donated to blood bank

JASDAN

10-05-2015	Dr. V.B. Kasundra and association with general practitioners organized a free camp for diabetes in Morbi District. Many patients with diabetes are given medicine and screening of diabetes done any some 15-20 newly diagnose patients of diabetes.
17-05-2015	"Free diagnostic & therapeutic camp" Specially for geriatric patient and Specially patients with diabetes's & hypertension and old aged patients provided with wooden sticks

JETPUR

31-05-2015 Blood Donation Camp. Total 50 bottles of blood were collected.

MORBI

24-05-2015 Mega camp for cerebral palsy and physically and mentally handicapped patients. Total 100 patients were benefitted.

31-05-2015 Lecture on diabetes and Insulin use by Dr. J.B. Patel and Dr. Chirag Aghara for general public. Total 290 patients were benefitted.

Awareness campaign against abuse of steroids – pamphlets distributed in 300 doctors' clinic alopathy, ayurvedic and homeopathic GP Doctors for Prevention of misuse of steroid combination

RAJKOT

17-05-2015 Medical diagnostic camp at Police Head quarters. The camp was successful due to the efforts of all the 10 consultants from various branches

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BRANCH ACTIVITY

AHMEDABAD

31-05-2015 "Vit-D Update" by Dr. Ramesh Goyal and Dr. Vivek Arya.

AMRELI

15-06-2015 "Journey of life" by Dr. Sanjay G. Shah

ANAND

28-05-2015 "Medico legal aspects of patient care" by Dr. Sanjay Gupta.

"Violence against Drs.-Action committee's Recommendations" by Dr. Parimal Salvi

JAMNAGAR

17-05-2015 C.M.E. on Asthma

"Basic Pathophysiology" by Dr. Bhadresh Vyas

"Diagnosis of Asthma" by Dr. Suresh Thaker

"Long term management" by Dr. Kamlesh Shah

"Management of acute attacks" by Dr. Chetan Dabhi

"Practical Demonstrations and case studies" by Dr. Maulik Shah

"Asthma in Adults " by Dr. Ami Oza and Dr. Toshniwal

14-06-2015 C.M.E. on Anemia

"Biochemical indices for Anemia" by Dr. Bijoya Chatterjee

"Physiology & Biochemistry of Haemopoietic Factors" by Dr. Hardik Mahant

"Physiology & Biochemistry of Iron Metabolism" by Dr. Amit Kakaiya

"Pharmacotherapy in anemia " by Dr. Jayesh Waghela

"Pathophysiology of anemia" by Dr. J.R. Joshi

"Anemia in Children" by Dr. Sonal Mehta

"Anemia in Adults" by Dr. Hemang Acharya

"Anemia in pregnancy" by Dr. Heenaben Patel

"Anemia in oncology" by Dr. Bhargav Trivedi

JETPUR

02-05-2015 "Arthritis and its management" by Dr. Umang Shihora

01-03-2015 Sarva Rog Nidan Camp at Thorala Village

03-03-2015 "Controlling Hyperglycemia" by Dr. Sanjay Kyada

21-03-2015 "Safely transporting patient with shock" by Dr. Vanzara

25-03-2015 "Insulin in type-2 diabetes" by Dr. Pratap Jethwani

28-03-2015 "Sleep apnea syndrome" by Dr. Jayesh Dobariya

22-04-2015 "Stress-where we stand" ? by Dr. J.K. Nanavati

25-04-2015 "Malaria Updates" by Dr. Bhavin Faldu

02-05-2015 "Arthritis and its management" by Dr. Umang Shihora

KALOL

01-05-2015 "Interventional Radiology in Management of Medical & Surgical Emergencies" by Dr. Milan Jolapara.

"Role of IVUS in Coronary Interventions" by Dr. Bhavesh Roy

20-05-2015 "Role of Laparoscopy in Women's Health" by Dr. Mehul Sukhadiya

"Choti-Choti Batein in ENT Surgery" by Dr. Vinod Shah.

MORBI

09-05-2015 "Bariatric Surgery and out come" by Dr. Digvijay sinh Bedi

"Doctor Patient Relationship" by Dr. J.S. Bhadesiya

PALITANA

06-06-2015 "Urolithiasis" by Dr. Arvind Thanthvaliya

"Back Pain" by Dr. Suresh Parmar

17-06-2015 "Obstructive Sleep Apnoea" by Dr. Rajesh Ranglani

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

- AFAC Notice No. 17 will be collected from 15-6-2015 to 15-7-2015.
- Please send your Cheque/D.D. according to the column "Total Amount Payable" in AFAC Notice No. 17.

✻ **DO NOT DEPOSIT CHEQUE IN AXIS BANK / ATM DROPBOX**

✻ **THIS TIME SEND THE MULTICITY CHEQUE/AT PAR CHEQUE/ DEMAND DRAFT AT AHMEDABAD OFFICE**

Member who joins the scheme will get the benefit of the following diseases after completion of one year membership

1. **Coronary Heart Disease Group:** Angioplasty, by-pass surgery & valvular heart diseases surgery, permanent pace-maker implant.
2. **Kidney Disease Group:** Haemodialysis, Renal Transplant.
3. **Cancer Group** [All Cancers, except carcinoma in SITU]
4. **Brain Tumors Group**
5. **Joint Replacement Group:** Surgery for Total Knee and Total Hip Joints only : Member above 40 years of age at the time of joining the scheme, can get the above benefit after 7 years of joining the scheme.
6. **Brain Haemorrhage confirmed by CT Brain or MRI.**

Dr. Navnit Patel
Chairman

Dr. Abhay Dikshit
Hon. Secretary

IMA AKN SINHA INSTITUTE (HQs.)

OF CONTINUING MEDICAL & HEALTH EDUCATION AND RESEARCH
IMA Building, Dr. A.K.N. Sinha Path, South East Gandhi Maidan, Patna-800 004
Fax & Ph. No.: 0612-2320539, Email : aknsi01@yahoo.com
Website : www.imaaknsi.org

Dr. A. Marthanda Pillai
National President

Dr. K. K. Aggarwal
Hony. Scretary General

Dr. Arbind Kumar Sinha
Hony. Executive Secretary

Dr. Dillip Kr. Acharya
Hony. Director

Join Post Graduate Certificate courses

EXISTING COURSES (Postal Mode)

Duration of courses :- Minimum duration to complete the courses is 6 months and maximum recommended duration is 2 years. The courses have been granted CME Credit hours as given below :-

1.	Paediatrics	180	9.	Environmental & Occupational Health	150
2.	T.B. & Chest Diseases	100	10.	Reproductive & Child Health	80
3.	Adolescent Health	75	11.	Psychiatry & Psycho-sexual Medicine	100
4.	Geriatric Medicine (Revised)	190	12.	Medical Negligence & CPA	45
5.	Lactation Management	90	13.	Clinical Diabetes	100
6.	HIV/AIDS & STDs Management	135	14.	Clinical Cardiology	100
7.	Family Planning	110	15.	Rheumatology	100
8.	Torture Medicine	85	16.	Radiology (Radio-diagnosis)	100

Forthcoming Courses : ECG, Skin Care, Hospital Management, Clinical Pathology *All Courses are Indian Medical Association approved & recognized having authenticated CME Credit hours.*

Eligibility : MBBS and above

Information : *For information brochure and enrollment form send a self addressed envelope with Rs. 20/- stamp to* ***IMA AKN Slnha Institute, IMA Building, South East Gandhi Maidan, Dr. AKN Sinha Path, Patna-800 004, Bihar.***

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IMA AKNSI Office No.: ***0612-2320539***

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ATTENTION PLEASE !!

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LM/15381	Dr. Gupta Ajayshankar Ramjilal	Porbandar
LM/15382	Dr. Gupta Poonam Ajayshankar	Porbandar
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LM/22679	Dr. Jadav Ketan Yashvantrao	Vyara
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LM/16757	Dr. Singh Deepti Umeshbhai	Dadra-Nagar
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LM/13898	Dr. Shah Rakhee Nirajbhai	Vadodara
LM/02069	Dr. Shah Rashmikant Shantlal	Ahmedabad
LM/02070	Dr. Shah S.R.	Ahmedabad
LM/19595	Dr. Shah Siddharth Arvindbhai	Anand
LM/19596	Dr. Shah Diva Siddharthbhai	Anand
LM/21995	Dr. Sharma Deepakkumar Balram	Anand
LM/19143	Dr. Thacker Mandakinee A	Bhujkutch
LM/17982	Dr. Thakkar Rajeshkumar C	Deesa
LM/08355	Dr. Trivedi Leelaben B.	Ahmedabad
LM/20382	Dr. Varia Dushyant Jayantkumar	Bharuch

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 May -2015 in addition to their routine work. These are as under :

01-05-2015 to 31-05-2015 : Intra domestic house to house survey by the centers of Ahmedabad

22-05-2015 Sarvrog Nidan Camp at Rajkot center

11-05-2015 - Free Medical Camp in different wards of Ahmedabad.

Rander - Surat : Mothers - Iron : 2360 tables, Children - Calcium 1000 tablets were distributed & Vitamin A solution 20 children.

Nanpura - Surat : Mothers - Iron : 1500 tables, Children - Calcium 3000 tablets were distributed & Vitamin A Solution : 25 Children.

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

MAY - 2015

No.	Name of Center		New Case	Old Case	Total Case
(1)	Ambawadi	(Jamalpur Ward)	812	378	1190
(2)	Behrampura	(Sardarnagar Ward)	1035	192	1227
(3)	Bapunagar	(Potalia Ward)	1412	492	1904
(4)	Dariyapur	(Isanpur Ward)	700	130	830
(5)	Gomtipur	(Saijpur Ward)	1334	327	1661
(6)	Khokhra	(Amraiwadi Ward)	1960	365	2325
(7)	New Mental	(Kubernagar Ward)	390	94	484
(8)	Raikhad	(Stadium Ward)	338	109	447
(9)	Wadaj	(Junawadaj Ward)	626	138	764
(10)	Khambhat		—	—	—
(11)	Junagadh		----	----	----
(12)	Rander-Surat		----	----	----
(13)	Nanpur-Surat		----	----	----
(14)	Rajkot		911	955	1866

MAY - 2015

No.	Name of Center	Female Sterilisation	Male Sterilisation	Copper-T	Condoms (PCS)	Ocpills
(1)	Ambawadi (Jamalpur Ward)	10	—	21	1260	340P
(2)	Behrampura (Sardarnagar Ward)	19	---	43	6300	1220
(3)	Bapunagar (Potalia Ward)	46	---	60	16560	476
(4)	Dariyapur (Isanpur Ward)	20	—	30	3000	1045P
(5)	Gomtipur (Saijpur Ward)	24	---	29	26750	978
(6)	Khokhra (Amraiwadi Ward)	35	---	49	8500	170
(7)	New Mental (Kubernagar Ward)	30	---	24	7470	258
(8)	Raikhad (Stadium Ward)	37	---	40	11720	531P
(9)	Wadaj (Junawadaj Ward)	07	—	41	13000	1625
(10)	Khambhat	—	—	12	370	15
(11)	Junagadh	23	—	55	2000	246
(12)	Rander-Surat	11	—	24	2200	45P
(13)	Nanpura-Surat	24	—	33	2500	105P
(14)	Rajkot	15	-1	43	300	238

Dr. Bidhan Chandra Roy

Birth Date : July 1, 1882
Born in : Bankipore, Patna, Bihar, India
Died on : July 1, 1962
Career : Physician, Politician

Dr Bidhan Chandra Roy, one of the very few people who are talented enough to acquire both the M.R.C.P. and F.R.C.S. degrees, was an eminent physician, one of the most important freedom fighters for India and also the second Chief Minister of West Bengal. Bidhan Chandra Roy led a very eventful life during which he excelled in each profession he had taken up. In addition, Dr Bidhan Chandra Roy also laid the foundation stone of cities Bidhannagar and Kalyani in West Bengal. After his flourishing terms as a part of the alumni of the Calcutta Medical College and as the Vice Chancellor of Calcutta University, Bidhan Chandra Roy entered into active politics and subsequently was elected the Chief Minister of West Bengal, a post that he held till his death. Dr Bidhan Chandra Roy is fondly remembered through the celebration of the National Doctor's Day on July 1 (his birth and death day) every year.

Childhood and Education

Bidhan Chandra Roy was born on July 1, 1882 in the Bankipore region of Patna, Bihar. He was the youngest of the five children of his parents. Bidhan Chandra Roy's mother died when he was 14 years of age and it was his father who took over the reins of the family. Since his father had to remain outdoors for his work as an excise inspector, the five siblings had to share responsibility of all household work.

After completing his graduation in Mathematics, Bidhan Chandra Roy applied for admission in both Bengal Engineering College and Calcutta Medical College. Being academically competent, he successfully qualified both but chose to pursue medical studies. Life at the Calcutta Medical College was very difficult for the future physician. Not only was there the pressure of studies, he also had to earn enough money to support himself in the city as his father was no longer in service. It was during his study years at

the Calcutta Medical College that the Partition of Bengal was announced. Though the freedom fighter in Bidhan Chandra Roy wanted to be a part of the state's struggle, he convinced himself that studies were more important than any other activity at that point of time in life.

Career

Dr Bidhan Chandra Roy joined the Provincial Health Service after his studies at Calcutta Medical College were over. While he was appointed as a doctor, B. C. Roy also lent a helping hand as a nurse whenever he had the time. Additionally, he even established a private practice to earn extra money. In February 1909, Bidhan Chandra Roy left for England to continue further medical studies at St Bartholomew's Hospital in London. But the Dean at the hospital did not want to accept the application of an Asian. Unwilling to return defeated, Bidhan Chandra Roy submitted the same application thirty times, before the authorities at St Bartholomew's Hospital finally relented and allowed him to take admission. By the year 1911, Bidhan Chandra Roy had completed both his M.R.C.P. and F.R.C.S. degrees in a span of only two years and three months, a rare achievement. He returned to India in the year 1911 to join as faculty of Calcutta Medical College, subsequently shifting to the Campbell Medical School and then the Carmichael Medical College.

Right from his childhood days, Bidhan Chandra Roy had learnt about social service from his father. Therefore as a doctor too, he worked for the common man by donating large sums of money towards the establishment of medical colleges which would provide both medical education and medical aid to people. Several medical institutions in Calcutta, like the Jadavpur T.B. Hospital, the R.G. Kar Medical College, the Chittaranjan Seva Sadan, the Chittaranjan Cancer Hospital, the Victoria Institution and the Kamala Nehru Hospital were set up by Bidhan Chandra Roy. Bidhan Chandra Roy entered politics in the year 1925. He contested elections from Barrackpore constituency of the Bengal legislative council and won against popular opponent Surendranath Banerjee.

In the year 1928, Bidhan Chandra Roy was elected to the All India Congress Committee. He became the leader of the Civil Disobedience Movement in Bengal in the year 1929 when he coaxed Pandit Motilal Nehru to nominate him a member of the CWC. Bidhan Chandra Roy's involvement with the CWC brought improvements in education, introduced free medical services and led to the establishment of grant in aid hospitals, charitable dispensaries, good roads and better water and electricity supply.

He was instrumental in starting the Indian Medical Association in 1928 and making it the largest professional organisation in the country. He served the association in various capacities including as national president for two terms. The Medical Council of India

was his creation and he was its first president in 1939, a position he held till 1945. He played a key role in establishing the Indian Institute of Mental Health, the Infectious Disease Hospital and the first-ever postgraduate medical college in Kolkata.

In the year 1942, Bidhan Chandra Roy was elected as the Vice Chancellor of the University of Calcutta. It was during his term that the Japanese bombings in Rangoon took place, leading to a revolution in Calcutta too. Bidhan Chandra Roy was of the belief that education should not suffer as the more educated the youth, the better they can serve their country. Keeping this principle in mind, B C Roy made special air-raid shelters for students and teachers for classes to be held even at a time of war. He also conducted relief activities for the suffering.

Chief Minister

Dr Bidhan Chandra Roy's name was proposed by the Congress for the post of the Chief Minister of West Bengal. However, Bidhan Chandra Roy himself never wanted to assume office as the Bengal CM as he wanted to remain dedicated to his profession as a physician, a position he thought would be jeopardized if he assumes such an important office in politics. It was on the insistence of Mahatma Gandhi that Bidhan Chandra Roy agreed to become the Chief Minister of West Bengal and was elected to the position on January 23, 1948. His 14 years as the second West Bengal CM was immensely successful. Bidhan Chandra Roy was instrumental in seeing the end to violence and food and job shortages in the state following the creation of East Pakistan. Though he entered into active politics, Bidhan Chandra Roy never forgot the value of education in one's life. According to him, only education could pave the way to a good and resourceful human being.

Death

Dr Bidhan Chandra Roy died on July 1, 1962 a little while after he had completed his daily activities of treating patients who visited him during early hours of the morning and also going over political matters of West Bengal.

Honors

In recognition of his immense services to the society, Dr Bidhan Chandra Roy was awarded the highest civilian award, the Bharat Ratna by the government of India on February 4, 1961. Dr Bidhan Chandra Roy's residence was converted into a nursing home named after his mother Aghorkamini Devi. The government of India set up the Dr B C Roy Memorial Library and Reading Room for Children in the Children's Book Trust in New Delhi in the year 1967. The B C Roy National Award was also started in the year 1976 to celebrate the contributions of individuals in the fields of medicine, politics, science, philosophy, arts and literature.

QUIZ

(૧) પદ્મશ્રી, પદ્મભૂષણ, પદ્મવિભૂષણ, ભારતરત્ન, દાદા સાહેબ ફાળકે એવોર્ડ, ઓસ્કાર, ઘણા બધા ડી-લીટ તથા ડોકટરેટ એવોર્ડ મેળવનાર મહાનુભાવ કોણ હતા ?
(a) ડૉ.એ.પી.જે.કલામ (b) સત્યજીત રે (c) લત્તા મંગેશકર (d) વિશ્વનાથ આનંદ

(૨) શશાંક એટલે કયા પ્રાણીનું મુખ ?
(a) કુતરું (b) ઘોડો (c) બકરી (d) સસલું

(૩) રાજ કપૂર, રાજેન્દ્રકુમાર તથા દિલીપકુમાર હાલના કયા દેશમાં જન્મ્યા હતા ?
(a) શ્રીલંકા (b) પાકિસ્તાન (c) બાંગ્લાદેશ (d) નેપાળ

(૪) નીચેનામાંથી ક્યો દેશ ક્રિકેટમાં એક વખત વર્લ્ડકપ જીતી શકયો છે ?
(a) ઇંગ્લેન્ડ (b) ન્યુઝીલેન્ડ (c) સાઉથ આફ્રિકા (d) શ્રીલંકા

(૫) ભારતના યુદ્ધ કાફલામાં 'રાફેલ' શું છે ?
(a) સબમરીન (b) યુદ્ધ જહાજ (c) તોપ (d) લડાકુ વિમાન

(૬) ૧ પાઉન્ડ એટલે આશરે કેટલા ગ્રામથાય ?
(a) ૨૫૦ (b) ૪૫૦ (c) ૬૦૦ (d) ૭૫૦

(૭) વર્લ્ડ હેરિટેજમાં ગુજરાતના કયા શહેરને ગણતરીમાં લેવામાં આવ્યું છે ?
(a) પોરબંદર (b) ચાંપાનેર (c) પાટણ (d) જામનગર

(૮) ભારત ક્રિકેટમાં વર્લ્ડકપ ૧૯૮૩માં જીત્યું હતું ત્યારે આપણી ટીમનો ૧૨મો ખેલાડી કોણ હતો ? કમનસીબે તે એક પણ વન-ડે માં રમી શક્યો ન હતો ?
(a) ચેતન ચૌહાણ (b) દિલીપ દોશી (c) અશોક માંકડ (d) સુનીલ વાલ્સન

(૯) ટાઈમ મેગેઝીને ૨૦૦૫માં આપેલા અભિપ્રાય પ્રમાણે દુનિયાની ૧૦૦ ઉત્કૃષ્ઠ શ્રેષ્ઠ ફિલ્મોમાં ભારતની કઈ ફિલ્મસમાવી શકાય ?
(a) લગાન (b) શોલે (c) પ્યાસા (d) મધર ઈન્ડિયા

(૧૦) પ્રેમના પ્રતિક એવા ગુલાબના છોડનું ભારતમાં આગમન કયા મુઘલ રાજા દ્વારા થયું હતું ?
(a) બાબર (b) અકબર (c) હુમાયુ (d) શાહજહાં

ડો. આશિષ ચોકસી, D. Ped., મેમનગર, અમદાવાદ

Ans = 1 (b), 2 (d), 3 (b), 4 (d), 5 (d), 6 (b), 7 (b), 8 (d), 9 (c), 10 (a)

Management of cases of Child Sexual Abuse

Physical Treatment of Child Sexual Abuse

Under Rule 5 of the POCSO act, emergency medical care is to be provided by any medical facility, private or public; and no magisterial requisition or other document is to be demanded as a precondition to providing emergency medical care. Such care includes treatment for cuts, bruises, and other injuries including genital injuries, if any;

Inpatient care is recommended if the child's safety is in jeopardy or if the child has an acute traumatic injury requiring inpatient treatment.

Antimicrobial therapy should be initiated in prepubertal children based on the results of laboratory testing. Because nausea is a common side effect, antiemetics may also be prescribed.

Pregnancy and STDs in sexually abused children

- Pregnancy test should be done on girls 11 years and older, and on any girl who has either had any menstrual periods, or who has breast development or pubic hair.
- Urine test is as sensitive and accurate as blood test, and easier for patient
- The doctor must provide information about emergency contraception, and, unless medically contraindicated, offer emergency contraception.
- Emergency contraception (EC) should be offered when "
  - There may have been semen to vulvar or vaginal contact within the previous 5 days AND
  - The patient is post-menarchal.
- Legally, the child can provide consent and must be given an assurance of confidentiality for reproductive health care. The patient must provide informed consent.
- If the patient is not able to give informed consent, consent must be obtained from parents, guardian, or surrogate decision-maker
- Routine testing for all STDs in children has a very low yield. Therefore, testing is only recommended when:
  - there is a clear report of genital to genital or genital to anal contact with a teen

  - or adult OR
  - there are signs of disease, specifically vaginal or urethral discharge, or genital ulcers OR
  - there is a positive diagnosis of another sexually transmitted disease.
- In all cases, follow-up for lab results must be arranged. Prophylactic treatment of STDs should not be given to children, as it may compromise assessment and conclusions about abuse or assault. Treatment should be initiated only after confirmation of infection.

Discharge Instructions

- Discuss medical findings
- Explain tests results if any, which were obtained
- Explain follow-up for medical test results
- Explain if police or any other authority will be contacted by medical provider, as required by law
- Assess support systems and immediate safety of child
- Offer patient education materials, if available
- Give written discharge instructions
- Make suitable referrals for mental health care

Role of Mental Health Professionals

- **Assessment of Lethality**: Usually victims of sexual abuse are vulnerable to considerable psychological distress and hence may tend towards self-harming behavior. Such indicators should be duly noted by professionals not only for warning family members but also in providing immediate help to the child regarding this.
- **Catharsis:** Help the child narrate the incident and undergo complete catharsis to reduce the burden of trauma. Also provide help in handling range of emotional conflicts experienced.
- **Psychological Debriefing:** this is done by providing emotional and psychological support to the child following trauma to prevent development of PTSD and other forms of negative sequelae.

- **Normalize the Feelings of Victim:** let the child know that it's absolutely okay to feel the way he or she is feeling. This helps to validate the child's feelings and unconditionally support them. This will also encourage them to emotionally express themselves completely.
- **Instilling Hope:** It is important to instill hope and attempt a positive resolution of the traumatic experiences of child. This also helps in reducing obsessive deterioration of self-respect when child come to believe and trust that a change is possible.
- **Interviewing skills:** The mental health professional should ensure that the interview with the child adheres to the following guidelines:
  - To begin interviewing the child, it is important to create a safe therapeutic environment where the child feels accepted and validated in herself/himself.
  - The session flows with the child's expression of inner feelings.
  - Assessment of Psycho-social Issues: it is important to take a detailed history of the family background with specific emphasis on parental practices and type of family interactions. This helps in assessing any dysfunctional family boundaries and communication pattern which may be responsible or have contributed for CSA.
  - An assessment of the child's relative strengths and weaknesses may be significant for further building one's coping strategy in therapy
  - Enquiry should be done in gentle, casual, non-confrontational and non-threatening manner
  - Provide an assurance of safety, security and confidentiality to the child as otherwise the child's fear of further harm consequent to disclosure would impede revelation.
  - Validate and affirm that she/he did the right thing to reveal the truth
  - Avoid barging the child with too many questions
  - Avoiding trying to gather all the information in one session itself and thereby unnecessarily pressurizing the child.

Myths and misconceptions about child sex abuse

- The abuser is usually a stranger: In most cases, the abuser is a person known to the child. The people most likely to abuse a child are the ones with the most opportunity, most access, and most trust.
- Incest, i.e. sexual abuse by a person related to the child, is not common amongst well-educated or well-off people: Incest happens in all kinds of families, including families like ours. It does not depend on class, socio-economic status, education, etc.
- Sexual abuse never happened and the child is making it up or exaggerating: Children rarely make up stories about things that traumatise them. In fact, research shows that children often minimize and deny, rather than embellish what has happened to them.
- No damage is done by the abuse unless the child is visibly physically harmed: Some acts, like fondling and oral sex, leave no physical traces. Even if the child has not been physically abused, any kind of sexual abuse causes psychological trauma to the child.
- Many children do not reveal sexual abuse because they are enjoying it: The reason children do not report it is because they are afraid, ashamed, or have been bribed or threatened.
- He looks normal and acts normal, so he can't be a child molester: Sex offenders are knowledgeable about the importance of their public image, and can hide their private behaviour from their friends, neighbours, colleagues, and even their own family members. Some child molesters appear to be charming, socially responsible, caring, compassionate, morally sound, and sincere and parents and other responsible adults trust these individuals.
- Child molesters molest indiscriminately: N ot e veryone w ho c omes i n c ontact with a child molester will be abused. Sex offenders tend to carefully pick and set up their victims by "grooming" in which the perpetrator skilfully manipulates the child into participating.
- A child says that they have been sexually assaulted and then later says that it didn't really happen. This clearly means that they are lying: Children may retract an allegation because of enormous pressure placed on them to make it go away. Disbelieving adults give the child the idea that if they say it was a lie things will return to normal. However an offender will not stop abusing and often becomes more aggressive knowing that if the child says something again people will not believe them.

- The victim is always a girl: Just as women can be sex offenders, boys may be victims of abuse. Unfortunately, child sexual abuse with male victims is underreported due to social and cultural attitudes: boys are taught to fight back and not let others see vulnerability. Boys are aware at an early age of the social stigma attached to sexual assault by another male, and fear appearing weak to others. All of these attitudes make male child victims less likely to tell of their abuse.
- Children are abused because their parents have neglectful style of parenting and fail to supervise their child properly. T hough s ometimes a bsence o f s ex e ducation i n childhood makes a child an easy traps, however, usually offenders are quite tactful in manipulating both the caregivers and the child and they are to be essentially blamed for.
- Sexual abuse victims are "damaged goods" and their lives are ruined forever: While sexual abuse is incredibly damaging, victims are not "damaged goods." Healing is easiest when the intervention is immediate and appropriate therapy is provided. For adults who have repressed memories, the recovery process can be lengthy. However, all victims of abuse can become fully functioning, healthy children and adults.

- Courtesy : UNICEF

NEWS CLIP (CSA Workshop)

CITY

IMA moots free treatment for child abuse survivors

TIMES NEWS NETWORK

Ahmedabad: The Indian Medical Association (IMA) is going to issue a white paper on child sexual abuse, asking private hospitals to provide free treatment and counselling to survivors.

"Private hospitals have to provide free treatment to victims and counsel them at every level. Besides mandatory reporting to the police, every doctor is expected to offer mental assessment and counselling in cases of rape trauma syndrome and child sexual abuse accommodation syndrome. In rare cases, doctors should also provide rehabilitation," IMA secretary general Dr K K Aggarwal said.

Addressing a symposium on child sexual abuse, held in association with Unicef, he said that it is the duty of every doctor to ask such patients to come for a follow-up.

The paper will also bust several myths about child sexual abuse. "There is a misconception that the abuser is always a stranger, but abuser is mostly known to the victim. Another misconception is the child exaggerates the incident or sexual abuse is not common among well-off people," he said.

Dr Aggarwal said the paper will also list the limitations of POSCO Act. "The act has raised the age of consent from 16 to 18 years without considering scientific evidence on adolescent sexuality. Children involved in sexual activity will be treated as juveniles in conflict with the law.

Maggi row: Focus on lead content

Indian Medical Association (IMA) has written to the Centre, saying banning Maggi for one month will not solve the issue. It has asked the government to investigate the reason behind high lead content in the product. "Amid growing debate on harmful effects of ajinomoto or MSG in Maggi, we want the Centre to focus on lead. Everybody isn't allergic to ajinomoto, but lead is bad for all. Lead is absorbed at a faster rate in kids, which causes more physical harm," said IMA secretary general Dr K K Aggarwal. TNN

Thumbs up to prescriptions in capital letters

IMA secretary general Dr K K Aggarwal on Sunday hailed the Medical Council of India's (MCI) decision to make it mandatory for doctors to write the names of the drugs in capital letters while giving prescriptions.

"It is a welcome development. We don't have any objection to it. I don't think I have ever received a prescription from a doctor that can be read easily by a literate person," he said.

He said once the prescription is written in capital letters and is legible, it will hugely benefit patients as well as chemists who will have a clarity of the drug and it will also take away the fear of misinterpretation. TNN

'Care for child abuse must be timed right'

Doctors say at IMA workshop held on Sunday

dna correspondent
@dnaahmedabad

Children, the future of our country, remain vulnerable, both due to their inability to protect themselves, and also due to lack of awareness about child sexual abuse and courses of remedial action. To address the issue, the Indian Medical Association (IMA), Gujarat, held a regional workshop on Sunday in Ahmedabad. More than 140 doctors attended the workshop on 'Child Sexual Abuse – Prevention and Response'.

"India has the largest child population in the world. There's a steady increase in sexual crimes against children", said Dr Chetan Patel, president, IMA, Gujarat.

"As health professionals we are often the first point of contact with abused children and their families", added Patel.

The workshop was on little discussed topics on child sex abuse along with recently adopted law by India – The Protection of Children from Sexual Offences Act (POCSO), 2012.

Talking about care, Dr KK Aggarwal honorary general secretary of IMA said, "The mental impact of sexual violence can be severe with child victims often having to find to ways to cope in isolation. It is a must that the right kinds of intervention be provided at the right time."

Doctors of IMA, Gujarat at Sunday's workshop on 'Child Sexual Abuse – Prevention and Response' —Gargi Raval.dna

AhmedabadMirror | MONDAY, JUNE 15, 2015 | 9

Maggi noodles controversy

Find source of lead: IMA

Health ministry forms panel to probe source of lead after IMA sought thorough probe

Ahmedabad Mirror Bureau
amfeedback@timesgroup.in
Tweets @ahmedabadmirror

The union health ministry has ordered formation of a committee involving ministry officials as well as members of Indian Medical Association and Medical Council of India to investigate the Maggi noodles controversy. This step was taken after IMA wrote a letter to the ministry, seeking thorough probe in the matter.

After talking to Maggi manufacturers, IMA claims to have identified five sources that could have led to higher concentration of lead. "Lead could have gotten into the product through water, wheat, masala, turmeric and packaging," said IMA Secretary-General K K Aggarwal. He was in the city to attend a seminar on child sexual abuse that IMA had organised with UNICEF.

Lead could have gotten into the product through five sources: water, wheat, masala, turmeric and packaging. It is important to fix the source so we can prevent this from happening again

K K AGGRAWAL
IMA secretary general

According to experts, the level mono sodium glutamate (MSG) can be controlled as it is an additional content provided in making Maggi noodles, but the government has been unable to trace the source of lead. "Without knowing the source of lead, how will they control it?" he asked.

In another development, IMA has sent a notice to the health ministry expressing their opposition to the proposal that MBBS graduates could practise only if they cleared an exit exam.

IMA alleged that the proposal itself shows that the government does not believe in its own exam system. Dr Aggrawal said, "MBBS graduates pass out after 5 long years of extensive studies. So the government is proving itself that it does not believe in its own system. Instead, there should be an entrance test to provide efficient parameters in selecting qualified doctors."

Dr R N Tandon of IMA said a doctor spends almost 15 years to become a specialist and adding another examination will delay their specialisation. "Rather than introducing more exams, government should focus on developing infrastructure," he added.

Regional Workshop (West Region) on "Child Sexual Abuse-Prevention & Response"

I.M.A.G.S.B. NEWS BULLETIN JUNE-2015 / MONTHLY NEWS

Regional Workshop (West Region) on "Child Sexual Abuse-Prevention & Response"

AMACON-2015 Ahmedabad Medical Association

* * * * *

CME on Anaemia Jamnagar Branch

"World Thalassemia Day" Anand Branch

* * * * *

"World No Tobacco Day" Onco Cyclothon Bhavnagar Branch

Mega Camp "Cerebral Palsy" Morbi Branch

* * * * *

Blood Donation Camp Jetpur Branch

IMA
NATIONAL PENSION SCHEME

For any Help :-

Dr. K. V. DEVADAS
Secretary, I.M.A., N.P.S.
Vysakham, M. O. Road, Kunnamkulam P. O.
Ph : 04885 227388 (O), 04885 222888 (R)
Mob : 9387107788, 9400567788
Email : drdevadaspalliative@gmail.com

IMA NATIONAL PENSION SCHEME

1. **Aims and objectives of IMA Pension Scheme**
   a. To provide monthly pension to medical practitioners (IMA Life Members) after the age of 60 years or at the age the member ask for. To provide financial assistance to the doctor at the time of crisis in life.
   b. To provide financial assistance for the marriage of daughter in badly needed cases.
   c. To extend financial hand for the education of children in times of financial crisis / disabled conditions of the IMA member.
   d. To support the activities of National IMA
2. **Eligibility for Membership**
   a. He / She has to be a life member of IMA.
   b. No upper age limit.
   c. Monthly pension starts when the member becomes 60 years or at an age above 60 years as he desires.
3. **Admission Fee.**

Below	30 years	-	Rs. 3000/-
	30 - 35	-	Rs. 4000/-
	36 - 40	-	Rs. 5000/-
	41 - 45	-	Rs. 6000/-
	Above 45	-	Rs. 7000/-

4. **Premium for the Scheme :-**
   Premium for the Scheme shall be paid every year; notice for this will be issued to the member 30 days before the due date.

PENSION SCHEME

A Rate of Interest	9%			
	A+Bx 5 Yrs		A+Bx 10 Yrs	
B Amount payment	Amount	Monthiy Pension	Amount	Monthiy Pension
12,000	78,280.01	587.10	1,98,723.52	1,490.43
25,000	1,63,083.36	1,223.13	4,14,007.33	3,105.06
50,000	3,26,166.73	2,446.25	8,28,014.67	6,210.11
100,000	6,52,333.46	4,892.50	16,56,029.34	12,420.22
200,000	13,04,666.91	9,785.00	33,12,058.68	24,840.44
500,000	32,61,667.28	24,462.50	82,80,146.70	62,101.10
1,000,000	65,23,334.56	48,925.01	1,65,60,293.39	1,24,202.20

5. Annual Fee.

a) Every member of the scheme shall pay Rs. 1000/- every year as annual fee. It will be divided as follows.
b) Rs. 300 to the Pension Scheme.
c) Rs. 200 to the National IMA
d) Rs. 200 to Education purpose of a child when a member becomes disabled and on request.
e) Rs. 300 for the purpose of marriage of a daughter when a member becomes disabled and on request.

6. Choice of 7 units pension premium is floated.

5a. Rs. 12,000 / year
5b. Rs. 25,000 / year
5c. Rs. 50,000 / year
5d. Rs. 1,00,000 / year
5e. Rs. 2,00,000 / year
5f. Rs. 5,00,000 / year
5g. Rs. 10,00,000 / year

7. Flexibility :

a. Member can step up the scheme from 5 (a) to 5(b), 5(c), 5(d), 5(e), 5(f) or 5 (g) after completion of 10 years.
b. He can also step down the next category from 5(g) to 5(f), 5(e), 5(d), 5(c) 5(b), 5(a) after 10 years.
c. A member can continue to be member of this Scheme and contribute to the Scheme up to the age of 60 years or further (at the discretion of the Managing Committee)
d. He may avail pension benefit after the age of 60 years or at an age above 60 years as he desire.
e. The pension amount depends upon the premium and interest accrued.
f. He can withdraw the whole amount or part thereof, in case of emergency with the permission of the Managing Committee.

JAI IMA JAI HIND

A+Bx 15 Yrs		A+Bx 20 Yrs		A+Bx 25 Yrs	
Amount	Monthly Pension	Amount	Monthiy Pension	Amount	Monthiy Pension
3,84,040.78	2,880.31	6,69,174.36	5,018.81	11,07,887.72	8,309.16
8,00,084.98	6,000.64	13,94,113.26	10,455.85	23,08,099.42	17,310.75
16,00,169.93	12,001.27	27,88,226.52	20,911.70	46,16,198.84	34,621.49
32,00,339.87	24,002.55	55,76,453.04	41,823.40	92,32,397.69	69,242.98
64,00,679.74	48,005.10	1,11,52,906.08	83,646.80	1,84,64,795.38	1,38,485.97
1,60,01,699.34	1,20,012.75	2,78,82,265.20	2,09,116.99	4,61,61,988.44	3,46,214.91
3,20,03,398.68	2,40,025.49	5,57,64,530.41	4,18,233.98	9,23,23,976.89	6,92,429.83

IMA NATIONAL PENSION SCHEME

INDIAN MEDICAL ASSOCIATION

APPLICATION FORM

(Read the instructions given overleaf, incomplete application from will be returned)

Please Use capital letters

E. No.
R. No.
Date

1. Name
2. Permanent Address
   District
   State N I P
   Phone Number MOB
3. Father's Name
4. Name of Spouse
5. Age DOB
6. Qualification Year Of Passing MBBS
   College
   University
7. Registration No R f O r a e Y
8. Name of Medical
9. Date of Joining IMA
10. Name of Local Branch
11. Name of State Branch
12. IMA Life Membership No
13. Schemes , If Any
14. Doucment Enclosed To Prove Age
15. Correspondence Address
    District
    State N I P
    Phone Number MOB
16. Email .....

Name of Nominee (s)	Relationship

DECLARATION

I, Dr. ..... aged .....Years hereby apply for the membership of the IMA National Pension Scheme, Indian Medical Association. I declare that I am not suffering from any terminal illness. I hereby declare that I am a Life, member of IMA through ..... local branch/state Branch continuous membership in IMA Since the year..... I further agree to abide by the rules and Bye-laws of IMA National Pension Scheme

Enclosed herewith D.D/ cheque for Rs..... of with Rs..... being the admission fee (payables per the age on admission) Rs 1000/- towards Annual FEE plus Annual premium subscription of Rs.....(Rs.12,000/- or any higher amount). I understand that my enrolment to the Scheme will be effective only after realization of the cheque / D.D and issuing of the policy document.

I do hereby declare that the above statements are true and that I have withheld no information whatsoever regarding the application and I agree to pay the amount demanded as per the constitution of this Scheme. I shall abide by all the future amendments of the bye-law of the scheme

Details of payment : Cheque ☐ D.D ☐ Core banking ☐

Cheque/D.D. No..... Bank.....

Date of application : ..... Signature of the applicant

NAME OF THE PROMOTER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Certificate from the Branch Secretary /President

I, Dr..... Secretary/ president, IMA ..... Branch do hereby certify Dr. ..... is a life member Of IMA ..... Local / State Branch and that he/she is having continuous membership in IMA since..... (year)

Signature

Date.....(Branch Seal) Secretary/ President, IMA Local Branch

I Membership of Pension Scheme

A. Admission fee

Below 30 years	Rs. 3000/-
30 -35	Rs. 4000/-
36 – 40	Rs. 5000/-
41 – 45	Rs. 6000/-
Above 45	Rs. 7000/-

B. Annual membership Rs. 1000/-

C. Annual Subscription Rs.12,000/-

Or any higher amount desired by the member of the Scheme.

Total to be paid at the time of admission : A+B+C

II Age proving document

III IMA Life Membership Certificate

NB : 1. Cheques or D.D are to be drawn in favour of IMA National Pension Scheme Payable at Kunnamkulam

2. For Out station Cheques/ D.D, Please add Rs 40/- Extra towards Bank Charge

IV. Eligibility of membership, any life member of IMA is eligible to become a member of Pension Scheme

V. Future yearly payment falls due in April

A. Annual membership Rs .1000/-

B. Annual Subscription Rs .12,000/- or any higher amount Total to be paid annually A+B

Completed proforma with necessary documents (II &III) and the required payments are to be sent to:

Dr. K. V Devadas
Hon. Secretary, IMA National Pension Scheme
Vysakham
Kunnamkulam P.O, Kerala State, 680503
Tel : 04885 222888,04885 227388,
Mob : 09387107788, 9400567788
Email:drdevadaspalliative@gmail.com

For Office Use Only

Date Of Applications ☐☐☐☐☐☐☐☐ Date of Receiving ☐☐☐☐☐☐☐☐

Date Of Enrolment ☐☐☐☐☐☐☐☐ Receipt No: ☐☐☐☐

Date ☐☐☐☐☐☐☐☐

VERIFICATION REPORT FROM IMA NATIONAL HEAD QUARTERS ☐ Life ☐ Annual

Non Member ☐ Cheque/DD Encashad : Yes / No/Repaid

Policy Sent on : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Signature

Secretary , Pension Scheme

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSIONNEW DELHI
FIRST APPEAL NO. 320 OF 2013

(Against the Order dated 01/04/2013 in Complaint No. 43/2012 of the State Commission Chandigarh)

1. Amit Sarkar & Anr.
   S/O. Sh. A.K. Sarkar, R/O. House No. 1922,
   Mauli Jagran Complex, Ut, Chandigarh, Punjab
2. Mrs. Konika Sarkar
   W/O. Sh. Amit Sarkar, R/O. House No. 1922,
   Mauli Jagran Complex,
   Ut, Chandigarh .....Appellant(S)

   Versus

1. Pgimer & 3 Ors.
   (Pgi), Through Its Medical
   Superintendent/Direector, Sector12,
   Chandigarh
   Punjab
2. Advanced Trauma Centre Of Post
   Graduate Institute Of Medical Education
   & Research (Pgi)
   Through Its Centre Incharge , Sector12,
   Chandigarh
3. Dr. Jujhar, Junior Resident, Orthopaedics,
   Atc, Post Graduate Institute Of Medical
   Education & Research (Pgi), Sector12,
   Chandigarh
   Punjab
4. Dr. Murali G. Senior Resident ,
   Department Of Forensic Medicine, Postgraduate
   Institute Of Medical Education
   & Research (Pgi), Sector12
   Chandigarh
   PUNJAB .....Respondent(s)

Complainant's submission:

Brief facts are, that only daughter of Complainants Ms. Anupama, aged about 16 years, studying in Class XI was travelling in a CTU bus on 17.07.2012 from her school to her residence. The bus was being driven rashly and negligently by the bus driver. It is stated, that in the absence of the conductor, she fell down from the bus and her left leg was crushed under the rear tyre of the same.

She was taken to Post Graduate Institute of Medical Education & Research, Chandigarh (for short, 'PGI') where she died on 24.07.2012, due to medical negligence. It is stated that injured Ms. Anupama was taken to Advance Trauma Centre of PGI (for short, 'ATC') by the police, where her left leg was bandaged by Dr. Jujhar, Junior Resident (OP No.3). It is alleged that bandaging was done in a most incompetent manner, as blood kept on oozing out.

It is further stated, that complainants were told that injured girl required an emergency operation which was being arranged by the Doctors concerned, whereas Xrays and other tests were carried out. It is alleged, that the required operation was never arranged and injured continued to suffer in excruciating pain, both mentally and physically. The condition of injured started deteriorating day by day, but no medical attention was given to her by PGI doctors, after the initial bandaging. So much so, even the bandage was not changed nor the wounds washed for days together, by ATC doctors..

The attitude of doctors on duty was most insensitive and opposed to the medical norms. Ultimately, it resulted in development of gangrene and septicemia and Opposite Party No.1Hospital amputated the left lower limb of Ms.Anupama, in a projected attempt to prevent the gangrene from spreading to other parts of the body. The doctors of Opposite Party No.1 failed to check or control the spread of gangrene, leading finally to the untimely death of Ms.Anupama on 24th July, 2012 at O.P. No.1Hospital.

It is further stated that O.P. No.1Hospital was taking the plea of overcrowding in its OTs. However, the precious life could have been saved even without operation, had adequate medical care and treatment been provided. The cause of infection and gangrene was because the dressings and bandages of the patient were never changed. The deep wounds were never washed hygienically and medical treatment prior to operation was not adequately provided. In case, O.P. No.1Hospital was unable to provide adequate and proper medical care to the patient, it should have referred her to some other Hospital, which also it failed to do. It is further alleged, that O.P. No.1–Hospital was deliberately keeping the treatment history and medical papers of the deceased under wraps, so that the same could be manipulated to their advantage and help them escape the charge of medical negligence and apathy.

Total compensation demanded was rupees 86 lakhs under different heads.

Respondent's Submission:

In their written statement, Opposite Parties No.1 to 4 denied that the bandage was done in an incompetent manner. According to them, the blood oozing from the dressing was because of the wound. It is denied that operation was never arranged. It is stated that as per record, Ms.Anupama was planned for surgery–debridgement external fixator at the time of admission. Complainants have themselves stated in their complaint, that on 18.07.2012, operational medicines and implant were ordered for the patient, which is indicative of the fact that the surgery was duly planned.

The Central Registration File (Cr File) shows, that patient was transfused blood. Due to heavy rush of the patients, she was taken up for surgery on the night of 19.07.2012, as on an average in those days were 80-90 patients admitted in the Department of Orthopedics in ATC against available 17 beds. Out of these 8 similar serious open fracture surgeries were pending. Out of two operation tables in the ATC, one was exclusively dedicated to these “serious open fracture surgeries” i.e. 50% of the available infrastructure. Ms.Anupama could not be given preference over those 8 patients, as it would have amounted to sacrificing

other 8 patients' interest. As it was, in spite of approximately 40 patients pending for surgery, she was put on priority list among 8 patients of "serious open fracture surgeries".

It is further stated that due to heavy rush of the patients, the patient was first taken up for surgery on 19.07.2012. The statistics of the relevant period i.e. 17th to 19th July, 2012 regarding total cases with ATC has been reproduced, in para 4 of the written statement. It is also stated, that patient was found unfit for anesthesia and was shifted back to the operation theatre recovery. Further, it was recorded in CR file that after midnight of 19.07.2012, the patient was anemic and blood pressure was 85/50.

As per record, patient was actually taken up for surgery at the operation theatre but since she was haemodynamically unstable, she was transfused 4 units of blood and two units of fresh frozen plasma. Further, the patient was taken up for surgery on the morning of 20.07.2012, when she underwent hip disarticulation and debridement of the anterior abdominal wall. It is denied, that patient was not given medical attention or that the bandage was not changed, which resulted into gangrene and septicemia. It is further stated, that gangrene and sepsis could also set in, following severe wound contamination due to the mechanism of injury (crushing) and place of injury (road side accident). Further, dressing was changed three times before surgery, one each on 17th, 18th and 19th July, 2012. It is denied, that attitude of the doctors on duty was either insensitive or opposed to medical norms. It is denied, that patient lost consciousness on 20.07.2012 due to pain and trauma.

It is further stated, that despite the surgery for hip disarticulation, patient went into shock and CPR was given and a defibrillator was used to revive the heart. She was intubated and put on a ventilator with triple inotropes. Due to persistent low blood pressure, she developed decreased urine output on 21.07.2012. Peritoneal dialysis was started and it continued. Further, Ms.Anupama suffered cardiorespiratory arrest on 24.07.2012 and unfortunately she expired. It is also stated, that the crushed nercotic tissue needed removal and disarticulation of the limb was a life saving measure. It is denied that infection and gangrene were due to bandaging and dressing not being changed. The gangrene and sepsis could also set in following due to severe wound contamination due to mechanism of injury. The patient's relatives were given a detailed death summary, which was duly recorded in the CR file. It is further stated, that as per the prevalent practice medical file (detailed medico legal record) was not handed over to the patient, but was kept in the record of Central Record Department. Thus, there was no medical negligence or deficiency in service, on the part of O.Ps.No.1 to 4 as alleged.

The State Commission, while partly allowing the complaint observed;

"11. Admittedly, the patient Ms. Anupama was admitted in the Opposite Party No.1Hospital on 17.07.2012 with crush injuries, on her left thigh. Whereas she was taken for surgery on the night of 19.07.2012 and the surgery could not be performed because she was anemic and blood pressure was 85/50. The perusal of Page 34 of the CR file also showed that she was haemodynamically unstable and 4 units of blood and two units of fresh frozen plasma was transfused. The perusal of the history file at Pages 3 to 7 of the deceased Ms. Anupama shows that at the time of her admission in the hospital on 17.07.2012, as also on 18.07.2012 and 19.07.2012, there were no signs of gangrene and septicemia. In the notes on page 44 of the patient file it was categorically stated that "wounds Needs debridgement". This was said repeatedly on 17th 18th and 19th July, 2012. It was for the first time that on 20.07.2012 that the patient developed gangrene and septicemia due to which her left leg was amputated.

However, the condition of the patient deteriorated and ultimately she expired on 24.07.2012. From the facts and circumstances of the case, as also from the enquiry reports, it is apparent that there was considerable delay in properly treating the patient. Had the doctors of the Opposite Party No.1Hospital properly treated the patient within the reasonable period after her admission and done the needful to prevent the gangrene and septicemia, then the complications would not have arisen and the life of the only daughter of the complainants would have been saved. But due to nonavailability of the proper medical treatment, in time, the condition of the patient deteriorated badly, gangrene and septicemia developed for which disarticulation of the hip and debridement of the anterior abdominal wall was done and her life could not be saved. This fact is corroborated from the enquiry reports placed, on record. The same cannot be brushed aside, as the same have been given by the experts/doctors in the medical field. Hence, the objection of the Counsel for Opposite Parties No.1 to 4 that the enquiry reports could not be read into evidence is baseless and the same is rejected. Since the enquiry reports have been furnished by the team of doctors who are experts in the medical field, the objection of the Counsel for Opposite Parties No.1 to 4 that no expert opinion was led by the complainants in support of their contention is without any merit and substance and the same is rejected accordingly. However, we find force in the submission of the Counsel for the complainants that it is a clear case of res ipsa loquitur (the things speak themselves). Thus, we hold that the death of Ms.Anupama took place due to per se negligence of the treating doctors of Opposite Party No.1Hospital by not treating the patient with due care and skill. Had the concerned doctors exercised due care and skill they would have followed the requisite protocol by performing the operation on the crushed leg of the patient on the very day of her admission, as a result whereof, development of gangrene and septicaemia would have been avoided and her life would have been saved. The complainants lost their only daughter of about 16 years, on account of the palpable negligence and carelessness of the Opposite Party No.1Hospital and its concerned doctors, which caused a lot of mental agony and physical harassment to the complainants and thus, they are liable to be compensated on this count."

The State Commission, vide impugned order partly allowed the complaint with cost. It directed Opposite Parties No.1 to 4 to pay jointly and severally a sum of Rs.7 lacs as compensation to the complainants on account of the expenditure incurred by them on the medical treatment of Ms.Anupama, the amount she would have contributed for supporting her parents upto the date of her marriage, had her life been not cut short untimely; and mental agony, physical harassment and emotional trauma, her parents would suffer, throughout their life as they lost their only daughter, in addition to Rs.3,00,000/ already paid to the parents of the deceased Ms. Anupama on humanitarian grounds by the Chandigarh Administration. The amount of compensation of Rs.7 lacs shall be paid by Opposite Parties No.1 to 4, jointly and severally and to pay Rs. 25,000/- as cost of litigation.

Being aggrieved, Complainants filed for enhancement, whereas Opposite Parties No.1 to 4, filed for dismissal of the complaint before NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION (NCDRC), NEW DELHI.

NCDRC took into account all the above mentioned matters and also studied the report of inquiry committee, headed by Prof. S.S. Gill which was constituted to carry out broad based inquiry into the cause of patient late Ms. Anupama. This Committee gave its report along with recommendations for improvement of services. Its conclusions are reproduced as under;

*"**Conclusion:***

After detailed examination of records pertaining to the case, visit to ATC and Emergency Deptt., PGIMER, Chandigarh and examination of the medical and nursing staff, the Committee observed that patient Ms. Anupama Sarkar who had sustained severe injuries in a road traffic accident on 17.7.2012 and was brought to ATC, PGIMER. After initial medical management and investigations, she was kept in the preoperative ward under monitoring and all the modalities for surgery were arranged. As there were other patients waiting for surgery in the ATC, the operation of this patient got delayed.

It would have been appropriate for the treating team to periodically reassess all the patients and reprioritize the OT schedule according to the seriousness of this case visàvis the other cases. The mechanism of injury of this patient should have raised a high index of suspicion that the patient had sustained crush injury of the thigh and was likely to develop serious complications. However, the team decided to stick to their previous waiting list and hence this patient could not be taken for surgery till 19.7.12. This was an error of judgement.

Though the Orthopaedics team insisted that there were serious cases which could not have been delayed, the Committee feels that priority should have been rearranged for this patient. All the doctors who deposed before the Committee accepted that there was a delay which was due to heavy rush of many serious patients. However, the Committee opined that this patient should have been given due priority over other cases.

Recommendations for improvement of services:

Based upon the overall circumstances, which lead to the death of patient Ms. Anupama Sarkar, the Committee recommends the following Immediate, Short term and Long term measures:-

1. *As the present arrangement of Faculty Incharge, ATC seems inadequate and lack supervision since it is on a part time basis, therefore, ATC and the Emergency Department of PGIMER should be put in the charge of a Professor/Additional Professor drawn from any of the following specialities. General Surgery, Orthopaedics, Neurosurgery, Anaesthesia, Plastic Surgery and Internal Medicine.*
2. *It is recommended that all doctors and nurses belonging to ATC and Emergency Department such as General Surgery, Anaesthesia, Orthopaedics, Neurosurgery, Internal Medicine who are involved in the care of injured patients must undergo Advanced Trauma Life support (ATLS) and Advanced Trauma Care for Nurses (ATCN) Courses respectively.*
3. *At the entry point where the patient is first received, there should be one senior resident who would be responsible for screening and prioritizing.*

   A junior resident should assist him.
4. *There should be a facility to track the management of each serious patient. There should be an adequate number of doctors, phlebotomists, nurses, paramedics and class IV staff for examination/ treatment, transport, taking blood samples, collecting reports, getting x-ray and CT scan done. The staff on duty should have mobile phones provided by the hospital.*
5. *All categories of manpower such as doctors, nursing staff, operation theatre technicians, hospital attendants, sanitary staff, security guards, medical social workers should be adequately augmented and trained.*
6. *The Incharge ATC should ensure that weekly audits of the functioning of the ATC are carried out, presented and discussed.*

7. *The Medical Superintendent should ensure weekly coordination meetings of different subspecialities involved in the services of trauma patients in ATC and Emergency Department.*
8. *To improve regular flow of patients, all patients from ATC and Emergency Department should be moved out to the respective department after short listing of the patients. One officer should be designated who would be empowered and the responsible to ensure the movement of patients and thereby ensuring adequate number of beds in ATC and Emergency Department.*
9. *All patients in ATC and Emergency Department who are under observation as well as on treatment should be counted as admitted patients.*
10. *PGI policy should be amended to allow the referral of patients not requiring tertiary care to nearby hospital after initial care.*
11. *Proper recording of events shall be maintained in the patient's file i.e. date/time, name of examining consultant/residents, with legible signatures. This should include communication with the patient or his attendants.*
12. *Training of doctors/nurses/paramedical and class IV staff to strengthen their communication skill is recommended.*
13. *The condition/progress of their patients shall be communicated to the patient's attendants preferably by the attending senior doctor or nurse on a regular basis.*

Short Term

1. *It is recommended that PGIMER, Chandigarh develop a training site to provide certified Advanced Trauma Life Support (ATLS), Advance Trauma Care for Nurses (ATCN) Course and ACLS Course for residents and nurses who deal with trauma and emergency patients.*
2. *Each department associated with trauma patients should have consultants and residents posted for a continuous period of four weeks in trauma centre to maintain continuity and better patient care. The department should display a list of consultants/senior residents/junior residents on duty daily.*
3. *A cadre of Trauma Nurse Coordinator should be created to monitor the management of injured patients throughout their hospitalization and report to the administrative head of the ATC about any deficient management.*
4. *Referral slip of patients referred from other hospital should clearly mention the reasons for referring the name, designation and contact number of the doctor referring.*
5. *The institute in consultations with other health authorities in UT should develop a common pool of emergency beds."*

Long Term

1. *Establishment of an Academic Department of Emergency Medicine and Initiation of MD Course in Emergency Medicine at PGIMER, Chandigarh to provide immediate and efficient immediate care to severely injured patients like Anumapa.*
2. *After creation of such a department it should be put in the charge of a Professor/additional Professor drawn from any of the Specialities as follows: Emergency Medicine, General Surgery, Internal Medicine, Neurosurgery, Anaesthesia, or Orthopaedics, provided respective facility is willing to devote full time for the development of the speciality of Emergency Medicine at PGIMER, Chandigarh.*

3. *There should be a provision to appoint adjunct faculty from other specialities to work in the Department of Emergency Medicine.*
4. *Looking at the large number of injured patients coming for the treatment at PGIMER, Chandigarh, there is a need to increase operation theatres and trained manpower at all levels i.e. Facility, Residents, Nurses, and paramedics and class IV. It will be highly appropriate to create dedicated Faculty Residents and Nurses for ATC on the same pattern as Apex Trauma centre, AIIMS. The Number of dedicated staff could be as follows: Faculty-Emergency Medicine 6 (for providing 24 hour faculty supervision in emergency Department), Orthopaedics-5, Surgery -5, Plastic Surgery-4, Neurosurgery-5, Anaesthesia-6, Intensivist/Critical Care physicain -6, Urology-1, Otolaryngologist-1. Enhancement of manpower will help in making dedicated trauma teams.*
5. *MS/Mch Course in Trauma and Critical care is initiated at PGIMER, Chandigarh as soon as possible.*
6. *Specialized services of Plastic Surgery, Neurosurgery, Cardiology and Critical Care must be upgraded in other hospital of Chandigarh.*
7. *Improved coordination between hospitals located in Tricity (Chandigarh-Mohali-Panchkula) for dealing with certain category (low injury severity score ISS) of injured patients. It will allow PGIMER to deal with the most severely injured and polytrauma as tertiary care referral centre.*
8. *PGIMER authorities should take up the matter of opening up the satellite centres in Mullanpur (Punjab) and Panchkula (Haryana) so that patients are first seen and screened there and the patients requiring tertiary care only are referred to PGIMER, Chandigarh. These centres should be managed by PGIMER directly.*

The Committee deeply sympathizes with the parents of Ms. Anupama Sarkar who lost their daughter following a serious accident and severe injuries."

NCDRC noted *"Therefore, cumulative effect of the entire material and documents placed on record including findings of the Committies' reports, the negligence on the part of the Opposite Party No.1Hospital is writ large in this case.*

The OP No.1Hospital has tried to take shelter on the ground that there were other serious patients who were ahead of the deceased for the purpose of having surgery. However, respondent no.1Hospital has not placed any medical record of such patients."

NCDRC also observed that O.P.No.1 Hospital is a prestigious medical institute. Therefore, it is expected from such institute that it should work not in a purely bureaucratic manner i.e. patient should be treated as per seniority in the queue, but it should be run in a professional manner. The medical surgeries, operations and other emergency treatments are to be administered keeping in view the nature of ailment, seriousness and other exigencies as per the best judgement of the treating doctor. In the present case, it is an admitted fact that condition of the patient was quite serious from the time she was admitted in the Hospital. Keeping in view the nature of ailment from which the patient was suffering, O.P. No.1Hospital should not have insisted on red tapism. On the other hand, it is really unfortunate that due to the bureaucratic approach and red tapism adopted by O.P. No.1Hospital, a precious life of young girl could not be saved.

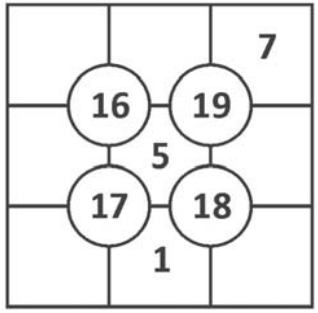
Accordingly, appeal filed by the complainants was partly allowed and following direction was passed:

"The appellants in this appeal, shall be entitled to a further sum of Rs.10,00,000/(Rupees Ten Lacs only), in addition to sum of Rs.7,00,000/(Rupees Seven Lacs only) as already awarded by the State Commission besides Rs.3,00,000/(Rupees Three Lacs only) already paid by the CTU. This amount shall be payable by O.P. No.1Hospital".

Games Corner

Dr. Chandresh Jardosh
Surat

Chhota Sudoku



"Place the numbers 1 to 9 in the spaces so that the number in each circle is equal to the sum of the four surrounding spaces."

7 BR OK EN Words

By using following keys, join the broken words & find out the 7 different items seen at the time of Animal.

Key	Words
4 Letters	1
5 Letters	3
7 Letters	2
8 Letters	1

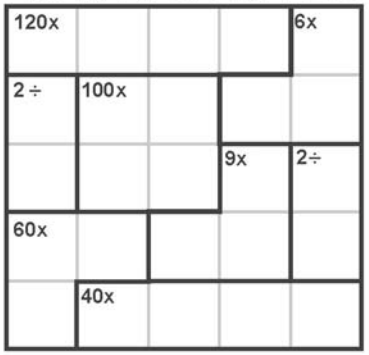
ON	ZE	EL	LL	GER
HA	EEP	OP	LI	NT
TI	OCK	BU	SH	BRA
LE			ARD	EP

Sudoku

			7	9		4	1	
		7				9		3
		4						
		5			9			2
			1	2	8			
9			3					
						8		
4		1				3		
	8	2			6			

The objective of sudoku is to enter a digit from 1 through 9 in each cell, in such a way that:
Each horizontal row contains each digit exactly once
Each vertical column contains each digit exactly once
Each 3 by 3 square contains each digit exactly once

KEN KEN PUZZLE



1 write down 1 to 5 in each row and each column in such a way they come only once, in each row and column.
2 The heavily-outlined groups of squares in each grid are called "cages." In the upper-left corner of each cage, there is a "target number" and a math operation (+, –, x, ÷).
3 Fill in each square of a cage with a number. The numbers in a cage must combine—in any order, using only that cage's math operation—to form that cage's target number.

FOR EXAMPLE

4 The number written in the cage of one square, will be the answer for the cage.
5 Important: You may not repeat a number in any row or column. You can repeat a number within a cage, as long as those repeated numbers are not in the same row or column.

Be a Member

of

- **ACADEMY OF MEDICAL SPECIALITY**
- **C.G.P. I.M.A. G.S.B.**
- **HEALTH SCHEME**
- **SOCIAL SECURITY SCHEME**
- **NATIONAL SOCIAL SECURITY SCHEME**
- **PROFESSIONAL PROTECTION SCHEME**

BeWise-BellyWise
Reduce Abdominal Girth – Happily

Times out of number, people who are well qualified & occupying responsible positions in various fields like politics, medicine, civil services, cinema & the like, neglect their health with disastrous consequences. The loss is too great to describe in words. Scientific evidence shows beyond doubt that each & every health problem like Heart attack / cancer / BP / Diabetes starts with the person being overweight or obese. Apart from the usual list of problems associated with being overweight or obese,please note that **excess fat** in the body acts as a dumping ground. All the pollution related waste goes there. That is why incidence of cancer is more in overweight & obese. **Excess fat** acts as a competition for oxygen. This matters when we cross 70 years of age. A simple observation will convince you. Look around at public figures & your known acquaintances who are 80 plus & mentally sharp. They all are lean. So friends BMI of 20 or 21 is what we should aim for. And in that respect, I too have to go a long way! The usual pros & cons of being overweight & obese do matter. However this is something new that has convinced me at this point in time. **Excess fat** plays havoc with the Endocrine System which is akin to President or CEO of an organization / company.

Doctor's Health– Special Concern: National Social Security scheme of IMA & State Social Security scheme of IMA gives out statics of the deaths occurring in the medical fraternity. The analysis shows that the average life span of a medical Doctor is 59 years, while that of the average population is 70 years. This is a sad fact of the tough life medico's face & we must care for our health. Everything else comes later.

Does Abdominal Girth Reduction System Work?Rest assured it works! Experience cannot be exchanged! So invest your time & energy & be in equilibrium.

The Key Words: Eat when really hungry – Eat mindfully/slowly/Dil Se – Stop before being Full – Full stop!

Where Did We Go Wrong?All of us, myself included, have tried many ideas about reducing weight & / or abdominal girth. The results have been poor. This has resulted in an attitude that it is impossible. "I am

going to remain like this (overweight / obese) for ever. I am going to die like this. (Mi aataasachmarnar - dherisakat)." This was exactly my attitude when I first started out on this system. What is new? Well! The current emphasis, on what to eat & what not to eat is the culprit. 95% to 100% emphasis is on this aspect. If the direction is wrong, then there is no hope of reaching the destination. This is exactly the case with abdominal girth reduction / weight loss. The right direction is giving 95% weightage on how we eat & 5% to what. This is THE change in Waist Reduction System.

Believe in self: Having tried out many ideas we have lost our confidence. All Waist reduction programs sound like a political speech. Very good to listen to – with no result or positive outcome! However trying Waist Reduction System – experiencing the magic yourself, is the only way out. I have gone down from 84 kg to 76 kg. Abdominal girth has gone down from 38 inches to 34 inches and the progress continues.

Exercise: Traditionally exercise has always been associated with motion & movement. *Citius, Altius, Fortius*, which is Latin for Faster, Higher, Strongeris the motto of Olympics. We perceive it as the ultimate truth. It was indeed difficult for me to digest that this is not correct. It hurt my misplaced pride that I was wrong for 57 years of my life. I take solace in the fact that it is better late than never! What we are looking at is Physiological fitness. Yogasanas achieve their goal by strengthening the internal organs rather than the apparatus of locomotion. Yogasanas bring about awareness of the body by uniting the body & the mind. Modern research confirms this fact.Yogasanas have a major role to play in Abdominal Girth Reduction by stimulating endocrine & lymphatic system.

This is different & better than conventional wisdom of calorie burning. However do not give up your daily dose of walk / jog / Gym. Add Yogasanas to these activities. Remember that right dose of Yogasanas leave you refreshed & energetic. Quest for perfecting AbdominalGirth Reduction workshops has given me a new insight to the way our body functions. This benefit is now for all to experience, benefit & share.

Quest for Changeis the most important part of the workshop. We provide support for one year.

Original Article by : **Dr. Shirish Patwardhan,** Pune
Compiled by : **Dr. Jignesh C. Sha**h, M.D. (Gynecologist)
Navawadaj, Ahmedabad.
Feedback / comments : imagsb@gmail.com

Third MBBS Syllabus

Community Medicine

Goal:

The broad goal of the teaching of undergraduate students in community medicine is to prepare them to function as community and first level physicians in accordance with the institutional goals.

Curriculum

- Basic concept of Health and disease
- Sociology and health
- Epidemiology
- Communicable disease epidemiology
- Non-communicable disease epidemiology
- National Health Programmes of India
- Environment and impact on health
- Entomology
- Occupational Medicine / occupational health
- Genetics and health
- Nutrition and health
- Health care management India and International
- Primary Health care
- International Health and travelers health

BOOKS RECMMENDED.

1. Text book of Community Medicine, Kulkarni A.P. and Baride J.P.
2. Park's Textbook of Preventive and Social Medicine, Park
3. Principles of Preventive and Social Medicine, K. Mahajan
4. Textbook of Community Medicine, B. Shridhar Rao.
5. Essentials of Community Medicine, Suresh Chandra.
6. Textbook of Biostatistics, B. K. Mahajan
7. Review in Community Medicine, V.R. Sheshu Babu.
8. Sociology and Health Niraj Pandit
9. National Health Programme, J Kishor

FURTHER READINGS

Epidemiology and Management for health care for all P.V. Sathe and A.P. Sathe.

Essentials of Preventive Medicine O.P. Ghai and Piyush Gupta.

Ophthalmology

Goal:

The broad goal of the teaching of students in ophthalmology is to provide such knowledge and skills to the students that shall enable him to practice as a clinical and as a primary eye care physician and also to function effectively as a community health leader to assist in the implementation of National Programme for the prevention of blindness and rehabilitation of the visually

INTRODUCTION ANATOMY & PHYSIOLOGY OF THE EYE

COMMON DISEASE OF EYE.

A) Conjunctiva.

Symptomatic conditions: - Hyperemia, Sub conjunctival Haemorrhage.

Diseases: - Classification of Conjunctivitis

:- Mucopurulant Conjunctivitis
:- Membranous Conjunctivitis Spring Catarrh.
:- Degenerations :- Pinguecula and Pterigium

B) Cornea: - Corneal Ulcers: Bacterial, Fungal, Viral, Hypopyon.
:- Interstitial Keratitis.
:- Keratoconus.
:- Pannus
:- Corneal Opacities.
:- Keratoplasty.

C) Sclera : :- Episcleritis.
:- Scleritis.
:- Staphyloma.

D) Uvea :- Classification of Uveitis
:- Gen. Etiology, Investigation and Principles Management of Uveitis.
:- Acute & Chronic Iridocyclitis.
:- Panophthalmitis.
:- End Ophthalmitis.
:- Choriditis.

E) Lens :

I) Cataract – Classification & surgical management of cataract.
:- Including Preoperative Investigation.
:- Anaesthesia.
:- Aphakia.
:- IOL Implant

F) Glaucoma :
:- Aqueous Humor Dynamics.
:- Tonometry.
:- Factors controlling Normal I.O.P.
:- Provocative Tests.
:- Classifications of Glaucoma.
:- Congenital Glaucoma.
:- Angle closure Glaucoma.
:- Open Angle Glaucoma.
:- Secondary Glaucoma

G) Vitreous :
:- Vitreous. Opacities.
:- Vitreous. Haemorrhage.

H) Intraocular Tumours :
:- Retinoblastoma.
:- Malignant Melanoma

I) Retina :
:- Retinopathies : Diabetic, Hypertensive Toxaemia of Pregnancy.
:- Retinal Detachment.

:- Retinitis Pigmentosa, Retinoblastoma

J) Optic nerve :
:- Optic Neuritis.
:- Papilloedema.
:- Optic Atrophy.

K) Optics :
:- Principles : V.A. testing Retinoscopy, Ophthalmoscopy.
:- Ref. Errors.
:- Refractive Keratoplasty.
:- Contact lens, Spectacles

L) Orbit :
:- Proptosis – Aetiology, Clinical Evaluation, Investigations Principles of Management
:- Endocrinal Exophthalmos.
:- Orbital Haemorrhage.

M) Lids :
:- Inflammations of Glands.
:- Blepharitis.
:- Trichiasis, Entropion.
:- Ectropion.
:- Symblepharon.
:- Ptosis.

N) Lacrimal System :
:- Wet Eye.
:- Dry Eye
:- Naso Lacrimal Duct Obstruction
:- Dacryocystitis

O) Ocular Mobility :
:- Extrinsic Muscles.
:- Movements of Eye Ball.
:- Squint : Gen. Aetiology, Diagnosis and principles of Management.
:- Paralytic and Non Paralytic Squint.
:- Heterophoria.
:- Diplopia.

P) Miscellaneous :
:- Colour Blindness.
:- Lasers in Ophthalmology – Principles.

Q) Ocular Trauma : - Blunt Trauma.
:- Perforating Trauma
:- Chemical Burns
:- Sympathetic Ophthalmitis

2) Principles of Management of Major Opthalmic Emergencies :
:- Acute Congestive Glaucoma.
:- C. Ulcer.
:- Intraocular Trauma.

:- Chemical Burns.
:- Sudden Loss of vision
:- Acute Iridocyclitis.
:- Secondary Glaucomas

3) Main Systemic Diseases Affecting the Eye :
:- Tuberculosis
:- Syphilis
.:- Leprosy
:- Aids.
:- Diabetes
:- Hypertension

4) Drugs :
:- Antibiotics
:- Steroids.
:- Glaucoma Drugs.
:- Mydriatics.
:- Visco elastics.
:- Fluoresceue.

5) Community Ophthalmology :
:- Blindness : Definition Causes & Magnitude
N.P.C.B. – Integration of N.P.C.B. with other health
:- Preventable Blindness.
:- Eye care.
:- Role of PHC's in Eye Camps.
:- Eye Banking.

6) Nutritional :- Vit. A. Deficiency.

Books for Ophthalmology

- BASAK - OPHTHALMOLOGY ORAL & PRACTICAL
- BASAK - ESSENTIALS OF OPHTHALMOLOGY
- CHATTERJEE -HANDBOOK OF OPHTHALMOLOGY
- D.K. (SAMANT) - OPHTHALMOLOGY: THEORY PRECTICAL WITH MCQ'S
- KHURANA - OPHTHALMOLOGY
- NEMA - TEXTBOOK OF OPHTHALMOLOGY
- PARSON'S - DISEASES OF THE EYE
- SEETHARAMAN - PRACTICAL OPHTHALMOLOGY
- SHEKHAR - MCQ'S IN OPHTHALMOLOGY

ENT

Goal –

The basic idea of undergraduate students teaching and training in otolaryngology is that he /she should have acquired adequate knowledge and skills for optimally Dealing with common disorders, emergencies in E.N.T .and basic principles of impaired hearing rehabilitation.

Course

Throat

Anatomy/physiology

Diseases of buccal cavity

Diseases of pharynx
Tonsils and adenoids
Pharyngeal tumours and related
Topics (trismus, Plummer .Vinson Syndrome etc.)
Anatomy /physiology/examination
Methods/symptomatology of larynx
Stridor /tracheostomy
Laryngitis /laryngeal trauma/ Laryngeal paralysis/ foreign body larynx/Bronchus, etc.
Laryngeal tumours
Nose and paranasal sinuses
Anatomy /physiology/ exam.
Methods /symptomatology
Diseases of ext. nose/cong.
Conditions
Trauma to nose/p.n.s/Foreign Body. / Rhinolith
Epistaxis
Diseases of nasal septum
Rhinitis
Nasal polyps/nasal allergy
Sinusitis and its complications
Tumours of nose and Para nasal sinuses
EAR
Anatomy /physiology
Methods/methods of examination
Cong.diseases/ ext.ear /middle ear
Acute/chronic supp. otitis media
Aetiology, clinical features and its
Management/complications
Serous/adhesive otitis media
Mastoid/middle ear surgery
Otosclerosis/tumours of ear
Facial paralysis/Meniere's disease
Tinnitus /ototoxicity
Deafness/hearing aids/rehabilitation
Audiometry
Books for ENT

- BHARGAVA - A SHORT TEXTBOOK OF E.N.T. DISEASE
- DHINGRA- DISEASE OF EAR, NOSE AND THROAT
- HATHIRAM- E.N.T. SIMPLIFIED
- LOGAN TURNER'S - DISEASE OF THROAT, NOSE AND EAR
- PRABHAT- PRACTICAL EN

Third Year part – II consist of four subjects – medicine, surgery, obstratics and gynecology and pediatrics

Medicine

GOAL :

The broad goal of the teaching of undergraduate students in Medicine is to have the knowledge, skills and behavioral attributes to function effectively as the first contact physician.

Medicine includes the assessor branches like skin, psychiatry and pulmonology

(TB and chest). Thus curricula includes

- Introduction to Medicine
- Infectious Diseases/Tropical diseases Cardiovascular System
- GIT, Liver, Pan. Chest + Miscellaneous
  TB
  Psychiatry
  Skin
- Neurology
  Haematology/Haemato-oncology
  Tutorials
  Skin / STD
- Endo + Misc + Genetics (3 Lectures.)
  Nephro. +Clinical Nutrition
  Tutorial Medicine, Skin, Tb, Psychiatry,

Medicine books recommended

- ALAGAPPAN -MANUAL OF PRACTICAL MEDICINE
- API - TEXTBOOK OF MEDICINE
- CHAMBERLAIN'S- SYMPTOMS & SIGNS IN CLINICAL MEDICINE
- CORKE - PRACTICAL INTENSIVE CARE MEDICINE - PROBLEM SOLVING I THE ICU
- DAVIDSON'S - PRINCIPLES & PRACTICE OF MEDICINE
- GOLWALLA- MEDICINE FOR STUDENTS
- HARRISON'S- PRINCIPLES & PRACTICE OF MEDICINE (2 VOL SET)
- HUTCHISON'S - CLINICAL METHODS
- KUMAR - CLINICAL MEDICINE
- KUNDU - BEDSIDE CLINICS IN MEDICINE PART- I
- KUNDU - BEDSIDE CLINICS IN MEDICINE PART- II
- MEHTA -COMMON MEDICAL SYMPTOMS
- MEHTA -PRACTICAL MEDICINE
- PATEL -CLINICAL MEDICINE
- PATEL- CLINICS IN INTERNAL MEDICINE
- WASHINGTON- THE WASHINGTON MANUAL OF MEDICAL THERAPEUTICS
- VAIDYA - CASSETTE CLINICS IN MEDICINE (6-VOL SET)
- VAIDYA - GENERAL PRACTICE (A PRCTICAL MANUAL)

Surgery

Goal

The broad goal of the teaching of undergraduate students in Surgery is to produce graduates capable of delivering efficient first contact surgical care.

Surgery includes orthopedics, anesthesiology and radiodiagnosis as minor subjects

I. A. GENERAL PRINCIPLES

1. Wound healing and management, scars: Hypertrophic scar and keloid; First aid management of severely injured.
2. Asepsis, antisepsis, sterilisation.
3. Surgical sutures, knots, drains, bandages and splints.
4. Surgical infections and rational use of antibiotics: Causes of infection, prevention of infection, common organisms causing infection.
5. Boils, cellulitis, abscess, necrotising fascitis.\
6. Tetanus and Gas gangrene: Prevention of Tetanus and Gas Gangrene.

7. Chronic specific infections: Tuberculosis, Filariasis, and Leprosy.
8. Antibiotic therapy.
9. Hospital infection.
10. AIDS and Hepatitis B; Occupational hazards and prevention.

I .B 1. Mechanism and management of missile, blast and gunshot injuries.
2. Surgical aspects of diabetes mellitus.
3. Bites and stings.
4. Organ transplantation - Basic principles.
5. Nutritional support to surgical patients.

II. RESUSCITATION.
1. Fluid electrolyte balance.
2. Shock: Aetiology, pathophysiology and management.
3. Blood transfusion : Indication and hazards.
4. Common postoperative complications.

III. COMMON SKIN AND SUBCUTANEOUS CONDITIONS.

1. Sebaceous cyst, dermoid cyst, lipoma, haemangioma, neurofibroma, premalignant conditions of the skin, basal cell carcinoma, naevi and malignant melanoma.
2. Sinus and fistulae. Pressure sores; prevention and management.

IV. ARTERIAL DISORDERS.

1. Acute arterial obstruction : diagnosis and initial management; types of gangrene ; diagnosis of chronic arterial insufficiency with emphasis on Burger's disease, athreosclerosis and crush injuries.
2. Investigations in cases of arterial obstruction. Amputations;
3. Vascular injuries : basic principles of management.

V. VENOUS DISORDERS.

1. Varicose veins: diagnosis and management; deep venous thrombosis: diagnosis, prevention, principles of therapy; thrombophlebitis.

VI. LYMPHATICS AND LYMPH NODES.

1. Diagnosis and principles of management of lymphangitis, lymphedema, acute and chronic lymphadenitis; cold abscess, lymphomas, surgical manifestations of filariasis.

VII. BURNS.

1. Causes, prevention and first aid management; pathophysiology; assessment of depth and surface area, fluid resuscitation; skin cover; prevention of contractures.

VIII. SCALP, SKULL AND BRAIN.

1. Wounds of scalp and its management: recognition, diagnosis and monitoring of patients with head injury including unconsciousness; Glasgow coma scale recognition of acute / chronic cerebral compression.

IX. ORAL CAVITY, JAWS, SALIVARY GLANDS.

1. Oral cavity: I) Cleft lip and palate; Leukoplakia; retention cyst; ulcers of the tongue.
II) Features, diagnosis and basic principles of management of carcinoma lip, buccal mucosa and tongue, prevention and staging of oral carcinomas.

2. Salivary glands: I) Acute sialoadenitis, neoplasm: diagnosis and principles of treatment.

IX. B. Epulis, cysts and tumours of jaw: Maxillofacial injuries; salivary fistulae

X. NECK.

1. Branchial cyst; cystic hygroma.
2. Cervical lymphadenitis: Non-specific and specific, tuberculosis of lymphnodes, secondaries of neck.

X. B. Thoracic outlet syndrome: diagnosis.

XI. THYROID GLAND

1. Thyroid: Surgical anatomy, physiology, investigations of thyroid disorders; types, clinical features, diagnosis and principles of management of goitre, thyrotoxicosis and malignancy, thyroglossal cyst and fistula.

XI. B. Thyroiditis, Hypothyroidism.

XII. PARATHYROID AND ADRENAL GLANDS.

1. Clinical features and diagnosis of hyperparathyroidism, adrenal hyperfunction/ hypofunction.

XIII. BREAST.

1. Surgical anatomy; nipple discharge; acute mastitis, breast abscess; mammary dysplasia; gynaecomastia; fibroadenomas.
2. Assessment and investigations of a breast lump.
3. Cancer breast : diagnosis, staging, principles of management.

XIV. THORAX.

1. Recognition and treatment of pneumothorax, haemothorax, pulmonary embolism: Prevention/ recognition and treatment, flail chest; Stove in chest ; Postoperative pulmonary complications.

XIV. B. Principles of management of pyothorax; cancer lung.

XV. HEART AND PERICARDIUM.

1. Cardiac tamponade
2. Scope of cardiac surgery.

XVI. OESOPHAGUS.

1. Dysphagia: Causes, investigations and principles of management.
2. Cancer oesophagus : Principles of management.

XVII. STOMACH AND DUODENUM.

1. Anatomy; Physiology, Congenital hypertrophic pyloric stenosis; aetiopathogenesis, diagnosis and management of peptic ulcer, cancer stomach; upper gastrointestinal haemorrhage with special reference to bleeding varices and duodenal ulcer.

XVIII. LIVER

1. Clinical features , diagnosis and principles of management of : Amoebic liver abscess, hydatid cyst and portal hypertension. Liver trauma.

XVIII. B. Surgical anatomy; primary and secondary neoplasms of liver.

XIX. SPLEEN

1. Splenomegaly: causes, investigations and indications for splenectomy: splenic injury.

XX. GALL BLADDER AND BILE DUCTS

1. Anatomy, physiology and investigations of biliary tree; clinical features, diagnosis, complications and principles of management of cholelithiasis and

cholecystitis; obstructive jaundice.

XX. B. Carcinoma of gall bladder, choledochal cyst.

XXI. PANCREAS.

1. Acute pancreatitis : Clinical features, diagnosis, complications and management.
2. Chronic pancreatitis, pancreatic tumours.

XXII. PERITONEUM, OMENTUM, MESENTERY AND RETROPERITONEAL SPACE.

1. Peritonitis : Causes, recognition and principles of management; intraperitoneal abscess.

XXII B. Laparoscopy and laparoscopic surgery.

XXIII. SMALL AND LARGE INTESTINES

1. Diagnosis and principles of treatment of : Intestinal amoebiasis, tuberculosis of intestine, carcinoma colon; lower gastrointestinal haemorrhage; Enteric fever, parasitic infestations.

XXIII. B. Ulcerative colitis, premalignant conditions of large bowel.

XXIV. INTESTINAL OBSTRUCTION.

1. Types, aetiology, diagnosis and principles of management; paralytic ileus.

XXV. ACUTE ABDOMEN.

1. Causes, approach, diagnosis and principles of management.\

XXVI. APPENDIX

1. Diagnosis and management of acute appendicitis, appendicular lump and abscess.

XXVII. RECTUM.

1. Carcinoma rectum: diagnosis, clinical features and principles of management; indications and management of colostomy.

XXVII. B. Management of carcinoma rectum; prolapse of rectum.

XXVIII. ANAL CANAL .

1. Surgical anatomy. Clinical features and management of: fissure, fistula in ano, perianal and ischiorectal abscess and haemorrhoids; Diagnosis and referral of anorectal anomalies.

XXVIII. B. Anal carcinoma.

XXIX. HERNIAS.

1. Clinical features, diagnosis, complications and principles of management of : Umbilical, Inguinal, epigastric and femoral hernia.

2. Omphalitis.

XXIX . B. Umbilical fistulae, Burst abdomen, ventral hernia.

XXX. GENITO- URINARY SYSTEM.

1. Symptoms and investigations of the urinary tract.

XXXI. KIDNEY AND URETER

1. Investigations of renal mass; diagnosis and principles of management of urolithiasis, hydronephrosis, pyonephrosis, and perinephric abscess, congenital anomalies of kidney & Ureter and renal tumours.
2. Renal tuberculosis.

XXXII. URINARY BLADDER.

1. Causes, diagnosis and principles of management of haematuria, anuria and acute retention of urine.

XXXIII. PROSTATE AND SEMINAL VESICLES.

1. Benign prostatic hyperplasia: diagnosis and management.

XXXIII. B. Carcinoma prostate.

XXXIIII. URETHRA AND PENIS

1. Diagnosis and principles of management of Phimosis, paraphimosis and carcinoma penis.
2. Principles of management of urethral injuries.
3. Urethral strictures.

XXXV. TESTES AND SCROTUM

1. Diagnosis and principles of treatment of undescended testis; torsion testis; Hydrocoele, hematocoele, pyocoele, varicocele, epididymo-orchitis and testicular tumours.

XXXVI PAEDIATRIC SURGERY

1. Oesophageal atresia and Intestinal atresia
2. Anorectal malformations
3. Constipation in children: Hirschsprung's disease, Acquired megacolon,
4. Congenital diaphragmatic hernia
5. Extrophy, Epispadias complex and hypospadias
6. Spinal diastrophism and Hydrocephalus
7. Urinary tract infections in children- Vesicoureteral reflux, posterior urethral Valves, Vesico Ureteral Junction obstruction/Duplex ureter, Obstructive uropathy in Children : Hydronephrosis, Hydroureteronephrosis
8. Testicular Maldescent
9. Umbilical Hernia, Exompholos: Major/minor
10. Wilm's Tumours: Neuroblastoma, Ganglionioneuloblestoma, Ganglioneuroma, Endo-dermal Sinus Tumours.
11. Hamartomas in Children: Lymphangioma and Cystic hygroma, Haemangioma. Biliary Atresia and Surgical jaundice

Surgery Books

1 . Charles V. Mann, R.C.G. Russel, Norman S., Williams, Bailey and Love's Short Practice of Surgery, 23rd Edition, 2000 Chapman and Hall.
2. K.Das: Clinical Methods in Surgery, 8th Edition, 1968, Suhas Kumar Dhar, Calcutta.
3. JSP Lumley : Hamilton Bailey's Physical Signs 18th Edn Butterworth/Heinemann. 1997,
4. Somen Das ; A Practical Guide to Operative Surgery, 4th Edition, 1999, s. Das, Calcutta
5. SHORT CASES IN SURGERY – BHATTACHARYA
6. MANIPAL - MANUAL OF SURGERY
7. NAN - UNDERGRADUATE SURGRY
8. PARULEKAR - PRACTICAL SURGERY
9. PATEL - HANBOOK OF SURGICAL INSTRUMENTS FOR UNDERGRADUATES
10. R.D.B'S - ART OF CLINICAL PRESENTATION IN SURGERY
11. R.D.B'S - ART OF STUDYING SURGICAL PATHOLOGY
12. VAIDYA- CASSETTE CLINICS IN GENERAL SURGERY (5-VOL SET)

REFERENCE TEXT BOOKS

1. James Kyle : Pye's Surgical handicraft, Indian edition, k.m. Varghese Company David C.
2. Sabiston ; Text Book of surgery : The Biological basis of Modern Surgical Practice, 15th Edition, 1971, W.B. Saunders.
3. Seymour I. Schwartz, G. Tom Shines, Frank C. Spencer, Wendy Cowles Husser: Principles of Surgery, Vol. 1 & 2, 7th Edition, 1999, Mc Graw Hill
4. R.F. Rintoul : Farqharson's Text Book of Operative Surgery, 8th Edition, 1995, Churchill Livingstone.
5. Sir Charles Illingworth, Bruce m. Dick: A Text Book of Surgical Pathology,12th Edition, 2979, Churchill Livingstone.
6. R.W.H. McMinn : Last's Anatomy: Regional and Applied; 10th Edition, 1999, Churchill Livingstone

Obstratics and Gynecology

Goal-

The broad goal of the teaching of undergraduate students in Obstetrics and Gynaecology is that he/she shall acquire understanding of anatomy, physiology and pathophysiology of the reproductive system & gain the ability to optimally manage common conditions affecting it.

1. Applied anatomy of female genital tract.
2. Development of genital tract
3. Physiology of menstruation
4. Puberty and menopause
5. Physiology of ovulation / conception / implantation.
6. Early development of human embryo.
7. Structure, function and anomalies of placenta.
8. Physiological changes during pregnancy / diagnosis of pregnancy.
9. Antenatal care, nutrition in pregnancy, detection of high-risk pregnancy.
10. Normal labour - Physiology, mechanism, clinical course and management, pain relief in labour.
11. Normal puerperium and breast-feeding.
12. Examination and care of newborn.
13. Contraception - Introduction and basic principles
14. Maternal mortality and morbidity, perinatal mortality and morbidity. National health programme - safe-motherhood, reproductive and child health, social obstetrics.

GYNAECOLOGY

1. Development of genital tract, congenital anomalies and clinical significance, Chromosomal abnormalities and intersex.
2. Physiology of Menstruation, Menstrual abnormalities - Amenorrhoea,Dysmenorrhea, Abnormal Uterine Bleeding, DUB.
3. Puberty and its disorders, Adolescent Gynaecological problems.
4. Menopause & H R T.
5. Infections of genital tract, Leucorrhoea, Pruritus vulvae, Vaginitis, Cervicitis, PID, Genital TB, Sexually transmitted infections including HIV infection.
6. Benign & Malignant tumours of the genital tract. Leiomyoma, carcinoma cervix,

carcinoma endometrium,chorio carcinoma, ovarian tumors. Benign & Malignant Lesions of Vulva
7. Radiotherapy & Chemotherapy in Gynaecology.
8. Other gynaecological disorders - Adenomyosis, Endometriosis
9. Genital Prolapse, Genital Tract displacement,
10. Urinary disorders in Gynaecology, Perineal tears, Genital Fistulae, RVF & VVF.

FAMILY PLANNING :

1. Demography and population Dynamics.
2. Contraception - Temporary methods /Permanent methods.
1. MTP Act and procedures of MTP in first & second trimester.
2. Emergency contraception. :
3. Complications in early pregnancy.
4. Hyperemesis gravidarum / abortion / ectopic pregnancy / gestational trophoblastic disease.
5. Obstetrical complications during pregnancy -APH - Accidental hemorrhage. Placenta praevia / Poly hydramnios / oligohydramnios, multifetal pregnancy/ Medical disorders in pregnancy.
6. Anemia, Heart disease. Hypertensive disorder, PIH and Eclampsia, Diabetes, jaundice, pulmonary disease in pregnancy, Infections in pregnancy
7. Urinary tract diseases, sexually transmitted infections including HIV, malaria, TORCH etc.
8. Gynaecological and surgical conditions in pregnancy, Fibroid with pregnancy, ovarian tumours, acute abdomen, genital prolapse.
9. High risk pregnancy, pre-term labour, post term pregnancy, IUGR, IUFD, pregnancy wastages, Rh incompatibility, post caesarean pregnancy.
10. Induction of labour.
11. Abnormal position & presentation : Occipito posterior, Breech, Transverse, Face & Brow, Compound, Cord Presentation and prolapse.
12. Abnormal labour - abnormal uterine action, CPD.
13. Obstructed labour, uterine rupture.
14. Third stage complications - Retained placenta, PPH, Shock, Uterine inversion, Fluid Embolism.
15. Puerperial Sepsis and Other Complications in puerperium.
16. Evaluation of Foetal Health during pregnancy and labour.
17. Drugs used in obstetric practice.
18. Operative procedures in Obstetrics : Caesarean Section, Instrumental Vaginal Delivery. Forceps, Vacuum,
19. Maternal Mortality and morbidity, Perinatal mortality and morbidity. National program - safe motherhood, reproductive and child health , Social Obstetrics.

NEW BORN :

1. Examination and care of new born & low birth weight babies.
2. Asphyxia and neonatal resuscitation.
3. Diagnosis of early neonatal problems.
4. Birth injuries, jaundice, infection.
5. Anencephaly & Hydrocephalus and other Congenital Anomalies of fetus.

Preventive Oncology

Principles of gynaecological surgical procedures

Pre and post operative care in Gynaecology

Ultrasongraphy and Radiology, in Gynaecology
Endoscopy in in Gynaecology
Drugs and hormones in Gynaecology
Surgical procedures in obstetrics
Maternal mortality
Perinatal mortality
Recurrent pregnancy wastages
High risk pregnancy
Rural obstetrics
Drugs in Pregnancy
Drugs in obstetric practice
In addition, integrated teaching with other departments like anatomy, physiology, biochemistry, pathology, microbiology, Forensic Medicine and Preventive and Social medicine to be organized for selected topics.

Books for Ob/Gy

- AFTARY - MANUAL OF OBSTETRICS (HOLAND & BREWS)
- DAWN- TEXTBOOK OF OBSTETRICS & NEONATOLOGY
- DAWN- TEXTBOOK OF GYNECOLOGY, CONTRACEPTION & DEMOGRAPHY
- DUTTA- TEXTBOOK OF GYNECOLOGY
- DUTTA-TEXTBOOK OF OBSTETRICS
- KERKAR-TEXTBOOK OF OBSTETRICS
- KHAN-FIVE TEACHERS GYNECOLOGY
  MUDALIAR-CLINICAL OBSTETRICS
- OXORN-FOOTE - HUMAN LABOR & BIRTH
- PARULEKAR-PRACTICAL GYNECOLOGY & OBSTERICS
- PARULEKAR - HANDBOOK OF PRACTICAL GYNECOLOGY & OBSTERICSSHAW'S-TEXTBOOK OF GYNECOLOGY
- VAIDYA-CASSETTE CLINICS IN GYNECOLOGY-OBSTERICS (4 VOL SET)
- VIRKUD (D.K.) - MANUAL OF PRACTICAL OBSTETRICS AND GYNECOLOGY
- WANI -ESSENTIAL OBSTERICS

Pediatrics

Goal

The broad goal of the teaching of undergraduate students in Pediatrics is to acquire adequate knowledge and appropriate skills for optimally dealing with major health problems of children to ensure their optimal growth and development.

Curriculum
Introduction of Paediatrics.
History taking in children.
Examination of Children.
Normal Growth
Normal Development.
Introduction to newborn and normal newborn baby.
Temperature regulation in newborn.
Breast feeding and lactation management.
Infant and child feeding (include complimentary feeding)
Normal fluid and electrolyte balance in children.
Immunization.
Birth Asphyxia

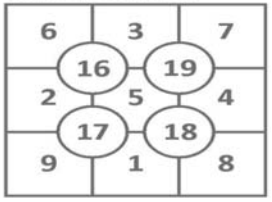
Low Birth Weight Babies.
Neonatal Respiratory Distress.
Jaundice in newborn.
Neonatal Infections.
Neonatal convulsions.
PEM and its management.
Vitamin and micronutrient deficiencies.
Nutritional anaemia in infancy and childhood.
Acute diarrhoea.
Hypothyroidism in children.
Congestive heart failure - diagnosis and management.
Congenital heart disease.
Rheumatic heart disease.
Hypertension in children.
Acute respiratory infections.
Bronchial asthma.
Nephrotic syndrome
Acute glomerulonephritis and hematuria
Abdominal pain in children.
Chronic liver disease including ICC.
Haemolytic anaemia including thalassemia.
Leukaemias.
Bleeding and coagulation disorders.
Seizure disorders.
Cerebral Palsy.
Common exanthematous illness.
Childhood tuberculosis
Other topics:
Fluid and electrolyte balance -pathophysiology and principles of Management.
Acid-base disturbances - pathophysiology and principles of management.
Adolescent growth and disorders of puberty.
Congenital heart disease.
Acute respiratory infections, Measles, Mumps, Chicken pox
Other childhood malignancies.
Coagulation disorders - Haemophilia
Mental retardation.
Approach to a handicapped child.
Acute flaccid paralysis.
Behaviour disorders.
Meningitis.
Diphtheria, Pertussis and Tetanus.
Childhood tuberculosis.
HIV infection.
Malaria.
Neurocysticercosis.
Enteric fever.
Immunization.
Paediatric prescribing.
Common childhood poisonings.

Integrated Seminar Topics :
Convulsions
Coma
PUO
Jaundice
Portal hypertension
Respiratory failure
Shock
Rheumatic Heart Disease
Hypertension
Diabetes mellitus
Hypothyroidism
Anemia
Bleeding
Renal failure
Tuberculosis
Malaria
HIV infection
Neurocysticercosis
Perinatal asphyxia (with obstetrics)
Intrauterine growth retardation (with obstetrics)

Books for Pediatrics
- D.K. - PEDIATRICS
- GHAI-ESSENTIAL PEDIATRICS
- GUPTE -THE SHORT TEXTBOOK OF PEDIATRICS
- MAYOOR CHHEDA-PRATICALS ASPECTS OF PEDIATRICS
- SHEJWAL-CLINICAL PEDIATRICS FOR GENERAL PRACTITIONERS

Answers

Chhota Sudoku



7 BR OK EN Words

1 LION
2 TIGER
3 ZEBRA
4 SHEEP
5 LEOPARD
6 BULLOCK
7 ELEPHANT

Sudoku

6	5	3	7	9	2	4	1	8
2	1	7	8	5	4	9	6	3
8	9	4	6	1	3	2	5	7
1	3	5	4	7	9	6	8	2
7	4	6	1	2	8	5	3	9
9	2	8	3	6	5	7	4	1
3	7	9	5	4	1	8	2	6
4	6	1	2	8	7	3	9	5
5	8	2	9	3	6	1	7	4

KEN KEN PUZZLE

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2	1	5	9x 3	2÷ 4
60x 5	4	3	1	2
3	40x 2	1	4	5