Academy of Family Physicians of India

KARNATAKA

AFPI KARNATAKA QUARTERLY NEWSLETTER

President's Letter

Dear friends,

It is a delight to see the release of this new issue of the AFPI Karnataka Newsletter. Much credit is due to Dr. B. C. Rao for his insistence that a newsletter is a critical output of any organisation and AFPI Karnataka simply must bring one out every quarter.

I also thank Dr. Akshay S. Dinesh for serving as the editor of the AFPI Karnataka newsletter from 2019-2022. During his tenure, we saw the AFPI Karnataka newsletter go digital, get catalogued in an easily searchable format, and also the expansion of topics and areas of coverage including health equity. Additionally, Dr. Askhay helped us arrive at a description of our newsletter as:

> "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"

I also take this opportunity to welcome Dr. Ramya S Iyer, DNB Family Medicine and Fellowship in Infectious Diseases to the core editorial team.

Finally: We want to hear from all of you. Every bit of experience that comes by virtue of being a family physician, is a story worth sharing. In our regular sections, there is always space for cases, reflections, short picture essays, quizzes, dilemmas, humour, and even the occasional rant (may be edited to allow relatively safe consumption). Also new ideas for the newsletter are ever welcome.

Dr. Ramakrishna Prasad
President
AFPI Karnataka

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Editorial Note

Every organisation needs a mouth piece, especially one like ours. Our members are located across the state and the country and the only way they can effectively communicate with each other is by way of the newsletter. The newsletter serves another purpose. Not all the articles, research outputs, practice experiences or case reports will find an outlet in indexed journals and it is also quite cumbersome to get them published. Our own newsletter comes in handy to get these published without any hassles. It is therefore my appeal to you all members and non members alike to make use of this newsletter to publish your work. It is also possible that if we find such material worthy of much wider publicity, we will help you to get the same published in journals which will have a much wider readership.

Dr. B.C. Rao

AFPI-NEWS

AFPI Karnataka is organising CMEs on a regular basis every month with an aim to conduct sessions which are highly relevant to family practice. Here is an update on the last 6 months.

On 16th August in association with Sparsh hospital AFPI conducted a CME on "**Oncology update for Family Physicians**". It was a hybrid session, there were both online and offline attendees. Dr Sushrutha Mysore Shankar, consultant breast surgery and surgical oncologist spoke about "*Dilemmas in the evaluation of breast mass*", Dr Dayananda S delivered a talk on "*Genetic screening for breast and ovarian cancer*". Dr Mohammad Idris shariff, member of AFPI, currently working as consultant family physician at Health assurance hospitals company Dhaman, Kuwait was the guest of honour and he spoke about "*Family practice in India vs Kuwait*". The sessions were well appreciated by the attendees.

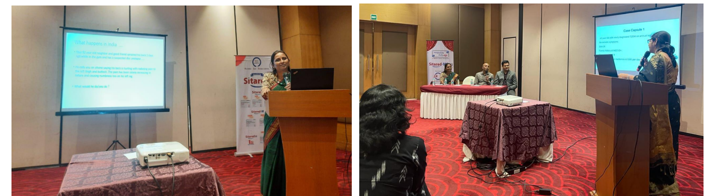
In the month of September, AFPI in association with Karthik Clinic and Ultrasound Centre and The Pocket Family Doctor conducted a half-day "**CME on Infertility update**". It was a one of its kind CME as an AFPI member Dr Krithika Ganesh organised this CME in her own clinic. The topics covered during the session were well appreciated by the participants as the topics were relevant for clinical practice. The topics were basics of infertility assessment in primary care, clinical assessment of male infertility, panel discussion on PCOS and fertility, counselling for the infertile couple.

The **GP forum** was recommended by senior advisors Dr. B.C.Rao and Dr.Subramanyam to discuss interesting and challenging cases in primary care.

In the month of October, AFPI in association with Manipal Hospitals conducted "**CME on Cardiology update**". Dr. Syed Mubarak, a member of AFPI presented on "*ECG interpretation, a case based discussion*" and Dr. Kumar Kenchappa, Interventional Cardiologist, Consultant Manipal Hospitals, spoke about "*Post-Myocardial Infarction Management in primary care*".

In the month of November, AFPI conducted a "**Webinar on Diabetes update for Family Physicians**". Topics covered in the session were - "*Tools to upgrade your Diabetes Practice*" by Dr.Smruti Haval and "*Approach to Diabetic Nephropathy*" by Dr. Impana. This session was moderated by Dr(Col). Mohan Kubendra, Senior Family Physician and was chaired by Dr.Aravind C, Consultant Nephrologist and Transplant Physician, Trustwell Hospital and by D. Swathi Sachin Jadhav, Consultant Endocrinologist, Trustwell Hospital.

In the month of February, AFPI conducted a **CME** in which the Keynote Session titled "*Family practice in Australia*" was delivered by Dr. Swapna Bhaskar, ex-President, AFPI Karnataka, followed by a



Dr Shalini Chandan, Scientific Chair

AFPI Karnataka.

Secretary's Report

The 3rd State conference was conducted in December 2022. It was an experience worth sharing.

I took charge as honorary General Secretary of AFPI Karnataka from Dr. Srividhya Raghavendran, who had already set a benchmark. It was indeed a responsibility, which had to be shouldered along with the new President and newly shuffled team.

We started out by identifying our goals to be achieved during our tenure as office bearers. To mention a few:

- AFPI activities outside Bangalore geography. Reach out to other parts of Karnataka.
- To conduct a CME every month. It could be an online CME or an offline CME
- Engage with community and create awareness about preventive and primary health care
- Engage Family Medicine Post Graduates
- Engage medical students with an intention to create awareness about the importance of Primary health care provided by Family Medicine practitioners.
- Engage with the policy makers and decision makers in academia.

As I look back, I would like to express my gratitude to the team of the AFPI Karnataka office bearers and the ever supportive members of AFPI Karnataka.

The last 9 months have been a roller coaster ride. The 3rd State conference, organised in Mysore has been challenging and a great learning experience. It was a challenge in many ways:

- Outside Bangalore, with just 3 AFPI members in Mysore who took the lead.
- First time engagement with the medical students , with an entire day planned for the medical students and PGs.
- First time an attempt to engage the undergraduate academia, policy decision makers and other medical associations.

The challenges were in choosing the venue, raising sponsorships, inviting the delegates, and in the logistics to enable a smooth conference.

Interpersonal relations were tested but as we say "every cloud has a silver lining". The challenges come with enormous learning too.

- Learning of do's and don'ts
- How much to do
- What not to do
- How to optimise the resources at every level
- The level of engagement with sponsor
- The continuum of relationships with the supporters
- Setting boundaries in various professional and personal relations
- How much is too much and too less
- The list goes on...as learning is a continuous process.......

With all the above said things, I gathered a huge load of memories to cherish in my goody bag, which will stay with me forever. We met various people from the world of Medicine with a different persona.

I realised the strength of the great supportive team without whose unconditional support, we wouldn't have reached and achieved whatever little we have achieved.

I will cherish for life the memory of organising 3rd State conference Family Medicine - Update 2022 and wouldn't barter this.

Looking forward to continued support for such events in the future.

Dr. Harshapriya J

General Secretary, AFPI Karnataka.

AFPI Academy of Family Physicians of India

New Featured Quarterly Case Series in the Journal of Family Medicine & Primary Care (JFMPC) titled, "Family Health in the Hinterland"

Over the last two decades, despite significant advances, **rural health** is particularly plagued by *Urban-Rural Maldistribution* and *Misplaced priorities of the medical education system*.

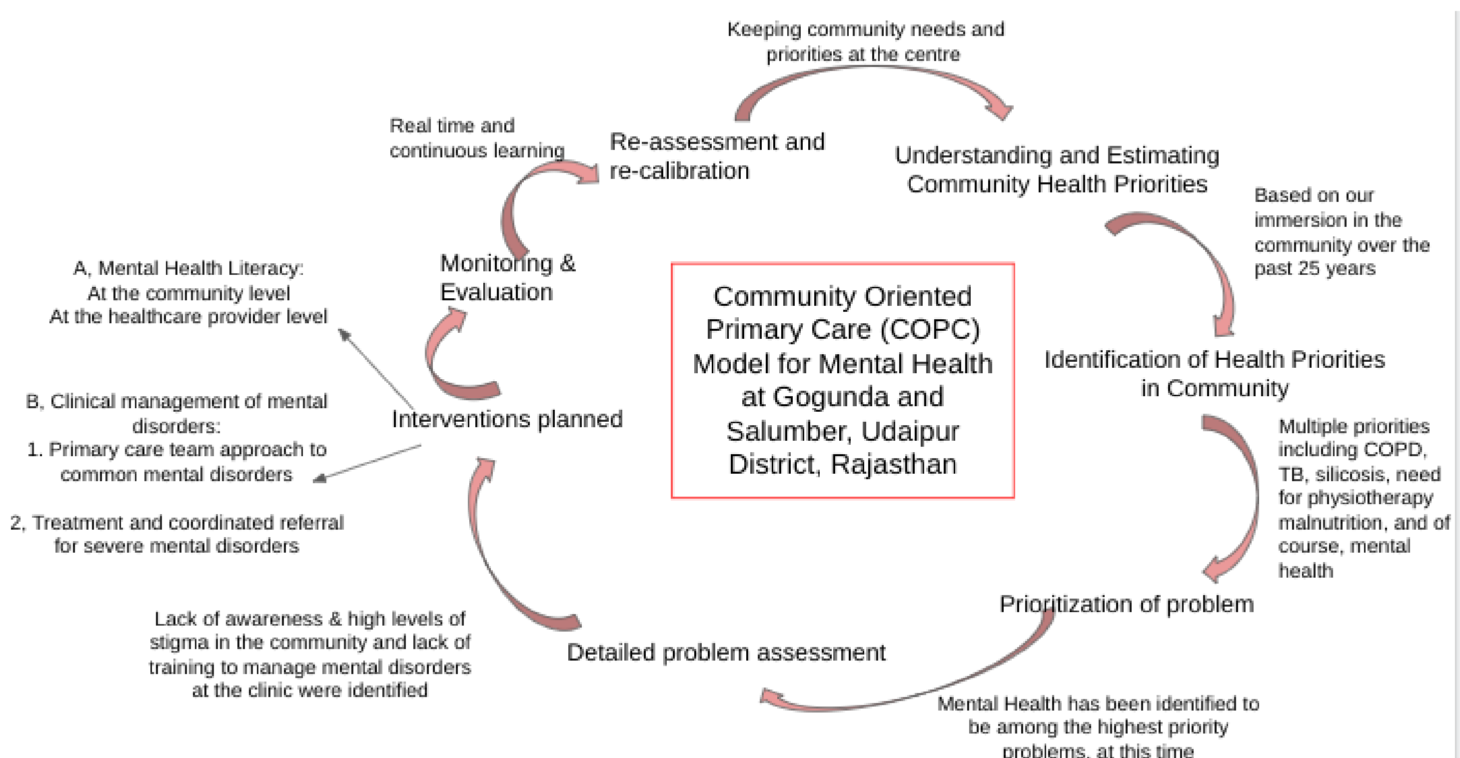
The current medical education system doesn't give adequate exposure to the students in the practice of primary health care with professional identity, mentorship, peer recognition (in the medical profession), training is effective teamwork and career growth. Students and young health professionals are often not exposed to the practice of family medicine - that is accountable and addresses the needs of first contact based care on continuity of provider-patient relationship, is comprehensive, coordinated, and sensitive to the local context.

Community Oriented Primary Care (COPC):

In its most general definition, COPC is the "provision of primary care services to a defined community, coupled with systematic efforts to identify and address the major health problems of that community through effective modifications both of the primary care services and other appropriate community health programs". Towards this, the conceptual framework for COPC is based on 5 principles: (*a*) responsibility for comprehensive care of a defined population; (*b*) care based on health needs and its determinants; (*c*) prioritisation of those needs to implement health programs; (*d*) programs that integrate promotion, prevention and treatment; and (*e*) community participation. Fig 1: Conceptual Framework of COPC applied to primary care mental health services

The Role of the Family Physician in Rural Practice:

In rural areas, family physicians in rural practice need to play several roles including: 1) Proving Direct Clinical Care; 2) Consultant to nurses, interns, junior medical officers and community health workers; 3) Capacity builder; 4) Supervisor; 5) Clinical governance/Continuous Quality Improvement (CQI) lead; and 6) Champion of COPC. These demand a range of clinical skills, social skills, leadership skills and to be able to work in teams, understand



community needs, and engage with the community actively.

Our Rural Primary Care & Community Oriented Primary Care (COPC) Practice Context:

BHS is a not-for-profit organisation where community clinics are led by qualified nurses supported by a Family Physician. Community health workers and volunteers (Swasthya Kirans) further extend the community reach of services and promote healthy behaviours.

Each AMRIT Clinic, managed by Basic HealthCare Services (BHS), provides primary health care that is responsive, empathetic primary health 'circle of care', that is rooted in the community including providing preventive, promotive and primary curative services to a cluster of about 3000 tribal families. Most of these families own small unirrigated farms and have limited employment opportunities. Such a situation forces many young men to migrate to cities for labour. Food is scarce, and malnutrition levels among children and adults are high. Terrain is hilly, and habitations are scattered. Nearest functional government health facilities are 20-30 kilometres away.

AMRIT Clinics also utilise a range of innovations including *HR Innovation, Partnership innovation, and Technology innovations* to address a range of day to day situations that are highly challenging such as: What does a mother do when the child is sick, father is away to a city for manual labour, and there is no health facility for 20 kilometres, and no transport? How does a health provider manage an elderly woman with severe pneumonia when there is no X-Ray machine, no blood gas analysis and there is no referral possible? What nutrition advice do you give to the family of a severely malnourished young man with silicosis and tuberculosis, who cannot afford any milk or oil or egg? How do you maintain your sanity when you see a woman in labour walk 5 kilometres to reach the Clinic at night across the hill?

Intent of the Quarterly Rural Health Feature Series:

This quarterly feature series on rural health intends to inspire students and practitioners to engage in rural community practice, dive into a unique opportunity to observe from close, healthcare of adults, children, and whole families from remote communities, gain insights on delivering healthcare in places with limited resources to learn and impart lessons on what changes in clinical approach, programs and policies might be required to improve the care for these neglected and often forgotten, populations.

In each article, we will provide a case study, try to locate it in a wider context, discuss learnings from clinical, epidemiological, health systems, and policy lenses, and propose a call for action. Each case study will illustrate the principles of family practice such as "deep generalism"; "person and family orientation"; "continuity of care"; "community based care"; "building a trusting relationship"; "counseling"; and "an effective steward of resources" are highlighted. Additionally, these articles will: (1) reflect on the clinical insights, joy, challenges, and dilemmas of physicians in addressing health needs of the rural communities; (2) contrast between a disease-oriented (specialist approach) and a person-oriented approach combined with COPC; and (3) suggest a course correction to the existing paradigms in medical and health sciences education of both generalists and specialists.

Ultimately, our hope is to enable students and practitioners of medicine to be more effective in delivering primary care and appreciate the privilege they have of serving as physicians in the community.

So please stay tuned!

Dr. Ramakrishna Prasad & Dr. Pavitra Mohan

Feeding nutrition into your primary care consultations

As primary care practitioners working closely with the community, a bulk of our practice constitutes chronic, lifestyle diseases. It is well known that better dietary practices help in prevention and control of these illnesses. Yet we don't give due importance or time to diet counselling in our OPD settings.

The reasons for this are manifold. First of all, the lack of emphasis on nutrition throughout our medical training. Apart from minor exposure in community medicine and paediatrics, the importance of diet and the role of the medical practitioner in improving nutrition of the patients is largely ignored. The same goes for post graduate training as well where the emphasis is on diagnosis and treatment rather than prevention and support. As a result, most doctors are ill equipped and lack the necessary skills in diet counselling.

Secondly it is the sheer volume of patients and lack of time that prevents physicians from delving deep into patient's dietary practices. The cultural variations in diet in our country and lack of access to healthy foods for certain strata of society are other reasons that prevent physicians from broaching this topic. But there have been many studies that have proven the positive role that dietary modifications can make on people's health and wellbeing. Here are a few ways in which you can try to include nutrition into your daily practices.

Keeping a Food log.

Just like we ask patients to maintain blood sugar and home bp monitoring values in a book so that we can see them during follow ups, ask the patient to maintain a food log too. Note down everything they eat in a day honestly including snacks and beverages. You can go through this along with their blood sugar/ bp values and identify potential problem foods and suggest alternatives accordingly.

Involve the patient in making healthier food choices.

Lecturing the patient about why he/she shouldn't drink pepsi or eat French fries, most likely makes them feel guilty or judged, thereby closing them off to anything you say. Instead, ask them an open question "So how do you think you can eat healthier?". Be non judgemental and supportive. Most patients realise their mistake but are stuck in bad habits and routines. Pick one meal, craving or habit and suggest ways to make changes. Focus on the why rather than the what. Since it was identified by the patient themselves, they will be more likely to follow it.

Avoid Jargon

Instead of mentioning big names like DASH diet, mediterranean diet, keto etc, try to explain the core basis of healthy eating. Principles of healthy eating include higher intake of whole grains and fibre rich food, variety of vegetables and fruits, low saturated fats , lean meat, limited sodium and processed foods and adequate water intake. These are universal and easier for the patient to incorporate into their daily diet rather than adopting a whole new diet pattern which is alien to them.

Address gross myths.

I recently had a patient who had hypothyroidism and obesity. When I was trying to ascertain the issues with her diet she confidently stated that she uses only olive oil for cooking. Upon further enquiry I realised she was having bondas, pakodas and other deep fried items with tea everyday. She felt it was alright since she was anyway frying it in olive oil which according to her was healthy fat. Just taking a few minutes to identify and bust this myth made a difference. Had I not enquired, she would have continued with unhealthy dietary habits, oblivious to the myth.

Keep cultural background in mind

Since we see patients from a variety of cultural backgrounds in India, especially in urban setups,

it is important to take this into consideration while suggesting diet changes. For example, suggesting ragi porridge as a healthy breakfast to a Punjabi man would not help since he may have never heard of it or not be willing to try something so unusual in his cultural context.

Avoid Generic statements.

Telling someone to just “reduce salt” may not be helpful unless we identify specific high sources of sodium in their daily diet and ask them to avoid those. For example pickle, papad, chutney, spice mix powders etc. These are part of the diet since childhood for many and unless we point it out, it is not obvious to the patients what has high sodium content in their daily meals.

Concentrate on protein

The Indian diet is low on protein. Even those who eat meat do not do so on an everyday basis in our country. It is important to suggest healthy sources of plant protein and help the patient incorporate these instead of carbohydrate rich foods. Including protein and fibre rich foods, vegetables at the beginning of the meal is helpful in diabetes and prediabetes patients.

Dr Krithika Ganesh, MBBS, DNB (Family Medicine)

Ayushman Bharat - An Untapped Valuable Resource

Ayushman Bharat - the name resonates with the spirit of health empowerment — so is the scheme!

Famously also known as "Modicare", it is the world's largest healthcare system and it has been 3 years since its revelation.

The scheme has 2 elements:

1. Health wellness centres based on "prevention is better than cure": The centres provide primary, outpatient care and referral access to secondary and tertiary health care when needed.
2. Health insurance scheme - in secondary and tertiary care. Aims to provide free access to health insurance coverage for low-income earners in the country. Almost 55 crore people can be benefited with 5 lakh rupees per family per year as promised in this scheme in empanelled hospitals, both public and private.

In 2018 there were millions of Indians who were pushed below the poverty line for primarily one sole reason - they did not have sufficient income to spend on their health. With the quest to reduce the medical expense burden on families the government came up with the above zealous scheme.

We have a very ambitious and inspiring prime minister and more so his projects and schemes reflect his progressive thought process. The same is with the revolutionary scheme released under the name of AYUSHMAN BHARATH.

This article brings to you a neutral perspective and possibly an eye-opener for the ones who are willing to give a thought around this article and promote what's best available for our patients.

Who is eligible under this scheme?

Rural	Urban
Labourers Scheduled Tribes And Scheduled Castes Landless Households Manual Scavengers	Rag Pickers Beggars Street Vendors Construction Workers And Security Guards Etc.

The primary question to all my compatriots here- do you know what the Ayushman Bharat scheme is?

Most of the medical population have just heard about this and assume – " it may be just another project on the national front". I remember in a gathering of medical associates some of the medical faculty was not even aware that it is a medical scheme! Hence This article brings to you all in simple terms- what Ayushman Bharat is and why as doctors we need to make the medical world in India aware of the same.

Let me share a short scenario: A daily wage worker, a diabetic, unable to get medications for himself, lands up finally as an amputee, as his leg turns gangrenous. The sole breadwinner now has to beg on streets to earn a living.

This is just a small glimpse into the window of the world of the downtrodden, there are many lakhs such below poverty line families devoid of medical help and eventually disappear without being heard by anyone at all.

Brief about Jan Aushadi Kendras

The biggest scheme easily available now under ayushman bharat is called Pradhan Mantri Bharatiya Jana Aushadhi Pariyojana, the sole purpose of this scheme is to get medications for

every household for affordable prices through exclusive outlets called Jan ayushadi Kendra . This scheme was launched on 23rd Sep 2014 and to date 8012 KENDRA'S are functional across the country with 1451 essential drugs available and 240 surgical items.

National sample survey says 72% of the economy goes into the expenditure of medicine procurement.

What do we get in Jan Aushadhi Kendra?

Am sure the medical practitioners would not have had the time to look into the hoardings of our PM at some medical outlets, but those are Jan Aushadhi Kendras which sell GENERIC MEDICATIONS.

The ones that we have learnt from our professors to prescribe from our college times are BRAND medications - which also the medical representative comes along with his handbags filled with catalogues to push us to sell through our prescriptions.

The Brand names (pharmaceutical industry) have to bear the brunt of their company marketing expenses, taxes, warehouse storage expenses, staffing finances, etc and naturally, have to cap the price of their medications almost 3 times that of the generic medications.

But imagine if every doctor in our country could mobilise generic medications, there would be so much more saved in every household to make a better living.

The intention of this scheme is beautiful, overwhelming or I would say heartening and definitely inspiring but there is always a roadblock when something has to be achieved and that is its implementation.

Who and what is the roadblock to jan aushadhi kendra?

You would be surprised to know but the roadblock to its implementation is the medical fraternity itself!

And why you may ask?

Well, ask any doctor randomly "Doc, what is Jan Aushadhi Kendra?" You may get an abnormal pause and then "Ahmmm. A national scheme?" Period. "OK. So is it available anywhere around?" Answer - "well maybe you need to check in a government setup."

Well, the point that I wanted to make up there was simply that we doctors need to know the policies the government is churning out in order to take it forward till the patient. If the doctor does not know about the medical scheme the entire benefit dies out even before it is born and nurtured.

Many misconceptions about Jan Aushadhi Kendra

Yes, many private pharmacists pursue the patient to buy medications at their stores rather than Jan Aushadi Kendras. And why? They claim the medications at Jan Aushadi Kendra are ineffective and that's why they are sold cheap.

It's dismaying that fellow Indians have to do this to lure customers but the fact is the Jan Aushadhi medications work well, have undergone necessary standardised quality checks, available in affordable prices for both rich and poor.

After utilising this scheme for many months now, I am sharing personal feedback here - your patients would not only be happy with the treatment but also the money they have actually saved over time. Else they would have had to spend thousands at the private pharmacy procuring medications out of your prescription.

The implication of easily available and affordable medications goes a long way in getting good compliance from a patient

perspective and reducing the financial burden on the family altogether.

Why do we not see many private hospitals participating in the ayushman bharath health insurance scheme?

Reason: The government reimbursement rates are as low as 11-15 per cent of the actual costs of surgeries or procedures. For example, if a tooth removal costs Rs X amount, the government is willing to pay only half of the X amount for the procedure, the hospital has to bear the extra costs by itself, then why would the private hospital want to be a part of this scheme. Under this health protection scheme, the proposed rates of over 1,350 surgeries and procedures are 15-20 per cent lower than Central Government Health Scheme (CGHS). The cost of therapies range anywhere between Rs 1,000 and Rs 1.5 lakh An aortic arch replacement under cardiothoracic surgery would cost around Rs 15 lakh in a tertiary care hospital, which the government, under Ayushman Bharat, is offering for Rs 1.5 lakh. A well-known chairman and managing director of a tertiary care hospital echoed the concerns of such reduced prices given by the government "The rates, which the government has offered, are not realistic. They haven't calculated our overhead expenditures," he said. These hospitals are also unhappy with the delayed cycle of payments under the existing CGHS. "Government takes six months to one year to pay our reimbursements for treatments under CGHS. We don't want to get into another scheme unless the government assures us that the payments are made within 15 days," said a senior official at a leading Delhi hospital. However, the government said it is voluntary for hospitals to participate in the scheme, due to rates that are not agreeable by private hospitals and slow payments by the government we find only a few hospitals attached to this scheme.

State government schemes - initiated by different state ruling parties other than the Ayushman Bharat.

State schemes already exist in a few states and hence do not see the requirement of adopting Ayushman Bharat completely as yet. Few states have started collaborating partially in order to share the financial burden.

Tamil Nadu CMCHIS - Chief Minister's Comprehensive Health Insurance Scheme (Amma Health Insurance)

Delhi Mohalla clinics - provides free medications and a few diagnostic tests free Delhi Arogya Kosh schemes

West Bengal - Swasthya Sathi scheme

Telangana Basti clinics - free clinic and few diagnostic tests free

Rajasthan Independent Rajasthan medical service corporation, Free medicine distribution.

Kerala Improve service infrastructure of existing clinics "Karunya Arogya Suraksha Padhathi (KASP) has now collaborated with Ayushman Bharat scheme.

PROBLEMS AT GROUND LEVEL-

- Primary care in health wellness centres are not being promoted nor been adopted by private hospitals as they have their own health check departments to promote and run which costs way more than the government primary care packages, also the number of screening programs are more comprehensive and versatile in private hospitals than the government health wellness centres.
- In order to make use of the Ayushman Bharat scheme benefits, a person must be hospitalised for at least more than one day, daycare charges are not applicable. Unless the beneficiaries are not hospitalised and just prescribed general medicines,
- Issues such as constraints on movement, limits on elective operations, reluctance from scheme users to attend hospitals

owing to fear of infection, classification of public institutions as special Covid centres have a considerable influence on the yojana's effectiveness.

- Due to a lack of adequate knowledge, many are not able to avail the scheme benefit. Not many are confident in promoting generic medications from Jan Aushadhi Kendras and the apprehensions have not been addressed by the government clearly.
- Last year nearly 111 hospitals were shamed for malpractices with this scheme.
- Before the lockdown, 51% of the empanelled hospitals were operational. This percentage decreased to 25% during the late lockdown phase, the number of active hospitals REDUCED by over 40%
- Small and medium-sized hospitals with less than 100 beds were the most hit.
- Fear of getting COVID-19 infection among hospital owners and employees, or fear of being stigmatised and losing business if they treat COVID-19 patients the staff have reduced hospital visits, with reduced manpower the burden of the ill population is higher on government hospitals again.
- Registration in this scheme is mostly online and most of the underprivileged do not have access to the portal to understand and use the benefits.
- Private hospitals and pharmaceuticals will definitely not want to promote government schemes that would incur losses to their companies

Misuse Of Scheme -

There has been misuse of the Ayushman Bharat scheme by private hospitals through the submission of fake medical bills. Under the Scheme, surgeries have been claimed to be performed on persons who had been discharged long ago and dialysis has been shown as performed at hospitals not having kidney transplant facilities. There are at least 697 fake cases in Uttarakhand state alone, where a fine of 1 Crore has been imposed on hospitals for frauds under the Scheme. Despite all efforts to curb foul-play, the risk of fraud entities profiteering from this system is clearly present in AB-PMJAY and needs transparency for the common man to put his faith in this system.

Current status of the scheme with improved initiatives announced recently

Under medical management procedures, the rates for ICU with ventilator support has been revised by 100 per cent and without ventilator by 136 per cent, while the rates for HDU (High Dependency Unit) has been revised by 22 per cent and the prices for routine ward has been revised by 17 per cent. Rate revision in radiation oncology procedures, medical management procedures like those for dengue, acute febrile illness etc, surgical package treatment for black fungus, and other procedures like right/left heart catheterization, PDA closure, arthrodesis, cholecystectomy, appendicectomy etc. also has been done.

Currently, Ayushman Bharat PM-JAY covers 1,669 treatment procedures out of which 1,080 are surgical, 588 medical and one unspecified package.

Ayushman Bharat Health Infrastructure Mission

Prime Minister Narendra Modi launched the Ayushman Bharat Health Infrastructure Mission, one of the largest pan-India schemes for strengthening healthcare infrastructure, from his parliamentary constituency Varanasi in Uttar Pradesh on Monday.

The prime minister also inaugurated various development projects worth more than Rs 5,200 crore for his constituency.

Its objective is to fill gaps in public health infrastructure, especially in critical care facilities and primary care in both urban and rural areas. It will provide support for 17,788 rural health

and wellness centres in 10 high focus states. Further, 11,024 urban health and wellness centres will be established in all the states.

Through this, critical care services will be available in all the districts of the country with more than five lakh populations through exclusive critical care hospital blocks, while the remaining districts will be covered through referral services.

People will have access to a full range of diagnostic services in the public healthcare system through a network of laboratories across the country, and integrated public health labs will be set up in all the districts.

What can we from the medical fraternity do to improve the healthcare system using this scheme?

First - Read about Ayushman Bharat scheme , Pradhan Mantri Ayushadi Yojana And Kendras . Find out functions of health wellness centres (primary care facilities).

Second- Find out Jan Aushadhi Kendras around your locality simply by googling " jana ayushadi kendra near me "

Third- As doctors most importantly advise generic medicine names As far as possible -- and send the patient to buy medications from these kendras and guide them.

Make patients aware of a scheme that can fund their surgeries or disease treatment if they are unaffordable and need financial support.

Fourth- Visit your primary health care centres , jan aushadhi kendra and look at the facilities available, all essential medications are available respectively - if not available then email to complaints@janaushadhi.gov.in; cl Toll-Free 1800-180-8080

Fifth - Go to the local area MLA or MP and ask them to open a Jan Aushadhi Kendra around your place if not there already.

This scheme acknowledges the Right to Medicine and the Right to be Treated well, especially impacting the lives of millions of families who are dying due to ill health.

Remember, we are the gateways for the benefit of national schemes to be introduced to the population that come to us for treatment. It's important that we as healthcare professionals have the necessary awareness and information to take national schemes forward to people, when people start using these schemes and mobilising provisions the government is providing, there is always a consideration in government boardrooms to take the scheme to the next level rather than scraping it as a whole.

Dr Amina Shah, Family Physician

Gleanings

Ramus Intermedius

Recently, my close relative, Mrs. V.J., a 74 year old lady suffered a Myocardial infarction while on a tour of Gujarat. She was in cardiogenic shock with pulmonary edema when she was seen by a cardiologist in the small town of Bhavnagar. An emergency ECG and subsequent coronary angiogram showed triple vessel disease with a complete block of Ramus Intermedius that had resulted in the lateral wall infarction and the subsequent events. She was successfully treated with stenting of this vessel and was discharged with the advice of elective stenting of the other two arteries at a later stage.

As this was the first time that I had heard of this name, I did a web search and also discussed it with my cardiologist friend. This is what I found out.

Ramus Intermedius is an aberrant coronary artery present in 20 to 30% of people. Normally the left Coronary artery divides into anterior descending and the left circumflex. In this 20 to 30% of people, the left coronary divides into not two but three and the one in the middle is termed as Ramus Intermedius, a kind of interloper so to say! Normal coronaries run on the surface inside set grooves. Being an interloper, Ramus Intermedius has no such groove to lie in, it just hangs on the surface without much anchoring. This abnormality does not prevent it from carrying major blood supply to parts of the left ventricle and in my relative's case, to the lateral wall of the left ventricle. As this was the culprit vessel, angioplasty and stenting were done on this vessel as a life saving measure with a planned stenting procedure later. Does the presence of this aberrant vessel make one predisposed to coronary artery occlusion? Cursory search was in the negative but I suggest further reading.

Dr. B C Rao

Bempedoic acid

This is a novel non-statin drug that inhibits cholesterol biosynthesis in the same pathway as statins. It is administered as a prodrug and is only converted to an active drug in the liver and not muscles.

Phase II and III clinical trials have demonstrated promising results regarding its safety and efficacy either as monotherapy or in combination with statins or ezetimibe among different patient profiles including patients with statin intolerance.

Bempedoic acid is currently FDA approved as an adjunct to diet and maximally tolerated statin therapy for the treatment of hyperlipidemia and cardiovascular outcomes trials evaluating the impact of bempedoic acid on hard cardiovascular endpoints are currently ongoing.

Several Indian brands of this drug is available in the market

Bedaquiline

Recently, the Indian patent office rejected the application for extension up to 2027 from July this year when the patent expires on the drug Bedaquiline. The applicant is Johnson and Johnson [J J Pharma]. One of the two persons who contested this application is a drug resistant TB survivor Ms Nanditha Venkatesan.

Herein lies the tale of the drug and the lady.

First the drug

Bedaquiline was first introduced in 2014 by JJ pharma for use in drug resistant TB Bedaquiline is a quinoline-based antimycobacterial drug used (as its fumarate salt) for the treatment of pulmonary multidrug resistant tuberculosis by inhibition of ATP synthase, an enzyme essential for the replication of the mycobacteria. It has a role as an antitubercular agent and an ATP synthase inhibitor.

Recommended Dose

The recommended dose of Bedaquiline for the treatment of pulmonary MDR in adults is:

- Weeks 1 – 2: 400 mg (4 tablets of 100 mg) given orally, once daily
- Weeks 3 – 24: 200 mg (2 tablets of 100 mg) three times per week, for a total dose of 600 mg per week

Initiation and Discontinuation

Bedaquiline is to be used for a period of 24 weeks.

- Bedaquiline may be used on a case-by-case basis for durations longer than 24 weeks when treatment options are limited.

This drug has a half-life of 4-5 months. Consider discontinuing Bedaquiline 4–5 months prior to discontinuing other drugs in the treatment regimen to reduce or avoid an extended period of exposure to low levels of Bedaquiline as a single drug and subsequent acquired resistance.

The drug does not have a very good safety profile as many side effects involving gastrointestinal and cardiovascular systems have been reported. Drug-drug interactions also have been reported. Thus, the drug needs to be used with caution even in MDR TB.

It costs 21000 Rs per patient for a six month regimen and the government is providing this drug free of cost under the NTEP program.

J&J introduced this drug to India in 2015 and has reaped the marketing benefits of this drug for the last 8 years and now the patent authority of this country has rejected its application for extension there are hopes that Indian drug companies will shortly roll out this much needed drug at a cheaper and affordable rate.

The lady

Nandita Venkatesan is a MDR TB survivor and an advocate for better access to anti TB drugs. She suffered permanent hearing loss due to Kanamycin injections. Though she had completed treatment and did not need Bedaquiline, she knew of the importance of the drug in the treatment of MDR TB. WHO has said that this drug is the backbone of the MDR TB and the duration of treatment can be up to 2 years and sometimes even more. Having suffered the side effects of Kanamycin which needs to be injected for extended periods of time into the buttocks [imagine the damage locally to patients with poor muscle mass] Nandita filed her objection to the pharma company's application along with a fellow sufferer from South Africa and won the case. She is hoping that this drug which now costs around 50 dollars [about 4500 Rs] per month will come down to as little as 800 Rs per month if generic production happens.

Neutrophilic Dermatoses

Neutrophilic dermatoses are a heterogeneous group of skin disorders which include Generalised Pustular Psoriasis [PPP], Hidradenitis suppurativa, Palmo plantar pustulosis, Sweet's syndrome, Pyoderma gangrenosum, Behcet's Syndrome. In these disorders, there is dysregulation of the IL36 family where there is over-expression of IL 36 due to genetic mutation in the inhibitory IL36 RA gene. The most studied of all the above is the PPP which has significant morbidity and mortality. Neutrophilic dermatoses are a heterogenous group of inflammatory disorders defined by a sterile neutrophilic infiltrate. They have diverse cutaneous and extracutaneous manifestations and may be associated with significant morbidity and mortality. Common associations include infectious, inflammatory, and neoplastic disorders as well as drugs. Scientific research has continued to unravel the complex pathogenesis of neutrophilic dermatoses involving abnormal neutrophil function and inflammasome activation, malignant transformation into dermal infiltrating neutrophils, and genetic predisposition. As new evidence emerges, targeted novel therapies for neutrophilic dermatoses are on the horizon. A targeted monoclonal antibody SPESOLIMAB which inhibits IL 36 receptor antibody has been recently approved by the FDA [10/10/22] for use in GPP.

More and detailed Information can be accessed by the given references.

References

1. Review article Frontiers in immunology 24/3/2019 Autoimmune inflammatory disorders Vol 10-2019
2. Current Dermatology 202211(2) 89-102 Neutrophilic dermatoses

Case Reports

Case Report 1:

Conservatively managed Cholecystitis in preexisting Cholelithiasis

Normally, a case of acute cholecystitis with gallbladder stones is a medical/surgical emergency and is referred to a secondary / tertiary care hospital for stabilisation and or surgery. Here a case is described which resolved completely with oral antibiotics and other supportive measures.

Dr P, a 23-year-old doctor presented on 27/5/22 with severe bouts of vomiting and retching along with pain in the pit of the stomach and right upper abdomen, there was also fever of 101 degrees. On examination she had tenderness in the above areas but no guarding and there was no icterus, and her general condition was good. She was asked to take paracetamol, domperidone and was asked to get liver function tests, hemogram, urine analysis along with an abdominal ultrasound scan.

She reported back on28/2/22 and following are the test results:
LFT - normal. Hemogram: Within normal limits. Urine analysis not done due to onset of menstruation. US scan: Gall bladder well distended. Wall thickness normal. Few calculi are seen, largest measuring 7mm. CBD normal and no intrahepatic biliary dilatation. Ovaries. Peripherally arranged follicles with normal sized ovaries. Impression. Cholelithiasis. Bilateral mild polycystic ovaries.

On examination [28/5/22],nausea was present, but vomiting was under control, but she still had a fever of 100 degrees. She was put on oral norfloxacin 400 mgs twice a day and was asked to continue the other drugs. She was also advised to seek help in her hospital if symptoms aggravated for possible use of higher antibiotics and may be surgery.
She reported back on 30/5/22 with complete resolution of symptoms with no vomiting, pain, or fever. Her appetite too was normal.
She was advised as to what needs to be done in case of recurrence and the pros and cons of elective surgical intervention

Discussion

It is common knowledge that female sex, obesity, diabetes, pregnancy, contraceptive use and some conditions like hemolytic states predispose to the development of stone disease. One of the studies showed that 20% of adults over the years 40 and 30% over the years 70 will have gallstones. There is also a female male ratio of 4:1. Most studies which compare intervention to nonintervention show that intervention has better long-term benefits. This is true also for symptomatic stone disease either alone or associated cholecystitis. It is also true that with the advent of laparoscopic cholecystectomy, there is more evidence in favour of surgical intervention. Though conservative wait and watch management has few takers, family doctors who can watch and wait with the patient for long period of time, have the option of giving this advice, after adequate warning to the patient as to the possible urgent need of surgical intervention

A case of acute cholecystitis in a preexisting cholelithiasis which was treated conservatively with excellent outcome is presented and the pros and cons of conservative versus operative treatment is briefly discussed

References

1. Tokyo Guidelines 2018: antimicrobial therapy for acute cholangitis and cholecystitis - J Hepatobiliary Pancreat Sci. 2018 Jan;25(1):3-16. doi: 10.1002/jhbp.518. Pub 2018 Jan 9
2. Managing a case of acute calculous cholecystitis at home: Highlighting the role of family physicians in providing home-based care - J Family Med Prim Care. 2019 Jul; 8(7): 2548–2550. PMCID doi: 10.4103/jfmpc.jfmpc_259_19 Ashoojit Kaur Anand, 1 Praneeth Pilala , 2 Swathi S. Balachandra, 3 Prathamesh Sharad Sawant, 4 Ramakrishna Prasad, 3 and B. C. Rao 3

Case report 2:

Missing Pulse

Normally thromboembolism of the brachial artery is rare, especially presenting in family medical practice. One such case which on presentation mimicked the possibility of angina/neuralgia is presented here Mr. UM, a 55-year-old factory manager, developed acute pain below the left elbow up to the hand which lasted several hours and subsided on taking Diclofenac 50 mgs. He came to see his FP next morning and on examination:

Normal built with satisfactory general condition. Not in any distress though he said there is some pain still persisting in his left forearm diffuse in nature. His left hand felt cold when compared with the other hand. There was no sweating. Radial and ulnar pulses were absent on the affected side but were normal on the right side. Brachial artery was felt in his upper arm with a normal pulse. BP could be recorded in the left upper arm. Carotids and femoral pulses were felt and were normal. No abnormal sounds or murmurs were heard on auscultation of his heart. BP was normal

A clinical diagnosis of acute occlusion of the brachial artery at the elbow was made and arrangements were made to admit the patient.

Course in the hospital

Basic tests were done preparatory to the planned procedure which included a hemogram, blood sugar,T4 and TSH, serology to exclude hepatitis and HIV infection, an ECG, ECHO cardiogram and a CT angiogram of the Aorta and its branches.

Echo was normal except concentric LVH. CT Angio summary: Occlusion due to thrombus in the brachial artery about 5cms proximal to the elbow joint. The artery reforms 4 cms distal to the elbow joint. The aorta and its branches including the left subclavian were normal

After the preanesthetic check he was operated on 24/12/22. Operation notes:

Incision made till the brachial artery was exposed. Artery controlled with double loop and clamps on either side. Fogarty's catheter was used and inflated and passed towards the artery and embolectomy done. Free gushing of the blood noted. Arteriotomy closed with 5-0 prolene and clamps released. Good distal pulses felt and confirmed with hand held doppler. Wound closed with normal procedure.

At the time of discharge, he was pain free with normal sensations in the forearm and hand with warmth being equal to the right side

Discussion

Upper limb thromboembolism is comparatively rare. In this case the cause is speculative as his heart and blood vessels showed no clots. One possibility is local trauma due to lifting weights in the Gym though he does weights as a part of his exercise schedule and reports no unusual strain preceding the event. Family doctors should be on guard and any person coming with an absent pulse with or without other symptoms, the possibility of thrombo-embolism should be thought off as was in this case. Early detection and prompt action possibly saved this patient from serious complications.

The reporter acknowledges inputs from Dr Padma Kumar [cardiologist] and Dr Azeez [vascular surgeon].

Dr. B C Rao

Residents' Corner

Journal Club at Lourdes

As part of the academic activities in the Department of Family Medicine, Lourdes Hospital and PG Institute of Medical Science and Research, we have a journal club which is held fortnightly. Most of the articles reviewed are from JFMPC, AFP, BMJ and other journals. A resident is assigned to initiate the discussion on an article with relevance to family medicine and primary care from any national or international journal. Rest of the residents are informed regarding the article well in advance so that everyone has gone through the article before the journal club discussion. Under the guidance of our Head of the department, Dr. Resmi S. Kaimal, the article is critically reviewed and discussed. This is greatly beneficial for us to grasp the significance of research in medical practice and to easily understand the concepts of research methodology. Not only this, our seniors have always credited these discussions for helping in their thesis preparations as well as enhancing academic knowledge and guiding them in publishing articles.

Dr. Bushra Thasneem N., Dr. Minnu Thomas, Dr. Anagha Vijayan, Dr. Sameena M.N., Dr. Flossy Mathew, Dr. Lamiza Abdusalam, Dr. Unaisath K., Dr. Goutami Bodapati, Dr. Najeeba K.T., Dr. Fathima Febin, Dr. Rahima Ali, Dr. Hamnas Muhammed

Announcement about 4th State Conference

The 4th AFPI Karnataka State Conference is being organised in Belagavi on 5th and 6th of August 2023.

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