AFPI
Academy of Family Physicians of India

KARNATAKA

AFPI KARNATAKA QUARTERLY NEWSLETTER

President's Letter

Hello everyone,

It is my pleasure to announce the release of 9th edition of AFPI Karnataka Newsletter, the core mission of which is to act as an instrument for reflections of your practice experience and publication of quality articles of importance to primary care physicians. I can say with conviction that the newsletter has come a long way in earning the respect it deserves. I hope that you will enjoy reading this issue.

Looking back at the last quarter- AFPI National president Raman Kumar took time off from an event he was attending in Bangalore to interact with the state AFPI leaders on 17th January and updated us on the latest progress in development of Family Medicine in the country. In yet another notable new collaboration, two events of relevance to Primary care physicians were conducted at Aster CMI Hospital, one on Hypothyroidism & Diabetes diet management and another on Types of Genetic testing & genetic counseling. A 3 day Comprehensive Palliative care course was organized by AFPI Karnataka in collaboration with Cytecare Cancer Hospitals in which 35 Primary care physicians were trained and empowered to provide basic palliative care at the community level.

No goals are fixed for any organization, only dreams are there to be made a reality. If every member has the inner feeling of being part of their own fraternity, one can visualize the growth of the organization and their dreams turning into reality. What better opportunity than the National conference to get a feel of being part of own fraternity and organization. Preparations for the 4th National Conference FMPC-2019 has entered a decisive phase and readers who have attended previous FMPCs will know that it is one of the most collegial and supportive environments for growing as a person, a professional and a member of a great organization.

Our vibrant & able organizing team is working hard to make this conference interesting, innovative and a memorable one. Besides providing adequate space for the core clinical content and skills of primary care, our conference aims to create a platform to share primary care practice innovations which improve access, quality, and outcomes, facilitate interdisciplinary learning and engagement to foster mutually beneficial partnerships.

As a prelude to the conference we are trying to establish academic collaborations and new partnerships. Exciting Pre-conference events like short film contest, quiz, exchange programs & workshops are being discussed. We are planning to have "Inspiration Room" within this conference where you can hear from primary care doctors and leaders, their stories . So

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start thinking and discussing with your colleagues and not miss this opportunity to be part of FMPC – 2019.

Although the editorial plans to do everything that they can to ensure that our newsletter contains interesting, provocative articles that are of interest to a wide range of practitioners, it needs contributions from more members if the content is to remain fresh and interesting. Also if you have ideas for other kinds of materials that we might publish in the newsletter, please let us know. We welcome Letters to the Editor which we will try to publish in future issues of our newsletter.

Once again my sincere thanks to the editorial and earnest request to all readers to actively contribute in complementing the efforts of the team.

Col (Dr.) Mohan Kubendra
President
AFPI Karnataka

Editorial Note

Conference time

Come August 2019, AFPI Karnataka will host the biennial national conference in family medicine and primary care. Unlike specialty-oriented conferences this conference is unique in that this has multiple stakeholders.

Besides family medicine/primary care physicians, the stakeholders are broad including citizens, medical students, other community based care providers or members of a primary care team (such as nurses, clinical pharmacists, counsellors, office staff etc.); specialists who either serve as consultants to family physicians or who refer their patients to family physicians for ongoing and comprehensive primary care; public health professionals who are engaged in the study, publishing, advocacy, or policy formulation of issues relevant to primary care from a health systems, financing, economic evaluation, or health equity perspective, representatives of the government at the local, state, national level and the industry ranging from established pharma companies, vaccine manufacturers, distributors, startups innovating in or for primary care etc. are key stakeholders.

The nation is facing a health crisis. On the one hand we have world class expertise in doing sophisticated and advanced procedures and attract patients from even the developed world, we lag woefully behind in providing to a large percentage of our people affordable basic preventive and curative care. We are behind countries like Sri Lanka, Bangladesh and Thailand. These nations have done better and their maternal and infant mortality rates are lower than ours. Even in nutrition index we are behind. What is the point in performing advanced surgical procedures when you cannot provide potable water, nutritious food and basic primary health care to our people?

Primary health is the bedrock on which the whole structure of health care should be built. In our country primary health care delivery has been neglected and over the years it has become the least preferred career choice of young medical graduates. Unless strong and effective measures are taken at all levels which include health planners, government bodies like NITI AYOG, medical educators to strengthen primary health and make it an attractive career choice. Unless this is done the situation will only become worse.

AFPI-NEWS

CME at Aster CMI Hospital

The first scientific session for the year 2019, was conducted by AFPI in association with Aster CMI Hospital at Aster on 19 January 2019. The topics for the session were “Hypo & Hyperthyroidism in General Practice - When to refer; and Millets”. We were also honored by the presence of Dr. Raman Kumar, National President AFPI.

True to the topic – it started off with a Millet lunch, thanks to Dr. Mahesh, Endocrinologist who organized it and proved its benefits to the audience who managed to stay interactive throughout the session without the usual postprandial effects (either the millets effect or Dr. Mahesh’s excellent talk that kept audience awake is a different debate altogether). Very important and relevant topics covered

were Healthy diet and effects of Millets in our diet, Thyroid & Pregnancy, Subclinical Hypothyroidism. It was well attended, well executed and a fruitful session.

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Palliative Care Course

A 3 days Comprehensive Palliative care course was organized by AFPI Karnataka in collaboration with CyteCare Cancer Hospitals in which 35 Primary care physicians were trained and empowered to provide Basic palliative care at the community level.

AFPICON Kerala news

AFPI Kerala chapter conducted the third state conference of Family Medicine and Primary Care- AFPICON KERALA 2019, on the 12th and 13th of January 2019, at Hotel Nila Residency, Shoranur, Palakkad, Kerala. The theme of the conference was "*Family medicine- Empowering primary care*". AFPICON Kerala 2019 preparations started off aiming to enrich the knowledge and skills of family physicians and general practitioners, along with empowering the general practitioner with the core concepts of family medicine. Shoranur was chosen as the venue to boost AFPI Kerala activities there, as well as to empower the general practitioners in Palakkad district.

The Organizing Chairperson for the event was Dr.Nadeem Abootty, with Dr. Kailas P as Organizing Secretary.

The pre-conference activities started during the early half of the 2018 and it picked up pace when the media committee started the 100 days countdown and launched the 100 faces of AFPI Kerala , 100 family physicians. This was a huge success with the 100 faces going viral on the social media, one new face each day. It projected the different facets of family medicine and the strength of AFPI Kerala. Dr Mathews, needs a special mention for all the hard work behind the countdown and 100 faces of AFPI Kerala.

Travancore Cochin medical council awarded 5 TCMC credit hours for the program.

On Jan 12, the first day of AFPICON Kerala 2019, we had two workshops - RECTIFY (Rural emergency care for family doctors) workshop handled by Dr Nishanth Menon and team and workshop on common devices used in family practice dealt by the team from Calicut Medical College. Both workshops were excellent and well appreciated ,with 120 delegates participating in the workshop.

On Jan 13, inauguration of the event was done by Sri M.B Rajesh, member of parliament from Palakkad constituency. Dr Raman kumar (WONCA SAR president and AFPI national president) attended as chief guest. An academic feast followed with a variety of scientific sessions. There was an interesting panel discussion on the theme – 'Return Of Family Doctor', with senior faculty and eminent personalities from Kerala government health sector on stage. The General practitioner survey conducted by Dr.Jisha was also discussed during the conference.

State level quiz competition and poster presentation for postgraduates and medical students were simultaneously conducted in multiple halls. Special appreciation was given to all participants by the panel of judges,for keeping high standards in posters presented . A total of 327 delegates participated in the event. The program ended on a high note with prize distribution and vote of thanks.

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CME on RNTCP updates

On the 22nd March, to sensitise general practitioners about new updates in RNTCP and tuberculosis management, a CME was held at P D Hinduja Sindhi hospital, Bengaluru in collaboration with AFPI Karnataka and Karnataka Health Promotion Trust (KHPT).

The CME had more than 40 to 50 general practitioners with eminent speakers like Dr Anil S deputy director and also in charge of RNTCP Karnataka, who spoke on updated RNTCP guidelines. Dr Somashekhar, nodal officer Drug Resistant TB (DRTB) centre, spoke on logistics of TB treatment and Dr Shobha Ekka head of project Joint Effort for Elimination of Tuberculosis (JEET), spoke on the operational efficiency of the project. Dr Sowmya B Ramesh, family medicine consultant at P D Hinduja Sindhi hospital and core member of AFPI Karnataka served as the coordinator for the program. The participating practitioners involved themselves in enthusiastic interactions during the CME justifying the call for " ***It's time for action*! *It's time to End TB***"

If any of you suspect tuberculosis and need to coordinate regarding tests or treatment (including geneXpert testing or getting medications from the RNTCP program), **please contact Ms Ishajan, from JEET. Her number is: +91-7795045040.**

FMPC 2019 update

AFPI Conference app

FMPC 2019.... On your finger tips.

A new experience at FMPC 2019, Bangalore.

Making use of our smart phones in an even smarter way, and sticking to our theme of "Technology innovations for better delivery of primary care", get ready for the next big thing!!!

Conference registration, latest updates, Abstract submission, Contests/ Quizzes, Delegate interaction, and much more...

Everything at your fingertip, or on your thumb!

Watch this space for more!!!!!

Jyotika17@gmail.com

Idea

Inspiration Room

Burning Need: Doctors often get trained and work in very negative or very lonely environments. They face huge challenges every day while providing quality care, which drains out their positivity.

One single change: Stories are powerful! They can bring about paradigm shift in mindsets, help people rediscover and reaffirm their positive values, and give them the ideas and energy to bring

about change in their environments! I want conference attendees to get inspired by the success stories of Family Physicians transforming their communities!

Format: Successful Family Physicians from diverse backgrounds, with diverse learnings, tell their powerful stories in Panel Discussions and Interactive Lectures. We can group these stories by context (rural, urban, govt, charitable, etc) or by learnings (community engagement, multiple services, lifelong learning etc), or by maturity of practice (starting out, early stage, successful, mentoring others, etc)

In addition, we have 2-3 workshops on finding inspiration through stories (Narrative Medicine Workshop being planned by Dr Jaya, and nurturing your ideas into successful projects (I'm planning a workshop on adding new services and products to your existing practice)

Just outside the inspiration room, we can have more things which don't fit into traditional conference formats . These include: Career fest (stalls of interested organisations), pre-recorded video stories running in a loop on a TV, stalls with Lean FP Toolkit (including Home Visit bag), Wall of Challenges, Wall of Solutions, a Human Library etc etc

Impact:

1. These sessions will inspire conference attendees to look at their communities, practices, co-workers, career, even themselves in a more positive light

2. These sessions will get them to think more positively about Family Practice as a career

3. These sessions will help them to discover and create innovative solutions to big challenges they face in their own practices..

All of this will create an ever-growing army of change-makers in all corners of India, who will make quality primary care accessible for everyone!

Dr Devashish Saini

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Update from Scientific Committee regarding FMPC 2019

Join us at the 4th National Conference of Family Medicine and Primary Care, August 1st, 2nd, 3rd and 4th in Bangalore, Karnataka and map your career path in family medicine.

The 4th National Conference offers workshops, special interest discussions, and hands-on skills courses to fit you and your needs.

A highly devoted team of AFPI members has been working towards bringing the most diverse group of people in Family Medicine and identifying and engaging topics of interest for the Scientific session.

Where have we gotten so far?

SESSIONS	DESCRIPTION	VENUE
Satellite Sessions *(1st Aug 2019)*	Around 4 hospitals have been identified as Satellite Centers to conduct academic workshops before conference. Details to be shared soon.	TBA
PG Update *(2nd Aug 2019)*	Will comprise of academic updates in first half followed by interactive workshop by esteemed international faculty. We are planning to have a career fiesta at the end of day with potential recruiters under one roof.	Satish Dhawan Auditorium, IISc
Main Conference *(3rd and 4th August 2019)* **(Workshops/ Presentations/ Panel discussions etc)**	Initial round of high-quality workshop proposals has been received and is under review by the peer review committee comprising of various faculty members from different parts of India. Although the deadline for workshop proposals has lapsed, we might be able to accommodate few workshops of exceptional quality in lieu with the themes of the conference. The abstract submission deadline for paper presentations/ posters is 30th April 2019 and we have started receiving abstracts already.	J N Tata Auditorium Hall A Hall B Hall C
Poster Presentations *(3rd and 4th August, 2019)*	Share your passion with a diverse group of doctors and come see what your peers are passionate about in family medicine and how they've made a difference through poster displays.	TBA

Team AFPI Karnataka is also working on the app for FMPC 2019 and will be available for download soon. Stay tuned with the AFPI WhatsApp and Telegram groups for further updates.

Gleanings

Evidence-based medicine ..... Or is it?

NOTE: Partially Reproduced from Indian Journal of Vascular & Endovascular Surgery

"We are Drowning in Information, but Thirsting for Knowledge"

Let me preface this editorial by acknowledging that I do believe in evidence-based medicine (EBM), but with some personal reservations and perhaps bias. Although not nihilistic, it is hard to believe "All is right with EBM."

One of my colleagues forwarded a 2-year blog by Dr. Anish Koka, a cardiologist in the USA, titled "On defense of small data," which I have professed strongly to peer groups I am part of, and a follow-up blog by Dr. Michel Accad, an internist also from the USA, "The devolution of EBM." And listened to the podcast on their website on "Beyond EBM; Case-based reasoning and the integration of clinical knowledge" by Dr. Mark Tonelli, Professor of Medicine from the University of Washington-"one of the earliest, most thoughtful, and most articulate academic critics of the EBM dogma. Professor Tonelli was responding to the query – Can anyone question EBM and not be considered some kind of fringe lunatic?" I do share some of the skepticism and cynicism they express, especially its relevance and transfer of these guidelines to most of the world which comprises low-to-middle income countries (LMICs).

This article is based on blogs, articles from non-peer reviewed and open access journals/opinions, and my own thoughts with all its prejudices and decrees. This article is definitely not evidence based; these are my own reflections.

My inquisitorial of EBM began when I had to (a) look for evidence for endovascular procedures for critical limb ischemia (CLI) and (b) gather data about CLI from countries outside high income countries (HICs), to be a part of an international EBM document. These HICs, on either side of the Atlantic, are well-honed, equipped and funded, to conduct quality clinical trials in a controlled environment, on large numbers of patients from multiple centers. They do an exemplary job and produce high quality data. These form the basis of EBM for the medical community of the *entire* world!

Let me address the category (b) first – broadening the heading to:

EBM and Low-to-Middle-Income Countries – Is it Relevant and Transferable?

Gathering data from LMICs – the phrase "mission impossible" springs to one's mind. We, in India, are fully aware that any vascular data – epidemiological, clinical and others– can be derived only from few centers, perhaps <50 for a population of over a billion! It would be a Herculean task, if it can be done at all, to collect similar data from other regions like Africa. The epidemiological data come from small pockets, diligently collected by select few physicians/healthcare workers. "In defense of small data, these perhaps represent the community/region/countries just akin to Gallup polls, where opinion sampling is fairly representative of events polled. However, such "small data" will not find its way in to acclaimed peer-reviewed journals and guidelines because they do not meet their rigorous reporting standards (data are flawed because they do not take in to account the natural variability of any biological data) and this "knowledge" is not disseminated because they are not published; in fact, these "small data" are shunned. The

paradoxical "Catch-22" situation; and the vicious cycle continues!

Even for diagnosis, treatments, and outcomes, these LMI countries rely on one's clinical experience and acumen, not always depending on EBM – not because of lack of awareness, but because of other loco regional factors. To quote from above, "I realize it has become dangerous to use one's clinical experience to inform one's views. While I have no quarrel with evidence, the reality is that the longer I practice, the more I realize that clinical scenarios rarely fit even the best designed clinical trials." I do share this view and this is fairly true across LMICs.

The disparity in the social and economic status of populations within LMICs is considerable and the system of health care in these regions is a multi-tiered out of compulsion. The EBM has to be tailored to the individual needs, especially because of economic constraints, and no EBM is created to cover this inequality – one size does not fit all! It is also true that "Important medical problems occurring in HICs can, depending on site-specific conditions, provoke much more severe challenges when occurring in low- and middle-income countries." Some of these challenges are listed below (Chinnock *et al.*).

These are especially true of CLI, where an infected foot wound dominates and dictates the patient care.

Large randomized, multicentric, controlled studies conducted under ideal conditions, can rarely be applied to these groups of patients. However, it would be incorrect to state that EBM is not relevant or applicable in LMICs. To quote again from Chinnock *et al.* "If the case for the use of systematic reviews is good in developed countries – and we think it is – then the case is even stronger in the developing world. Wherever health care is provided and used, it is essential to know which interventions work, which do not work, and which are likely to be harmful. This is especially important in situations where health problems are severe and the scarcity of resources makes it vital that they are not wasted." This statement is valid indeed, especially in countries like India, where we can provide care as per the decrees of EBM to wealthy. But for others, we need to modify these, which are unfortunately dictated by socio-economic status, with optimal use (and reuse) of resources without wastage.

There are several reasons why EBM is not routinely used in LMICs. "Evidence synthesis through systematic reviews or meta-analyses is often produced in HICs. However, these publications may not always be useful out of these settings. Firstly, access to medicines and interventions in LMICs are more limited than in HICs. There is insufficient public spending (*lack of health insurance, out of pocket payments– Ed.*) and shortages due to problems in supply. Additionally, contextual differences can apply, such as cultural differences (*barefoot walking leading to injury/CLI – Ed*). Therefore, the implementation of clinical practice guidelines produced in HICs is not always a straightforward process in low and middle-income countries." But then how do we bridge this gap – "This type of work should be adapted from a collaborative approach, taking into account structural and organizational differences in specific regions."

The trials from which EBM emerges rarely contain cost-benefit analysis. Naturally, the "Healthcare professionals in developing countries sometimes wonder whether their reliance on older, cheaper, 'lower-tech' approaches have made their practice quite distinct from that of their colleagues in richer regions. Yet the authors of systematic reviews seem, by and large, to prefer to take on the task of assessing the evidence for more recent (and generally more expensive) technologies." This is especially true in minimally invasive procedures, where ever-changing endovascular

tools, pushed into the market and forced on to the healthcare provider by profit-seeking industries, drive up the costs! Those in LMICs rightfully wonder how "the magic tool" from yesterday has become redundant today because it employed a "lower technology." The relevant evidence for this rapid change is hard to find.

The EBM and guidelines borne out of them are just that – GUIDELINES. They should not mandate "THAT" is the way to deliver care even in LMICs. Perhaps, these guidelines should be modified or suggest alternatives that can be practiced in LMICs; but it should be done by specialists in each region incorporating reasonable local evidence and data, however small they may be. It is hoped that the legal profession does not use some of the "undoable" EBM to pin a doctor down for not following these guidelines from HICs. Health policy makers should be aware of regional limitations in adapting EBM *verbatim*.

I conclude this section with this realistic statement, "When so-called developing countries first gained freedom from their colonial oppressors, Ernst Schumacher pointed out that there was a need, not for the "best" technology, but for "appropriate" technology. When it comes to healthcare, practitioners and patients of these countries need and deserve nothing less than the most "appropriate evidence."

It would be apt to recall the clarified definition of EBM by Sacket in 1996, nearly a decade after Eddy introduced the term – "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients… (It) means integrating individual clinical expertise with the best available external clinical evidence from systematic research…." Perhaps, we can integrate this with Confucian philosophy, "If you do not have the best, do the best with what you have." This integration of past and present would work well for LMICs!

Let me track back to category (a) – look for evidence for endovascular procedures for CLI. Since most of the randomized controlled trials have acronyms, risking raised eyebrows and frowning foreheads, I will label this section as:

"It's like a paradox: The more we insist on scientific reliability, the less certain our knowledge seems to become."

Suresh K.R.

Evidence-based medicine ..... Or is it?. Indian J Vasc Endovasc Surg [serial online] 2018 [cited 2019 Mar 13]; 5:213-6. Available from: http://www.indjvascsurg.org/text.asp?2018/5/4/213/247273

Suggested reading, not referenced in this article:

1. Does evidence based medicine adversely affect clinical judgment? *BMJ* 2018; 362 doi (Published 16 July 2018) Cite this as: BMJ 2018;362: k2799; https://www.bmj.com/content/362/bmj.k2799.full?ijkey = PeMeQDKT6KUKXYHandkeytype = ref

2. Alvan R. Feinstein (1967). Clinical Judgement. Williams and Wilkins

3. Cochrane A. L. (1972). *Effectiveness and Efficiency: Random Reflections on Health Services*. Nuffield Provincial Hospitals Trust.

A doctor's dilemma

During a discussion with a young doctor I was confronted with this question of alcohol use and abuse. He was a vehement votary of banning its use even on social occasions. This had me thinking. Doctors, to some extent along with teachers set standards of social behavior and teach what is good and what is bad. The campaign against use of tobacco has brought down its consumption in all forms to a great extent. So is advocacy of taking exercise as a preventive to cardiovascular disease and diabetes.

However, similar campaigns against substance abuse do not seem to have had much effect. The use of opioids in various forms and the use of Marijuana appears to have taken hold of in the developed world and we seem to be catching up.

Human beings from time immemorial, have brewed alcohol and have used it. In many primitive societies and tribes it is part of their social and religious life. Banning may not prove effective and may even be counterproductive.

There is no doubt that alcohol addiction causes immense damage to the physical health and family life of the individual, especially among the socioeconomically backward.

So, the only way to limit its use is by persuasion and finding alternative methods of entertainment for people.

As a first step, should we as doctors stop serving alcohol in our social and professional meetings?

Dr B. C. Rao

Case Reports

Conservative Management of Acute Calculous Cholecystitis in an elderly patient by Family Physicians

Home based care when provided by family physicians not just reduces the cost of treatment but promotes recovery, increases comfort and convenience for patients and families. In this paper we describe the possibility of safe, home based conservative management of acute calculous cholecystitis in a patient-centered and evidence-based manner by a team of family physicians with backup support of their specialist referral network.

A 82 years old male, who is a retired Indian Air Force officer and had gone on a strenuous hike on the 26th of December, developed vomiting on the night of 31st December, 2018.
This was after a drink of scotch (approximately 30 ml) and a light dinner. He had 5-6 episodes of vomiting which was followed by pain in the upper abdomen, 2-3 episodes of loose stools that night. His daughter, who is a physician, gave Inj Ondansetron, Pantoprazole and 500ml of IV Normal Saline as he appeared dehydrated. On the 2nd day he fell thrice, once in the bathroom and subsequently twice in the bedroom while attempting to walk. And this was attributed by him, to pain and a feeling of tiredness. There was no loss of consciousness or any significant injuries due to the falls. On Day 3 he developed fever, and the temperature ranged from 100.2 – 102 ° F. His oral intake had drastically reduced.

In terms of past medical history, he was known to have bilateral hearing impairment, chronic

gastritis, asthma and atopic dermatitis with eczema and was on treatment with Asthalin inhaler as needed and Formoterol Fumarate inhaler twice a day. He also had Benign Prostatic Hypertrophy and was on Tamsulosin capsule daily. He did not have any other comorbidities like hypertension, diabetes, liver disease or cardiac illness.

On day 3, a complete blood count revealed a total leukocyte count of 20,000 cells/cumm, total bilirubin of 1.21 mg/dl and Troponin T was negative (table 1). During a home visit by the Family Medicine team, examination revealed that he was mildly disoriented, was noted to be wheezing and had a temperature of 100.2 ° F, blood pressure was 166/90 mm of Hg, respiratory rate was 30/min and heart rate was 120/min. His abdomen was soft with tenderness right upper quadrant, epigastrium & periumbilical region. Due to the elevated WBC count, and concern for an intraabdominal infection, oral Ciprofloxacin 500mg twice daily was started. Paracetamol and Dicyclomine were continued for analgesia. Abdominal ultrasound and urine routine was advised.

On day 4, the ultrasound showed thickened gallbladder wall (4mm) with multiple calculi (4-5mm). A diagnosis of acute calculous cholecystitis was made.
The option of surgical management was discussed but the family was concerned about his age and postoperative complications. They indicated a desire for non-operative management if possible. On further discussion, the option of non-operative management at a hospital was offered. The family were reluctant for hospitalisation due to concern of hospital acquired infection. Hence they requested for home- based care. After due discussion of risks and benefits, a review of the literature, and telephonic conversation with trusted surgeon in the family physician's referral network, this decision was agreed upon by both the family and the treating family medicine team.
The patient was asked to continue oral Ciprofloxacin 500mg BD for 10 days, analgesics, and to take soft, bland diet. Regular home visits were made. The family medicine team was also available on call and the family was advised to call the treating physician if there was any worsening of symptoms like persistent vomiting, pain, continuous fever or inability to retain fluids.

Over the next 10 days, fever resolved, pain decreased, the patient stabilised. He was found to be depressed as he was not able to perform his regular daily activities without help. The psychologist who is part of the team counseled him and there after he progressively improved. By day 15, he had returned to his usual state of health. However, the 16th day ultrasound showed irregular wall thickening of gallbladder with minimal pericholecystic fluid. Also multiple calculi with sludge was present. A surgical referral was sought and interval cholecystectomy was advised after 6 weeks.

A repeat ultrasound at 6 weeks following the onset of symptoms showed resolution of cholecystitis with gallbladder stones of 4-5mm which were still noted. The patient is currently active, has deferred surgical management and is being monitored by the family medicine team. A strict diet is being maintained which is fat free, protein rich (pulses and legumes) and fruits given at regular intervals. Patient was restricted with tea/coffee/alcohol and refined sugars. As he is very fond of sweets he was advised to take yogurt instead.

Family doctors when visit the patients at their home, get a better understanding of the patient's family, environment, culture and economic condition which helps them in the holistic management of the patient. Home based care reduces cost, stress for patient and caregivers but can prolong the recovery period 3. However, this requires a team effort with supportive network of primary care physicians and specialists who practice evidence based medicine.

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Practice Experience

Hip replacement surgery at 10:30 am under general anesthesia. 2 hrs in recovery room. Patient made to walk at 1 pm and 4 pm made to walk again and to take few steps up and down. Discharged home the same evening.

This is no fiction but actual fact!

My 65-year-old relative went through this experience in the US recently. We have come a long way from the days when prolonged hospitalization was the norm. I recall the days not so long ago when we kept the patient virtually immobile in bed for 3 weeks even after a disc prolapse. Surgery for enlarged prostate was a two-stage procedure associated with prolonged hospitalization and suffering for the patient.

What has changed? Much has changed on many fronts - Innovative technology - the advent of scopes has revolutionized surgery; Accurate diagnostics - like the CT and MRI has helped speedy diagnosis and early treatment. These and procedures like primary angioplasty have made the hospital stay shorter and shorter.

Added to this is the cost of keeping the patient in the hospital. The longer the stay, the more expensive will be the costs. More the patient turn over better it is for the hospital. This is especially true in corporate health care.

Last but not the least is the fear of hospital acquired infections. These infections tend to be multidrug resistant and difficult to treat.

Many of the procedures currently done in a hospital can be done in the community, either at the home of the patient or in the doctor's clinic. It reminds of the days when my surgeon friend and I enucleated an eye which had become a ball of pus in the patient's home under local anesthesia and a circumcision done the same way on a bedridden patient.

For us, who work in the community, this is a golden opportunity to spread our wings. Let us take this example. We have a bold orthopedic surgeon who will discharge his patient the same day and hands the patient over to the family doctor to monitor and follow the instructions at home for the next week or so. What if the surgeon sees the patient along with the FP in the patients home or in the FP's premises? A win-win situation for all concerned don't you think?

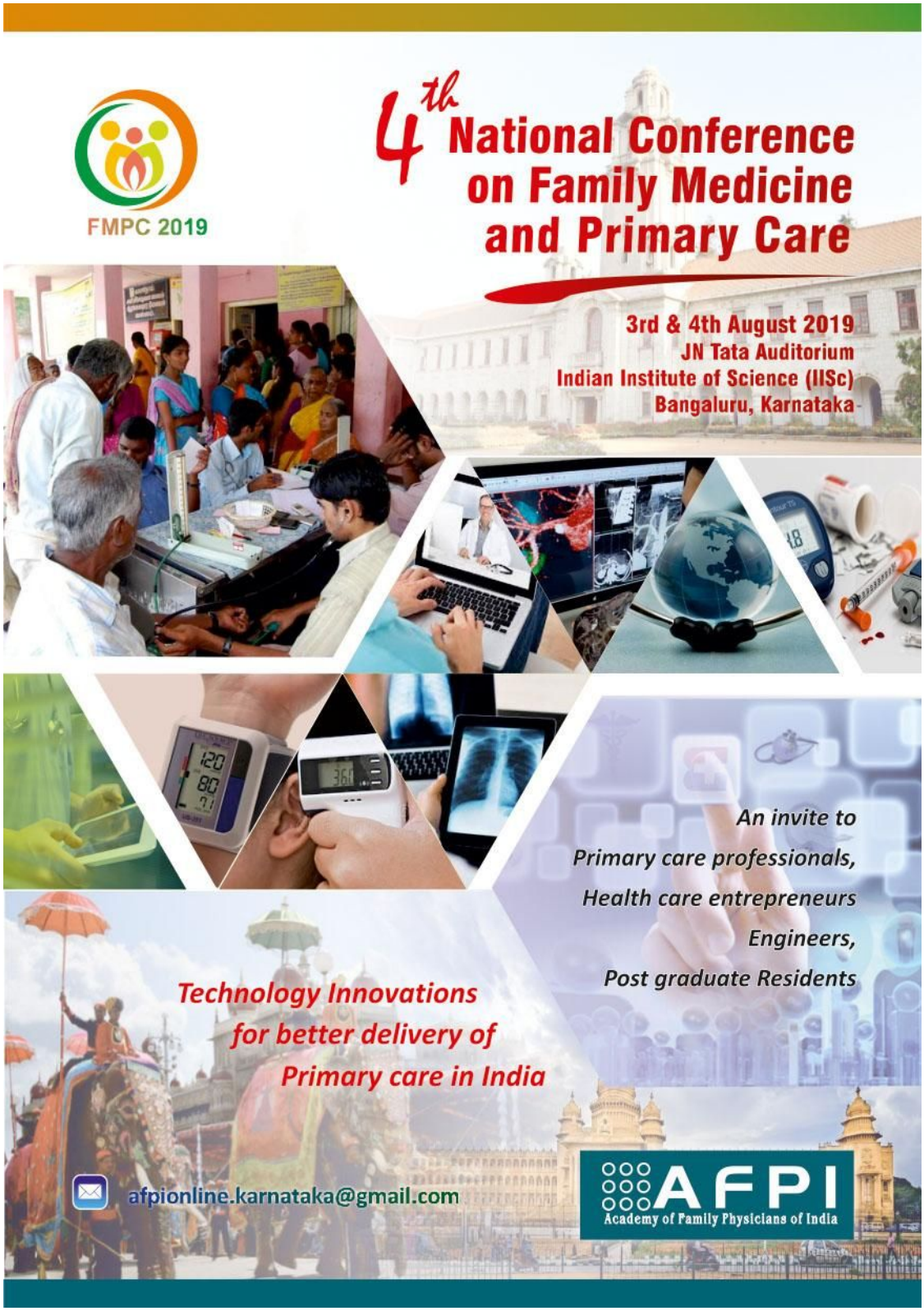
Dr. B. C. Rao

Masala

As doctors, many times the grammatical and usage errors of our patients both bring a smile and deepen our bond. Here are a couple of funny instances.

An architect friend was discussing the floor plan of a building and suggested some changes to which the contractor said, "No sir! the owner will not agree because she is very orthopedic (intended word - orthodox). :)

Looking at the small built woman who was brought in as a potential home help, the lady of the house said, "She looks so small, how will she manage the workload?" To this the agency representative who had brought the woman responded, "Madam, she may be small but she is very strong. She has contained three children, you know…"


FMPC 2019
4th National Conference on Family Medicine and Primary Care
3rd & 4th August 2019
JN Tata Auditorium
Indian Institute of Science (IISc)
Bangaluru, Karnataka
An invite to
Primary care professionals,
Health care entrepreneurs
Engineers,
Post graduate Residents
Technology Innovations
for better delivery of
Primary care in India
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AFPI
Academy of Family Physicians of India

Invitation

It is our immense

pleasure to welcome you to the "4th National Conference on Family Medicine and Primary Care" on 3rd and 4th August 2019 at Bengaluru - The Silicon Valley of India. The theme of the conference is "Technology Innovations for better delivery of Primary Care in India". The objective of FMPC-2019 is to create a platform to bring together various stakeholders in Primary Care and healthcare technology.

Healthcare delivery in India is rapidly transforming due to increasing demand, accessibility and innovations on the technology front, by way of apps, telemedicine, EHR, medical devices and more. This shall make healthcare equitable, transparent, and accessible to all and will also provide an ethical revenue stream for health care professionals and organizations.

Category	Early Bird	31st May 19	Spot Reg.
AFPI Member	INR 5000	INR 6000	INR 7000
Non AFPI Member	INR 6000	INR 7000	INR 8000
PG Student (AFPI Member)	INR 4000	INR 5000	INR 6000
PG Student (Non AFPI Member)	INR 5000	INR 6000	INR 7000
Accompanying Person - Indian	INR 3000	INR 4000	INR 4000
Corporate Delegate	INR 30000	INR 35000	-
SAARC Delegate	US $ 200	US $ 300	-
SAARC Accompanying	US $ 100	US $ 150	-
International Delegate	US $ 400	US $ 500	-
International Accompanying	US $ 200	US $ 300	-
Sr. Citizen Above 70 Years (AFPI Member only)	FREE	FREE	FREE

Register online: https://in.eregnow.com/ticketing/fmpc2019

Beneficiary Name:
Academy of family Physicians of India karnataka
Bank Name : Bank of India, Bettahalasur
Branch Add.: Bettahalasur cross, Bellary Road,
Bangalore - 562157, karnataka
A/c Number: 848020110000327
IFSC Code : BKID0008480

Col (Dr) Mohan Kubendra
Organising Chair Person

Dr Swapna Bhaskar
Organising Secretary

Dr Raman Kumar
President AFPI

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ALPCORD NETWORK

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http://www.afpikarnataka.in

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