API DK Lahari

(An official publication of API DK Chapter)

September 2020. VOL.1 ISSUE NO.1 Published Quarterly

ART MAY CHANGE, NOT OUR CARE

Dr. Chakrapani M
Editor in Chief

Dr. B Sadananda Naik
Executive Editor

Dr. Archana Bhat
Production Editor

www.apidk.org

CONTENTS

PRESIDENT MESSAGE

Dear Colleagues, Namasthe.

DR.VENKATESHA BM

New dreams, new hopes, new experiences and new joys. It gives me great pleasure to welcome you all through the Inaugural first quarterly issue of E-Magazine of API DK Chapter **'API DK Lahari'**. I congratulate the E-Magazine committee under the able guidance and supervision of Prof. Chakrapani M., Editor-in-Chief a very intellectual, farsighted leader and an enthusiastic executive editor , Dr. Sadananda Naik for taking up the challenge along with all other members of the editorial board.

I am sure all our API DK Chapter members will definitely support this initiative by involving themselves in writing academic, non academic articles, experiences and interesting case reports in future issues.

I wish E - Magazine committee of API DK good luck.

DR.VENKATESHA BM
PRESIDENT, API DK CHAPTER (2020-2021)

PROFESSOR OF MEDICINE

FATHER MULLER MEDICAL COLLEGE

MANGALORE - 575 002

MOBILE: 9845210425

EMAIL: bannurvenkatesh@rediffmail.com

VOICE OF THE EDITOR IN CHIEF

DR.CHAKRAPANI. M

Medical practice is evolving and changing rapidly. Physicians have to update the clinical skills and knowledge constantly. While journals and guidelines provide evidence-based information, there is a need for integrating it with pragmatic and practical knowledge which can come from practising physicians. There is a need to share our thoughts, experiences and ideas among ourselves - vocal to local. API Dakshina Kannada is providing a platform for this exchange of information and experience in the form of official publication of the Association. I would like to congratulate and compliment Dr Venkatesh B M and his team for taking this initiative. Lahari will be the official platform and voice of physicians of Dakshina Kannada and this publication will be compiled and curated by an experienced and energetic team of section Editors under the leadership of Dr SadanandaNaik who will be the executive editor. The contents of the publication have been well thought out and include medical and non-medical articles covering all facets of the profession. I request all the members to make full use of this publication by sharing their ideas and thoughts with other members of DK chapter of API. Rich experience of seniors and energetic technological knowledge of junior physicians can be integrated in Lahari which will enhance the standards of the profession.

DR. CHAKRAPANI. M

Professor

Department of Medicine

KMC, Mangalore

chakrapani.m@manipal.edu

Mobile No. 9448812207

EXECUTIVE EDITOR'S MESSAGE – COVER PAGE STORY

COVER STORY SAYS IT ALL

ART MAY CHANGE, NOT OUR CARE

DR B. SADANANDA NAIK

Practice of medicine is a centuries old art of healing. In the ancient times, the physicians depended heavily on their astute observational skill in the diagnosis and treatment of the health ailments. They used to pick up signs and symptoms of various illnesses with a precision of the eye of a hawk as they had no instrument to rely on. The modalities of therapy were quite limited but there was no limit for the compassion and dedication.As the days passed, the physicians started developing various skills to examine their patients, like listening to the chest directly, feeling pulse etc.Then came the stethoscope, thermometer, sphygmomanometer etc., which obviously made their life easy to unearth the secrets of the ailments. Inspection, palpation, percussion and the auscultation became the most reliable allies of the physicians.

Invention of antimicrobials including antibiotics came as a shot in the arms and this gave them immense confidence while treating patients especially the more serious ones. Physicians over the years learnt that a disease can not only be treated but could also be prevented as the vaccines made their way. Very soon, the medical management started moving from clinical to digital with the availability of a variety of imaging technology. Slowly but steadily the experience-based medicine made way to the evidence-based medicine and bedside medicine to Telemedicine.

The pandemic of COVID-19 not only made the life a physician difficult but also different. The PPE, an integral part of the present medical care while keeping the virus away, turning out to be a new barrier between the physician and his ailing patients. The patients do miss the healing and comforting gentle touch of their doctors. Thus, every aspect of the medical treatment of a patient got changed but not the care, the compassion, dedication with which physician's tried to heal their patients. The promise in the Hippocratic Oath, which said,

“primum non nocere” -first do no harm continue to guide us in the turbulent and changing world. We are proud to be one among this great tribe and long live this great art of healing.

DR B. SADANANDA NAIK

Executive Editor

Senior Physician,

Alva’s Health Centre,

Moodabidri-574227

D.K. Karnataka

Cell: 9845051005

Email: sadanandanaik2@gmail.com

INTRODUCING OUR EDITORIAL TEAM

Editor's message I/C scientific content	**DR CHAKRAPANI M** EDITOR IN CHIEF	
Co-ordination of editors i/c View point section	**DR B.SADANANDA NAIK** EXECUTIVE EDITOR	
I/C production, page setting, design, receiving all the write ups and forwarding to appropriate section editors/ information	**DR ARCHANA BHAT** PRODUCTION EDITOR	
I/C news and views [non academic articles] section, obituaries, Member's accomplishments	**DR CHRISTOPHER C. PIAS** SECTION EDITOR	
Academic Articles	**DR ARCHITH BOLOOR** SECTION EDITOR	
P.G. write ups	**DR AKSHATHA NAYAK** SECTION EDITOR	

Journal scan - Glimpses on leading research	**DR B. SADANANDA NAIK** SECTION EDITOR	
Journal scan - Glimpses on leading research	**DR ANURAG BHARGAV** SECTION EDITOR	
MEDICO LEGAL CORNER	**DR RAMACHANDRA BHAT** SECTION EDITORS	
QUIZ	**DR SURESH** SECTION EDITOR	
NON-ACADEMIC ARTICLES	**DR ANITHA SEQUIRA**	
NON ACADEMIC ARTICLES	**DR . MOHAMMAD ASHRAF**	

SECRETARY'S REPORT

DR. ARCHANA BHAT

Greetings from API D.K. Chapter. The new team took over the API D.K.Chapter on April 2020 onwards. In view of the lockdown from the month of march onwards the official meetings were indefinitely postponed due to COVID -19 crisis. We initiated COVID webinar on April 17,2020 first of its kind in the API D.K. Chapter history, a virtual meeting regarding flattening the covid curve and the preparedness for the future.

COVID 19 CME WEBINAR was organized by the API D.K.Chapter for all the general practioners, IMA members and API D.K. Chapter members on April 30.The use of PPE, approach management and chemoprophylaxsis oxygen therapy, handling of covid deaths, clinic practice during covid pandemics and prevention of transmission were the topics included in the CME. The CME had active participation by 90 doctors and concluded with question and answer sessions.

International symposium on COVID -19 global scenario was conducted on May 15,2020. Dr Venkat Shenoy ,consultant anaesthetist , Essex,U.K. elaborated on the ground zero reality of COVID in U.K. Dr Thomas Kottukapaly,St.Helier Hospital,London spoke on management of covid.Dr Rekha Pai M.,consultant infectious disease, Alfred Hospital,Melbourne spoke on infection control issues for covid in Australia.

The web launch www.apidk.org was launched on 19.06.2020 at Father Muller Medical College Hospital by Dr B.H.Krishnamoorthy Rao,founder President of API,D.K.Chapter at 3 pm .Dr B.H.Krishnamoorthy Rao spoke on the initial days in 1991 when the association was established with only 40 members and now it has grown to 160 members. Rev Fr. Ajith Menezes, Administrator, FMMC was the guest of honour. He spoke on use of technology in the present covid era and importance of virtual meet.Dr H. Prabhakar spoke on the importance of website for API D.K.Chapter to foster communication among its members.GerardColaco, guest speaker spoke on effective personal investments in covid era.The programme was live telecasted on YouTube, was viewed by more than 150 participants.

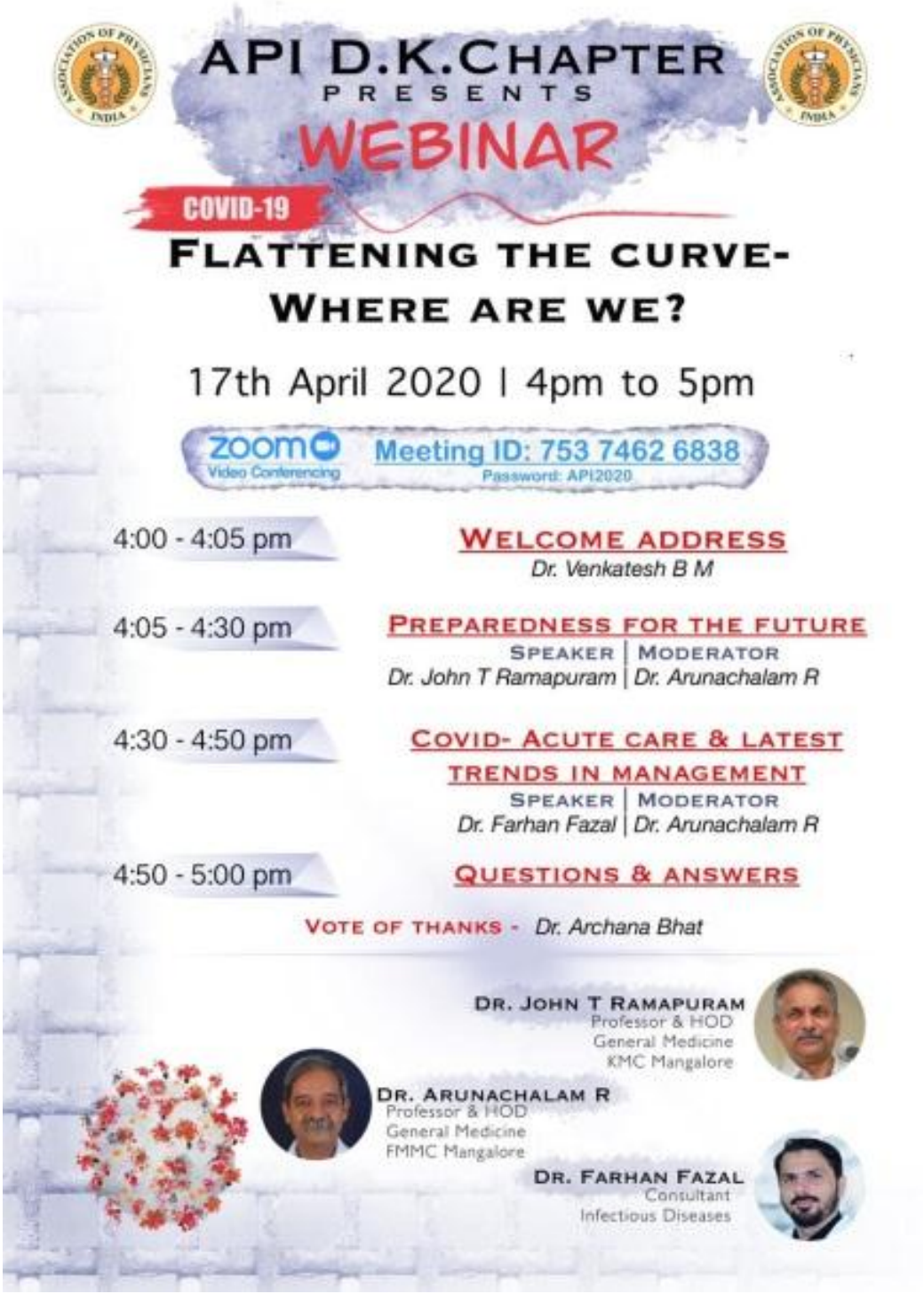
API monthly meeting webinar was conducted on July 17.DrShiranShetty spoke on acute pancreatitis with case snippets.DrArunaYadiyal spoke on psychological stress and importance of unlocking mind during these difficult times.

COVID CME – FACTS.FIGURES AND EXPERIENCES was conducted on August 2, 2020.The speakers included Dr Ravi Vasvani, professor,YMCH spoke on his experiences in handling covid management. Dr Sharath Babu,nodal officer, Wenlock Hospital, Dr. Deepak Madi, consultant, KMC Mangalore and Dr FarhanFazal were the resource persons. Dr Roshan,Professor ,FMMC and Dr PrabhaAdikari HOD ,Geriatric medicine , YMC were the

chair persons. The sessions had active participation with 80 participants with question and answer session.

The monthly API webinar on 21/8/2020 included interesting talk on Febrile Neutropenia by Dr Hemanth Kumar , oncologist , FMMC and an introduction to butterflies in Mangalore by Dr Guruprasad Bhat , oncologist YMC .Dr Nishitha Shetty , oncologist ,FMMC moderated the first session.

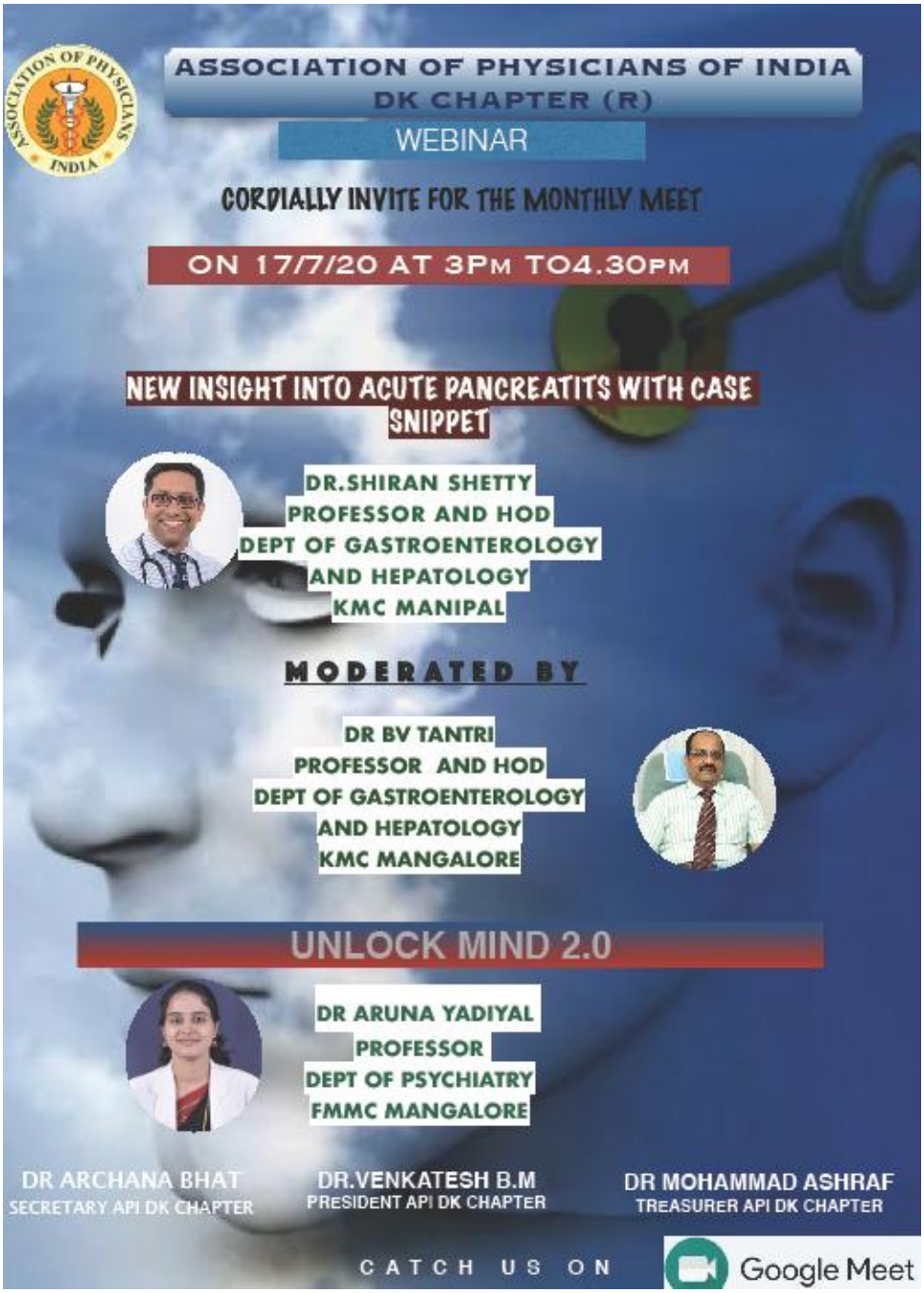
Good things remain good only because they are always scarce. I am glad to pen for this wonderful e magazine of our API D.K Chapter as an appreciation of the commendable efforts put forth by our magazine committee team for its grand beginning. I extend my sincere thanks to all our members who have contributed to this issue and have enriched this novel venture.


API D.K.CHAPTER
PRESENTS
WEBINAR
COVID-19
FLATTENING THE CURVE-
WHERE ARE WE?
17th April 2020 | 4pm to 5pm
zoom Video Conferencing
Meeting ID: 753 7462 6838
Password: API2020
4:00 - 4:05 pm
WELCOME ADDRESS
Dr. Venkatesh B M
4:05 - 4:30 pm
PREPAREDNESS FOR THE FUTURE
SPEAKER | MODERATOR
Dr. John T Ramapuram | Dr. Arunachalam R
4:30 - 4:50 pm
COVID- ACUTE CARE & LATEST TRENDS IN MANAGEMENT
SPEAKER | MODERATOR
Dr. Farhan Fazal | Dr. Arunachalam R
4:50 - 5:00 pm
QUESTIONS & ANSWERS
VOTE OF THANKS - Dr. Archana Bhat
DR. JOHN T RAMAPURAM
Professor & HOD
General Medicine
KMC Mangalore
DR. ARUNACHALAM R
Professor & HOD
General Medicine
FMMC Mangalore
DR. FARHAN FAZAL
Consultant
Infectious Diseases


API DK CHAPTER
Presents
Covid -19 CME
We cordially invite all API D.K Chapter and IMA Mangaluru members for this webinar on
30/04/20 at 3pm to 5pm
3 to 3.05pm WELCOME ADDRESS
Dr Venkatesh B.M
President (API DK chapter)
3.05 to 3.20pm PPE -WHY !WHERE?HOW?
Dr Thomas.S.Kuruvila
Professor and HIC incharge
Dept of microbiology
FMMC
3.20 to 3.35pm APPROACH,MANAGEMENT AND CHEMOPROPHYLAXIS.
Dr Prabha Adhikari
Professor and HOD
Dept of Geriatric medicine
YMCH .
3.35to 3.50pm O2/NON-INVASIVE/INVASIVE VENTILATION THERAPY IN COVID .
Dr Dattatray Prabhu
Intensivist
KMC Mangalore
3.50to 4.05pm HANDLING AND ANALYSIS OF COVID-19 DEATHS .
Dr.Shafir Kassim,
Assistant Professor
Dept of medicine
KMC mangalore
4.05 to 4.20pm CLINIC/OPD PRACTICE DURING COVID PANDEMICS.
Dr.B.Sadanand Naik
Consultant Physician
Alvas Health Center
Moodbidri
4.20to 4.35 pm COVID 19-PREVENTION OF TRANSMISSION .
Dr Rashmi Kundapur,
Professor,Dept of community medicine ,KSHEMA
Secretary(IMA Mangaluru)
4.35to 4.50pm QUESTION AND ANSWERS
Vote of thanks
Dr Archana Bhat
Secretary (API DK Chapter)
zoom
WEBINAR ID:84323332462
PASSWORD :API2020
Moderators
Dr.EVS Meben
Professor and HOD
Department of medicine
AIIMS
Dr N.Hegde
Professor .
Dept of medicine
FMMC


API DK CHAPTER
INTERNATIONAL SYMPOSIUM ON COVID 19
GLOBAL SCENARIO
We cordially invite all API members for the monthly meeting on
15/5/2020 at 3 to 4.15pm
3.05 3.20pm
GROUND ZERO REALITY
Dr Venkat Shenoy
Consultant in Anaesthesia ,Intensive care
Basildon and Thurrock university Hospital
Essex.UK
3.20to 3.40pm
MANAGING COVID -CASE BASED LEARNING
Dr Thomas John Kottukapally
Acute and Tropical Medicine
St Helier Hospital
London,UK
3.40to 4.00pm
INFECTION CONTROL ISSUES FOR COVID IN AUSTRALIA
Dr.Rekha Pai.M
Consultant General medicine and
infectious diseases
Alfred hospital
Melbourne
Australia
4.00to 4.15pm
QUESTION AND ANSWERS
MODERATOR
Dr.Mohammad Ismail.H
Professor
Department of medicine
KMC Mangalore
Dr Venkatesh B.M
President (API DK chapter)
Dr Archana Bhat
Secretary (API DK Chapter)
Dr Mohammad Ashraf
Treasurer (API DK Chapter)
Cisco Webex
Webinar ID:916118413
Password :API2020
or
Join the link below


ASSOCIATION OF PHYSICIANS OF INDIA
DK CHAPTER (R)
VIRTUAL MEET
CORDIALLY INVITE FOR THE MONTHLY MEET
AND WEBSITE LAUNCH
ON 19/6/20 AT 3PM TO4.30PM
WEBSITE LAUNCH
DR.B.H.KRISHNAMOORTHY RAO MD
FOUNDER PRESIDENT API DK CHAPTER
AND SENIOR PHYSICIAN
GUEST OF HONOUR
REV..FR..AJITH.B MENEZES
ADMINISTRATOR FMMC
DR H.PRABHAKAR,
INTERVENTIONAL CARDIOLOGIST FMMC
FORMER PRESIDENT API DK CHAPTER
EFFECTIVE PERSONAL INVESTMENTS IN
COVID ERA
GUEST SPEAKER
MR GERARD COLACO
PERSONAL INVESTMENT ADVISOR
MANGALORE
PRESIDE OVER BY
DR.VENKATESH B.M
PRESIDENT API DK CHAPTER
DR ARCHANA BHAT
SECRETARY API DK CHAPTER
DR MOHAMMAD ASHRAF
TREASURER API DK CHAPTER
EXECUTIVE COMMITTEE
MEMBERS
www.apidk.org
LIVE TELECAST ON
YouTube


ASSOCIATION OF PHYSICIANS OF INDIA
DK CHAPTER (R)
WEBINAR
CORDIALLY INVITE FOR THE MONTHLY MEET
ON 17/7/20 AT 3PM TO4.30PM
NEW INSIGHT INTO ACUTE PANCREATITS WITH CASE SNIPPET
DR.SHIRAN SHETTY
PROFESSOR AND HOD
DEPT OF GASTROENTEROLOGY
AND HEPATOLOGY
KMC MANIPAL
MODERATED BY
DR BV TANTRI
PROFESSOR AND HOD
DEPT OF GASTROENTEROLOGY
AND HEPATOLOGY
KMC MANGALORE
UNLOCK MIND 2.0
DR ARUNA YADIYAL
PROFESSOR
DEPT OF PSYCHIATRY
FMMC MANGALORE
DR ARCHANA BHAT
SECRETARY API DK CHAPTER
DR.VENKATESH B.M
PRESIDENT API DK CHAPTER
DR MOHAMMAD ASHRAF
TREASURER API DK CHAPTER
CATCH US ON
Google Meet


ASSOCIATION OF PHYSICIANS OF INDIA
DK CHAPTER
WEBINAR
CORDIALLY INVITE ALL THE API DK CHAPTER AND
IMA MANGALURU MEMBERS
COVID-19 CME
FACTS,FIGURES &EXPERIENCES
ON 2/8/2020 3 TO 4.30PM
3.05 to 3.25 pm
MANAGEMENT OF COVID
SYMPTOMATIC /ASYMPTOMATIC CASES
DR.RAVI VASWANI
PROFESSOR,
DEPT OF MEDICINE
YMCH
3.25 to 3.45pm
MANAGEMENT OF COVID WITH
RESPIRATORY DISTRESS
DR SHARAD BABU .S
PULMONOLGIST
WENLOCK DISTRICT HOSPITAL
3.45to 4.05pm
MORTALITY IN
COVID
DR DEEPAK R MADI
ASSOCIATE PROFESSOR
DEPT OF MEDICINE
KMC MANGALORE
4.05to 4.25 pm
ROADMAP TO PREVENT
MORTALITY
DR FARHAN FAZAL
CONSULTANT
INFECTIOUS DISEASE
KMC MANGALORE
4.25 to 4.40
QUESTION AND ANSWERS
MODERATORS
DR ROSHAN .M
PROFESSOR
DEPT OF MEDICINE
FMMC
DR PRABHA ADIKARI
PROFESSOR
DEPT OF MEDICINE
YMCH
CATCH US ON
GOOGLE MEET
DR VENKATESH BM
PRESIDENT API DK CHAPTER
DR ARCHANA BHAT
SECRETARY API DK CHAPTER
DR MOHAMMAD ASHRAF
TREASURER API DK CHAPTER

DR. ARCHANA BHAT

Secretary API DK Chapter 2020—2021

Associate Professor

Department of Medicine

Father Muller Medical College

Mangalore

Mobile : 9591438216

archanaacharya24@gmail.com

VIEW POINT

DR.MANJUNATH

RATIONAL TREATMENT: ARE WE THERE YET?

The COVID-19 pandemic has brought in an avalanche of treatment options based on anecdotes, observational data and expert opinions. This avalanche is threatening to bury our scientific approach to treatment. Treatments based on poor evidence (? Should we call them evidence) are being portrayed as panacea. Most of these therapies may not have any benefit. But what if our misguided enthusiasm harms the patient? These therapies corrupt the very premise of practice of medicine "Do no harm". There is more to lose than gain with this approach. Shockingly enough, despite lack of evidence, some of us seemed to be convinced regarding use of HCQS for COVID prophylaxis for our personal use.

Tons of tablets of Favipiravir, HCQS and ritonavir/lopinavir have passed through the gastrointestinal tracts of hapless patients. Gallons of Tocilizumab and plasma are being relentlessly pumped into veins of sick patients. These therapies are cost a fortune and there is very little evidence of benefit. The issue of cost becomes very important in low resource settings like ours, wherein the same finances which are used for ineffectual therapies can be used to provide better ICU care to our patients. If we leave cost issues apart, the real question is are we doing more harm by resorting to use of unproven therapies. These issues made me reflect and look back into history of medicine. I tried to compile treatments which are used for years without any benefits. What I found was a bit alarming; some therapies are not only ineffective but also potentially harmful.

One frightening story is the use of Atenolol for treatment of primary hypertension. This drug became a trial standard for antihypertensives. Any new drug for hypertension would get approval only after it was proved that it was as good as atenolol. Atenolol enjoyed this cult status till 2002 when the results of LIFE trial were published. This trial showed that Losartan was better than atenolol(1). That was not the end of the story. A metaanalysis concluded that atenolol was no better than a placebo for primary hypertension(2). Put in proper perspective, for 20 years, we were using a drug which was not only ineffective but also harmful.

The chronicle of evidence based medicine is replete with such stories. There are instances of many therapies which were used for years and got reversed after proper evidence was generated. Recently published ISCHEMIA trial on role of percutaneous coronary intervention in management of stable angina is another illustration(3). The trial found that among patients with stable angina, there is no evidence that an initial invasive strategy, as compared with an initial conservative strategy, is helpful.

The surgical branches are also not immune to reversal phenomenon. Futility of Vertebroplasty for osteoporotic fractures and Mammography for women in forties are other such examples(4,5). Arthroscopy for degenerative meniscal tear was(?is) a big business, till a good trial outrightly disproved the utility(6). All these interventions were used for years till one fine day a good trial unequivocally declares them ineffective.

This brings us back to the question with which I started. Are we justified in using unproven potentially harmful therapies for treatment for management of COVID. For example, a RCT has convincingly debunked the utility of HCQS for postexposureprophlaxis(7). RECOVERY trial has busted most of our preconceived notions about ritonvir/lopinavir, HCQS and plasma therapy. Roche, the company which markets Tocilizumab, itself has accepted the futility of Tocilizumab in treating COVID pneumonia(8).

It is time for us to reflect on what treatments are being used for COVID. Our aim is to provide care to patients with based on good evidence. Basing our treatments on anecdotes could be counterproductive. Sir Hutchinson has rightly said : from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us.

1. Dahlöf B, Devereux RB, Kjeldsen SE, et al. Cardiovascular morbidity and mortality in the Losartan Intervention For Endpoint reduction in hypertension study (LIFE): a randomised trial against atenolol. *Lancet*. 2002;359(9311):995-1003.

2. Carlberg B, Samuelsson O, Lindholm LH. Atenolol in hypertension: is it a wise choice? *Lancet* 2004;364:1684–9

3. Maron DJ, Hochman JS, Reynolds HR, Bangalore S, O'Brien SM, Boden WE, et al. Initial Invasive or Conservative Strategy for Stable Coronary Disease. N Engl J Med. 2020 Mar 30;382(15):1395–407.

4. Buchbinder R, Osborne RH, EbelingPR,etal. A randomized trial of vertebroplasty for painful osteoporotic vertebral fractures. N Engl JMed. 2009;361:557–568.

5. Moss SM, Cuckle H, Evans A, Johns L, Waller M,Bobrow L. Effect of mammographic screening from age 40years on breast cancer mortality at 10 years' follow-up: A randomised controlled trial. Lancet. 2006;368:2053– 2060.

6. Sihvonen R, Paavola M, Malmivaara A, Itälä A, Joukainen A, Nurmi H, et al. Arthroscopic Partial Meniscectomy versus Sham Surgery for a Degenerative Meniscal Tear. N Engl J Med. 2013 Dec 25;369(26):2515–24.

7. Boulware DR, Pullen MF, Bangdiwala AS, et al. A randomized trial of hydroxychloroquine as postexposure prophylaxis for Covid-19. N Engl J Med. DOI: 10.1056/NEJMoa2016638.

8. https://www.clinicaltrialsarena.com/news/roche-actemra-covid-data/

Dr MANJUNATH J

Professor and Head,

Department of Nephrology,

Father Muller Medical College,

Mangaluru

Email: drmjkulkarni@gmail.com

Mobile: 7795069393

Twitter: @drmjkulkarni

.

MY JOURNEY AS WRITER

Two roads diverged in a wood, and I—

I took the one less traveled by,

And that has made all the difference.

-Robert Frost

DR. ARCHITH BOLOOR

As a clinician, an academician and a doctor, a large part of my life revolves around questions. Your clinical acumen, your compassion and your worth as a doctor is amplified a thousand-fold by the clarity with which you answer what is asked. When I sat down to write medical books, I was faced with the difficult task of compiling years of medical training and experience into a capsule that can help you do the one thing that none of my early training taught me – the ability to understand, analyze and answer a question.

The year was 2011 when my teacher Dr.RamadasNayak, asked me to take the plunge; to write a book in Medicine. Of course, being the persistent man that he is, he did not stop there. He put me in touch with Jaypee Publishers and slowly, but surely, made me take that first hesitant step. It was a slow start. I took me nearly a year to finish one chapter. But I was motivated and persuaded by several people around me, and finally my first book, The Exam Preparatory Manual of Medicine was ready in 2016. Fuelled by the appreciation and the critique I received for my first textbook, I found it natural to take up editing the two volumes of the prestigious K.V.K Das Textbook of Medicine, which was in its sixth edition. Subsequently, the second edition of my textbook came out in a quick span of 18 months. Many of my colleagues, peers and even students have very graciously contributed their own "trade secrets" for me to add on in several sections of the Exam Prep Manual. As a student, I was and always will be a very visual-tactile learner. So it was only natural that as an author the same learning mode has crept into my books, becoming what my students now call "The Boloor Style" of editing with flow charts and diagrams which I have often created for use in my lectures to improve the students' understanding of complex topics.

It was my long-standing dream to write a clinical textbook ; A book that I would have liked to read during my undergraduate and postgraduate days. A book that contained all matter relevant for a student facing a clinical examination, with due emphasis on the elusive and myriad clinical methods. Thus, aided by my postgraduate student Dr.Anudeep, I had the pleasure of publishing "An Insider's Guide to Clinical Medicine" in 2019.

I have two more books in the works. The first one is a novel idea, "Mastering Medicine: MRCP Made Easy". It was the next project that I took up and the book has been designed

keeping in mind the new curriculum and needs of students. The second, and probably the project that is closest to my heart is the South Asian Edition of The Washington Manual of

Medical Therapeutics. The Washington Manual was the handbook that I used to carry every day to my residency, poring over its pages, always referring to it during times of crisis while on duty in the wards and even otherwise, it was my constant companion during my resident years. Little did I know then, that in a decade's time I would be editing its first South Asian Edition. Although a year ago in 2019, I had worked with WolterKluwers Health, India on the handbook Antibiotics Basics for Clinicians, it did come as a real surprise this January, when I received the call offering me the honour of editing this book. It was an uphill task but with my colleagues from across India, pitching in to help, the process was smoother than I imagined. Just when things were falling in place, we found ourselves up against the COVID-19 pandemic; a crisis no one could have anticipated or prepared for. Working as frontline health care workers, my peers and I still managed to find the time to compile this edition, the experience of which has been infinitely memorable.

It gives me immense pleasure to announce the release of both these books, which are due this month.

Writing books is harder than I thought and much more rewarding than I could have ever imagined it to be. None of this would have been possible without the help of my family, my mentors and my friends. A very special note of gratitude goes out to all my teachers, who are responsible for what I am today and for having ignited the passion of teaching in me.

The woods are lovely, dark and deep,

But I have promises to keep,

And miles to go before I sleep,

And miles to go before I sleep.

-Robert Frost

DR. ARCHITH BOLOOR

Associate Professor

Department of Internal Medicine

KMC, Mangalore

archith.boloor@manipal.edu

Mobile. 9886144081

BEER BELLY: TRUTHS AND MYTHS

DR.B.SADANANDA NAIK

"Oh my God! What have you done to your body? Where is your six pack abs, I can't take this pot belly", blabbered a friend. "It's all because of that damn beer man", he answered rather sheepishly and with full of confession. This is a common piece of conversation between the two friends, who meet after many years. But, is there any truth behind this blame? Or is it a baseless allegation? Can we really hold beer responsible for the ever ballooning infamous paunch? This article tries to have a scientific insight into this popular belief.

Beer is one of the ancient alcoholic drinks tried all over the world and its popularity next only to water and tea. It is prepared from malted barley by brewing and has bitterness due to the use of hops while brewing to balance the sweet taste of malt. The yeast ferments the malt into alcohol. The commercial brewing process involves the forced carbonation. The usual alcohol by volume or the strength of commonly available beer is around 4 to 6%, even though more lighter beers or stronger once also are available to the tune of 0.5% to 20% [ABV].

Beer belly, wheat belly, wine belly ….So on... But, all are pot bellies!

The available information on this topic of beer belly is neither fully true nor totally false, in other words it's simply a half truth. The truth is that the beer is as good or as bad as any other fattening high calorie food stuff when consumed in large quantity. It is not the beer as a drink per say which is responsible for the pot belly but it is the high calorie it yields when taken in large quantity and other circumstantial associates. The excess of calorie consumed may be it is beer or wine and so on; the net result will be weight gain in the form of fat getting accumulated around the abdominal organs otherwise known as visceral fat. So it's all the same for the alcoholic beverages when it comes to the risk of developing pot belly. Larger

the quantity and also higher the percentage of alcohol in the drink the chances of developing the paunch or so called Beer belly is higher.

Belly fat deposition in Men and Women:

When one takes more calories than what can be handled or burnt, the excess calorie gets stored as fat. When one takes 300-1000 kcal of alcohol and 1500 kcal from the food, there is always energy excess and will be stored as abdominal fat which will increase the belly size. So, when there is higher percentage of alcohol in the beverage, higher its calorie value and the extra calories gets stored in the belly as fat.

This fat storage depends on the sex, age of the person. In males, this extra fat tend to deposit around the abdominal organs as men have less subcutaneous fat and this results in pot bellies and in women this fat gets deposited more in the subcutaneous area, buttocks, thigh and also in the bellies. The sex hormone levels play a vital part in deciding the storage areas for fat. The alcohol tend to tilt the fine balance between the testosterone on one side and the cortisol, oestrogen on the other side and eventually this results in fat storage in the abdomen. The fat deposition pattern is similar to men once the ladies attain menopause and that is the very reason for the post-menopausal ladies to sport pot bellies. So, this pot belly or beer belly is nothing but simply an excess of visceral and subcutaneous abdominal fat.

Fat is not accumulated as a loose substance inside the abdomen or any other parts of the body.It gets stored in the fat cells or adipocytes. The adipocytes get enlarged to accommodate more and more fat. When somebody loses weight, these cells metabolize the fat and the cell reduces in size. However, the total no. of fat cells will remain constant in most of instances.

Beer, the told and untold story:

There is nothing special or specific about the alcohol in the beer, it's just like any other alcohol drink. There is hardly any fat in the beer but it is definitely a fattening diet! And like all the fermented beverages it contains lots of calories and these extra calories get converted into fat, to be used as energy source later. The alcohol in the beer gets metabolized or used up first instead of fat and the fat in the food gets deposited in the abdomen and leads to pot

belly or a paunch. A typical beer has 150 -175 kcals per can or bottle i.e. nearly 12 ounces with a alcohol percentage of around 4.9 and a pint of 5% strength beer yields 215 kcals. So, if someone takes several bottles of beer in a single go, definitely leads to a heavy calorie overload. In addition to the quantity, the higher the alcohol percentage, higher will be calorie value.

Beer like any other alcohol drink do increase the appetite and hunger and results in consumption of high calorie food like fried items, potato chips, chicken wings etc. which appear to taste irresistibly delicious. The bittering component of beer [hops] and carbon dioxide gas seems to be responsible by their unique gastric stimulation. So, even when the calorie consumed via beer is low but the super high calorie rich fried food consumed along results in weight gain following the intake of beer. And finally, the beer does contain phyto oestrogens which cause hormonal changes in men and make them store more fat in the belly.

The quantity of beer consumed is always more than other types alcoholic beverages like wine, whisky etc. which obviously leads to more calorie consumption. But, if one takes large quantities of wine or other drinks the same logic will hold good to them as well. So, the beer with low alcohol percentage in moderate quantity along with low calorie healthy food could help to avoid beer belly by avoiding weight gain without having to give up the beer drinking.

Alcohol facts:

One gram of alcohol yields nearly 07 kcal of energy and because it is devoid of nutrition in the way of vitamins, minerals, protein, fibre or essential fatty acids etc. is also termed as a food source with empty calorie.

• Alcohol suppresses the carbohydrate and fat oxidation and at the same time enhances the conversion of consumed carbohydrates into fat which in men gets stored in the abdomen resulting in increase in the abdominal girth which is called as beer belly or otherwise simply a paunch. Alcohol suppresses the testosterone secretion and at the same time increases the cortisol level resulting enhanced storage of fat in the belly in the men.

• Unlike the fat and carbohydrate which can be stored in the body, to utilize in the hours of need later, the alcohol in the blood is not stored and it remains in the tissue fluids until elimination. The final metabolites are utilized same as the protein, carbohydrates and fat.

• Drinking alcohol on empty stomach is not advisable as normally the food in the stomach slows down the gastric emptying significantly and hence slows down the absorption of alcohol. So, drinking alcohol on empty stomach should be discouraged

• The major enzyme system(s) responsible for the oxidation of ethanol, alcohol dehydrogenase, and to a lesser extent, the cytochrome P450-dependent ethanol-oxidizing system, are present to the largest extent in the liver. Liver damage lowers the rate of alcohol oxidation and hence, elimination from the body.

Tips to the Beer lovers!

Here are the few tips for the hard-core beer lovers to send few beer down and keep the six pack belly as good as before.

• Opt for light beers with low alcohol percentage which amounts for 100 kcals or less of calorie consumption, especially when one would go for a long session with the beer

• Alternate alcoholic drinks with low calorie, non-alcoholic drinks or beverages and sometimes even water would do. This will drastically help to reduce the alcohol consumption and hence the calorie cut

• Don't go for cocktails or mock tails, as they contain more sugary ingredients and could yield more calories than plain beer or alcohol drink

• Eat a low calorie diet for lunch when a big drinking night with lots of munchies is on the card

• Healthy meal with low calorie carbohydrates or protein before or along with drinks will help to overcome the craving for high calorie bar food

• Do not drink alcohol on empty stomach , it increases the appetite there by more snacking

Pre order healthy and low calorie food before starting the drink, so that one can avoid eating easily available and tempting high calorie fried items

The final word :

Beer Belly is a simply a preferential collection/deposition of fat in the subcutaneous area of the abdomen and around the abdominal organs in men who would consume excess of calories from any source, which could be any form of alcohol, sugary beverages, oversized portions of high calorie food and not enough exercise.

Losing weight is the only way to reduce the pot belly and it is heartening to know that when one loses weight, it is the abdominal fat [visceral fat] which is metabolically active which gets used up first. In order to avoid or at least reduce the pot bellies, one has to cut down the intake of calories and at the same time burn calories in the form regular exercise.

DR.B.SADANANDA NAIKM.D.

Senior Physician

Alvas Health Centre, Moodabidri-574227

Karnataka

Email address: sadanandanaik2@gmail.com

Tel: +91-9845051005

MEMORABLE PATIENTS

The truth will set you free

DR. PRASHANTH Y.M

A young man in his early thirties had an accident and was to undergo a surgery for his broken arm. He was an obese teetotaller and routine pre-anaesthetic evaluation was unremarkable. Post surgery, he went into delirium on the second postoperative day and had two episodes of generalised seizures. Examination revealed that blood pressure was high and he had sinus tachycardia. Neurological investigations and blood investigations were unremarkable. On repeated and persistent questioning his wife revealed that he used to consume something surreptitiously in his washroom. The washroom cabinet search yielded tablet morphine. We had answers for his increased salivation and pinpoint pupils. The patient was treated for Morphine withdrawal. Later, on recovery he revealed that he was taking morphine using a prescription given to his late mother for terminal cancer.

Patients do tend to hide the facts. “Only the true whole truth can set us free.”

I am all ears

A young girl in her late teens was brought by her elderly grandmother, surprising considering her parents were still around. She had no complaints but the old lady insisted that she did have a problem. She said she was clumsy and jerked when startled. These episodes used to worsen when she was sleep deprived. These episodes used to occurring frequently since several years but had worsened over the years. Everyone considered her meek and easily frightened. Her parents had taken her to various doctors but to no avail. She was to be taken to the local tantrik but the grandmother insisted on taking her to a big hospital in the city. The clear history by an observant granny made it obvious and the 3 to 6 Hz generalised polyspike and wave discharge on EEG confirmed juvenile myoclonic epilepsy. The tearful gratitude on their faces after two days of Sodium Valproate with complete resolution of the jerks made our day.

A careful and patient hearing leads us all the way.

DR. PRASHANTH Y.M

Associate Professor

Department of Medicine

Father Muller Medical College

drprashanthym@gmail.com

Mobile. 9886267264

MEMBERS ACCOMPLISHMENT

DR MOHAMMED ISMAIL

Member's accomplishments:

Dr Mohammed Ismail Hejamadi, former secretary API-Dk Chapter, Prof and unit chief in the department of medicine Kasturba medical College, Mangalore has been awarded the Karnataka Beary Sahithya Award in the field of Medicine for his dedicated, untiring and charitable work in this field and also honoured with the Title –' The Gem of Medical Field 'by Mangalore Literature Club ,

Dr.Chakrapani M, Professor of Medicine, Kasturba Medical college, Mangalore was honoured on the occasion of Doctors Day celebration by the Indian Medical Association, Mangalore branch and IMA Trust, Mangalore. The function was held on August 15, 2020, at the IMA house. An avid lover of classical music he has learnt flute and has given many recitals in and around Mangalore.Recipient of many awards including Good Teacher award, and awards for contribution to research, Dr.Chakrapani Has been the former president of API-DK chapter and chairman of ISCCM Mangalore branch.

FAREWELL TO THE LEGENDS OF MEDICINE DEPARTMENT FMMC

The department of General Medicine, Father Muller Medical College, Mangalore organized a farewell function to the two Senior Professors who retired from 33 years of active service Dr K.Sundara Bhat and Dr Narasimha Hegde on 18th August 2020. Rev Fr.Richard Coelho , Director , Father Muller Charitable Institutions praised about the dedication and selfless service and patient care rendered by these Professors during their tenure to the institution.

POST GRADUATE WRITE UP – THE UNDOING OF A DOCTOR

THE UNDOING OF A DOCTOR

DR VISHAKHA PANICKER

JR General Medicine

KMC Mangalore

9916752123

panickervishakha@gmail.com

The world has been spinning out of control for the last few months. None of us have had a moment to pause. As we try to gather our senses, slow down momentarily and try to gain a perspective now, my mind wanders to a particular date.

6th of April 2020. I was chatting with my friend, presently doing her residency in the department of Paediatrics in New York. The joy of reconnecting with an old acquaintance quickly turned morbid as our conversation unsurprisingly shifted to the pandemic. New York was then the hotspot and India was just bracing for the impact.

She talked about the morgues overflowing, trucks carrying bodies, adults being treated in paediatric wards, drugs stockpile running dry, masks out of stock and so on. We tried weakly to mask our horror with light hearted banter. This was the city of medical advancements and top notch healthcare infrastructure. India was next.

“Stay safe, no heroics ok!!”

After all the propaganda, the young amongst our lot, brimming with energy and boosted egos in all its short-sighted glory, believed the time had come to suit up and serve their country, a

message reiterated by the politically motivated anchors on television and emotive posts on social media.

We were likened to soldiers manning the frontline for the nation. We comforted our worried families, and miles away from home, prepared to head straight into what was being claimed to be a battle. Who wouldn't want to save the day?

I, however was sceptical, having heard of bitter tales of cities reeling under the impact of the pandemic.

Here is the thing about battles; it's not just fought by foot soldiers trained for hardships and self-sacrifice, but also by multiple hierarchical organisations coordinating and choreographing scenarios that have already been anticipated, planned and prepared for with robust infrastructure.

And here we were; hardly trained for sleepless nights and empty stomach with authorities thrown into complete disarray in an area out of their expertise with infrastructure that would collapse on our heads any day.

We, as doctors, are trained for much of our life to pursue unquestionable knowledge, unrelenting will to treat, all while having selfless empathy for the sick. This is unwittingly accompanied by a desire to occasionally pull off acts of heroism.

So it was no surprise when we took this challenge in a stride.

Were we really up for it?

The older and wiser in our profession would have foreseen the unravelling that was to occur in the next few weeks.

The pandemic inevitably hit India as per its predicted itinerary.

It has been everything that was promised. Death, mayhem, confusion, fear, paranoia, hysteria - as if straight out of a dystopian Hollywood movie.

As we gathered for one of the many training seminars, a professor confided "the first time a patient I was treating turned out to be positive, I sat in my building's parking lot for 15

minutes, gathering courage to go upstairs and meet my child". This voiced fear was soon to become common workplace conversation.

The morbidity and mortality of the disease does not just include the patients. It includes their families, the doctors and every healthcare worker who watch helplessly as the patient decompensates with nothing left in their arsenal to fight back.

With no previous such experience to fall back upon, we have not just been facing a disease that is unknown and contagious, but also a changed humanity.

Fear and paranoia unravelling human psyche is being seen in hospital corridors and waiting rooms, where bystanders are responding unpredictably to bad news.

"I'm sorry sir, your father will need to be put on ventilator" is being met with "When do I get my swab?"

"Your daughter's reports are in. She tested positive" is being responded with "Don't tell anyone"

Novice doctors usually familiarise themselves with common patient bystanders reactions, and have planned responses in the ready. All these jedi mind tricks are now useless.

We are neither able to predict the disease outcome nor the bystander reaction. It's like being stripped off the elements that we were in control of till now.

The psychological impact on residents even though is so stark, has been hardly discussed. Young individuals, away from their family, find themselves in a world feeding off fear and paranoia, subconsciously stigmatising the ones in close contact while roaming around powerlessly in the only place where they had felt some sense of control previously – the hospital.

We were being trained for challenges but this one was not in the syllabus.

The last few weeks saw a lot of my colleagues getting drained. Work pressure was not the only reason. I saw friends whose parents turned positive in another state, holding themselves together and continuing to report to duty. I saw a few asking recommendations for

counsellors to speak to. There was my own flatmate, who had to shuttle between hospital and taking care of me as I tested positive since we were the only family we had here.

A friend called the other day, quarantined as her first contact had tested positive. She was troubled. Sitting at home alone, she could not bring herself to do anything productive, lying on her bed staring at the walls. She called to ask if there was anyway she could get out of quarantine and go back to work. It had me thinking.

Once the mayhem dies down and the cacophony wears itself out. Once there is silence again. When we won't have a crazy work load to keep ourselves occupied. When we run out of excuses to pause and reflect. What then?

Will there be cracks in our psyche that will be evident? Will our faith in science be in trouble? Will we be untrusting of people?

We love a good challenge, but has this one taken it too far?

When push comes to shove who are we really?

JOURNAL SCAN

Section Editors - Dr Chakrapani M & Dr B. SadanandaNaik

List of publications of our API-DK Chapter members in the indexed journals in the present quarter

DR ARCHITH BOLOR ET AL.

1) Mapping local patterns of childhood overweight and wasting in low- and middle-income countries between 2000 and 2017.LBD Double Burden of Malnutrition Collaborators. Nat Med. 2020 May;26(5):750-759. doi: 10.1038/s41591-020-0807-6. Epub 2020 Apr 20.

2) MiRNA-146a Polymorphism Was Not Associated with Malaria in Southern India.van Loon W, Gai PP, Kulkarni SS, Rasalkar R, Siegert K, Wedam J, Boloor A, Baliga S, Kumar A, Jain A, Mahabala C, Shenoy D, Devi R, Gai P, Mockenhaupt FP Am J Trop Med Hyg. 2020 May;102(5):1072-1074. doi: 10.4269/ajtmh.19-0845.PMID: 32124721

DR MAHESH PADYANA ET AL.

3) Padyana M, Gopaldas J, Karanth S. A stitch in time … dengue with spontaneous splenic rupture. Radiology of Infectious Diseases, https://doi.org/10.1016/j.jrid.2020.04.002

Dr FarhanFazal et al.

4) Fazal F, Gupta N, Khot W, Ray Y. Collateral damage due to COVID-19 [published online ahead of print, 2020 Jul 26]. *Trop Doct*. 2020;49475520942387. doi:10.1177/0049475520942387

DR ARCHANA BHAT ET AL.

5) Bhat, A., Arunachalam A., Periera, P., &Aroor, A. (2020). Study on Vitamin D deficiency in patients of diabetes mellitus presenting with Acute Coronary syndrome in a tertiary care hospital in South India. Asian Journal of Medical Sciences, 11(5), 49-53. https://doi.org/10.3126/ajms.v11i5.29206

DR B. SADANANDA NAIK ET AL.

6) Naik SB, Guruprasad M. Accidental Acute Talcum Powder Inhalation in an Adult: A Rare Case with a Short Review of Literature. Indian J Crit Care Med 2020; 24 (6):490-491.

7) Naik BS. Can a health care worker have sex in the time of COVID-19? [published online ahead of print, 2020 Aug 1]. Eur J ObstetGynecolReprod Biol. 2020;S0301-2115(20)30500-5. doi:10.1016/j.ejogrb.2020.07.059

8) Naik S, Acharya V. Can a Healthy Lung Keep the COVID-19 Away? J.Assoc Physicians India August 2020:68:94

9) Moleyar VS, Noojibail A. Diseases with skin and lung involvement: Pulmonologist's perspective. Med J DY PatilVidyapeeth 2020;13:106-12

10) Moleyar VS. Diseases involving the lung and upper gastrointestinal tract – A Pulmonologist's perspective. Med J DY PatilVidyapeeth 2020;13:302-5

SUMMARIES OF IMPORTANT PUBLISHED ARTICLES

Effect of Convalescent Plasma Therapy on Time to Clinical Improvement in Patients with Severe and Life-threatening COVID-19A Randomized Clinical Trial

Citation

Li L, Zhang W, Hu Y, et al. Effect of Convalescent Plasma Therapy on Time to Clinical Improvement in Patients with Severe and Life-threatening COVID-19: A Randomized Clinical Trial [published online ahead of print, 2020 Jun 3] [published correction appears in doi: 10.1001/jama.2020.13216]. JAMA. 2020;324(5):1-11. doi:10.1001/jama.2020.10044

Highlights

In this randomized clinical trial that included 103 patients and was terminated early, the hazard ratio for time to clinical improvement within 28 days in the convalescent plasma group vs the standard treatment group was 1.40 and was not statistically significant. In summary, convalescent plasma therapy did not significantly improve the time to clinical improvement in patients with severe or life-threatening COVID-19.

DR B.SADANANDA NAIK

Senior Physician

Alvas Health Centre

Moodabidri-574227
D.K. KARNATAKA|

9845051005
Email: sadanandanaik2@gmail.com

COVID-19 gastrointestinal symptoms mimicking surgical presentations

J. Ashcroft, V.E. Hudson, and R.J. Davies Ann Med Surg (Lond). 2020 Aug; 56: 108–109.

Recent studies from Wuhan, China have shown that 2–10% with SARS-COV-2 may present with gastrointestinal (GI) symptoms such as diarrhea, reduced appetite, abdominal pain and vomiting, and notably 10% of patients describing nausea and diarrhea prior to, or independent of, respiratory symptoms. Abdominal computed tomography (CT) scans were reported as either normal or with clear surgical diagnoses identified (ileus, cholecystitis, and appendicitis) in some of the studies.

This early evidence suggests that COVID-19 infection may be co-existent in those with distinct surgical presentations or in some cases may present with mesenteric inflammation or congestion mimicking a surgical diagnosis such as appendicitis. The ACE2 receptor, which is integral to virus entry into cells as a host receptor, is expressed in the GI tract mucosa and may represent a pathophysiological process explaining this presentation. Careful review of CT imaging of the abdomen should be undertaken for mesenteric stranding or congestion which could represent active COVID-19 infection. It is essential to emphasize that CT imaging of the chest may not demonstrate classical COVID-19 respiratory findings in infected patients and this is true of gastrointestinal presentations.

Comment

This report shows that gastrointestinal symptoms are not uncommon in SARS-COV-2 infection. Symptoms may be atypical. Abdominal pain representing gastrointestinal COVID-19 infection should be considered in all patients presenting with abdominal pain, and particularly those with symptoms suggesting an active infection or with recent COVID-19 suspected or confirmed contacts. CT imaging of the chest, abdomen and pelvis in addition to routine bedside laboratory tests and COVID-19 RTPCR testing should be undertaken in this cohort to guide appropriate management plans and to reduce the risk of transmission to both patients and healthcare workers.

DR. SURESH SHENOY

Associate Professor.

Dept of Gastroenterology.

Kasturba Hospital

B.R.Ambedkar Circle

Mangaluru.

Mobile no.9972724845

Email :sureshshenoy76@gmail.com

Dexamethasone in Hospitalized Patients with Covid-19 - Preliminary Report

Horby P, Lim WS, Emberson JR, et al. [published online ahead of print, 2020 Jul 17]. N Engl J Med 2020;10

There are many treatment options for COVID-19 but their efficacy is questionable. Steroids were contraindicated in COVID 19 during the early stages of pandemic. Corticosteroids reduce the production of many chemokines which may attenuate the host inflammatory response.

RECOVERY [Randomised Evaluation of COVID-19 therapy] trial was established as a randomised clinical trial to test range of potential treatments for COVID-19, including low-dose dexamethasone. Other treatment options were lopinavir-ritonavir, hydroxychloroquine, azithromycin, tocilizumab, and convalescent plasma. This study was conducted at 176 National Health Service organizations in the United Kingdom.

A total of 2104 patients were randomised to receive dexamethasone 6 mg once a day (oral/IV) for ten days. This was compared with 4321 patients randomised to usual care alone. Overall, 482 patients (22.9%) in the dexamethasone group and 1110 patients (25.7%) in the usual care group died within 28 days after randomization.In the dexamethasone group, the incidence of death was lower than in the usual care group among patients receiving invasive mechanical ventilation (29% vs. 41%) and among those receiving oxygen without invasive mechanical ventilation (23% vs. 26%) but not among those who were receiving no respiratory support at randomization (17.8% vs. 14%).Based on these results, 1 death would be prevented by treatment of around 8 ventilated patients or around 25 patients requiring oxygen alone.

Short course of dexamethasone, an inexpensive drug will improve outcomes in patients with moderate / severe COVID-19.

DEEPAK MADI,

Associate Professor, Medicine.

KMC, Mangalore [MAHE]

deepak.madi@manipal.edu

Swabs Collected by Patients or Health Care Workers for SARS-CoV-2 Testing

Tu YP, Jennings R, Hart B, et al. N Engl J Med 2020;383(5):494-496.

Tongue/ nose/ mid-turbinate-No pain but similar gain???

Rapid detection of COVID-19 is the key in controlling the present pandemic. Nasopharyngeal and oropharyngeal swabs are used for COVID-19 testing. Healthcare workers are needed for sample collection. Collection of nasopharyngeal / oropharyngeal specimens causes discomfort to many patients. Patients are also reluctant to come to hospitals for sample collection for various reasons. Studies have evaluated the utility of non-nasopharyngeal samples including saliva for COVID-19 detection.

Yuan et al.obtained swab samples from the nasopharynx and from at least one other location in 530 patients with symptoms of COVID who attended any one of five ambulatory clinics in Washington. Patients were asked to collect tongue, nasal, and mid-turbinate samples, in that order. A nasopharyngeal sample was then collected from the patient by a health care worker. Samples were tested by RT-PCR. When a nasopharyngeal sample collected by a health care worker was used as the comparator, the estimated sensitivities of the tongue, nasal, and mid-turbinate samples collected by the patients were 89.8% (one-sided 97.5% confidence interval [CI], 78.2 to 100.0), 94.0% (97.5% CI, 83.8 to 100.0), and 96.2% (97.5% CI, 87.0 to 100.0), respectively.

Even though the sensitivity is not 100%, considering the present situation in our country this looks like a good trade-off. In future patient driven sample collection from sites other than the nasopharynx will be an important factor in breaking the chain of transmission.

DEEPAK MADI,

Associate Professor, Medicine.

KMC, Mangalore [MAHE]

deepak.madi@manipal.edu

Perioperative Cardiovascular Risk Assessment and Management for Noncardiac Surgery: A Review

Smilowitz NR, Berger JS. Perioperative Cardiovascular Risk Assessment and Management for Noncardiac Surgery: A Review. *JAMA.* 2020;324(3):279–290. doi:10.1001/jama.2020.7840

Patients undergoing noncardiac surgery often have underlying cardiovascular disease (CVD) or CVD risk factors, which can increase their risk for perioperative complications. To determine best practices for perioperative CV risk assessments — a common reason for cardiology consultation — these authors comprehensively reviewed clinical practice guidelines, meta-analyses, and randomized clinical trials. Highlights from NEJM Journal Watch were as follows:

- The medical history and physical exam are the foundation: They can identify underlying risk factors and assess the patient's functional capacity. The inability to perform workloads under 4 metabolic equivalent tasks is associated with greater risk for perioperative CV complications.
- Predicting patient- and surgery-specific CV complications: Risk calculators (e.g., from the National Surgical Quality Improvement Program or the Revised Cardiac Risk Index) are available.
- Left ventricular systolic function: Routine evaluation is *not* recommended in the absence of symptomatic valvular disease or specific indications.
- Stress testing: Routine use is *not* indicated for low-risk patients. Guidelines differ on stress testing with imaging for patients with poor functional capacity.
- Preoperative invasive coronary angiography or measurement of biomarkers (e.g., cardiac troponin): These are *not* recommended routinely in asymptomatic patients.
- Perioperative initiation of beta-blockers or aspirin: This is *not* recommended without specific indications because of associations with greater risks for adverse events.
- Initiation of statin therapy: In the authors' opinion, this is favored (and the American College of Cardiology/American Heart Association [ACC/AHA] practice guidelines recommend it before vascular surgery).

- Perioperative management of angiotensin-converting–enzyme inhibitors and angiotensin-receptor blockers: Canadian and European guidelines recommend discontinuation perioperatively, while ACC/AHA guidelines state that continuing them is reasonable.
- High-risk populations: Older adults and patients with coronary stents have higher risks for adverse perioperative cardiovascular events.
- Elective noncardiac surgery after placement of a drug-eluting stent: Ideally, this should be delayed for >1 year, although some studies found it safe after 3 to 6 months.

DR B.SADANANDA NAIK

Senior Physician

Alvas Health Centre

Moodabidri-574227

D.K. KARNATAKA|

9845051005

Email: sadanandanaik2@gmail.com

INTERPRETING A COVID -19 TEST RESULT

Watson J,Whiting PF,Brush JE.Interpreting a COVID-19 test result.BMJ. 2020; 369:m1808.

https://doi.org/10.1136/bmj.m1808

Highlightsfrom BMJ

- No test is 100% accurate
- Interpreting the result of a test for covid-19 depends on two things: the accuracy of the test, and the pre-test probability or estimated risk of disease before testing
- A positive RT-PCR test for covid-19 test has more weight than a negative test because of the test's high specificity but moderate sensitivity
- Accuracy of viral RNA swabs in clinical practise varies depending on the site and quality of sampling.
- A single negative covid-19 test should not be used as a rule-out in patients with strongly suggestive symptoms
- Clinicians should share information with patients about the accuracy of covid-19 tests
- If your swab test comes back positive for covid-19 then we can be very confident that you do have covid-19
- However, people with covid-19 can be missed by these swab tests. If you have strong symptoms of covid-19, it is safest to self-isolate, even if the swab test does not show covid-19
- A single negative test result may not be informative if the pre-test probability is high

DR ARCHANA BHAT

Associate Professor

Dept of Medicine

Father Muller Medical College

Mangalore

LISTEN TO THE LEGEND – AN INTERVIEW WITH DR K. SUNDARA BHAT (AS TOLD TO DR ARCHANA BHAT)

1. Our beloved Dr. K S. BHAT Sir, could you please share your childhood memories with us?

I was born in 1953 as the last child of NarayanaBhat and Saraswati in villages Manjanady near Konaje. I have six brothers and two sisters. Ours is an Agricultural family. I had to walk a long way to reach my Government Kannada School which was situated at a distance of 3km from our house and my high school was even farther away, nearly 10 km away. But walking through tough was full of fun. Climbing trees, plucking wild fruits en route was our daily ritual. Believe me in those days, learning was natural and we never experienced stress like these days.

2. Sir, something about medical education and how did you get into Fr Muller's hospital?

I was a KMC Alumnus all through, did my MBBS and MD from KMC, Manipal. I was fortunate to get an ICMR fellowship which made me self-sufficient during my post graduate days. After completing my MD, I worked at few private hospitals in the south and central part of Kerala as a physician till 1987. Got a lot of clinical experience under testing conditions with no access to any reference books or journals. I believe these days life of a clinician is quite easy compared to those days, with medical information at finger tips with a click of a button. But, destiny has its own say, one day I came across a newspaper ad from Fr Muller's hospital, Mangalore seeking application for physician's job. My hand written Inland letter got me the interview and there I was as a physician in 1987. I am sure not many will believe me, if I tell you that my starting monthly salary was just Rs 2800. I thoroughly enjoyed the busy and quality clinical work and never thought of changing the Institution till I retired. I was also fortunate to get the experience of teaching faculty when the medical college was started.

3. Sir, you are better known as a 'snake bite' doctor of famous Kankanady hospital, is it true?

I don't claim to be a specialist in snake bite management but, yes, I was a bit more interested in the treatment of snake bites than other medical problems. During my post graduate days, I was very fortunate to work under Prof Vittal Rao, who was a master in treating snake bites with various complications especially the renal failure. KMC Manipal was one of the very few centres in Karnataka to have a dialysis unit. Even during my Kerala tenure, I did get the opportunity to treat several snake bite patients with serious life-threatening complications. The famous herpetologist, Rom Whitaker from Chennai did influence my snake bite treatment protocol. I started to use adequate dose of ASV, though many doctors

called it 'High' dose. I followed the same strategy even after joining Fr Muller's hospital and found almost nil mortality and minimal morbidity. Two patients whom I treated at Kerala cemented my belief in this protocol.

I feel its worth sharing my experience with those two patients.

It was one of those Sunday mornings and I was getting ready to go out with my family. Heard the emergency bell, our paging device in those days! Ran to the emergency room, only to find a patient with no respiration and paralysis of all four limbs as well.

She was unresponsive and the nurses were all over her, trying to give ambu-bag ventilation and trying desperately to start an intravenous line. Unusually, her pulse and blood pressure were normal and the same familiar smell of snake healer's oil was obviously indicating that it's a snake bite. These local snake bite healers used to apply some oil with a characteristic smell over the wound and invariably all the snake bite patients were taken to them before visiting hospitals.

We were fortunate to have a staff nurse trained in anaesthesia who could do endotracheal intubation. Ventilation was started using ambu-bag and 35-40 vials of ASV were administered over next few hours. We took turns to giveambu-bag ventilation, which included few relatives of the patient as well. In about six hours' time, the patient made a dramatic recovery and was extubated successfully. But what she told us on recovery was more astonishing. This is what she told, " I could hear everything, people were telling, it's

too late, no chance etc.. She could also feel the difference in the quality of ventilation, felt really uncomfortable at times, (that's when the relatives took charge!) These patients do not lose consciousness but simply won't be able to respond.

Over the years I did treat several thousand patients with snake envenomation and really loved doing it. My protocol was simple, there is only one drug available for treatment of snake envenomation, that is ASV and only ASV. Every symptom in venomous snake bite is due to envenomation, so start ASV early and adequately. No patient with snake bite deserves to die when in the hospital, if they come alive to the hospital, they should go back alive as well. I never bothered whether my protocol is evidence based or not as long as the end result was favourable.

4. Some memorable days of your patient encounter which you would like to pen down

I feel it's worth sharing an experience with another equally memorable patient and of course he did not have snake bite. He was a 35-year-old man from Kozhikode with all the features of uremic encephalopathy and the treating nephrologist had informed the relatives about the grave prognosis and nothing much could be done at this point. On their way back home, relatives wanted to try their luck at our hospital. He was found to severe uraemia with blood urea more than 300mg%, uremic pericarditis and encephalopathy and I promptly advised them to take him to CMC Vellore for haemodialysis. But the relatives kept pestering me to do something to save his life. Finally, I thought of trying peritoneal dialysis on him. I had the fortunate experience of managing hundreds of acute renal failure cases under the guidance of Prof Vittal Rao, Manipal, hence started peritoneal dialysis using ryles tube as the dialysis catheter. This innovative idea was given by one of the general surgeons of our hospital, who, though was a MBBS graduate, was as good as any experienced surgeon. The patient

improved with few cycles of peritoneal dialysis. I was really glad when he got discharged. He was later treated at a nephrology centre with haemodialysis and survived for many years. The relatives wanted to meet the nephrologist and give him a piece of their mind.

5. Your fascination for nature has made you famous as GREEN DOCTOR. How did this happen?

Since childhood I was fascinated by honeybees. I used to keep a few honeybee hives where ever possible. During my primary school days I have worked in agriculture fields and farms.

That memory and lot of empty space in terrace once again brought me back to terrace gardening. I started with soilless gardening. This attracted lot of attention by plant lovers and gardening public. It gave me lot of opportunity to meet and discuss gardening issues. I feel very happy about it.

ಗ್ರೀನ್ ಡಾಕ್ಟರ್

ತಮಗೆ ಬೇಕಾದ್ದು ತಾವೇ ಬೆಳೀತಾರೆ ಬಂಧುಗಳಿಗೆ ಹಂಚ್ತಾರೆ

• ರಾಘವೇಂದ್ರ ಅಗ್ನಿಹೋತ್ರಿ ಮಂಗಳೂರು

ಹಸಿರು ಹೊದ್ದ ಮನೆ, ವಿಧ ವಿಧ ತರಕಾರಿ, ಸೊಪ್ಪಿನ ಬೆಳೆ, ಕೃಷಿಕರನ್ನೂ ಮೀರಿಸುವ ಈ ವೈದ್ಯರ ತಾರಸಿ ಕೃಷಿಯನ್ನು ಕಂಡರೆನಿಬ್ಬೆರಗಾಗುವುದರಲ್ಲಿಸಂದೇಹವೇ ಇಲ್ಲ. ಮಂಗಳೂರಿನ ಈ ವೈದ್ಯರ ಹಸಿರೊಂದಿಗಿನ ಒಡನಾಟ ಇಂದಿನದ್ದಲ್ಲ.

ಮಂಗಳೂರಿನ ಹೃದಯ ಭಾಗವಾದ ಪಂಪ್‌ವೆಲ್ ಸಮೀಪವಿರುವ ಸುಂದರ ಹಸಿರು ಮನೆಯ ಮಾಲೀಕರಾಗಿರುವ ಈ ವೈದ್ಯರ ಹೆಸರೂ ಡಾ. ಸುಂದರ. ವೃತ್ತಿಯಲ್ಲಿವೈದ್ಯರಾದರೂ ಬಿಡುವಿನ ವೇಳೆಯಲ್ಲಿ ಬೆವರು ಸುರಿಸಿ ತಾರಸಿಯಲ್ಲಿ, ಮನೆ ಸುತ್ತ ಬೆಳೆ ಬೆಳೆಯುವ ಆಪ್ತ ಕೃಷಿಕ. ಮೊದಲೆಲ್ಲ ಏಳು ಗಂಟೆಗೆ ಬಾಳೆ, ಬದನೆ, ಹಾಗಲ, ಹೀರೆ, ಕಾಯಿಹೀರೆ ಹೀಗೆ ಪಟ್ಟ ಮುಂದುವರಿಯುತ್ತಲೇ ಹೋಗುತ್ತದೆ. ಒಟ್ಟಿನಲ್ಲಿ ಹಸಿರು ಹೊನ್ನು ಇವರ ಮನೆಯಲ್ಲಿ ತೊಡ್ಡು ಮಲಗಿವೆ. ತಮ್ಮ 10 ಸೆಂಟ್ಸ್ ಜಾಗದಲ್ಲಿ ಇಷ್ಟೆಲ್ಲಾ ಬೆಳೆದಿದ್ದಾರೆ. ಈದ ವರ್ಷ 8 ಕಿಲೋ ತೂಕದ ಭಾರದ ಕುಂಬಳಕಾಯಿ ಆದಾಗ ಕಂಡು ಸಂಭ್ರಮಿಸಿದ್ದಾರೆ.

ದೇಶದಲ್ಲೇ ಅಪರೂಪವಾದ ಉತ್ತರಕನ್ನಡದ ಜೋಯಿಡಾದ ಗುತ್ತಿನಾಡಿನಲ್ಲಿ ಬೆಳೆಯುವ ಕೆಸವಿನ ಜಾತಿಗೆ ಸೇರಿದ ಮುಳ್ಳಿ ಗಡ್ಡೆಯನ್ನೂ ಇವರು ಬೆಳೆಯುತ್ತಿದ್ದಾರೆ. ಸ್ನೇಹಿತರಿಂದ ಜೋಯಿಡಾದಿಂದ ತರಿಸಿ ಗಿಡ ಮಾಡಿದ್ದು, ನವೆಂಬರ್ ಹೊತ್ತಿಗೆ ಗಡ್ಡೆ ಕೀಳುವ ಸಿದ್ಧತೆ ನಡೆಸಿದ್ದಾರೆ. ಕಾಡು ಪ್ರದೇಶದಲ್ಲಿ ಬೆಳೆಯುವ ಕೊಡಸಗೆ, ಕರಂಡೆ, ಗೌರಿ ಹೂವಿನ ಬಳ್ಳಿಯೂ ಇವರಲ್ಲಿದೆ. ಪೂಜೆಗೆ ಬೇಕಾಗುವ ದರ್ಬೆ ಹುಲ್ಲು, ಬಲ್ಲತ್ತ ಗಿಡಗಳೂ ತಾರಸಿಯಲ್ಲಿವೆ. ಏಳ್ಮದೆಲೆ ಬಳ್ಳಿಯೂ ಮನೆ ತುಂಬ ಹಬ್ಬಿದೆ. ಇಷ್ಟೆಲ್ಲ ಬೆಳೆಯಲು ಪತ್ನಿ ವಾಸಂತಿಯವರೂ ಕೈಜೋಡಿಸಿದ್ದಾರೆ.

> ಇದುವರೆಗೆ ಯಾವುದೇ ತರಕಾರಿಗಳನ್ನು ಮಾರಾಟ ಮಾಡಿಲ್ಲ, ಮುಂದೆ ಮಾಡುವ ಉದ್ದೇಶವೂ ಇಲ್ಲ. ನನಗೊಂದು ಹಸಿರಿನ ಹುಚ್ಚು ಅಷ್ಟೇ. ನಾನು ತಿನುವುದನು ಜಾನೇ ಬೆಳೆಯುತ್ತಿದ್ದೇನೆ.

6. Few challenges for our medical profession at present as physicians

I firmly believe that general medicine practice has become "glorified general practice" with "super speciality" in almost every topic.

Medical profession is under tremendous pressure from all around. This is not confined to our country alone, it is a global phenomenon. We have to get adjusted to the new environment. I don't see any need to panic. I firmly believe that MD general medicine course should be abolished.

7. Since we are in compromising times owing to the dangers of Covid -19 ,what advice would you give us ?

Covid19 has brought in new challenges to medical profession. But such challenges keep coming up, now and then. When consumer protection legislation came, all medical professionals thought it is the end of profession. Nothing much has happened. Profession has enough resilience to meet challenges on the way.

Due to personal reasons I have decided to say goodbye to medical profession.

Remaining part of my life will be dedicated only to my hobbies of beekeeping, gardening and family.

8. Few lines for our API e- magazine

E magazine initiative of API is a good move. But I feel there is too much information about medical literature. So magazine should focus on non-medical topics.

QUIZ

1. The following are the causes of an elevated hemi diaphragm.
   a. Recurrent laryngeal nerve palsy.
   b. Surgical lobectomy.
   c. Subphrenic abscess.
   d. Severe pleuritic pain.
   e. Chronic severe asthma.

2. Magnesium deficiency
   a. Cause confusion, depression and epilepsy.
   b. Usually due to prolonged vomiting and diarrhoea.
   c. Found in uncontrolled diabetes and alcoholism.
   d. Found in primary hyperparathyroidism and hyperaldosteronism.
   e. Best treated with oral magnesium sulphate.

3. The following statements about diuretic therapy are true
   a. Frusemide reduces sodium reabsorption in proximal tubules.
   b. Thiazides aggravate hyperglycaemia and hyperuricemia.
   c. Triamterene antagonises aldosterone in the distal tubule.
   d. Amiloride is contraindicated in oliguric renal failure.
   e. Bumetanide produces hyponatraemia even when when oedema is still present.

4. The findings of reduced Serum free T4 and TSH concentration is compatible with the following conditions.
   a. Hypopitutarism,
   b. Primary hypothyroidism.
   c. Nephrotic syndrome.
   d. Pneumonia.
   e. Pregnancy.

5. Recognised causes of thrombocytopenia include,
   a. Megaloblatic anaemia,
   b. Acquired immune deficiency syndrome.
   c. Disseminated intravascular coagulation.
   d. Von Willbrand disease.
   e. Aspirin therapy.

6. Typical clinical features of acute circulatory failure due to anaphylactic shock include,
   a. Elevated JVP.
   b. Warm dry skin.
   c. Stridor.
   d. Confusion
   e. Polyuria.

7. Typical features of klebsiella pneumonia include,
   a. Upper lobe collapse on chest X-ray.
   b. Severe systemic disturbance and high mortality.
   c. Copious chocolate coloured sputum.
   d. Organism resistant to chloramphenicol and gentamicin.

e. Occurrence in previously healthy individual.

8. The following statements about aspiration pneumonia are true.
   a. Bronchiectasis is a recognised complication.
   b. Chest X-ray abnormality are typically bilateral.
   c. Lobar collapse predisposes to the development of lung abscess.
   d. Systemic onset is usually marked.
   e. Acute respiratory distress syndrome may be a complication.

9. Aetiological factors in development of the spectrum of autoimmune disorder include
   a. Loss of suppressor T cell control of helper T cells.
   b. Immunological exposure to sequestrated antigen.
   c. Bacterial mimicry of tissue antigen producing across reaction.
   d. Drug induced immune complexes activating complement.
   e. Major variation in the MHC.

10. The following statements about penicillin are true.
   a. All penicillin are bactericidal.
   b. Like the cephalosporin, these contain a beta lactam ring.
   c. Clavulanic acid inhibits bacterial beta lactamase.
   d. These can safely be used in cephalosporin allergic patients.
   e. They are best given intrathecally in bacterial meningitis.

ANSWER KEYS

1. a-F, b-T, c-T, d-T, e-F
2. a-T, b-T, c-T, d-T, e-F.
3. a-F, b-T, c-F, d-T, e-T
4. a-T, b-F, c-F, d-T, e-F
5. a—T, b-T, c-T, d-F, e-F.
6. a-F, b-F, c-T, d-T, e-F.
7. a-F, b-T, c-T, d-F, e-F
8. a-T, b-T, c-T, d-T, e-T.
9. a-T, b-T, c-T, d-T, e-T.
10. a-T, b-T, c-T, d-F, e-F.

Medico-legal Pearls

IS MEDICAL PROFESSION OUTSIDE THE PURVIEW OF THE CONSUMER PROTECTION ACT, 2019?

DR. NAGESH KR

Professor & Head,

Department of Forensic Medicine,

Father Muller Medical College, Mangalore.

Phone: +91 9845775907

Email: drnag2002@rediffmail.com

How Consumer Protection Act came into existence in India?

As the industrial revolution with the expansion of goods and services, which led to a variety of consumer goods for the need for consumers. Along with this, the competition among various manufacturing and service providers resulted in comprise in the quality of goods and services. As a result of this, the Indian Government enacted the Consumer Protection Act, 1986 with the objective of providing protection to the interests of consumers.

What is the meaning of Service?

In CPA 1986, “Service” is defined as the “service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service”.

In the Consumer Protection (Amendment) Act 2002, the words "users and includes the provision of" are rephrased as "users and includes, but not limited to, the provision of". After this, many Consumer Protection Bills were drafted with several changes. However, these were not successful to convert into an Act until the CPA 2019.

Why the Medical profession was brought under CPA?

In IMA v/s VP Shantha case in 1995, the Supreme Court held that the doctor-patient relationship is based on mutual contract and the service rendered towards the patient is considered as 'contract for service'. After this judgment, the medical profession was brought within the ambit of a 'service' as defined in the Consumer Protection Act, 1986.

'Contract for service' means a contract where one party undertakes to render services to another, where the service provider exercises a skill by using his or her own knowledge and discretion. Eg., professional or technical services. Whereas, 'contract of service' implies a relationship of master and servant. Here, the service provider (servant) is under obligation to obey orders of the master in the work to be performed. Hence, the 'contract of service' is beyond the ambit of the Consumer Protection Act.

Why confusion about exclusion of healthcare service from CPA?

On 5th January 2018, the Consumer Protection Bill 2018 was introduced in LokSabha by the Minister of Consumer Affairs, Food and Public Distribution. In this bill, "healthcare" was included in the definition of "Service". Immediately after this bill's introduction, many medical professionals and medical professional bodies protested throughout India. They expressed their apprehension that this bill may lead to defensive medical practice which is going to affect the patients adversely in terms of increased treatment costs that make healthcare unaffordable and inaccessible to weaker sections of the society. As a result of this, "healthcare" was removed from the definition of "Service" in the Consumer Protection Bill 2019 which was introduced in LokSabha on 8th July 2019. This led to headlines in the media as "Healthcare was removed from the list of services and consumers can no longer move to consumer court for medical negligence or file a complaint against doctors there". Even many medical practitioners in the country start enjoying that the medical profession is out of CPA. However, IMA as well as legal experts expressed that doctors are not fully protected yet.

Finally, the Consumer Protection Bill 2019 was passed in both houses and became an act "Consumer Protection Act, 2019" which was effective from 20th July 2020 onwards.

So, the inclusion of the word "healthcare" in the list of "Services" mentioned in the Consumer Protection Bill 2018 led to a confusion among the medical fraternity that healthcare receivers no longer can file a suit of medical negligence in the consumer courts.

What is the explanation of legal experts on this?

When CPA 1986 was enacted, there was no mention of healthcare/medical service in the definition of 'Service'. After the Supreme Court Judgement in IMA v/s VP Shantha in 1995, the healthcare service and medical professionals were brought under the purview of the Consumer Protection Act. Later, in Consumer Protection (Amendment) Act 2002, the words "includes, but not limited to" were added in the definition of service. This means that the legal suit can be made against any service lenders other than listed in the CPA 1986.

The definition of "Service" remains the same in all the proposed amendments including the CPA 2019. The mere inclusion of "healthcare" in the Consumer Protection Bill 2018 and subsequent exclusion in the CPA 2019 does not change the provision of suing the healthcare service for any negligent act or deficiency in service.

What are the provisions in CPA 2019 related to healthcare service?

Consumer Protection Act, 2019 was enacted to provide protection to the interests of consumers by establishing authorities for timely and effective administration and settlement of consumers' disputes.

The following provisions in the CPA 2019 can be related to healthcare service:

1. Under the meaning of *Deficiency*, the sentence "any act of negligence or omission or commission by such person which causes loss or injury to the consumer" was included, which can be directly related to medical negligence. And the sentence "deliberate withholding of relevant information by any person to the consumer" was included, which can be related to the 'consent in medical practice'.

2. As per CPA 2019, a complaint can be lodged at different Consumer Courts based on *the "value of the goods or services"* availed by the consumer. Whereas, before the enactment of CPA 2019, the *"claiming amount"* was the criterion for lodging the complaint at Consumer Courts.

The District Commission entertain complaints with the value of goods or services paid *up to one crore rupees*. The State Commission entertain complaints with the value of goods or services paid *more than one crore and up to ten crores*. The National Commission entertain complaints with the value of goods or services paid *more than ten crores*.

The punishment for non-compliance of the Consumer Court order is imprisonment for one month to three years; or fine from Rs. 25,000 to Rs. 1,00,000; or with both.

If anyone wants to appeal against the judgement of a Consumer Court in a higher forum or in Supreme Court, the appellant has to pay the 50% of the awarded compensation before such appeals are permitted.

3. Alternate Disputes Resolution mechanism:

   Consumer Mediation Cells attached to District / State / National Commission was established by the State/ Central Government. In the presence of the nominated mediator, a settlement can be reached in any dispute / complaint between two parties. If no agreement is reached between the parties, the mediator will refer the case to the Consumer Court for further hearing in all issues related to such dispute.

   Mediation is possible only if the criminal negligence has not led to grievous injury, loss of life or handicap. So, in all the Medical negligence cases mediation process is ruled out as per the Law.

4. Complaint can be lodged at a 'place where the complainant resides or works' even though the complainant availed the service at any place other than his/her residing place. That means the service provider has to attend the court proceedings, if demanded, at a place away from his/her place where the service was actually provided. However, a provision

5. of *hearing through Video Conferencing* by the District Commission has been provided to reduce the burden of traveling to distant places by the defendant.

6. Central Consumer Protection Authority (or Central Authority):

The *Central Authority* can do a preliminary inquiry into any complaints through their investigation wing headed by Director-General or District Collector and have powers to punish with penalty or refer the case to District, State or National Consumer Dispute

Redressal Commission. After a preliminary inquiry, the Central Authority is of the opinion that the matter is to be dealt with by a *Regulator* established under any other law for the time being in force, it may refer such matter to the concerned Regulator along with its report. For the purposes of the investigation, the Central Authority, Director General or District Collector may call upon any person inquiry and also direct him/her to produce any document or record in his/her possession. A person aggrieved by any order passed by the Central Authority may file an appeal to the National Commission within a period of 30 days from the date of receipt of such order.

As notified by the Central Government, the provisions of the Consumer Protection Act 2019 have come into force from 20th July 2020 (Except establishment of the Central Authority and the Regulator until further directions given by the Central Government).

SPLENDOR OF INDIAN MINIATURE PAINTINGS -DR MOHAN PAI

Splendour of Indian Miniature Paintings By: Prof. Dr. K. Mohan Pai

Aim of the Presentation:

1. To create awareness amongst the Medical Professionals to visit hundreds of Museums all around the World whenever they attend a Medical Conferences.

2. To introduce them to the **Splendour of Indian Miniature Paintings**

Materials and Methods: By showing three World's best Miniature paintings as a standard example of three stages of 450 years of development of this magnificent art form of India.

Review of literature: From Indus valley in 2000 BCE onwards the Indian artist had developed the technique of writing his history and literature in paintings on granite, mud, wood, fabric, murals and finally on the paper by 13th century AD. This became the source of inspiration for the famous Indian Miniature paintings, one of the great creations in the world of Art. This growth can be studied in three distinctive stages between 15th and the early 19th centuries.

(a) **The Early Phase**: ***(*Picture 1*)*** PreMugal western India or the Gujarthi style which produced the *Kalpasutra*(1439 AD) and the *Kalkacharya Katha* (1575 AD). But the finest amongst them is the famous love lyric *Chaurpanchshika*of the 11th century Sanskrit poet *Billahana*. The romantic interlude of poet Billhana himself and princess *Champavathi* got transformed in to 39 illustrated Miniature Paintings in *Mewar,* Rajasthan (1540-70 AD). The paintings are bright with golden borders, dark star studded night in the back ground and the lovers sitting in a marble structure decorated with color screens, pompons and the *MakaraThorana* the symbols of *Manmatha* the eternal lover.

(b) **The experimental Phase***:* (**Picture 2**) The subsequent century saw the various schools of Miniature Paintings experimenting in techniques, themes and gave various new patrons for the art. While the Mugal ateliers provided the newer techniques, Rajasthan gave new themes. Anand Coomarswamy, the famous art critic, in his Monogram '**Rajasthani Paintings'** published in 1917 has given vivid descriptions of various schools of Miniature Paintings like Mewar, Bundi, Mugal, Bundelkhand, Deccani but the finest example is ***Basholi***(Jammu) style which produced hundreds paintings between AD 1670 – 1760. These different schools of painting were established in the 16-18th centuries patronized

by the different Kings in northern India. The Mugals were also patrons of this art yet lacked the Indian themes. Basholi style is a classic example of the change, especially of the human figures and the surrounding back ground scenery. Krishna with his peacock feathered head gear and large eyes has a charming look and dominates and paintings.

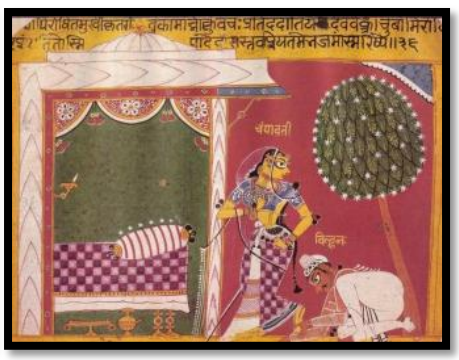
(c) **The Third and the last phase of Glory:** Aurangazeb's Anti Hindu policy brought the fine arts to abrupt halt and the best of the Miniature Painters migrated to the small Kingdoms in Himachal Pradesh in early 18th century. Raja **Goverdhan Chand** and **Sansar Chand** of **Kangra** (1780-1820 AD) gave such a boost to this art that more than 2000 classic Kangra Miniatures were made during the period. Picturesque Kangra Valley, perfected human figures with sharp nose, thin lips with an attractive smile, abundant natural dyes of various shades brought out the World famous Kangra Raagmaala series, GeethGovind series and many other themes.

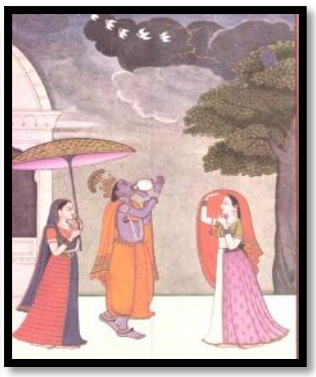
The Raag Megh (Picture 3) shown here is a classic example of this glory. The perfection achieved in human figures can be seen in that of Krishna and his two companions. His head tilted upwards and blowing a Conch at such natural looking clouds with *Saras Cranes* flying past. The colors of the dresses of his companions are perfect match to his own dress and the dismayed looks on their faces are marvelous examples of the perfection achieved in ***Kangra style***.

Conclusion: By mid-19th century British took over Whole of India. Attrition of Indian art forms including Miniatures became a rule only to be found again in Post Independent India. Today you can enjoy these beautiful Paintings **whenever you attend conferences** which are displayed in N. C. Mehta gallery at Ahmadabad, National Museum at New Delhi, Bharath Kala Bhavan in Banaras, Chathrapathi Shivaji Museum at Mumbai, Victoria and Albert in London, Louvre in Paris and dozen other Museums all over the World.

Pictures:

1. Early Phase – Rajasthani style Poet Billana'sChaurpanshashika 1540 AD
2. Development Phase – Basholi style 1680 AD
3. Era of Glory – RaagMegh, Kangra Style 1790 AD





ACKNOWLEDGEMENTS

1. ACKNOWLEDGEMENTS

1. The editorial team is indebted to Dr. Muralidhar Yadiyal and Dr. ArunaYadiyal for their contribution in finalizing the e-magazine name as API-DK-Lahari
2. The section editors of Journal Scan are grateful to Dr Krishna Mohan Prabhu, Moodabidri for his help in page setting
3. We acknowledge all the authors for their contribution for the e magazine
4. Mrs Gayathri hedge , Microbitskankanady in page setting
5. A1 Logics team for the valuable support in DTP design work and final design.

AUTHOR INSTRUCTIONS

GUIDANCE FOR AUTHORS AND CONTRIBUTORS

API DK LAHARI is a quarterly published e magazine of API D. K. CHAPTER , released in the www.apidk.org website with archival options of all the issues released stored in pdf format (each issue) also with download option .The magazine will include academic and non academic articles .The languages included will be English and kannada.We are hopeful that this will give a unique opportunity to all API members to share their vision and views on various aspects of our profession and beyond.

Contact details

Dr ARCHANA BHAT , API(DK) Secretariat

ASSOCIATE PROFESSOR ,

DEPARTMENT OF MEDICINE

FATHER MULLER MEDICAL COLLEGE

MANGALORE- 575002

Tel: ……9591438216……..

Website: ……www.apidk.org……..

Email: editorapidk2020@gmail.com

Submission Email Id:editorapidk2020@gmail.com

Instructions on preparation of the manuscript to be submitted

MANUSCRIPT MAY BE IN ENGLISH/KANNADA .

Font size -12 (Times New Roman) , double spacing ,1.5 inches margins all around the page.

All the write ups should include a Title page with author information

Title Page should contain the following

Full name/names of all the authors with contact address, cell number, email id, designation, position in the Institution and a passport sized recent photo

Paper/write up categories

1. Scientific articles
2. Member's accomplishments
3. Obituaries
4. News and Views
5. Post graduate corner
6. View point
7. Medico legal pearls

8. Journal Watch
9. Patient page
10. Listen to legend
11. Life beyond medicine [Non-medical topics]
12. General health articles [more for lay public]

Scientific articles

1.Case reports

Word count- 1500, Maximum of 03 tables & or figs, 07 Refs

2. Review article

Word count- 3500, Maximum of 5 tables or figs

3. Academic challenge

An interesting case presentation with detailed academic discussion

Abstract, word count -3500, Maximum of 5 tables or figs

4. Diagnostic test and interpretation

Word count- 1500

5. Images in Medicine

Photos with good resolution and quality, Word count -500

Abstract is required for case report, Review article, Academic Challenge, and Diagnostic test and interpretation. Word count is inclusive of abstract.

References should be in Vancouver style.

Member's accomplishments

Brief information by self or others on the accomplishments of our API members in profession, public life, academics and other walks of life

Word count- 1000

Obituaries

Condolence message and short write up on the deceased member

One message -500 words

News and Views

Write up on medical happenings with a personal opinion expressed

Word count -1000

Post graduate corner

Medical article by post graduates

Word count as per the criteria mentioned for the scientific articles by the members

View point

Write up on various problems or happenings in field of medicine or medical profession

Word count -1500

Medico legal pearls

Articles on medical legal aspects of including consumer protection act and other acts applicable to the medical profession

No word limits

Journal Watch

Brief discussion on the important medical publications [national or international] in the last quarter 500 words Each

Patient page

Article on being a patient by API members

Word count- 1000

Listen to Legend

Q AND A about 7 -10 in number with a legend in medicine

word count - 1000

Life beyond medicine

Write ups on Non-medical topics useful for doctors[Investments, sports, automobiles, travel, photography, trekking, cycling, electronic gadgets etc.]

Word count -2000

General Health articles

Medical articles on public health and other health related topics

Word count- 1500

Doctor,looking for your contribution for healthier ,happier India

BIOSYNC

PHARMACEUTICALS (P) LTD

Biosync pharmaceuticals (P) LTD 794-795 Guru Ramdas Nagar Ext. Laxmi Nagar,NewDelhi -92