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AFPI Karnataka Quarterly Newsletter

President's Letter

Hello everyone,

We are pleased with the positive reviews received for our previous two editions of the newsletter which places a great sense of responsibility on us. But I am sure our experienced and energetic editorial team with a focus on bringing high quality content in the newsletter, will not disappoint our esteemed readers.

This newsletter provides me with a chance to reflect on what the state chapter of the academy has been able to achieve in the last three months, particularly in relation to the areas identified in the last newsletter. The first area identified was the maintenance and strengthening of the Academy's strong collaborative ethos. We are pleased that the last quarter saw AFPI Karnataka conducting two major collaborative events in the form of a DNB resident's orientation program and a practice oriented program on mental health disorders. Orientation program conducted in collaboration with Rangadore memorial hospital saw the residents engaging in highly interactive deliberations through the day and it was heartening to see the residents going back confident and reassured about their career in Family Medicine. Another collaborative event on 'Psychiatric disorders in Family Medicine' generated a lot of interest and interaction among a well-attended delegates, mostly family practitioners.

Since the last edition a number of strategies have been put in place by our scientific and research committee. Notable one is an initiative by Dr B C Rao and Dr. Ramakrishna Prasad to create an opportunity for young doctors to evolve as researchers/ scholars. We hope and wish this initiative will meet with great success. Once again it's my earnest request to all readers to actively participate in making this newsletter an interesting and enriching magazine for family practitioners by way of documenting reflections of your practice experiences and writing articles. 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

Family medicine as it is known is a fledging specialty. It is heartening to know that more and more youngsters are taking to this and those coming out of institutions are setting up their offices.

How can some of us who are already established help these beginners? One way is to refer patients located in that area of practice. Another is to advice on methods of practice such as book keeping, reception, follow up strategies, networking with other doctors and institutions, offering services to neighboring offices, schools, colleges, technology companies, and utilizing the office as a collection center for labs, subletting extra space to other doctors on a time share basis are all possible ways of increasing footfalls and revenue without resorting to unethical practices.

We hope that more and more young doctors start their own practices as there is a strongly felt need for them in the community.

Inside this issue

AFPI News

OSCE Workshop for Second Year Residents

On Aug 22, 2017, a regional OSCE workshop was conducted by the USMKLE Department of Family Medicine under the leadership of Drs. Geeta Pangi, Smruti Haval, and Sunita Bidari. Dr. Ramakrishna Prasad represented AFPI Karnataka. It was truly a high quality experience for all participants. Participants (mostly DNB Family Medicine Residents) had come from Maharashtra (Pune/Mumbai), Andhra Pradesh (Puttaparti), and Karnataka. In the morning a few lectures orienting participants to OSCE were organized. Later, after writing stations, there were interactive scenarios in the afternoon. Scenarios had been carefully chosen that required thinking at 2-4 cognitive skill levels and covered the breadth of family medicine. Organization was smooth and seamless. The workshop started on time and ended on time. Since the department of Family Medicine at USMKLE has been conducting OSCE examinations for several years for their undergraduate medical students from Malaysia, they have accumulated a significant amount of experience. Additionally, Jawaharlal Nehru Medical College, Belgaum (JNMC) has a well-developed medical education unit that lent its expert support. It is hoped that the department will conduct such workshops at regular intervals and emerge as a regional center for excellence in FM education and evaluation that serves the North Karnataka, Maharashtra, and Telengana regions.

DNB Family Medicine Orientation Program, Rangadore Hospital

AFPI Karnataka takes pride in hosting the second DNB Family Medicine orientation program . This was conducted on 3rd September 2017 at Rangadore Memorial Hospital, Bangalore. The aim of this program was to welcome new residents into the AFPI family and to help final year residents understand the examination pattern and future career prospects. Renowned faculty members across Karnataka volunteered to present different topics conveying the agenda of the program. The program was very efficiently executed by the Rangadore Hospital residents Dr Shweta, Dr Kritika and Dr Deepa !

The program commenced with Dr Mohan Kubendra talking about the concept of Family Medicine followed by Dr Swapna Bhaskar enlightening us with the existing curriculum and the rotations. Dr Madhu Muddiah helped us understand “How to utilize in-patient postings to improve out- patient practice.” All these sessions turned out to be interesting and interactive.

AFPI News

DNB Family Medicine Orientation Program Contd.

The topic "Leadership and communication skills as a Family Physician" was dealt by Dr Ramakrishna Prasad and Dr Pallavi Hoskote. This indeed gave us an insight into the important skills required to be a good family physician. Dr Srividhya emphasized on valid points required to achieve milestones of evaluation in the DNB program. A few months back when OSCE was first introduced in the exam format of DNB , there was a lot of unsurity and fear among residents. Dr Roshni Jhan Ganguly helped residents get familiar to the OSCE exam pattern with her presentation.

Another very less spoken topic on "How to handle stress during post graduate training" was very well explained by Dr Jaya Bajaj. Scholarships and Publications in Primary care has often been less heard of and hence this was highlighted by our own Mentor Dr B C Rao and Dr Ramakrishna Prasad. Last but not least Dr Mohan wrapped up the program focusing on career options after completion of residency.

Overall a very engaging program with a very interactive audience – Truly successful!

Mental Health Update for Family Physicians

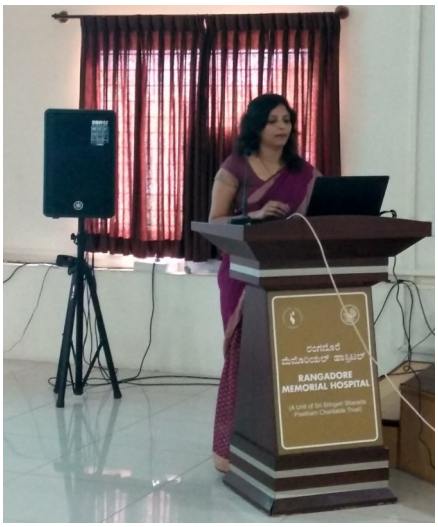
The Mental Health Update for Family Physicians was held at People Tree Hospital, Yeshwantpur on 10th of September, 2017.

This was organized by AFPI Karnataka in collaboration with People Tree Maarga and The Live Love Laugh Foundation. It was well attended and brought together a diverse group of healthcare professionals including family medicine specialists, psychiatrists, counsellors, postgraduates, and medical students. A notable feature was multiple collaborative presentations involving FM specialists and psychiatrists. Besides didactics, role play was effectively used by several presenters.

Upcoming AFPI Events

AFPI Quarterly CME on Paediatrics in collaboration with Rainbow Hospital, Venue: TBA, Date 5th Dec. Details will be announced soon

AFPI News (In Pics)



Real Time Learning

Management of heart failure in family practice

Drawn from the Friday night [30/6/17] discussion
Expert- Dr Girish Godbole, Consultant intervention Cardiologist, Vikram Hospital,
Moderator- Dr Syed Mubarak, Family Physician

Heart Failure

Definition

HF is a clinical syndrome characterized by typical symptoms like breathlessness, ankle swelling and fatigue that may be accompanied by signs like elevated jugular venous pressure, pulmonary crackles and peripheral edema caused by a structural and/or functional cardiac abnormality, resulting in a reduced cardiac output and/ or elevated intracardiac pressures at rest or during stress.

Typical Symptoms and Signs

Symptoms

- Breathlessness
- Orthopnoea
- Paroxysmal nocturnal dyspnea
- Reduced exercise tolerance
- Fatigue, increased time to recover after exercise
- Ankle Swelling

Signs

- Elevated JVP
- Hepatojugular reflux
- Third Heart Sound (Gallop rhythm)
- Laterally displaced apical impulse.

Diagnostic algorithm for a diagnosis of HF

(refer next page)

Recommendations for Diagnostic tests in patients with heart failure

- Hb, WBC
- Na, K, Urea, Creatinine, eGFR
- LFT
- HbA1C
- Lipid profile
- TSH
- Ferritin
- Natriuretic peptides
- ECG- 12 lead- to determine heart rhythm, HR, QRS morphology, QRS duration, and to detect other relevant abnormalities / 2D– ECHO
- Chest X ray to detect/exclude alternative pulmonary diseases. Also, identify pulmonary congestion/Edema. 2D ECHO.

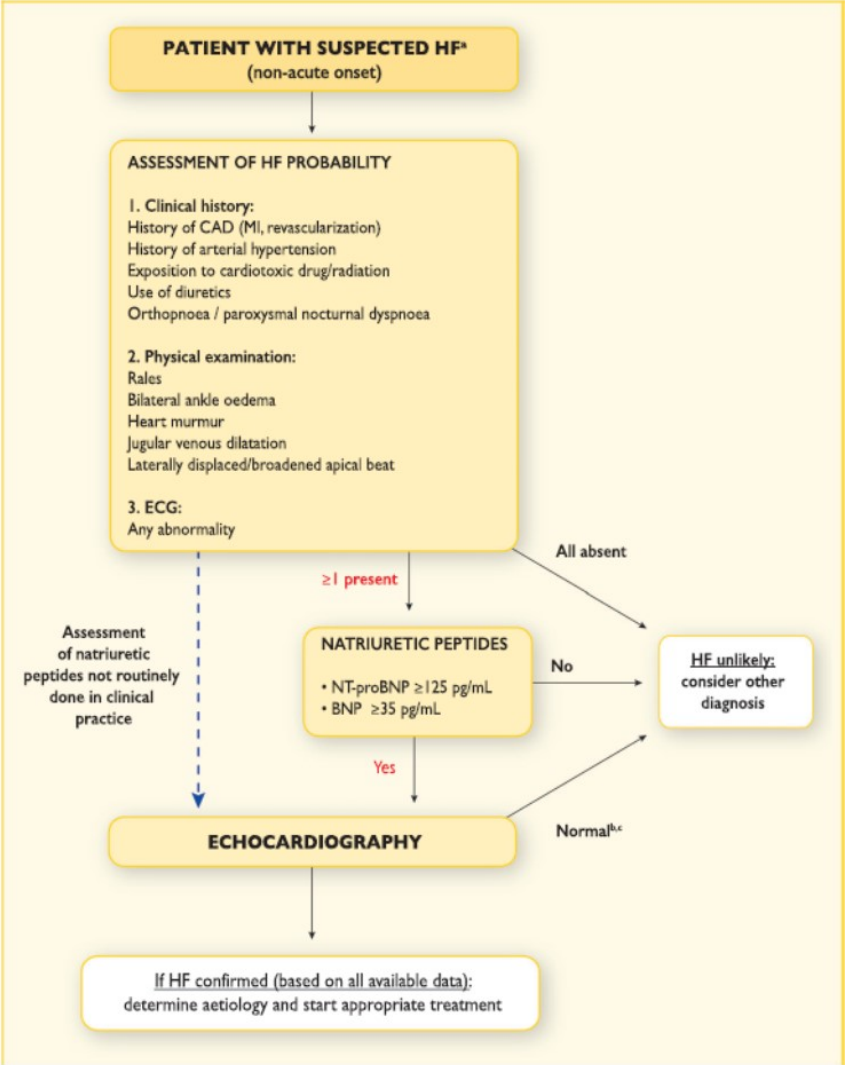
Recommendations to prevent or delay the development of overt heart failure or prevent death before the onset of symptoms.

- Treatment of hypertension is recommended to prevent or delay the onset of HF and prolong life.
- Treatment with statins is recommended in patients with or at high-risk of CAD whether or not they have LV systolic dysfunction.
- Counselling and treatment for smoking cessation and alcohol intake reduction.
- ACE-I is recommended in patients with asymptomatic LV dysfunction and history of MI.
- ACE-I is recommended in patients with asymptomatic LV dysfunction without history of MI.
- Beta-blocker is recommended in patients with asymptomatic LV dysfunction and history of MI.
- ICD (Implantable Cardioverter Defibrillator)

Pharmacological treatments indicated in patients with symptomatic (NYHA Class II-IV) heart failure with reduced ejection fraction

- An ACE-I is recommended, in addition to a beta-blocker, for symptomatic patients with HFrEF (heart failure reduced ejection fraction).
- An MRA (mineralocorticoid receptor antagonist) is recommended for patients with HFrEF who remain symptomatic despite treatment with an ACE-I and a beta -blocker.
- Diuretics are recommended to improve symptoms and exercise capacity in patients with signs and /or symptoms of congestion.

Angiotensin receptor/neprilysin inhibitor- Valsartan/ Sacubitril is recommended as a replacement for an ACE-I to further reduce the risk of HF in ambulatory patients with HFrEF who remain symptomatic despite optimal treatment with ACE-I, beta- blocker and MRA.



Diagnostic algorithm for a diagnosis of HF

Treatments that may cause harm in HF patients

- Thiazolidinediones(pioglitazone)- risk of worsening HF
- NSAIDs or COX-2 inhibitors- risk of worsening HF
- Diltiazen or Verapamil- risk of worsening HF
- Addition of ARB to the combination of ACE-I and MRA (risk of renal dysfunction & hyperkalemia)

Take home

- The goals of treatment in patients with HF are to improve their clinical status, functional capacity and quality of life, prevent hospital admission and reduce mortality.
- Neuro-hormonal antagonists (ACEIs, MRAs and beta-blockers) have been shown to improve survival in patients with HFrEF and are recommended for the treatment of every patient with HFrEF, unless contraindicated or not tolerated.
- A new compound – ARNI (valsartan + sacubitril) has recently shown to be superior to an ACE-I in reducing the risk of death from HF.
- ARBs have not been consistently proven to reduce mortality in patients with HFrEF and their use should be restricted to patients intolerant of an ACEI.

NSAIDs and Pioglitazone to be avoided in HF.

New 'Extreme' CVD Risk Category

According to the American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology (ACE), "the lower the LDL cholesterol the better, regardless of where your LDL is to begin with."

AACE/ACE now recommend LDL goals of < 55 mg/dL, < 70 mg/dL, < 100 mg/dL, and < 130 mg/dL for individuals at extreme, very high, high/moderate, and low risk for cardiovascular events, respectively.

Extreme-risk goals: LDL < 55 mg/dL, non-HDL < 80 mg/dL, apolipoprotein B (apoB) < 70 mg/dL

- Progressive atherosclerotic cardiovascular disease (ASCVD), including unstable angina, in patients after achieving an LDL-C <70 mg/dL.
- Established clinical cardiovascular disease in patients with diabetes, chronic kidney disease (CKD) stages 3/4, or heterozygous familial hypercholesterolemia (HeFH).

History of premature ASCVD (< 55 years of age in men, < 65 in women).

What are *BRCA1* and *BRCA2*?

BRCA1 and *BRCA2* are human genes that produce tumor suppressor proteins. These proteins help repair damaged DNA and, therefore, play a role in ensuring the stability of the cell's genetic material. When either of these genes is mutated, or altered, such that its protein product either is not made or does not function correctly, DNA damage may not be repaired properly. As a result, cells are more likely to develop additional genetic alterations that can lead to cancer.

Speciic inherited mutations in *BRCA1* and *BRCA2* increas e the risk of female breast and ovarian cancers, and they have been associated with increased risks of several additional types of cancer. Together, *BRCA1* and *BRCA2* mutations account for about 20 to 25 percent of *hereditary* breast cancers 1 and about 5 to 10 percent of *all* breast cancers 2. In addition, mutations in *BRCA1* and *BRCA2* account for around 15 percent of ovarian cancers overall. Breast and ovarian cancers associated with *BRCA1* and *BRCA2* mutations tend to develop at younger ages than their nonhereditary counterparts.

A harmful *BRCA1* or *BRCA2* mutation can be inherited from a person's mother or father. Each child of a parent who carries a mutation in one of these genes has a 50 percent chance (or 1 chance in 2) of inheriting the mutation. The effects of mutations in *BRCA1* and *BRCA2* are seen even when a person's second copy of the gene is normal.

What other cancers have been linked to mutations in *BRCA1* and *BRCA2*?

Harmful mutations in *BRCA1* and *BRCA2* increase the risk of several cancers in addition to breast and ovarian cancer. *BRCA1* mutations may increase a woman's risk of developing fallopian tube cancer and peritoneal cancer. Men with *BRCA2* mutations, and to a lesser extent *BRCA1* mutations, are also at increased risk of breast cancer 9.

Men with harmful *BRCA1* or *BRCA2* mutations have a higher risk of prostate cancer. Men and women with *BRCA1* or *BRCA2* mutations may be at increased risk of pancreatic cancer. Mutations in *BRCA2* (also known as *FANCD1*), if they are inherited from both parents, can cause a Fanconi anemia subtype (FA-D1), a syndrome that is associated with childhood solid tumors and development of acute myeloid leukemia. Likewise, mutations in *BRCA1* (also known as *FANCS*), if they are inherited from both parents, can cause another Fanconi anemia subtype.

Who should consider genetic testing for *BRCA1* and *BRCA2* mutations?

Because harmful *BRCA1* and *BRCA2* gene mutations are relatively rare in the general population, most experts agree that mutation testing of individuals who do not have cancer should be performed only when the person's individual or family history suggests the possible presence of a harmful mutation in *BRCA1* or *BRCA2*.
In December 2013, the United States Preventive Services Task Force recommended that women who have family members with breast, ovarian, fallopian tube, or peritoneal cancer be evaluated to see if they have a family history that is associated with an increased risk of a harmful mutation in one of these genes.

Several screening tools are now available to help health care providers with this evaluation. These tools assess family history factors that are associated with an increased likelihood of having a harmful mutation in *BRCA1* or *BRCA2*, including:

- Breast cancer diagnosed before age 50 years
- Cancer in both breasts in the same woman
- Both breast and ovarian cancers in either the same woman or the same family
- Multiple breast cancers
- Two or more primary types of *BRCA1*- or *BRCA2*-related cancers in a single family member
- Cases of male breast cancer
- Ashkenazi Jewish ethnicity

Gleanings

When an individual has a family history that is suggestive of the presence of a BRCA1 or BRCA2 mutation, it may be most informative to first test a family member who has cancer if that person is still alive and willing to be tested. If that person is found to have a harmful BRCA1 or BRCA2 mutation, then other family members may want to consider genetic counseling to learn more about their potential risks and whether genetic testing for mutations in BRCA1 and BRCA2 might be appropriate for them.

If it is not possible to confirm the presence of a harmful *BRCA1* or *BRCA2* mutation in a family member who has cancer, it is appropriate for both men and women who do not have cancer but have a family medical history that suggests the presence of such a mutation to have genetic counseling for possible testing.

Some individuals—for example, those who were adopted at birth—may not know their family history. In cases where a woman with an unknown family history has an early-onset breast cancer or ovarian cancer or a man with an unknown family history is diagnosed with breast cancer, it may be reasonable for that individual to consider genetic testing for *BRCA1* or *BRCA2* mutation. Individuals with an unknown family history who do not have an early-onset cancer or male breast cancer are at very low risk of having a harmful *BRCA1* or *BRCA2* mutation and are unlikely to benefit from routine genetic testing.

Professional societies do not recommend that children, even those with a family history suggestive of a harmful *BRCA1* or *BRCA2* mutation, undergo genetic testing for *BRCA1* or *BRCA2*. This is because no risk-reduction strategies exist for children, and children's risks of developing a cancer type associated with a *BRCA1* or *BRCA2* mutation are extremely low. After children with a family history suggestive of a harmful *BRCA1* or *BRCA2* mutation become adults, however, they may want to obtain genetic counseling about whether or not to undergoing genetic testing.

Do inherited mutations in other genes increase the risk of breast and/or ovarian tumors?

Yes. Although harmful mutations in *BRCA1* and *BRCA2* are responsible for the disease in nearly half of families with multiple cases of breast cancer and up to 90 percent of families with both breast and ovarian cancer, mutations in a number of other genes have been associated with increased risks of breast and/or ovarian cancers. These other genes include several that are associated with the inherited disorders Cowden syndrome, Peutz-Jeghers syndrome, Li-Fraumeni syndrome, and Fanconi anemia, which increase the risk of many cancer types.

Most mutations in these other genes are associated with smaller increases in breast cancer risk than are seen with mutations in *BRCA1* and *BRCA2*. However, researchers recently reported that inherited mutations in the *PALB2* gene are associated with a risk of breast cancer nearly as high as that associated with inherited *BRCA1* and *BRCA2* mutations. They estimated that 33 percent of women who inherit a harmful mutation in *PALB2* will develop breast cancer by age 70 years. The estimated risk of breast cancer associated with a harmful *PALB2* mutation is even higher for women who have a family history of breast cancer: 58 percent of those women will develop breast cancer by age 70 years. *PALB2*, like *BRCA1* and *BRCA2*, is a tumor suppressor gene. The *PALB2* gene produces a protein that interacts with the proteins produced by the *BRCA1* and *BRCA2* genes to help repair breaks in DNA. Harmful mutations in *PALB2* (also known as *FANCN*) are associated with increased risks of ovarian, pancreatic, and prostate cancers in addition to an increased risk of breast cancer. Mutations in *PALB2*, when inherited from each parent, can cause a Fanconi anemia subtype, FA-N,that is associated with childhood solid tumors.

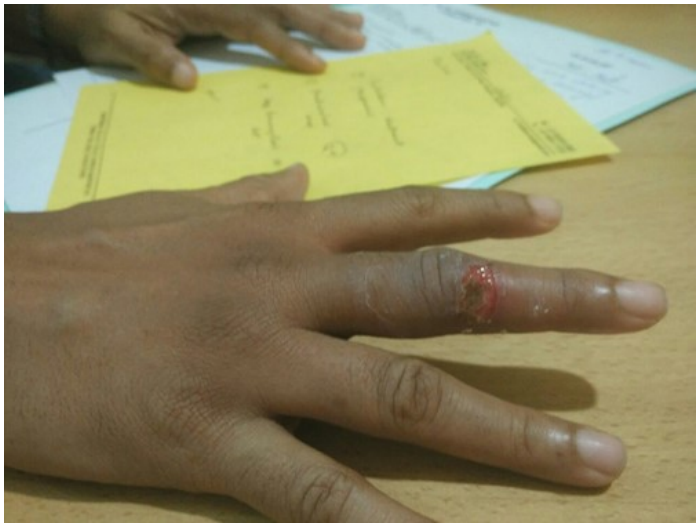
Although genetic testing for *PALB2* mutations is available, expert groups have not yet developed specific guidelines for who should be tested for, or the management of breast cancer risk in individuals with, *PALB2* mutations.

Case Report

A Case of acute swelling of hand

Mrs. S, a 40 years old lady, while walking in her home garden, on the afternoon of 6/6/17 at [Coimbatore] felt an itch around the middle of her right mid finger. She noticed a small bleb by night and by next morning the bleb had enlarged with redness and swelling. She also had severe pain in that area radiating to the hand. She sought help at the local clinic and the prescription showed the following medications: Inj. of avil, oral cetirizine, hyphenac, and amoxyclav. The wound was also dressed at that facility.
The adhered dressing was removed with some difficulty and this is how the hand looked on the morning of 9/6/17.

She is non diabetic, with normal blood pressure, had no fever but complained of severe pain in the hand with radiation up the forearm.

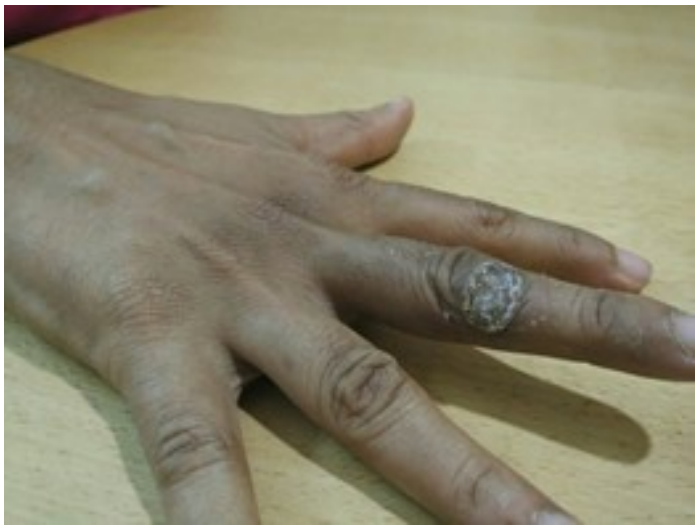


On examination, the wound looked clean with dusky swelling on the dorsum of the finger and the hand, spreading up to the wrist. Finger movements were possible but painful. The area was also tender to touch.

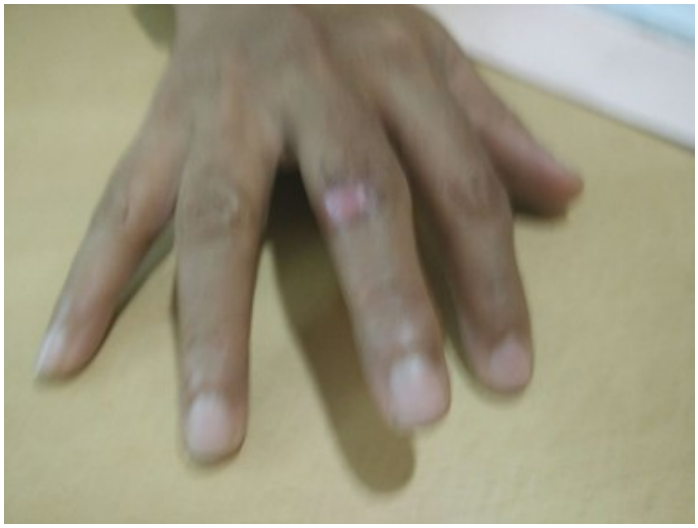
The problem here was to differentiate between a reaction to venom and an infection, as the treatment approach is very different for the two conditions and it was important to make an accurate diagnosis.

By the rapidly with which the lesion developed, it was thought to be a reaction to insect venom, despite the fact that the patient did not notice or see an insect actually biting her hand. As the reaction was severe and ongoing, it was felt that the patient would benefit with a short course of steroids. Accordingly, she was advised to take prednisolone 20 mgs twice a day, Allegra 120 mgs once a day and paracetamol 650 mgs as and when required, amoxyclav was continued and she was instructed to do wet dressings at home. She was asked to report back after three days.

She returned after 6 days and this how the hand looked.



There was no pain, movements were near normal and except for slight swelling around the scar, there were no other complaints. The scar looked healthy and there was no evidence of slough underneath. She, on her own had stopped all medications after three days! She came on July 10nth for some other problem and this is how her hand looked. There was no longer any pain, the eschar had dropped off.



Discussion

Family physicians often face this dilemma of differentiating acute inflammation caused by infection from that of other acute inflammatory conditions. Local examination is often inconclusive. Careful history taking helps in the diagnosis as it was in this case. This case was posted on our Family Medicine telegram group where there was a diversity of opinion between members with several members including a surgeon leaning towards infection as opposed to allergic reaction. The recommended action was antibiotics and wound debridement. However, I felt that given rapidity of development of symptoms, this was consistent with an allergic reaction to insect venom, hence chose to use a steroid.

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Practice Experiences

Practice Experience 1

My experience with Menke's

In our busy clinical practice we may miss uncommon diseases; which we may have only read about or rarely seen. The following is my experience with one such disease, which, fortunately has a happy ending.

It was one of those busy clinic hours a month back. In the waiting room there were a few patients. The next appointment was a family of three - husband, wife and their 9 month old son. The little boy was suffering from dry skin related eczema and I started taking relevant history and examining him e.g. allergy symptoms, cold and cough etc. However, during examination I found the kid to be slightly abnormal. He showed no social smile, no expressions, and was small for age. The thing which stood out to me was his HAIR-STYLE! He had spiky hair as if he had used hair gel and the hair was soft and brittle.

Curiosity got the better of me and I asked the parents if their kid was suffering from some other disorder. The lady was surprised and asked me for my diagnosis. I blurted out the first thing I thought of was MENKE'S KINKY HAIR SYNDROME. The parents were surprised at my spot diagnosis.

This kid had been treated for seizures, hypotonia and failure to thrive before the syndrome was finally diagnosed by a pediatric dermatologist. We discussed about the syndrome and treatment involved.

Menke's kinky hair syndrome is an X-linked recessive disorder that affects copper metabolism in the body causing accumulation of copper in certain organs and depletion in others. The gene involved is ATP7A gene that regulates ATPase enzyme. The features are, sparse kinky hair, unusual facial features like pudgy cheeks, hypothermia, being small for age and jaundice.

The syndrome was first described by Dr. John H. Menke and treatment was introduced by Dr. Bibudhendra Sarkar.

The treatment is regular injections of ATPase enzyme. The enzyme used to be prepared by Amrita institute, Kochi (AIMS) and which the patient's family used to get administered every 21 days. However, AIMS had stopped production of the enzyme. The patient and family were in a lurch as the condition was life-threatening, if not treated.

In a desperate attempt, the family contacted Dr. Menke. To their surprise, not only did Dr. Menke respond, he even connected them with Dr. Sarkar, the inventor of the treatment! Dr. Sarkar's office was more than helpful, and, informed them that the enzyme is currently being manufactured by the department of Pharmacy, Christian Medical College Hospital, Vellore.

The patient's family was happy that their cost of travelling and lodging every time they traveled to Kochi (min 50000/-) would be saved. Also the form of enzyme available at Vellore needs administration every 90 days, as against 21 days of the earlier version.

I have been following up with the patient family on a regular basis as cases like these are rarer than we think (he is the 5th reported case in India). This child could have been easily misdiagnosed as simple dry skin eczema. My happiness stems from the fact that I could be a part of this happy story.

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Practice Experience 2

Palpitation cure

Mrs. S sees me once in six months for checking her blood pressure and hypothyroidism. Generally both used to be under control. She has a BP instrument at home and her bimonthly record helps me to adjust the dosage of the medicines she is on.

This visit however was early and on phone she even felt I needed to see her at home as she was feeling very tired, on second thoughts she felt it easier and quicker to see me at my clinic. She appeared fairly ok, no breathlessness, sat comfortably, all vital signs including the blood pressure were normal. I wondered what was happening. Has she become a diabetic? I asked her, she said, "I did my blood sugar and it was normal". What about your thyroid? She said, "there is still three months' time for that test".
"What about medication?" She told me that she had stopped thyroxine two months back. This took me by surprise, as Mrs. S has been a very compliant patient and knew the consequences of stopping the medication. I asked her – "why?"
She said, "my friend was asked to stop this drug by her cardiologist as she was having palpitations and she told me the medicine can have this side effect, so I stopped taking". "She may have had palpitations, but why you stopped'? I asked. She said in all earnestness, "I stopped it before I got the palpitations like she did". I had no answer to this logic of hers.

Now we were back to square one, it took me half an hour of explaining the safety and that only over dosage can cause the heart rate to go up causing the palpitation that her friend is supposed to have experienced. I also told her to tell her friend that no cardiologist worth his salt will advise a patient to stop the drug. What he said must have been misinterpreted or misunderstood by this lady who in turn gave this rather unsolicited advice to Mrs. S and made her suffer. Her TSH values were sky high and took another six months and 3 to 4 visits to set her right.
I am forever surprised to see educated patients, adequately briefed, suddenly stopping the medication, just because some friend told him or her to stop. How come lay advice often scores over expert advice? At least in Mrs. S's case a cardiologist was involved, hearsay or otherwise, but it has happened in my practice, infrequently though, without any doctor getting involved. Strange, is not it?

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WONCA Europe Conference: A Reflection

There's no doubt that attending a conference is a professionally rewarding experience. Personally for me attending WONCA Europe Conference on the sidelines of my family vacation at this beautiful city Prague was a unique experience.

This massive conference was attended by about 4000 delegates, with over 500 'posters' per day and over 200 invited speakers. There were 10 concurrent oral sessions on diverse topics. I remember many well organized conferences but this one was a cut above all not just for the diversity of sessions but also for the logistic arrangements. The sign posting and live streaming of sessions in different halls at the reception area was quite innovative and an effective way of giving directions and avoiding confusion.

For me, the timing was perfect. I was lucky to be there at the venue just when the session I was most interested in was to begin. A session on 'person centered care - policy meets practice' It was nice to explore how policymakers and practitioners could find common ground, share experiences and make sure that Family Medicine is given ample attention and taken into due account before policies are operationalised.

Another part of the conference that left an impression was an informal open session held in the corridor where a random delegate is given 5 mins for presentation, followed by group discussion. This exercise opened my eyes to small group dynamics during the review and critiquing stage. Interactive skill stations at the venue and an organized visit to practice area were thoughtful endeavors.

Of course, one of the most rewarding things about conferences is the ability to network with colleagues and 'digest' the new information we are hearing about. It was my first exposure to meet the who's who of Family Medicine from Europe region which I consider a holy place for Family Medicine but I preferred to interact with someone as a novice and analyze their understanding of Family Medicine and their aspirations. I sat at a random table with people I didn't know with the hope of making new friends. It was amazing to see the clarity of thoughts on Family Medicine and it's development among very young doctors, some of them just passed out of Medical school. I see this as an impetus for my journey and although I still have many questions and options for the direction in which I would like to work, I was primarily inspired to keep learning.

WONCA Europe Conference: A Reflection *Contd*

Wonca Europe conference was a delightful change in substance and direction. The process of learning how Family Medicine is perceived and practiced has been enlightening for me. I have attended several medical conferences but rarely have I felt that I truly had so much to learn. My take-away from this one day learning was inspiration to delve more into Family Medicine education and a desire to explore my own questions regarding practice and seeing if what I am doing as a family practitioner is beneficial to me, my peers and to the community. Overall, this was an exceptional and memorable experience.

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The Spice Route Movement

'The Spice Route' is the WONCA South Asia Region working group for new and future doctors who have an interest in family medicine/general practice. It aims to promote excellence in this field and to address the challenges pertaining to global health. The creation of this group was inspired by the work of similar WONCA groups for new and future family/ general practitioners around the world: the Vasco de Gama movement in Europe, the Rajakumar movement in the Asia-Pacific region, Waynakay in the Ibero-americana region, and NAFFDONA in the North America region. There was active participation from approximately 80 new and future family / general practitioners from India, Nepal, Pakistan, Sri Lanka and Bangladesh.

To learn more about the Vision, Mission, and Activities of the Spice Route Movement, I welcome you to visit the website *http://www.globalfamilydoctor.com/groups/YoungDoctorsMovements/TheSpiceRoute.aspx*

Social Media Presence:
Twitter: @TSRmovement;

Facebook: https://www.facebook.com/TheSpiceRouteMovement

Membership:
The Spice Route Movement presents some exciting opportunities for young family physicians. Again details are on the website.

FM360 – FAMILY MEDICINE 360:
This is a global exchange program for those in Family Medicine/General Practice training and in the first five years of family medicine practice. It is supported by WONCA. It enables participants to spend up to four weeks visiting the Primary Health Care system of a different country, and includes host practices from all over the world. This Program is based on objectives, planned by the visitor and agreed by the host, in order to justify the quality of the exchange. During these four weeks, the visitor is expected to shadow the activities that take place at the host practice and to accompany the host in other community-oriented activities.

Note: For legal reasons, all activities are observational and visitors cannot engage in any clinical or administrative work.

The Spice Route Movement India Representatives:-

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The National Chapter plan of action 2017-2020:-

1. Creating a National database of young doctors in Family Medicine
2. Identifying a state representative in each state one among FPT & one among AFPI-First5
3. Creating a national framework for National Chapter
4. Facilitating interstate exchange programs
5. Creation of a National Quarterly newsletter
6. Facilitating utilization of scholarships for deserving young doctors to attend National/International conferences
7. Encourage Family Practice as preferred career option for young doctors
8. Mentoring young doctors in training and in first 5yrs of their training opening up research/publication opportunities for young doctors.

Dr. Mohammed Idris Shariff
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MASALA ...

Today I sent a patient with diabetes with epigastric discomfort for an ECG.

He came back with ECG, looking worried. I asked him what happened , snatching ECG from his hand.

He said " I have sinus problem sir"

Perplexed I asked " who said so ?".

He pointed to ECG and showed me "sinus rhythm" printed on it.

Ravikumar Kulkarni
ravikumarkulkarni@yahoo.com

An inspiring poem

"I bargained with Life for a penny,
And Life would pay no more,
However I begged at evening
When I counted my scanty store;

For Life is just an employer,
He gives you what you ask,
But once you have set the wages,
Why, you must bear the task.

I worked for a menial's hire,
Only to learn, dismayed,
That any wage I had asked of Life,
Life would have paid."
– Jessie B. Rittenhouse

ANNOUNCEMENTS

AFPI core committee meeting and formation of working committees for FMPC 2019. Date 5th Dec. Time and Venue: TBA

Your feedback is valuable to us. To share please contact the Editorial Team

www.afpikarnataka.in