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AFPI Karnataka Quarterly Newsletter

President's Letter

Dear Colleagues:

It gives me immense pleasure to share with you that the inaugural edition of our newsletter has received very positive reviews and the credit goes to our vibrant editorial team. It will be our endeavor to meet the expectations of our esteemed readers with a focus on bringing high quality content through this newsletter.

It's my earnest request to all members to actively participate in making this newsletter a most interesting and enriching magazine for family practitioners by way of documenting reflections of your practice experiences and writing articles.

It's heartening to note that our recent initiative of engaging our members through online case discussion is becoming popular by the day with some interesting topics presented and discussed by our faculty. I'm excited to announce that we have decided to make this a regular fortnightly online education program and are trying to get credit for the participants.

AFPI Karnataka chapter believes in fostering academic partnerships with various stakeholders having a common goal of educating family practitioners. With this objective, we have been conducting academic activities in collaboration with several institutions. On the 28th of May, we conducted 'Dermatology Update for Family Physicians' in collaboration with Manipal Hospital Bangalore. With each collaborative event, we have seen the academic credentials of AFPI scaling new heights.

I would like to thank the editorial team which is constantly working to set a benchmark by bringing in great ideas and delivering them effectively.

Looking forward to your active contribution and valuable feedback.

Col (Dr.) Mohan Kubendra

AFPI Karnataka will be hosting the next National conference of Family Medicine & primary care (FMPC) at Bangalore in the year 2019

Editorial Note

A dedicated newsletter succeeds only when a large number contribute and actively engage by sending their comments. The task of the editorial team is primarily to edit and present the material in a suitable perspective. The editorial team welcomes all recipients of this newsletter, regardless of their affiliation, to send in their papers, experiences, and case reports towards making this newsletter a rich reading experience.

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Inside this issue

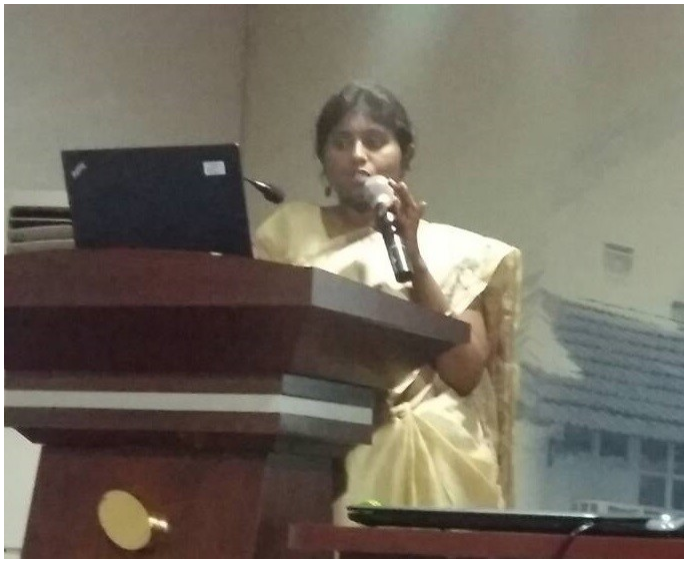
AFPI News

Second Quarterly CME

AFPI Karnataka conducted its *second quarterly CME* on dermatology in family practice in collaboration with Manipal Hospitals on 28th of May, 2017.

The program was presided over by Dr. B. C. Rao, Mentor AFPI, Dr. Mohan Kubendra, President AFPI Karnataka and Dr. Sachith Abraham, Head of the department of Dermatology, Manipal Hospital. Dr. Murali Srinivas (Chief of Clinical services at Manipal) was also present for the inauguration.

More than 70 doctors participated in the program.
The morning session started with a talk on Childhood Eczemas by Dr. Ravi Hiremagalore (Paediatric dermatologist). Case based discussions provided useful insights. Dr. Mukta Sachdev spoke on Acne, a common issue faced by family physicians. Dr. Hemavathi Dasappa of AFPI took us through a family physician's perspective on "Ulcers, Blebs and Blisters."



The morning session was followed by sessions on Vasculitis by Dr. Mukesh Ramnane (Dermatologist at Manipal) and the "Arts and Sciences of Creams and Lotions" by Dr. Srividhya Raghavendran (Family Physician). Dr. Roshni Jhan Ganguly spoke about the different morphology patterns of rashes and discussed case scenarios of systemic diseases presenting with a rash. Dr. Jaya Bajaj's talk focused on skin cancers. A detailed overview on Chronic Urticaria was given Dr Balachandran BV (Paediatric Allergist).

The CME concluded with practical discussions and live demonstrations of procedures in Dermatology.

Upcoming AFPI Events

CME on Psychiatric Disorders in Family Medicine

Date: 10th September, 2017

Last date to register: 3rd September, 2017

Venue: People Tree Hospital, Yeshwantpur

Orientation Program for Family Medicine Residents

Date: TBA

Venue: TBA

Real Time Learning

Since the publication of our first newsletter, AFPI Karnataka conducted 3 more Friday evening sessions on the topics: "Diabetes Management for Family Physicians" by Dr. Saikiran S. (Family Medicine specialist) and Mahesh Mrutyunjaya (Endocrinology); "Approach to Delayed Milestones in Early Childhood" by Dr. Gowri Chintalapalli (Family Medicine specialist) and Dr. Ravikumar (Pediatric Neurologist); and "Breast Cancer Clinical Practice Guidelines" by Dr. Jaya Bajaj (Family Medicine specialist) and Dr. Rajashekhar Jaka (Surgical Oncologist).

Following the discussion on Hepatitis B by Dr. B. C. Rao and Dr. Ramakrishna Prasad, Dr. Vinod Babu has summarized the discussion which appears in this newsletter. This newsletter also has Dr. Ratna Prasanna's summary of the session on management of UTI in family practice that was led by Dr. B. C. Rao and Dr. Hasit Mehta.

Hepatitis B in Family Practice

Introduction

Hepatitis B is not only one of the most common clinical encounters to a family physician but also a disease of major public health concern in Indian setting.

With approximately 36 million HBV carriers (4% of population) and lack of awareness among general public regarding modes of transmission along with overcrowded living conditions and poor hygiene, it is now all more important for family physicians to be aware of the common challenges in diagnosis, management, follow up and prevention of a patient diagnosed with HBV.

This is a humble effort by AFPI to instill confidence in FPs to be able to diagnose and manage this disease.

1. When to screen a patient for Hep-B in family practice?

- All antenatal women
- All pre-operative patients
- HIV+ patients
- Certain high-risk groups like health care workers, HIV+ patients, family members of known Hep B+ve patients, CKD patients on dialysis, professional blood donors, IV drug abusers, jail inmates, sex workers, etc.
- As a part of pre-travel assessment to a foreign country
- All patients presenting with clinical jaundice.

2. What history one needs to focus on?

- Onset, progression & duration of current illness.
- Past history of liver disease
- Symptoms of chronic liver disease like hematemesis, abdominal distension, piles, etc
- Blood transfusion
- Recent surgery or dental procedure.
- Child birth history
- Sexual history
- Partner's serology status
- Lifestyle habits (alcohol, smoking, drug abuse) & occupation
- Hepatitis B vaccination status

3. Which clinical features one needs to look for?

- Hepatomegaly
- Ascites
- Circulatory changes-spider nevi, palmar erythema, etc
- Endocrine changes
- Hemorrhagic tendency
- Signs of portal HTN
- Hepatic encephalopathy

4. What are the tests one needs to perform?

- HbsAg as a fast and inexpensive method to screen for Hep B.
- Ideally, HBsAb and HBc IgM also wherever possible.
- Once confirmed full Hepatitis B panel.
- Baseline LFTs, platelets, USG scan
- HBV DNA quantitative PCR/viral load
- APRI (AST to platelet ratio Index score)
- Fibroscan
- Liver biopsy if there is ongoing liver damage.

5. When to treat?

- Hepatitis B has 3 clinically distinct phases, immune tolerant, immune active & non-replicative phases.
- Patients in immune tolerant phase, hallmarked by HBsAg +ve, high HBV DNA titers but normal LFTs, does not need anti-viral therapy as there is no HBV mediated liver cell damage at this stage. 90% of adults and only 20% of infants in this stage clear HBV infection spontaneously and develop HBsAb.
- Patients in immune active phase (Chronic active hepatitis) need treatment with anti-virals tenofovir) and they tend to have elevated liver enzymes, HBsAg +ve status and HBeAg +/-. If HBeAg is positive, viral load tends to be high. Anti-viral therapy needs to be started in such patients without any delay as there is ongoing liver cell injury. APRI score + Fibroscan needs to be done to ascertain the extent of fibrosis.
- Emergence of anti-HBe antibody in such patient indicates onset of non-replicative phase and if there is no evidence of cirrhosis, anti-virals can be stopped with periodic monitoring of LFTs, HBeAg status and USG.

6. Who to treat?

- As a priority all adults, adolescents and children with Chronic hep-B and clinical evidence of compensated/ decompensated cirrhosis (or cirrhosis based on APRI score>2 in adults) should be treated regardless of ALT levels, HbeAg status or HBV DNS levels.
- Adults >30 years of age with persistently abnormal ALT levels and high HBV titers regardless of HBeAg status, but without evidence of cirrhosis.
- Where HBV DNA testing is not feasible, persistently abnormal ALT levels alone warrants treatment regardless of HBeAg status.

7. How often one needs to monitor these patients?

Every 6-12 months with LFT, CBC, AFP & USG liver.

Key Take-home points from discussion

- Coinfection with HCV and HDV follows more aggressive course and increases risk of HCC.
- USG has only 50% sensitivity in determining cirrhosis
- APRI is a simple, inexpensive, yet valuable tool in determining the stage of liver disease. APRI >1 indicates significant fibrosis, APRI>2 indicates cirrhosis (46% sensitive & 91% specific). To improve diagnostic accuracy, a combination of APRI score and Fibroscan is recommended.

http://www.hepatitisc.uw.edu/page/clinical-calculators/apri or QX Calculator app.

Thanks to Dr. B. C. Rao and Dr. Ramakrishna Prasad for leading this case discussion.

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Urinary tract infections in general practice

UTI may present with upper urinary tract symptoms, lower urinary tract symptoms, or systemic symptoms. Symptoms can help us to localize the site of infection

- Lower urinary tract symptoms are: Dysuria, Hematuria, Increased frequency, Supra pubic discomfort/ pain
- Upper Urinary tract symptoms are: Flank pain, Nausea/Vomiting
- Systemic symptoms are: Fever/chills/Rigors, Nausea/Vomiting, Fatigue – may be early symptoms of sepsis

All mentioned symptoms generally occur in adults, whereas presentation may be different in children & the elderly

- Child/infant may present with: Fever, Excessive cry, Vomiting, Irritability, and poor feeding
- Elderly may present with: Altered sensorium due to dehydration & dyselectrolytemia, reduced activities of daily living.

Symptoms differ with age & site of infection

Predisposing factors for UTI in adults irrespective of gender include: Uncontrolled DM, Immuno compromised states (chemotherapy/ nephropathy, Anemia), Poor Hygiene, STD, Debilitating illness, bedridden states/ Catheterisation, Preexisting Urogenital illness/Calculi

Predisposing factors in males	**Predisposing factors in females**	**Predisposing factors in children**
Prostate enlargement	PID	Reflux
Stricture urethra	Premenopausal	Posterior urethral valve
Reflux	Post menopausal age group (loss of estrogen causes loss of protective flora in vagina)	Phimosis
Epididymoorchitis		Congenital Anatomical variation

Coitus & Instrumentation may precipitate UTI at any age & in any individual

Predisposing factors differ in males & females & children. Always identify them to prevent recurrent infections.

Essentials to be considered in history & examination of patient with UTI

- *Personal history*: Ask for patient`s hygiene practices, Sexual history & Partners genital health, Barrier contraception/Spermicidal jelly usage, Presence of other predisposing factors/Co morbid illness

- *Past history:* If Documented UTI in the past (If possible also record the organism), Renal calculi, Preexisting Urogenital illness (E.g.: Voiding difficulties, incontinence, anatomical variations like diverticulum etc), Debilitating illness, Prostate problems (in males), Catherisation & indication.

- *General Physical examination:* Mental status (may be altered due to dyselectrolytemia), Temperature (may be febrile), Pulse rate (tachycardia may be present), Blood pressure (narrow pulse or low blood pressure may indicate hypovolemia or sepsis), Hydration status (Mucosal dryness-dehydration is common in children & geriatric population)

- *Systemic Examination:* CVS (tachycardia), RS (tachypnea), P/A (suprapubic tenderness in lower UTI, flank tenderness in upper UTI, also percuss for bladder fullness),P/V (Vulval hygiene , look for Vaginal discharge, Cervical motion tenderness),Genitalia (In a male & Child specially look for prepucal retraction, evidence of Phimosis),P/R-(Stool impaction & prostate size & consistency) (Constipation causes voiding difficulty & recurrent UTI)

Investigations are done to confirm diagnosis & identify the site of infection, detect predisposing factors & identify complications

Investigations to confirm diagnosis are:

1. Urine analysis for: Nitrates, Leukocyte esterase (both indicate urinary infection, bedside test)
2. Urine Microscopy to detect pus cells/Bacteria/casts/ crystals/RBCs. Casts indicate involvement of upper urinary tract.
3. Urine for culture-Most diagnostic (send the sample for culture before initiating antibiotics)
4. CBC for systemic infection
5. USG helps to localize the infection & also can detect renal scarring & post void residue & kidney morphology
    a. Always ask for post void residue in scan request form specifically as many radiologists don't perform it routinely
    b. Specially UTI in men & children & peri & post-menopausal women look into post void residue
    c. Specific way to asses post void residue is to catheterize & measure, since it is not always feasible & carries a risk of Catheter associated UTI, it is performed in Urinary obstruction patient with Retained urine.
    d. Scan is reasonably specific to asses post void residue

Investigations to detect predisposing factors: CBC (Anemia), renal functions tests & e GFR (Nephropathy), Sugar control (FBS, PPBS, Hba1c-poorly controlled DM)

Investigations to identify complications: Serum electrolytes (Dehydration & dyselectrolytemia), CBC (Leukocytosis- sepsis)

Techniques to collect urine sample:

- Mid-stream clean catch sample is collected in adults who can collect the sample & catheterized sample is collected in debilitated adults.
- Collection of urine sample is challenging in children. Opening the tap & encouraging the child to pass urine is one method. Pediatric uro bag collection & Suprapubic aspiration are other techniques.

Goal of History taking & examination & investigation of the patient with UTI is to establish the site of Infection & detect the predisposing factors for UTI & identify the complications of UTI

Management

Symptomatic /Empirical management: Urine Alkalinizing agents, Increase the Fluid intake, Antipyretics, Antibiotics, Antispasmodics, Urinary analgesic (like Pyridium)

Choice of antibiotic:

- Cotrimoxazole is the first line
- Broad spectrum cephalosporin
- Ciprofloxacin
- Amoxicillin clavulanic acid +- Amino glycoside for systemic infection
- Nitrofurantoin is the last choice as it is bacteriostatic but not a choice in Systemic infection

Avoid quinolones & keep them available for TB cases.

Duration of Treatment

- Uncomplicated lower UTI -3 days- follow up (clinical response & Urine routine will guide about extension of antibiotic usage)
- Upper tract or febrile UTI -10-14days
- Make sure infection has resolved or prove it has not resolved at the end of antibiotic course

Special points for Geriatric patients with UTI

- Prone to dehydration& dyselectrolytemia early & become delirious
- Admit & hydrate well
- Complicating factors + Elderly require aggressive management

Special points in pediatric age group

- Pediatric cases with recurrent UTI With VUJ reflux require surgical intervention, hence refer to urologist promptly.

Few points about Recurrent & persistent UTI

- Investigatory screening is recommended in recurrent UTI & in complicated UTI patients
- Persistent UTI –always look for focus & evaluate for TB
- Recurring UTI with culture negative pyuria-is an indication to evaluate for TB
- Urinary AFB is reasonable first step & cost affordable to check for TB but specific being gene expert
- Mannose & cranberry juice usage lacks definitive evidence but few patients have benefited in practice.
- Many life style advices that are given in general practice lack supportive evidence but not harmful if advised especially in recurrent UTI. Few Examples are quoted below:
  - ◊ Urinating before & after intercourse
  - ◊ Avoiding bubble baths, strong detergent usage, Tampons & vaginal douches
  - ◊ Changing barrier contraceptive methods to alternate methods, Avoiding
  - ◊ Cleaning from front to back & care about undergarment hygiene
  - ◊ Men with BPH are advised to Urinate in sitting position (Less post void residue in doing so than standing)

Summary

- Symptoms of UTI depend upon the site of infection & systemic spread
- Symptoms differ with pediatric population& geriatric population & they are prone for dehydration & dyselectrolytemia early.
- Search for causative & complicating factors in history/clinical examination & investigations
- Children & men with UTI require through checkup of Urogenital system & structural defects & strictures
- Make sure to ask & examine for sexually transmitted infections in reproductive age group females
- Send urine for culture before initiating antibiotics
- Ultrasound can help to localize infection in doubtful cases & also it can pick up renal scarring in chronic pyelonephritis & post void residue & prostate size in men
- Start empirical antibiotics with trimethoprim sulfamethoxazole, broad spectrum cephalosporin, amoxicillin clavulanic acid with or without amino glycosides for systemic infection, quinolones & Nitrofurantoin are the last resorts as there is problem of resistance.
- Treat uncomplicated UTI for 3 days & complicated or systemic UTI for 10-14 days with antibiotics
- Make sure infection has resolved or prove it has not at the end of treatment

Complicating factors & systemic UTI always require aggressive management in elderly.

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Ymada

A new drug used in congestive heart failure. It is a combination of Secubutiril and Valsartan. When used in Congestive Cardiac Failure (CCF) it is significantly better than ACE inhibitor Enalapril with comparable safety. It acts by boosting the natriuretic peptides and inhibiting the renin angiotensin aldosterone system [RAAS]. The trials reveal that this drug combination reduced the risk of death from cardiovascular causes by 20%, reduced the incidence of hospitalization by 21%, and all-cause mortality by 16%. Caution in warranted in patients with hepatic or renal impairment. There is a distinct possibility that this drug will replace the ACE inhibitors in the treatment of chronic heart failure in the future. This drug is available in the Indian market and like all new and patented drugs, it is expensive.

Is PCOS an Autoimmune Condition?

Currently, the diagnosis of PCOS is a diagnosis of exclusion typically made using the Rotterdam criteria, which require two of the following three to be present: oligo- or anovulation; clinical and/or biological signs of hyperandrogenism; and detection of polycystic ovaries by ultrasound. There is no laboratory based assay to diagnose PCOS.

At the annual meeting of the American Association of Clinical Endocrinologists (AACE) 2017 Annual Scientific & Clinical Congress, the development of an ELISA assay that detects serum autoantibodies directed to the 28-amino acid second extracellular loop of the GnRH receptor that can be an inexpensive, sensitive, and specific test to identify subjects with PCOS-activating autoantibodies, was reported. This finding has the potential to transform our understanding of PCOS and pave the way for significantly more targeted and effective therapies.

Given the burden of PCOS encountered by family physicians in practice, further updates are eagerly awaited.

Can Thirty-Minute Office Blood Pressure Monitoring reduce overtreatment of white coat hypertension in Primary Care?

Abstract

Purpose: Automated office blood pressure monitoring during 30 minutes (OBP30) may reduce overtreatment of patients with white-coat hypertension in primary health care. OBP30 results approximate those of ambulatory blood pressure monitoring, but OBP30 is much more convenient. In this study, we compared OBP30 with routine office blood pressure (OBP) readings for different indications in primary care and evaluated how OBP30 influenced the medication prescribing of family physicians.

Methods: All consecutive patients who underwent OBP30 for medical reasons over a 6-month period in a single primary health care center in the Netherlands were enrolled. We compared patients' OBP30 results with their last preceding routine OBP reading, and we asked their physicians why they ordered OBP30, how they treated their patients, and how they would have treated their patients without it.

Results: We enrolled 201 patients (mean age 68.6 years, 56.7% women). The mean systolic OBP30 was 22.8 mm Hg lower than the mean systolic OBP (95% CI, 19.8–26.1 mm Hg). The mean diastolic OBP30 was 11.6 mm Hg lower than the mean diastolic OBP (95% CI, 10.2–13.1 mm Hg). Considerable differences between OBP and OBP30 existed in patients with and without suspected white-coat hypertension, and differences were larger in individuals aged 70 years or older. Based on OBP alone, physicians said they would have started or intensified medication therapy in 79.1% of the studied cases (95% CI, 73.6%–84.6%). In fact, with the results of OBP30 available, physicians started or intensified medication therapy in 24.9% of cases (95% CI, 18.9%–30.9%).

Conclusions: OBP30 yields considerably lower blood pressure readings than OBP in all studied patient groups. OBP30 is a promising technique to reduce overtreatment of white-coat hypertension in primary health care.

IMichiel J. Bos, MD, PhD; Sylvia Buis, MD, MPH
Ann Fam Med. 2017;15(2):120-123.

Our online learning program on Friday night has been successful so far. To participate as a faculty / consultant please contact Dr. B C Rao or Dr. Jaya Bajaj.

CMV Esophagitis in a patient with drug resistant HIV

A 37-year-old male patient, a fitness trainer by profession, patient presented with severe epigastric pain. He was admitted to the hospital by the gastroenterologist with a working diagnosis of acute pancreatitis. The. The patient reported that the pain was directly related to the intake of food and drink, resulting in a feeling of fullness and a burning sensation on swallowing similar to heartburn (odynophagia). The increasing discomfort had, during a course of approximately 4 weeks, caused a decreased in food intake, resulting in weight loss of nearly 10 kg. By the time of admission, even the intake of fluids had become difficult. The patient was emaciated.

Five years back, the patient had been diagnosed with HIV infection and had been started on anti-retroviral therapy (Tenofovir/Lamivudine/Efavirenz) which he was on at the time of admission. A review of his record from the ART center, a consistent drop in CD4 counts. The most recent count was 54 cells/cubic mm.

. With the patient reporting increasing pain on swallowing (odynophagia)), a gastroscopy was performed, showing a deep ulceration in the mid esophagus with its base covered with slough (see Fig1).

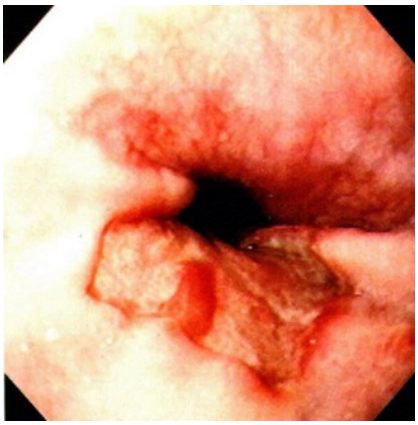

Figure 1: Endoscopic findings in the esophagus of the patient
Source: Wilcox, CM et al. Prospective endoscopic characterization of cytomegalovirus esophagitis in AIDS. Gastrointestinal Endoscopy. July–August, 1994Volume 40, Issue 4, Pages 481–484

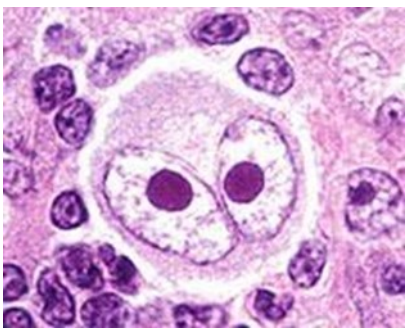

Figure 2: Owl's eye inclusions in the nucleus typical of CMV infection

Source:https://classconnection.s3.amazonaws.com/12/flashcards/3011012/jpg/owl_eye1366847227068.jpg. Downloaded on 5/7/17.

Biopsies from the ulcers and plaques were taken. Histology revealed the presence of owl's eye nuclear inclusions (see Fig 2) suggestive of cytomegalovirus (CMV) esophagitis,

Subsequent to this report, the patient received intravenous ganciclovir 5 mg/kg every 12 hours for7 days. The therapy was well tolerated with no adverse effects. There was a reduction in odynophagia. The patient was discharged in a much better condition with the advice to be on oral Valgancyclovir 900 mg twice daily for 14 days.

An opportunistic infection such as CMV esophagitis in someone on ART raised the concern that his antiretroviral therapy was failing. This could be the result of either poor adherence or the development of resistance. In our patient, a diagnosis of ART Failure was made.

Discussion

Patients with CMV esophagitis present with odynophagia or dysphagia, described as difficulty in swallowing or a sense of obstruction—either substernal, epigastric, or in the throat. Liquids are often better tolerated than solids such as meat, which may worsen both odynophagia and dysphagia. Pain may be exacerbated by the ingestion of acidic liquids and belching (eructation). This could result in weight loss and dehydration. The endoscopic appearance of CMV esophagitis is characterized by large (sometimes >10 cm^2), shallow, "punched-out" ulcers, either solitary or multiple, located in the middle or distal part of the esophagus. A diagnosis of CMV esophagitis is confirmed by biopsy and histology findings, immunohistochemistry, and PCR.

ART Failure is becoming an increasingly common problem as patients mostly go undetected d. Viral load testing is not available at most government ART centers. Lack of awareness among caregivers and cost further complicate the issue. Genotype (drug resistance) testing is rarely done in India. . Presently, it is done only at few centers in the country. As a result, in our current scenario, patients are generally recognized very late into the disease, often too late.

In our patient, genotype testing for HIV was difficult due to financial constraints. His ART was modified to Tenofovir/Lamivudine/Atazanavir based on anticipated resistance profile by the HIV specialist, who is also a Family Medicine physician. A letter was written to the government ART center requesting a change to the above ART combination. It still took 3 months for patient to get this therapy through his ART center, which is valuable time lost in treatment at such a critical stage.

As our relationship with the patient grew, another facet in his case was that his wife was HIV negative. They had fallen in love and despite him telling her about his HIV status, she had married him. They had, however, not consummated their marriage due to concern for transmission. One of the couple's regrets was their belief that they would never be able to have children together.

A paradigm shift

As our therapeutic relationship evolved, we worked with the patient and his wife to change their outlook towards their future. We explained that HIV infection is not a death sentence and millions of patients are living healthy and fulfilling lives after their diagnosis. We also spoke about the multiple safe and simple options for them to consummate their marriage and even have children. It is now well known that among serodiscordant couples (where one partner is HIV positive and the other is negative), if the positive partner's viral load is undetectable (which is the goal of ART), the risk of transmission to the uninfected partner even with unprotected sex is extremely low. In fact, a large international study (where there were participants from India as well), found zero transmissions among serodiscordant couples when the positive partner's viral load was undetectable. This risk can be further reduced by offering preexposure prophylaxis (PrEP) to the negative partner. These conversations and messages helped him and his wife to change their outlook. The couple were counselled about the possibility of them having children after his present infection is controlled (viral load becomes undetectable after appropriate switch in ART).

It is nearly 4 months since we first saw this patient and we are happy to report that our patient who came with little expectation of improving has gained nearly 10 Kg since switching his ART. His CD4 has risen from 54 cells/cubic mm to nearly 260 cells/cubic mm. They still have not consummated their marriage but are moving in that direction.

Personally, this case resulted in a paradigm shift in my thinking about HIV infected patients. My purpose of this case report was to show that motivation and counselling in a patient suffering from HIV/AIDS (CMV esophagitis with ART failure in this case) can bring in a complete change in their thought process and outlook towards the disease and their future. The realization that HIV can be effectively controlled even in the face of ART failure that enables a patient to lead a healthy and fulfilling life has the ability to transform outcomes for patients and their families.

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Practice Experiences

Doctor as the detective: A case of painful muscle spasms

The call came again from Mr. Devarajan's apartment. I had gone there the same afternoon and found him fairly alright though his arm was still twitching a bit. He was able to swallow food and was comfortable and even spoke to me with some optimism which had cheered me. Now, comes this call of distress.

Devarajan was a senior executive in one of the top food processing companies with its headquarters in Bangalore. When this incident occurred some fifteen [now 20] years ago, I was the company's medical advisor and would visit twice a week in the afternoon. The company had built apartments next to the office for twenty odd senior officers with built in amenities, befitting a successful company. Devarajan and his family were occupying one of these. My practice being close by, I got not very infrequent calls from these in-house families whenever there was an illness that needed to be attended to at home. Lately calls from Devarajan had become frequent and urgent and what was worrying was that I had not been able to find out what was wrong with him.

I saw him sitting hunched up with head held up. There was uncontrollable twitching of the face and lips with drooling of saliva. His jaws were clenched tightly and he could open the mouth with great difficulty. Neck was held rigidly at a tangent. Lower limb, abdomen and trunk muscles were less affected and he was able to walk without any difficulty. Hands and arms were also rigid but not to the same extent as muscles of the face, jaws and neck. He was not able to speak with any degree of coherence. Going by the past experience I gave him an injection of Diazepam and oral clonazepam with baclofen [all are muscle relaxants].He settled within a few minutes and I was sure he would be ok at least till morning.

Devarajan began having these problems a month ago one evening. Though certain that these were caused by unopposed motor impulses from the brain I did not know the cause. Other conditions which cause rigidity and spasm like Parkinson's disorder and Motor neuron disease have a chronic course and there is usually a history of many years. Another factor was that he was too young to have any of these. A brain scan did not reveal any abnormality.

Elaborate blood studies, opinion from two well-known neurologists did not produce any result except the prescription which controlled the acute symptoms as described above. There was even a suggestion for a psychiatric consultation! I wondered how a person can voluntarily bring on these painful spasms just to mimic an illness even if he did have some psychiatric disorder.

The management was worried as the man's work was suffering and he could hardly attend office as he was doped most of the time [thanks to my ministrations] though during the day his problems were manageable. Devarajan's misery had me worried and puzzled. Worried because of his suffering and no long-term solution in sight and puzzled because I was unable to find a cause even with all the expert help that was available.

This was the state of unsatisfactory affairs when Devarajan had to go to Chennai on some errand for a week. He called me son after his return. I went to see him. He was not home. I went to his office. He was busy with work and welcomed me with a big smile. He was completely fit and there was no evidence of any illness at all and it was so since a week! Devarajan said when he was at Madras he went to see a doctor who practiced Ayurveda [Native medicine] and since he started the medication he has become free from all the symptoms that has been bugging him for the past one month. He just wanted me to see him free of the spasms and share the good news with me. I don't know who was more relieved, the doctor or the patient.

I have on occasions, though rarely, come across such cures. Though there is no evidence that alternative approaches have cured a particular condition which we, allopathic practitioners have been unable to cure, the cure itself is most welcome. Though how the medication brought on the cure was a puzzle, I was relieved that I no longer had to worry about Devarajan and see his misery.

This happy state of affairs did not last long. A week later he called me again as the problem had recurred and a telephonic consult with the Ayurvedic practitioner ended in doubling the dosage with no relief. This was the time I started looking for causes other than are normally known. Reference to a text book on advances in neurology made mention to acute onset of symptoms such as experienced by Devarajan, in persons exposed to pesticides, who have a genetic predisposition. But how is Devarajan, living in the well-appointed flat, be exposed?

The flats are treated once a month for vermin with insecticides. Could this be a cause? But why is he having this problem almost daily? Then it occurred to me. The possible cause could be the clouding that is being done almost daily to the whole campus to ward off the mosquitoes. The poisonous [to the mosquito] cloud contained organochlorines and there was indeed a reference that these can cause the symptoms.

I saw to that he stayed out of the campus. That cured him. He was one of those rare individuals who had a genetic predisposition to develop acute and painful muscle spasm and fasciculation when exposed to pesticide spray!

There are a few take home points from this case.

Firstly, my search for the incidence of muscle spasms with excessive salivation did not yield any results on PubMed. I eventually found references using the search words, "acute poisoning along with other signs and symptoms". Narrowing the search to the words, 'muscle spasms and inhaled pesticide' did not yield any additional information.

The second point is to refrain from the tendency to dump patients whose complaints don't fit into a clear diagnosis thoughtlessly as having a psychiatric illness.

Third point is the importance of follow up, when you see a patient for the same problem several times, often the cause becomes obvious, especially so when you make house calls.

Last, one should not give up.

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Why should I be a generalist? A Specialist's view

It often happened in my practice as a Urologist that I was the first point of contact for few of my patients. While I could address their Urological problem reasonably well, but my appreciation and management of their other problems, especially non-surgical; was under average. I was providing treatment for a part of the whole problem list, at times only a small part. An old adage – A Physician says hello to the heart while a Surgeon shakes heart's hand. I 'did shake hands with the heart' but had forgotten to 'say hello'! Consequently, I decided to relearn how to say a hello with a smile…while I shake hand.

My journey started with the IAPC certification course that I undertook in 2012 to manage my Oncology patients better. During that course I realised that all my other patients also needed me to be a better "overall" doctor and so the M. Med from CMC followed. It has brought much more understanding and enlightenment to me in managing the patient I treat as a whole. It has also been an enriching and humbling experience.

I probably felt that that non-Urological part of patient management was 'not my job or responsibility'. That's an incorrect approach and attitude. I now believe that every medical professional needs to be a good general doctor over and above anything else. We owe it to our patients, society and our calling; to be so.

I also feel the reverse is equally true! Most of us as family Physicians are better at managing some conditions / disorders of a certain system, than others. We are good at these things, it comes more naturally to us, we have a knack of it or whatever you call it. And therein lies the desire to do better in that field, the seed to be a Specialist. And we owe it to ourselves to find that domain and pursue it. Wouldn't it be great if every Generalist formally / informally pursued to be better at one speciality? Of course, never stop being a Generalist.

If I could, I would also urge my non-para-quasi clinical colleagues to not 'give up' on the clinical training they have received and if necessary brush it up and put it to good use. There always is and will be a need for good Family Physicians and we can use all the hands which are ready to help.

So let us continue to learn-unlearn-relearn. Let us, in our hearts, go back to school; and remain there for good.

Referral

All doctors must constantly learn to make, receive and reply to a referral. If involving a colleague, of any cadre, can improve a patient's management; it's always worth it. Before a referral I always ask and answer a group of questions. **WHICH** patient am I going to refer? **WHY** am I going to refer? **WHEN** am I going to refer? **HOW** am I going to refer? To **WHOM** am I going to refer? And lastly **WHAT** am I going to do with the end result?

Many Urological ailments (or of other specialities for that matter) need to be treated on chronic care basis and will remain a part of a Family Physician's day to day practice. So, let me answer the above questions from an FP's perspective.

Which – I should refer the patient in whom I am not sure what is happening and how to manage it.

Why – I may need to refer a patient to diagnose, to evaluate, to decide treatment, for intervention, for routine follow up, for a new development, for an emergency or for a second opinion.

When – The 'why' of a referral will also decide the 'when'.

How – Talking directly to the concerned doctor is a good add on but not a replacement of a written / e-mailed / messaged, documented format. The referral letter should contain the background (Medical & non-medical) of the patient, reason for referral and what is expected of the person referred to.

Whom – Identify the person(s) to refer to, preferably beforehand, from the viewpoint of the patients I serve, their residential location, their financial and medical insurance status and their preferences. Better the professional relations and rapport with the doctor referred to, better the outcome. And if the rapport is good, often it is not the patient who makes the referral journey, only the information to and fro.

What – Clearly state in the referral letter as to what do I expect to achieve from the referral. And be ready to incorporate that in the future management of that patient, once achieved. I will be looking after the patient before and after the referral, and hence a feedback about the patient to the referral person is always a good idea.

Keeping the above discussion in mind and one's individual prowess, every doctor can determine which patients **DO NOT NEED TO BE REFERRED.**

Following is a list of common urological conditions which an FP might routinely treat and a workable list for those conditions where an FP might consider a referral; addition / subtraction being a matter of personal discretion.

UTIs – Urosepsis, severe UTI with complicating factors (Uncontrolled DM, obstruction, renal dysfunction, neurovesical dysfunction, nosocomial, MDR, etc.), recurrent, refractory, UTIs with unusual features (Culture negative), with foreign bodies like catheter, UTIs at extremes of age, post treatment abnormal finding (Clinical or investigatory)

Urolithiasis – Multiple, obstructive, progressive, recurrent, with infection, with renal failure, post-intervention problems

BPH – To rule out malignancy and to define other associated factors, with haematuria-infection-retention-renal dysfunction-stones, worsening on treatment, treatment side effects, post-intervention problems
All cases of non-BPH obstruction in urinary tract should be referred.

Infertility – (Male patients only) – obstructive azoospermia, failed conservative management, with genital anomaly or disease.

Sexual dysfunction – (Male patients only) – Those in whom PDE5I is contraindicated or fails or creates a side effect, those with priapism

All suspected / proven cases of **TRAUMA, TUMOUR, TORSION (**OR ANY VASCULAR INSULT) should be referred.

All children with suspected / proven **CONGENITAL ANOMALY, AMBIGUOUS GENITALIA,** should be referred.

If a planned follow-up to the Urologist is requested at prior referral, the patient should be referred back accordingly with progress / investigations reports as planned.

My sincere thanks to team Newsletter and AFPI for this opportunity.

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Resident's Corner

There is never a lost cause

This dates to the first year after my medical schooling. I had joined the Neuro-Anesthesia department, NIMHANs as a junior resident to primarily work in the Intensive Care Units for 12 months on a contract basis. I was the only non-anesthetist working in the department and was often referred to as a "kid".

The Neuro-Medical ICU (NMICU) was six bedded and there was always a scarcity of beds. We had this patient being shifted from the Emergency Room (ER), with history of breathing difficulty. On evaluation, this was a known case of Myasthenia Gravis (MG) with a history of recurrent hospitalizations for his respiratory failure. In his medical condition, he would have no strength in his muscles including his respiratory muscles, and he would be laboring for air while being fully conscious. Were he not provided mechanical ventilation, , he would succumb. He was lucky to get a bed in the NMICU, as another patient had just been shifted out.

The patient was a senior engineer in one of the government companies in Bangalore and his cost of hospital care was well taken care of.

He had a devoted wife who had seen these hospital admissions before and was prepared for this time's ride too. But for me it was a new learning experience.

The patient was put on a ventilator, treatment as per Neuro ICU protocols was followed. He received Inj Neostigmine 3-4 times a day and felt stronger for 2 hours after each dose. It was [distressing] to see his strength go out of his muscles as the drug effect wore out. The nurses worked hard to make sure he was comfortable and did not develop bed sores. He would communicate with the ICU team and his family by scribbling on a note pad. I soon learnt his expressions and worked as his translator when he wanted to communicate.

I was growing in my knowledge and clinical skills as I was continuing to work there I would start the day at 8am and work till 8pm with half a Sunday off. I started mastering ICU protocols, ventilator management, establishing central venous lines, doing bedside tracheostomy etc. While I progressed with my clinical skills, our patient continued to be dependent on the ventilator. It was8 months and he did not seem to remit.

The neurologist took a call and wanted to get a thymectomy done for him. He was shifted to a corporate hospital and a well-known cardiothoracic surgeon removed his thymus and he was shifted back to our NMICU. The post-surgery management protocols were followed and he continued to be on the ventilator. Months passed by and his dependency on the ventilator continued and in addition he developed an open surgical wound which refused to heal.

His strong-willed wife was beginning to lose hope. All these months, she and I had developed a friendship and we both were coaxing each other that he would improve and walk home. She who was a house wife took up a librarian's job to support her family. Her daughter was going to take her 12th grade exams.

Soon it was 11 months and he was going in for multi-organ failure. His wife and me could not look into each other's eyes. I felt I had failed on my part to convince myself and her that he would walk home. I did not know what she was thinking. And after 11 months of NMICU stay, he passed away.

The man who orchestrated this great care, where a completely ventilator dependent person who could not even open his eyes due to muscle weakness was managed for almost a year with no lung infections, with no bed sores, no deep vein thromboses. taught me the value of life. He was the head of the Neuro Anesthesia Department. I was going into depression by this loss and wondered it was worth working this hard to prolong his life. When I asked his wife if we should have done it any differently, she replied that her engineer husband was a fighter and appreciated our efforts in striving to get him his remission.

I asked the HOD if we should have let him go long ago. To which, he narrated a story, that 10 years earlier, he had received a call while he was in the operation theater. There was a case in the ER with breathing difficulty. And since he was busy with a surgery case and all others were busy too, he asked the nurse to shift the patient to the OT. The nurse with the help of a ward boy in the ever-busy hospital rushed/ the patient on the ER cot itself to the side room of the OT. The HOD immediately intubated the patient who was drowning in his own lung secretions due to myasthenia gravis and shifted him to the NMICU. The patient survived and lived 10 years to come back again to the same hospital and same doctor, but this time luck was

The HOD asked me if he should have given up on the patient then? The HOD asked me if he should have given up on the patient this time or last time.

Dr. Syed Abu Sayeed Mubarak,
Family Physician, Bangalore.

MASALA ...

I was surprised when the couple asked me,' when did you return from gulf' I said I never went to Gulf'. But your man told us you had gone to Gulf when we came last Thursday before last, they said. Now I understood, my assistant had pronounced, Golf as Gulf!

Compliment?

He came to see me after ten years. These ten years he has been seeking help with someone else. I have stopped worrying about those who leave me for better medical pastures but I still am curious to know why they did leave me in the first place and more so why did they come back. I get some interesting answers, but what this man said took the cake. He said,' an old enemy is better than a new friend!'

ANNOUNCEMENTS

3rd Quarterly CME—Psychiatric disorders in Family Medicine

Date: 10th September 2017

Venue: PeopleTree Hospital Auditorium

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