AFPI Karnataka Newsletter

Issue: Volume 4, Issue 1

President's letter

Dr Swapna Bhaskar (President, AFPI Karnataka)

Hello Readers!

Welcome to a brand new year and a brand new edition of the AFPI newsletter! The year that passed by has been very exciting for AFPI Karnataka as we hosted the most awaited event – FMPC 2019 in August at JN Tata Auditorium, IISc campus. The mega event saw participation of over 700 delegates from all over the world along with eminent personalities from the RGUHS, NBE, BBMP, NHM and IMA. Family medicine and AFPI was brought to the forefront of the media and the health department too through this conference. We sincerely thank each and every delegate who came and graced this event and made it a grand success. We look forward to hosting many more such events and engaging all those who are part of this movement of taking family medicine into the core of the country's healthcare.

This edition is extremely special in that it's conceived and compiled by the young energetic new team of editors headed by Dr Akshay! I wish them all the best and hope to see further newsletters of high caliber with the involvement of primary care physicians from all parts of the state and country. Hope this new edition sets the trend for it !

We sincerely request all of you to contribute your valuable thoughts in the form of case reports, original research, medical updates etc.

Once again wishing you all a great year ahead…

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Editorial

Akshay S Dinesh (Primary Care Physician)

It is an honour that I accept with humility to be the editor of AFPI Karnataka newsletter. It will indeed be a difficult task to fill the shoes of Dr BC Rao who brought up this newsletter to what it is now.

With inputs from various readers and advisors, the editorial team has crystallized the mission of the newsletter into words as follows:

> "a semi-formal space where family physicians, general practitioners, and others interested in the field of primary health care can creatively share their experiences and express their opinions of what family medicine and primary health care should be, including their case reports, research papers, management, leadership, and relationship issues, administrative and entrepreneurial decisions, community work, and other articles about changing trends, thereby creating a community of learners and practitioners who inspire each other through their work and enhance and update their knowledge"

In the light of the above mission, the first task we embarked on is making the newsletter online-first so that a larger number of people will be able to find and read the newsletter. In fact, you will be reading this issue online. With that accomplished, from the next issue onwards we will strive to have many more articles and much more features that make readership and authorship easier.

The year that went by ended with the country facing tumultous times and hospitals and doctors being pushed to take a stand as neutral and peaceful venues. Let us hope that the new year will bring peace and prosperity. Wishing every reader success in sticking to their resolutions.

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Dr BC Rao

Dr Sunil Pandya (Neurosurgeon and scholar)

Dr Rao of Bengaluru is a seer not adequately recognized outside his own state.

He has chosen to be a family physician and has served his patients and their families for over 40 years. A respected colleague in Bengaluru tells me that Dr Rao ‘is one of the best physicians I have ever come across’.

Dr Rao is blessed with deep moral insight. Since this is coupled with humility of high order, many of us have been deprived of the opportunity to learn from him.

His familiarity with the writings of Hippocrates, Osler, Shelley, Matthew Arnold, Ralph Waldo Emerson, the Dalai Lama, Gerald Durrell, Plum Wodehouse and the bird- lover T.N.A. Perumal inspire respect.

He informed me that Dr M.K. Mani is one of his mentors. In turn, I have learnt from Dr Jaya Bajaj, scientific chairperson for the 4th National Conference on Family Medicine and Primary Care: ‘Dr B.C. Rao has been our mentor.' And so, the virtuous cycle continues to cast its beneficial spell.

I am trying to learn more about the man and his work but would like to present to you whatever I have uncovered in the hope that you will also benefit from what I am learning.

Apart from treating his patients with expertise, compassion and empathy, Dr Rao does his best to educate younger family doctors in Bengaluru. He plays golf twice a week and has a current handicap of 16. (Since I am an ignoramus on golf—as on many other subjects—I had to make enquiries before learning that a golfer with a handicap between 10 and 18 is a skilled player with a moderate handicap.) I am also cheered by the

fact that he is fond of studying birds and the lives of plants.

We are fortunate that he is fond of writing. Some of his essays can be found on his blog site: http://badakerecrao.blogspot.com/ 2007/ The blog appears to stop at 2016 but he continues to inform, educate and, at times, amuse right up this date.

He has other achievements to his credit. He set up a study group of general physicians in Bengaluru. Professional bodies such as the Indian Medical Association profess to promote learning but end up catering to politically powerful individuals and the interests of the sponsors of meetings—usually from the pharmaceutical companies.

Dr Rao describes his initial experiences as he set about trying to form a group dedicated only to learning:

My practice those days was semi-urban, though today it is fully urban and, in the vicinity, there were four general practitioners [GP], two of them senior to me. I felt I should moot the idea to them. The first worthy I went to thought I was a patient and I could see the disappointment on his face when he came to know that I am a fellow GP and possibly a competitor. He was polite but dismissive of the idea and told me to my face that he gets enough updates from pharma company representatives. I later came to know that he never attends any professional meetings but still was quite successful and no wonder he felt mine was a wasteful venture. The other senior was also lukewarm to the idea and felt he may not be able to attend given his busy schedule.

The other two agreed and we set up a meeting at my home. For want of an appropriate name we called it Doctors ' club.

Within a few years the club grew to 15 members who lived in different parts of the city. We decided to put a cap at 15 as we found it difficult to host more than this number in our homes. From the beginning we were clear—the meeting will be in our homes and the expenses will be borne by the member doctor and the hostess and no outside agency will be involved. As the meeting is held on Sunday afternoons, once a month, followed by high tea, alcohol does not come into the picture.

Did this experiment work?

This monthly activity has led this group of doctors to become good family physicians and I suspect their rate of referrals and needing specialist help is far less than others. It has fostered friendship based on respect and affection to each other and their families.

More recently, he has published a paper enshrining the principles that have guided his general practice and lessons learnt over the decades (Rao and Prasad 2018[1]). I hope that like me, you will find the case studies fascinating.

Readers of this Journal will be pleased to learn of how he studies each issue as it reaches him.

I am a regular reader of NMJI and I read the journal from the back to front. There are a few reasons why I do this. The front-page articles and papers are often full of statistics and other details which my old [grey] brain refuses to understand. In these, I end up reading the introduction and conclusion. Whereas in the back pages I find material that is more interesting and easier to understand and thus hold my undivided attention. These pages also cover a wider range of topics.

Professor Mani's Letter from Chennai is one such and those of us who worry about healthcare delivery and the related issues can easily understand and share his concerns.

1. Rao BC, Prasad R. Principles of family medicine practice: Lessons gleaned over a lifetime in practice. J Family Med Prim Care2018;7:303-8↩

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Child Development Assessment Tools

Dr Gowri RC (Family Physician, Developing skills in Child Development)

Why do we need this?

A rapid advancement has significantly increased the survival rate of High risk infants and some of these infants might have higher chance of developing milestone delays or developmental disabilities. Prematurity or other medical conditions put babies at risk for developmental delays. However, prompt detection and early intervention help a child reach their full potential for growth and development.

Present Scenario

Even though early identification and intervention is critical for well-being of children and their families, yet a significant number of developmental delays continue to go undiagnosed in the early part of life. Research shows that only 20-30% of the children were identified for disabilities before the pre-school years and in addition only few of the children under the age of three years avail early intervention services. So there is a substantial need to identify as early as possible those children in need of services to ensure that intervention is provided when the developing brain is plastic.

The next concern is that professionals use non-formal methods or observational method to identify developmental risk instead of using standardized screening tools in office practice.

The other major concern is lack of training among professionals in using standardized developmental screening tools.

Dr Nandini Mundkur and her team at Centre for Child Development, have developed online tools to help Professionals, like us Family Physicians, who are the first port of contact with Parents and Children, to pick up any signs of Developmental Delay and direct them to the right services at the right time, i.e. for early intervention.

Why Early Intervention ???

The first three years of life often called as the pre-school years are the most critical time period for the brain development. These early years provide the foundation for a child's future growth in most aspects of life, including physical health, academics and socio- emotional well-being. Decades of research has shown that neural circuits, which create foundation of movement, behaviour and learning are plastic during the first three years of life. Beyond three years, these domains are quite difficult to change. Moreover, brain development is influenced by early positive experiences such as emotional bondage with caring and responsive adults, environment that facilitate appropriate development and appropriate nutrition. So parental handling and environment in which the child grows will have a deeper impact on holistic development of a child.

Hence, family centred/directed early services to young children who have or at risk of developmental delays brings a positive outcomes across developmental domains including physical, language, cognitive and socio-emotional development.

Online Assessment Tools

This can be administered to all children, irrespective of high risk or not, as developmental problems can occur to any child.

TOTSGUIDE is an online portal catering to the developmental needs of children <5yrs.

It is first of its kind – developed in India which is culturally appropriate with good psychometric properties.

This portal is the result of combined efforts of specialists in Developmental Paediatrics, Psychology, Special Education, Physical and Occupational Therapy.

The services enlisted in this portal are also as available as an app in Google play store (iOS can access via web browser :

1. DOLPHIN – (Developing Opportunities for Learning in Parents to Help Infant Nurture)

This is a parent app, applicable from birth to 2yrs of age.

It offers 730 activities that focus on various domains under sensory stimulation, attachment-bonding, nutrition, sleep and to monitor milestones. The parents receive one activity per day, addressing one of these domains.

Added advantage of availability in different languages (Tamil, Kannada, Hindi, English)

2. Track and Act

This app can be used by parents or professionals to assess developmental age of a child. This can be used from 4months to 5yrs. It also has provision for age correction for prematurity until 2yrs of age.

Track and Act is an online validated developmental screening tool to assess milestones in 4 Developmental domains:

- Physical
- Language
- Cognitive
- Socio-Emotional

It generates a report which gives a score that helps a Doctor to identify any areas of developmental delay.

This has been designed especially for Indian children in Multiple Language Options (Tamil, Kannada, Hindi, and English)

Note: Professional who want to use this app in their clinic to assess children can contact the team for Partner Program.

For further information on the above apps, contact:

Mrs Bhagyalakshmi - +919629782822

Links for YouTube videos on apps:

- Track and act
- Dolphin

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Case Report

Patient With Fever

Dr H. S. Mrutyunjaya (Family Physician)

Presentation

34 year old Mr. P from Soraba presented with on and off fever for 3 months. He also had mild cough (on and off), diarrhoea, vomiting, severe headache, loss of appetite. He was extremely weak and had not attended to his work for 3 months. Fever was ranging from 101°F to 103°F and associated with chills and rigours. He is known to have severe migraine for the last 10 years.

History of Presenting Complaints

Patient started getting fever with mild cough, cold, at Soraba in the January of 2019. He was symptomatically treated. As the fever did not come down his sputum was examined for AFB at RNTCP Shimoga after a week and was negative.

After 15 days also, fever did not come down, so, he was admitted, at a medical college hospital in Mangalore for 8 days.

All relevant investigations - blood routine, blood culture, urine culture, X-ray chest, ultrasound abdomen - were done. Widal was positive and accordingly he was given a full course of anti-typhoid treatment - with ciprofloxacin and cefixime. As the patient yet went on getting spikes of high fever, patient got discharged against medical advice. The hospital diagnosed it as P.U.O.

After 15 days, he went to Sagara wherein X-ray chest was repeated, and routine blood counts, were done. Brucellosis and Proteus blood test were also done – and were negative.

He was given another course of anti-typhoid treatment, as Widal was strongly positive.

Then he took a different course of treatment. He went to “God Annamma”- for 3 weeks.

By this time his condition deteriorated and he visited Chamarajpet, where AFB and GeneXpert were repeated by RNTCP

Chamarajpet. It was negative. His X-ray and blood tests were repeated. They were also negative.

By this time patient was terribly sick and with his relatives help, he landed in my clinic on 10th April- exactly 3 months from the commencement of fever.

They asked me to see the records first, and patient was sitting in the waiting room. After going through – I was just thinking, what else I can do? They have done everything – blood counts, x-ray, blood culture, HIV test, blood for brucellosis and proteus, AFB, GeneXpert. Shuddering in my shoes, I just asked to bring the patient in for examination.

He was a 34 years gentleman, who looked sick and moribund, had lost weight of 12 Kgs in 3 months, weighing 42 kgs, dehydrated, speaking in monosyllables, no jaundice, 103°F fever, 120 pulse, on to himself, not bothered about surrounding and serious to see. His RS was normal on clinical exam. Per abdomen there was mild enlargement of liver and spleen. CNS was normal. No neck rigidity. Kernig's sign was negative. Babinski test- big toe was down going. CVS was normal. No bony tenderness and spine were normal.

First, I asked for routine blood test and x-ray chest, and ultrasound abdomen. It depends on man behind the machine - not the machine.

The new x-ray showed miliary opacities with right sided pleural effusion, mild, with hilar adenopathy suggestive of miliary tuberculosis. He was advised HRCT of lungs.

Abdomen ultrasound showed mild hepato-splenomegaly with portal adenopathy. Minimal ascites and right pleural effusion were also noted.

We aspirated pleural fluid under ultrasound guidance and found -exudate-Straw coloured, cell count 900 cells, Protein- 5.1 Gm/dl, cells type - Lymphocytes -80%.

CT thorax- miliary tuberculosis with right pleural effusion and subcarinal calcified lymph nodes.

Then the usual treatment of 4 drugs were started.

As the headache did not come down even after 10 days and he was not responding to usual treatment with analgesics (thinking of Migraine- as he had previous history of Migraine) – MRI Brain was done.

MRI of Brain report said multiple supra and infra tentorial ring enhancing lesions with few of them showing perilesional oedema, right frontal enhancing meninges, and right cerebellar hemisphere enhancing wedge shaped lesion were noted.

All these are suggestive of Koch's.

Final Diagnosis - Disseminated Tuberculosis

For disseminated tuberculosis and when the patient condition is serious and with the

involvement of brain, WHO recommends adding steroids to anti TB treatment to reduce the morbidity and mortality.

And, when brain is involved, the treatment of TB should be extended for a period of one year.

Pt was started on Inj. Dexamethasone in addition to standard 4 drugs regimen – calculating the dose for his weight. Inj. dexamethasone dose is 0.4mg/kg body weight, reducing by 0.1 mg ever week – total duration of 4 weeks of I.V. Followed by oral dexamethasone 4mg/day for the first week, and reducing by 1mg /day every week, total 4 weeks of oral dexamethasone. Totally 8 weeks of steroid.

Pt started improving from day 10, his vomiting stopped, headache reduced, started eating food, and in a matter of 3 weeks, increased his weight by 4 kgs, his fever stopped after about 3 weeks.

After 2 months, steroid was stopped (after tapering the dose). He was put on 3 drug regimens, from 3rd month. after 5 months patient has regained his original weight and started working.

Discussion

This is a case of fever, wherein, though there was history of cough, investigations did not reveal tuberculosis for three months, though he was extensively investigated. It was possible to diagnose, only when the disease got disseminated and involved both lungs with miliary tuberculosis with involvement of lymph glands, and enlargement of spleen and liver with ascites. As the patient had history of severe migraine, the diagnosis of brain involvement was delayed, thinking that, it may be migraine. The Kernig’s and Babinski signs and neck rigidity were absent, that also delayed diagnosis.

Though the patient was very serious with involvement of all organs, with proper anti-tuberculosis treatment patient recovered.

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Practice Experience

A Tale of Continued Diagnosis

Dr Sulaiman Sharieff (General Practitioner at Humanity Healthcare and Diagnostics, Tinfactory, Bengaluru (sulaiman94@yahoo.co.in))

Mrs. Pudina, aged around 30 yrs, is a working professional, from a middle class family. She is moderately obese, hypothyroid on treatment, with occasional episodes of allergic bronchitis, on inhalers sos. She has a child studying in primary school, while husband is an Entrepreneur. One fine day she develops moderate grade fever, headache, body pain, Throat irritation, and left side lower abdomen pain. She consults *Dr. Gabbar Singh*, a renowned Family Physician in her locality.

Mrs. Pudina's Temperature was 100°F, Heart rate was elevated, BP was normal. No significant Respiratory, cardiovascular or abdominal Signs could be elicited. Not finding her to improve with Paracetamol and anti-histaminics, Dr. Gabbar asks her to take a course of *Azithromycin*, for 5 days, and perform salt water gargles.

He assured her the lower abdomen pain could be due to impending dysmenorrhoea, as she was expecting her periods, which were recorded as Irregular.

She also informed Dr. Gabbar, that she was having homogenous, mucoid, white discharge through her vagina. Suspecting Bacterial vaginosis, she was advised for treatment with oral Metronidazole for 5 days and appropriate intimate hygiene with V-Wash solution or wipes.

Two days into treatment, vaginal discharge has reduced, but Mrs. Pudina developed urgency, burning while passing urine, and intense pain and burning sensation while passing motions. Unable to bear the pain, she had applied for Leave from work. She revealed that she was straining while passing motions. Her fever increased from moderate to high grade. Dr. Gabbar now advised her to consider a blood test – complete blood count, which showed an elevated Total counts (16,000) with Neutrophilic predominance, Dengue NS1 was negative, Peripheral smear

for Malaria Parasite was Negative, and Urine routine was normal.

Her antibiotics were now upgraded to Inj *Ceftriaxone* 1 gm IV BD, along with Oral Paracetamol, and IM Diclofenac sos. She was also started on Duphalac (laxative) suspension 20 ml BD, and advised to use "Smuth" Cream per-rectally.

Two days into her treatment, her per-rectal symptoms reduced, but left flank pain persisted, and fever spikes continued to be there more than 100°F, atleast twice a day. Dr. Gabbar advised to repeat CBC, along with a CRP (C-reactive protein), and plan for doing an Ultrasound of the abdomen. Total counts were increased to 20,000, hemoglobin had dropped from initial 12.4 to 11.6, platelets were normal, and CRP was more than 200 (high). At this juncture, Dr. Gabbar decided to consult a Specialist, *Dr. Mogambo*, a renowned Physician in their city.

Dr. Mogambo examined Mrs. Pudina, and advised for Blood Culture, Urine culture, and to go ahead with USG abdomen, and to continue medical care under the supervision of Dr. Gabbar. USG abdomen revealed *left side Ovarian cyst*, and mild hydronehprosis of left kidney. Dr. Mogambo opined, this could be a case of *Pyelonephritis*, and advised to upgrade antibiotics to *IV Meropenem* thrice daily, and to meet a Gynaecologist, and Urologist, and plan for DJ stenting of ureter, if not improved.

For the first time since a week, Mrs. Pudina did not spike any fever, and was happy to be back on her feet, carrying on her daily chores. Another day later, her fever spikes returned, and was treated with IV Paracetamol BD and sos. She now consulted a Gynaecologist at a Corporate Hospital, who advised a battery of investigations, and CT scan-abdomen. Her Biochemical parameters such as Creatinine, Electrolytes, and Liver function tests which were now worked out were within normal limits.

CT abdomen revealed *"Complex Ovarian cyst"* and to pleasant surprise, the Hydronephrosis (?Pyelonephritis) had now resolved. No evidence of abdominal lymph nodes or any other change in morphology. There was one blood test, which depressed her mood again, *"Ca-125"* which was elevated. Coming from a literate, working background, she and her doctor had worked out various possibilities of diagnosis.

Enter *Dr. Lal Pari*, the Gynaecologist/ Specialist Laparoscopic Surgeon. She patiently listened to the whole story, went through all the reports, and immediately took Mrs. Pudina for a Trans-vaginal Sonography, to understand the consistency and nature of the Ovarian swelling. The test revealed an *"Ovarian abscess"* and patient was advised Laparoscopic drainage under General anaesthesia. She also rightly assured Mrs. Pudina, that Ca-125 could be elevated due to ongoing Infection and inflammation, and told her not to worry about it now.

The procedure revealed frank pus, which was sent for Culture and sensitivity, post-operative period was uneventful. By then

Blood culture and Urine culture reports had come, both showed No growth. But the Pus culture revealed Growth of *"ESBL producing Escherichia coli"* an organism commonly causing urinary tract infection, probably implying an 'ascending' pelvic infection.

This bacterial isolate was reported susceptible to the action of Meropenem, and surprisingly to Co-trimoxazole. Patient was discharged with oral *Bactrim-DS*, and continued her follow up with Dr. Gabbar.

In the following week, Dr. Lal Pari treated Mrs. Pudina with IM Depot preparations of Progesterone, to take care of her Dysmenorrhea, with an advisory that she needs to get back to her atleast three months before her next conception.

After taking a few weeks off, Mrs. Pudina is now back to her work, hale and hearty, actively working on reducing weight, and trying to bring positive changes into the life of others.

This is the story of Dr. Gabbar and Mrs. Pudina. What would you do if you had been in place of Dr. Gabbar? Could your approach and management be any different from the one mentioned here.

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Urine Tuberculosis Test

Lipoarabinomannan (LAM) is a component of the cell wall shed by *Mycobacterium tuberculosis*. Tests based on the detection of LAM in urine have emerged as potential point-of-care tests for TB. Urine-based testing would have advantages over sputum-based testing because urine is easy to collect and store, and lacks the infection control risks associated with sputum collection.[1]

Earlier the test methods were able to detect LAM only in the urine of patients who were HIV positive and had active tuberculosis. But, researchers have been able to develop newer method that can detect LAM in urine of patients who are negative for HIV test as well.[2]

This new test will hopefully be available in India soon.

1. The use of lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV; Policy Update by WHO; Accessible at https://www.who.int/tb/publications/use-of-lf-lam-tb-hiv/en/↩
2. Urine lipoarabinomannan glycan in HIV-negative patients with pulmonary tuberculosis correlates with disease severity; https://stm.sciencemag.org/content/9/420/eaal2807↩

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Masala

A now famous surgeon practicing in one of our metro cities was posted to labour ward during his house surgeonship. On the first day as soon as he entered the labour ward, he was directed to conduct a delivery. As the lady was bearing down, this doctor was getting anxious and was fumbling.

The lady who turned out to be 4th para, said to him: "Beta, fikar mat karo. Woh apne aap aa jayega bahar, sirph aap pakadne ka he" [Son, don't fret. The baby will come out on its own, you just have to catch].

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Rural Sensitization Program

Tribal Health Initiative (A registered trust from Sittilingi valley, Dharmapuri)

Editor's Note: This is a promotional message that is republished here in public interest.

The Rural Sensitization Program is an experiential learning process for medical students, postgraduates and young doctors to expose them to rural perspectives. You will talk to health workers, farmers, craftsman, villagers to understand their stories and experiences. Through the observations, individual and group reflections and discussions, we hope that we can draw out together a broader map of the country's health problems and ways of addressing them.

Duration - 3 days

When - Batches in March, May, and September 2020

Number per batch - 30

Priority - First come first serve - Based on how soon you apply

Venue - Sittilingi, Dharmapuri district or Gudalur, Nilgiris (Both in Tamil Nadu)

For more details please contact - Sangeetha 8870193925, or rsptribalhealth@gmail.com

Application Form

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A journey towards health for all - a travel fellowship in primary health care

Tribal Health Initiative (A registered trust from Sittilingi valley, Dharmapuri)

Editor's Note: This is a promotional message that is republished here in public interest.

> "The real voyage of discovery consists not in seeking new landscapes, but in having new eyes." — Marcel Proust

If you wanted to see a tiger; would you rather go to the zoo or do you want to venture into the jungle? If you would like to see it in the jungle rather than in a cage in the zoo - far removed from reality , then read on.

While medical education in its entirety has shifted its focus towards urban tertiary health care, we know it is far from the reality of 'Health' in our country. Doctors often come out of medical colleges lost and disillusioned about the profession and the impact it has on our country.

With the guidance and mentorship of doctors working at the primary and secondary level, who decided to take the leap and address health in all its raw reality, this travel fellowship lets young doctors experience the path less traveled. It aims at making community-aware health care professionals by providing opportunities to experiment, innovate, become entrepreneurs and make a change in the present health scenario.

The primary intention is to provide a space to explore different dimensions of health care, through opportunities to visit, work at and interact with multiple models and people in the field of primary and secondary care.

The fellowship also provides an excellent platform to learn not just from the handful of organizations in which the traveler gets to work with, but also from the rich experiences of the fellow travelers.

At the end of the year long fellowship, one might cherish the experience of the path less traveled, might make one's own path, might have had a memorable one year of seeing India with new eyes or might have find

oneself. To all of which we will say- job well done!

If you really feel that this is for you - click here to for the brochure. To know more in detail about the program - click here.

If you want to apply - download the application form by clicking here - or email us - rhccfellowship@gmail.com