AFPI KARNATAKA NEWSLETTER

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Contents.

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President's letter

Family Physicians and Quality Improvement in Practice

Two important evolutions occur in the growth and maturation of FPs: a) shift from an episodic care orientation to a continuous care orientation; b) growth in skill and orientation in panel management in addition to individual patient care. Without the above, the principles of family practice cannot be actualized.

Panel management supports family physicians in providing longitudinal, proactive care to patients. Panel management includes:

A) Empanelment: Having an accurate list of active patients for each provider improves continuity of care and enables population-based care.

B) Panel clean-up involves creating registries that accurately reflect all patients within the panel who have a specific diagnosis.

C) Panel optimization involves using updated data to implement proactive care goals using decision support tools (could be in EMR)

Panel management improves patient care and workflow efficiency; b)Identify resources needed to improve care; c) Inform and plan proactive and preventative care.

Medical education, however, at both the undergraduate and postgraduate levels tends to pay little attention to systems thinking, practice management, clinical governance, patient experience, and processes and tracking outcomes for patient panels.

As a result, family physicians in practice must often learn quality assurance, processes, and clinical governance by themselves. The silver lining is that peer learning communities such as AFPI can serve as powerful catalysts and support networks towards such learning and application in practice.

In future issues of the AFPI Karnataka newsletter, it is hoped that several of you will share your practice improvement experiences.

With best wishes,

Dr. Ramakrishna Prasad

Dr. Ramakrishna Prasad
President, AFPI Karnataka

Editor's note

It is common knowledge that community needs family doctors and there is inadequate replacement when the existing doctors retire or have retired. This is not just an urban phenomenon and is across the board. The reasons are many. Important ones are, the medical education and training is heavily biased in favor of specialty and the young medical graduate will try his best to get into one spatiality or the other. The second is the low status the family doctor has in the eyes of the medical hierarchy, mostly centered in the institutions where the training is given. The young graduates hardly get trained to become family doctors. Most graduates are ill equipped mentally and professionally, to take up family medical practice in the community. There is also fear of failure and inability to take risks when one enters practice. Even those who have done their DNB in family medicine are averse to this and as I see it most of these end up becoming hospitalists, either manning the hospital's health clinics, working as assistants, duty doctors and casualty medical doctors. Hardly any one is given admission rights and to independently manage patients.

The situation is going to become worse in the coming years, when there is going to be a glut of these doctors who for one reason or the other, cannot become specialists, cannot get jobs and reluctant to take the risk of independent practice, will end up as…… Taxi drivers?

B.C Rao

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Secretary's report

As we reach the end of another quarter, and to the end of the tenure of existing AFPIKA Executive Committee, it is my pleasure to reflect on the remarkable progress and achievements we have made together at the Academy of Family Physicians, Karnataka. This newsletter is a testament to our collective commitment to advancing family medicine and improving healthcare outcomes for our communities focusing on the latest advancements in family medicine. The participation and enthusiasm shown by our members were truly inspiring. These events not only provided valuable learning opportunities but also strengthened our professional network.

This 2-year tenure was a roller coaster ride of hosting successful conferences and workshop, learnings, unlearning, personal growth, both introspectively and professionally.

Expanding the horizon of AFPIKA in Mysore and Belgaum gave EC the opportunity to increase the team strength and explore the vast potential existence of collaboration of Family Medicine with the Medical colleges, the government bodies, and the academia.

The key highlights of conferences being the opportunity and the platform for the budding undergraduate doctors to explore the importance of the friendly neighborhood family physician with their research and data.

AFPIKA, had the opportunity to meet and discuss the potential collaboration with family Physicians India and are awaiting good things to happen with this collaboration.

Our ongoing community outreach programs have continued to make a significant difference with our members organizing various camps and educative sessions to awareness drives, our members have tirelessly worked to promote preventive healthcare and provide essential services to underserved populations.

We are proud to report a surge in research activities, which we all would have observed in our WhatsApp group from our members. These contributions are vital in shaping evidence-based practices and highlighting the role of family physicians in the broader medical community.

The CME sessions conducted this quarter were well-received, offering up-to-date knowledge and skill enhancement opportunities for our members. One such session being on deaddiction. The feedback has been overwhelmingly positive,

Looking Ahead, as we move forward, there are several exciting initiatives on the horizon. AFPIKA is proud to host one of the prestigious international conference with WONCA South Asia Region conference on 4-5th April 2025. This initiative shall have inflow of delegates from across the world to the beautiful city of Bengaluru, with exchange of ideas, professional introspection and much more than what can be mentioned

The work for this has begun in full swing with the Organizing Committee shaping up and comprising of PAN India team. Do look forward for an exciting academic and cultural feast. Your active participation and feedback are crucial as we strive to elevate our standards and impact.

I would like to extend my heartfelt gratitude to all the members, volunteers, and partners for their unwavering support and dedication. Your efforts are the cornerstone of our success. Together, we are building a stronger, healthier future for AFPI Karnataka.

I encourage all members to stay engaged, share your experiences, and contribute to our upcoming events and initiatives. Let us continue to work together to advance family medicine and ensure the best possible care for our patients.

Thank you for your continued commitment and enthusiasm. Let us make the next quarter and incoming EC even more successful!

Dr Harshapriya Jyothinagar.

Dr Harshapriya Jyothinagar.

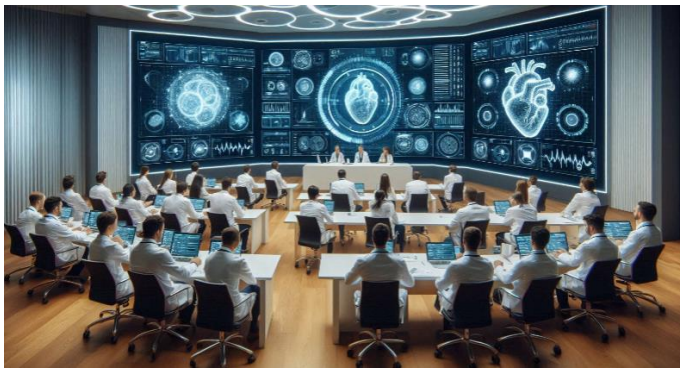
Hon Gen Secretary, AFPIKA

Celebrating 4 Months of Continuous Learning and Collaboration

Greetings from AFPI Karnataka! We are thrilled to share the latest updates on our Continuing Medical Education (CME) initiatives, marking a successful journey of collaborative learning over the past four months. Our focus has been on providing highly relevant sessions tailored for general practitioners, fostering interdisciplinary learning, engagement in primary care, and creating networking opportunities for medical professionals across Karnataka.

Recent CME Highlights:

April : Webinar - Sugars Under Surveillance - Exploring Continuous Glucose Monitoring (CGM)



In April, AFPI Karnataka organized an insightful CME session titled "Sugars Under Surveillance: Exploring Continuous Glucose Monitoring (CGM)." The session aimed at educating healthcare professionals about the nuances of using CGM in clinical practice. Key topics included the importance of CGM for managing diabetes, integrating CGM data into patient care, and enhancing patient outcomes through continuous monitoring. The session featured esteemed speakers such as Col.(Dr) Mohan Kubendra and Dr. Vinod Babu Veerapalli, who shared their expertise and practical insights on CGM technology. The session received excellent feedback from attendees, highlighting its relevance and applicability in clinical settings.

May Webinar: World No Tobacco Day - Ignite Health, Extinguish Smoke

Picture courtesy: WHO

The event focused on raising awareness about the harmful effects of tobacco use and promoting tobacco cessation. The workshop featured a case-based discussion led by Dr. Bhavya K Bairy, a Consultant Psychiatrist from Trustwell Hospitals, and moderated by Dr. Jyothika, a Consultant in Family Medicine. Participants engaged in discussions about the health risks associated with tobacco use, effective strategies for tobacco cessation, and public health measures to reduce tobacco consumption. The event underscored the importance of collective efforts in combating tobacco-related health issues.

June: CME on Antimicrobial Resistance - Importance, Challenges, and Strategic Approaches

In June, AFPI Karnataka, in collaboration with Bangalore Baptist Hospital, conducted a comprehensive CME on Antimicrobial Resistance (AMR) titled "Antimicrobial Resistance: Importance, Challenges, and Strategic

Approaches." The workshop aimed to address the critical issue of AMR and explore strategic approaches to combat this global health threat. The event featured eminent speakers such as Dr. A.K. Sharma, Senior Consultant Microbiologist, Dr. Srividhya Raghavendra HOD family Medicine, Baptist hospital, Dr. R. S. Patel, Infectious Disease Specialist and many more. Key topics included clinical practice guidelines on antibiotic prescription, surveillance strategies, novel research in AMR diagnostics, and policy advocacy. The workshop provided valuable insights into the evolving landscape of AMR and equipped participants with practical knowledge to tackle AMR challenges in their clinical practice.

As we reflect on these enriching experiences, AFPI Karnataka remains committed to advancing medical education, promoting collaboration, and fostering continuous learning. Stay tuned for more engaging initiatives in the upcoming quarters!

Shalini Chandran

Feasibility of comprehensive geriatric assessment in primary care. A Case Series.

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4- Professor,
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Background

A Comprehensive geriatric assessment (CGA) is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a older person to develop a coordinated plan to maximize overall health with aging[1].

It is essential in the elderly as geriatric syndromes are associated with multiple disorders that decrease the functionality and increases dependency, most of which are undiagnosed while treating only their primary complaints.

CGA Components

Objective

- To describe the feasibility of comprehensive geriatric assessment (CGA) in primary care with two case scenarios

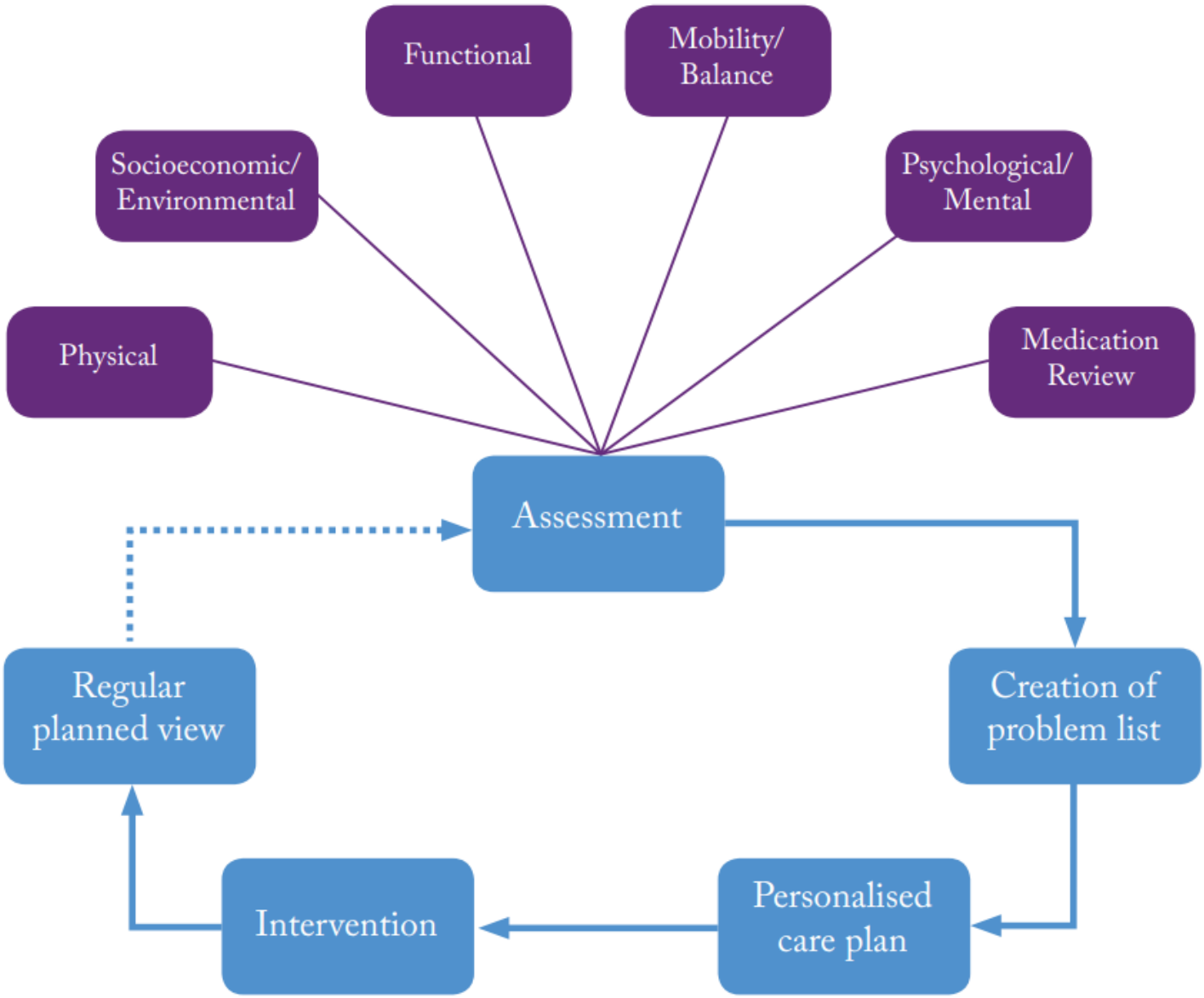
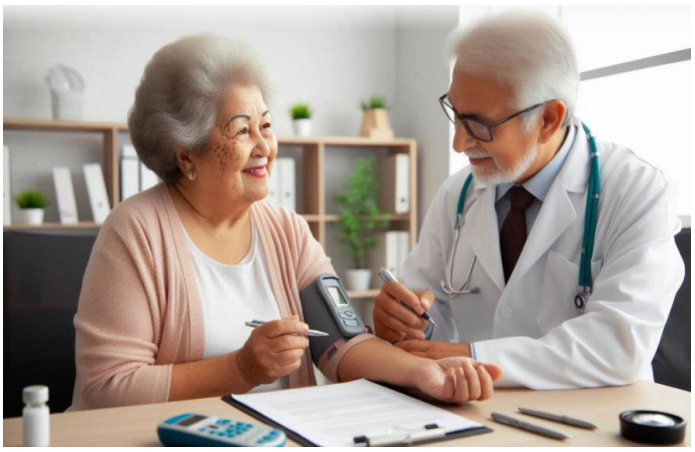


Fig 1: Components of of comprehensive geriatric assessment (CGA)

Case 1

A 70-year-old female has type 2 diabetes mellitus and hypertension for 20 years. She lives with her husband and her children stay 10 kms away. She is financially dependent on her husband. She frequently visits with complaints of episodes of low energy and generalized weakness. On examination, rigidity was present. She was diagnosed with Parkinson's disease. A CGA was done at all following visits that determined multiple needs for action.



TIME OF VISIT	ASSESSMENT	INTERVENTION
2022 APRIL-Visted for generalized weakness and low energy	1) Type 2 diabetes mellitus- under control 2) Hypertension- under control 3) Parkinson's disease- newly diagnosed 4) MMSE- 26 5) Geriatric depression scale- <5 6) ADL- 20 7) MNA- 11 (At risk of malnutrition)	• To continue medications - Oral Anti diabetic drugs - Anti-hypertensive drugs • Target HbA1c was increased to 8 • Initiated medicines for Parkinson's disease • Counselled regarding her further worsening and the need for family support.
2023 MARCH TO JUNE Visited for recurrent infections	1) Herpes zoster 2) Anaemia 3) Recurrent UTI 4) MMSE-23 5) Geriatric Depression scale- >10 6) ADL- 3 7) MNA- 6 (Malnourished)	• Teleconsultation support for follow up as mobilizing patient was difficult • Care giver burden was assessed and advised a full-time care giver through private agency. • Iron supplements and nutritional counselling given. • Started antidepressants but patient was non adherent.
2023 NOVEMBER	Routine home visit was done 1) MMSE-16 2) Geriatric depression scale- >10 3) ADL-5 4) MNA- 6 (Malnourished)	• For deteriorating MMSE Neurologist opinion was obtained. • Re-started antidepressants after root cause analysis. • Counselled care giver on engaging in few activities/games. • Emphasized on nutritional supplements and balanced diet

Components	Result
Vision	Normal
Hearing	Normal
Incontinence	No
Polypharmacy	No

Table 2

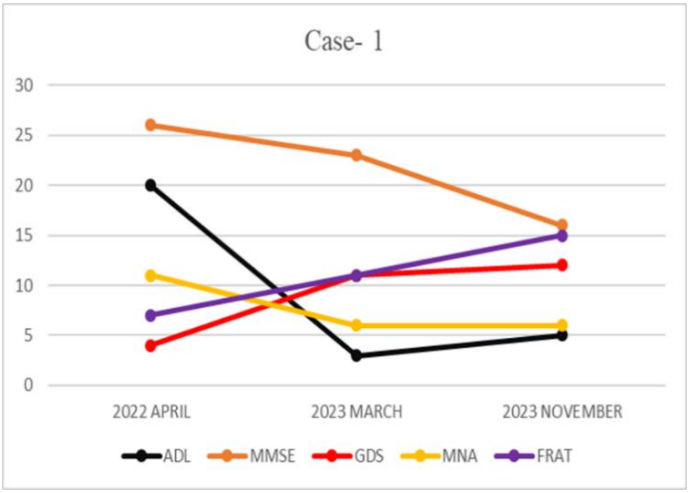
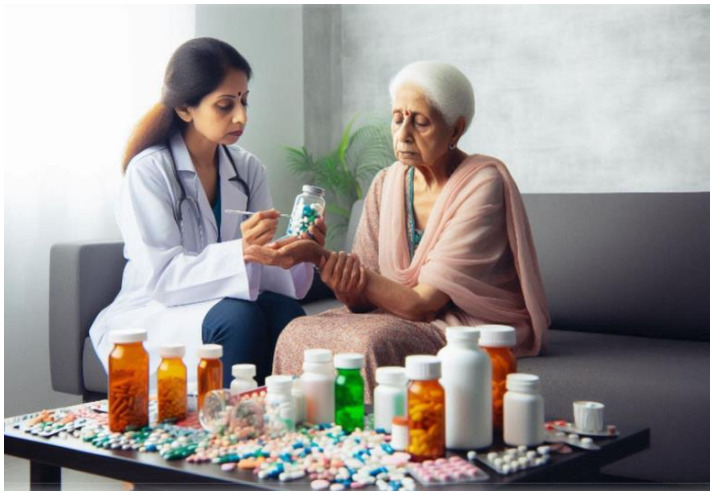


Fig 2: Case 1

Case 2

A 70-year-old female patient, an ex-policewoman, suffers with type 2 diabetes mellitus, hypertension, osteoarthritis and insomnia. She presented with generalized itching and arthralgia. She could not perform her daily routine activities and becoming depended to walk at home. She was on (Dapagliflozin + Sitagliptin), (Paroxetine + Clonazepam), Solifenacin for over 15 years. On examination, she had generalized rigidity. The CGA directed us to polypharmacy requiring intervention



TIME OF VISIT	ASSESMENT & PLAN OF ACTION	INTERVENTION
January 2023	1) Polypharmacy 2) Anti-depressant induced extra pyramidal side effects 3) Xerosis 4) Dementia 5) Type 2 Diabetes mellitus 6) Hypertension 7) Osteoarthritis 8) ADL-9 9) MMSE-18 10) MNA- 6 (Malnourished)	• Stopped Paroxetine. • Stopped Solifenacin • Continue Clonazepam • Start Donepezil • Counselled to slowly reduce clonazepam
February 2023	1) Extrapyramidal symptoms reduced 2) ADL-15 3) MMSE-22 4) MNA- 7 (Malnourished)	• Dose of Clonazepam tapered slowly
November 2023	Routine check-up 1) ADL-19 2) MMSE-23 3) MNA- 12 (Normal nutrition)	• Completely stopped Clonazepam

Components	Result
Vision	Normal
Hearing	Normal
Incontinence	No
Polypharmacy	Yes

Tab 2

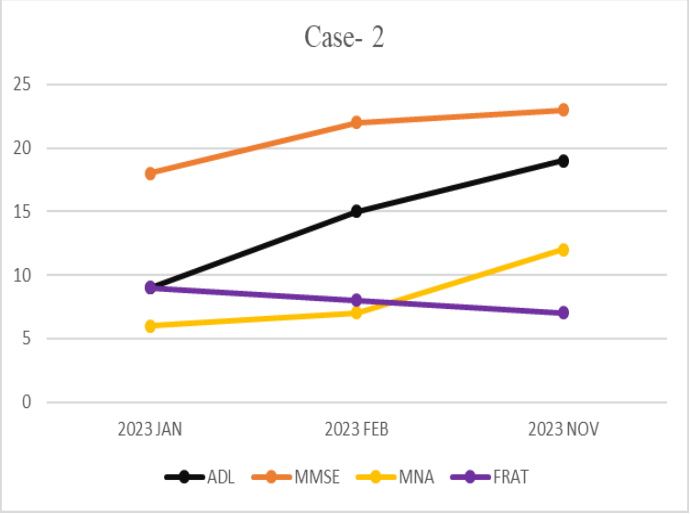


Fig 3: Case 2

Discussion

In our cases CGA took 25-30 minutes for each patient.

How did CGA help in our cases?

- Case 1- Through a CGA, additional diagnosis of depression and recognition of gradual deterioration in cognition and nutritional intake was detected.
- Case 2- Through a CGA, polypharmacy was identified, and prescriptions rationalised. This resolved many symptoms and improved her functional capacity.
- CGA uncovered problems and allowed targeted decisions that helped improve patient care

Why is CGA done?[4]

Evidence shows that CGA is effective in reducing mortality and improving independence (still living at home) for older people admitted to hospital as an emergency compared to those receiving usual medical care.

In community settings, the evidence shows that complex interventions in people with frailty can reduce hospital admission and can reduce the risk of readmission in those recently discharged.

CGA is also a vital part of the management strategy for older people suspected of having frailty in order to identify areas for improvement and support to reduce the impact of frailty.

Who does CGA?[4]

In many cases this will be the patient's GP – especially if they have known the patient for some time and have been involved in other aspects of their care. GP's in particular will be well placed to handle a medication review in the context of the overall person-centred goals.

In cases where there is particular complexity, or where there are concerns about underlying diagnosis or treatment options, a geriatrician working in a community setting could be involved in, or even lead, CGA.

Conclusion

- CGA is feasible as a structured tool which helps in taking decisions to treat patients with a well-coordinated plan. Hence can be used regularly in primary care setting to screen undiagnosed diseases in elderly.

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Home-Based Primary Care: A Paradigm shift in care for Dementia

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Abstract:

Dementia is one of the major fears and a growing need to be addressed in a country like India. According to the Global Burden of Disease Study (GBDS) 2019, from 2019 to 2050 the number of dementia cases will undergo a whopping increase of 166%, impacting the lives of ~152·8 million individuals; these estimates are similar to those predicted by WHO.**(1)** We report here a case of a 84-year-old lady whose main complaints were hallucinations and cognitive decline. MRI brain shows age-related cerebral atrophy and chronic lacunar infarcts in the right frontal and parietal regions which are consistent with features of mixed dementia (Frontal Lobe Dementia and Vascular Dementia). The objectives of this article are a) To plan and develop an individualized advanced care plan to understand and address individuals and families with dementia; b) To analyze various dimensions influencing the care and outcomes of the patients living with dementia, and c) To reflect on an integrative care model (in home-based primary care). Dementia needs a holistic multidisciplinary approach aimed to minimize the symptoms, provide a support system to the caregivers and enhance the quality of life.

Introduction:

Dementia is a clinical syndrome due to the disease of the brain. It is a chronic and progressive condition which involves the disturbance of multiple higher cortical functions - memory, thinking, orientation, comprehension, learning etc. Dementia is commonly associated with the deterioration of emotional control, social behaviour or motivation.

A looming public health crisis is the rising number of people with dementia, doubling every 20 years, due to global aging. Currently, there are approximately 47 million people with dementia in the world **[2]**, the great majority of whom are cared for by family members in the community **[3]**. The prevalence of Dementia in South Asia has increased by millions from 1990 to 2020. In India, the number of people living with dementia was 1.8 million in 1990 and has doubled to 3.7 million in 2020. The numbers in developing countries could be low because of lower survival age or under-assessment because of cultural or educational biases on screening and diagnostic procedures. In India, there are various other challenges in cognitive assessment, difficulty in assessing age (especially in rural and illiterate populations), multiple languages, other impairments like vision and hearing, specialized instruments and trained personnel to use the instruments to screen dementia.

Dementia has been a major contributing factor to the debilitation in the elderly by directly affecting the quality of life of individuals and families/caregivers. Thus, rendering them bed-bound after a duration of time.**(1)** A meta-analysis found dementia family caregivers to be significantly more stressed than non-dementia caregivers and to suffer more serious depressive symptoms and physical problems. A longitudinal study found incidence rates of 37 and 55% for major depressive and anxiety disorders in a 24-month interval for caregivers. **[4] [5]**

The core component of integrating principles of home-based palliative care is to help improve the emotional, physical, psychological and functional aspects of individuals to keep them free from

pain and comfortable. Palliative Care as opposed to care for cancer patients or terminally ill patients should be provided to anyone in need of symptom relief improving their quality of life (QoL) & dignified death/quality of death (QoD).

In the late phase of dementia, they often have restlessness, pain and discomfort which they are unable to express. Many a time, in hospitals or institutional settings such patients are overtreated for curative care (with an interventional approach) or undertreated for symptom management. Hence people living with dementia or chronic illness are better cared for at home till the end of their life. **(6)** This when addressed with an integrative multidisciplinary team approach can enhance the QoL of the patients and minimise the burden on the caregivers. Home-based primary care helps understand family dynamics, home environment, minimising hospital-acquired infections, social isolation, and cost of care. Additionally, logistics of moving, and managing patients, community awareness and acceptance play a crucial role in patients outcome and family support system.

Case

Mrs K 84 yr old a widow from the age of around 40 and would always be worried about her young daughter's safety, and managing the house and finances. She lived with her 3 children (2 daughters and a son who are in their early and late fifties), who remained unmarried, daughters took premature retirement to be at home to take care of their mother. Mrs K loved flowers, cooking and had retired from a reputed company. Bringing up 3 young children as a single parent was challenging. In early days, Mrs K would lie awake at nights to ensure their safety and would often take Tab Avil to fall asleep.

She was known to have Hypertension, Hypothyroidism and recently diagnosed with Heart Failure. She also was misdiagnosed to have diabetes (HbA1C of 5.7%) and was initiated on SGLT2 inhibitors for the last 5 months, leading to recurrent UTIs, and hyponatremia for which she was taken to the hospital on a few occasions for being unresponsive.

MRI of the brain done 5 months ago showed age-related cerebral atrophy & chronic lacunae infarcts in the right frontal and parietal regions. She was initiated on Tab Quetiapine 50 mg and then tapered to 25 mg half at night by the treating neurologist. Mrs K's mother probably had dementia as was described by her children.

With advancing age she developed behavioral changes, would sometimes be restless and hallucinate (Visual and Auditory). Unable to manage her aggressive behavior (unusual for her), hallucinations of someone walking outside her window, hearing mystical voices and at times she also insisted on going to her own house, her children reached out to our Home-Based Primary Care team in Dec 2022.

The family now decided not to get any further intensive investigations or provide aggressive treatment, but to keep her comfortable and maintain her Quality of Life (QOL).

On our first visit, she was very friendly but asked her daughters and son why they called us. Her bowels were regular and she was able to communicate the sensation/urge of passing urine or stools. Urinary control at times was lost and had to be in diapers for the same. Sleep was better after initiating Quetiapine, but continued to hallucinate.

Upon examination, she was courteous and soft-spoken. Neatly dressed and well groomed. Made eye contact and smiled frequently. She was partially dependent (needs assistance to have a bath or change clothes), walked with the help of a walking stick, sat down on the sofa in the living room. Spoke coherently and relatively answered the questions asked, but repeatedly asked the same questions and our names. She was unable to register a new conversation (for several months now). Had insight into her forgetfulness.

She had a low risk of fall, Pre frail, on a regular diet with an average appetite, her Vitals were as below: BP 110/65 mm Hg, Pulse - 73/minute, SPO2 of 97%; had pitting pedal oedema bilaterally;

GPCog done had a score of 1/9 , CVS: Diastolic Murmur (+); RS: Clear, NVBS; P/A: Soft

Management:

We considered increasing her Quetiapine to 50 mg at night as she could tolerate it well. Counseled the family and explained the progress of Dementia, the different stages of Dementia and other contributing factors affecting her quality of life.

Counselled on accepting her irrelevant conversation and avoiding disagreements (acknowledging the hallucinations to reduce her anxiety). Involving her in routine activities like some board games, and helping with the peeling of vegetables.

After about 20 days, the family informed us that she was very restless, her hallucinations had increased, and was unable to sleep much.

We discussed this concern internally with the team and initiated Tab Lorazepam 1 mg SOS in case of restlessness or hallucinations and sleeplessness. Explained the complications associated and the prognosis to the family. Slowly as time passed by her dementia further progressed, now was unable to recite her prayers or recall the names of her children. Additionally, there was an increase in her restlessness and hallucinations. She would walk out of the house and get into arguments with neighbors. Children had to forcibly bring her in, they then started locking the door to keep her inside the house. We then added Haloperidol 2.5 mg SOS, Memantine and Olanzapine to stabilize her mood and manage her hallucinations.

We continued to counsel the family at every visit, explaining on her becoming drowsy with increasing doses of medications, to be alert and monitor closely to avoid any falls. Avoiding to feed her when she is drowsy to prevent aspiration. Furthermore, as the symptoms became worse, we titrated the Memantine, Olanzapine and Quetiapine.

By around September 2023, she was unable to take regular food and was on soft food with an increased liking towards sweet food. She slowly progressed to having difficulty swallowing liquids on and off which would result in a cough (aspiration).

In November 2023, the family celebrated her 86th birthday with family and friends. She was

very happy to see everyone but could not recognize her siblings or even her children. The family was very supportive and would still laugh and joke about it during our visits.

She now started to have difficulty in finding words to speak or join words to form a sentence. We suggested they have a full-time paid caregiver on multiple visits of ours to help them get some respite. However, the children insisted on taking care of her, as they were not sure if the caregiver would be hygienic and understanding and empathetic towards her condition.

In Dec 2023, she started choking on her food (soft diet) and developed a cough with a wheeze. Her saturation dropped to 82%. She was unable to bring up the sputum. Nebulisation with the support of oxygen (through oxygen concentrator), decongestants (N Acetyl Cystine) and antibiotics (Doxycycline) were initiated preceding a dose of IV Hydrocortisone 100mg Stat. She got better slowly with an occasional cough on swallowing liquids mainly. She was calmer but had difficulty with her breathing due to repeated aspirations.

In the early hours of 9th March 2024 at around 2:30 AM, Mrs K passed away peacefully in her sleep while her elder daughter slept next to her. It was overwhelming to see the care being

provided by the daughters (mainly), supported by their brother.

The daughter has still not come to terms and wonders if she could have saved her had she not slept that night. This thought still haunts them to wake up at 2:30 AM with ears eager to hear her calling out. We are continuing to visit them and counsel them, helping them to grieve.

Discussion:

By 2050, more than 70% of the population around the globe will be living with dementia. These figures are very stark and of concern. Many countries do not have a National policy or plan for dementia. WHO's Global Action Plan on the Public Health Response to Dementia 2017-2025 states, Dementia as a public health priority, with ~50% of countries to diagnose ~50% of people with dementia and ~75% of countries by 2025 to provide support and training for carers/families. **(7)** This will involve diverse stakeholders integratively strategising an action plan for their countries adapted to local needs [care provider preparedness (medical/non medical), community acceptance and awareness, logistics, infrastructure, ease of accessibility etc].

For people living with dementia, the goals should be to avoid overcare (call on insertion of PEG/NG), control symptoms and promote well-being. In addition to the treatment of these symptoms, the promotion of well-being through biography- and needs-oriented interventions with the help of music, touch or empathic presence is of particular importance.

Family physicians play a major role in creating awareness on dementia, risk reduction (lifestyle modification, regular screening, mind gyming) and training of carers and families in management of people living with dementia. Understanding and working around various factors contributing to patient and caregiver well-being.

Incorporating team-based multidisciplinary care concepts through Home Based Primary Care can be a paradigm shift in primary care. They being the family doctors can provide support to families and help prevent depression, and anxiety among caregivers. This also will help reduce the risk of dementia among the family members as chronic depression is also a cause for dementia. Research suggests long term use of medications like proton pump inhibitors, antihistamines, antidepressants can lead to conditions like dementia **(8) (9) (10)**

Palliative care is not merely limited to end-of-life or terminally ill patients, but it caters to people throughout the spectrum of life and disease pattern/s to keep them comfortable and free from pain. Thus going beyond death (bereavement support) and continuing to build relationships with the patient and family through their life's journey.

Many studies describe that caring for a person with dementia is more stressful and challenging than caring for a person with a physical disability. Primary caregivers, many in the sandwich group face obstacles as they balance caregiving with other demands, including child-rearing, career, and relationships. This group is at an increased risk for burden, stress, depression, and a variety of other health complications contributing to comorbidities in their later life. **(11) (12)** The effects are diverse and complex, and many other factors may exacerbate how caregivers react and feel concerning their roles and responsibilities.**(13)**

Caring for people living with dementia at the end of their lives constitutes a collaborative effort which involves various health professionals, families, relatives and paid caregivers as well.

Counseling topics in the last phase of life mainly include the possibilities of relief, for example through care services or the use of volunteers. The topic of the end of life of the person living

with dementia is rarely the subject of counseling talks, because, from the perspective of some participants, these conversations require courage on the part of the professionals to actively seek out the conversation, based on what they sense is the right time. These skills are attributed to palliative care professionals in particular.

Mostly, patients/family members/clinicians might confuse palliative care with end-of-life care. As they respond with anxiety and hesitancy to the idea of receiving palliative care, it is essential to ask what they know and what they want to know and to explore their emotions. Clinicians can further enhance patients' understanding as palliative care is not intended to replace their current treatment plan but rather to augment it by being provided alongside disease-directed therapies. **(14)**

When asked how and where a person would like to be when sick, has a chronic long-term illness or at the end of life, one always wants to be at their home or in their familiar surroundings, with their loved ones around. No one wants to leave this world in distress, discomfort or in isolation. In the last 3 years during the pandemic, we have seen how families have suffered and still are suffering with the loss of their loved ones in ICUs and isolation and not being able to even say goodbye to their loved ones. It is the need to have home-based palliative care for every individual who is in need of symptom relief for a better quality of life or dignified death, be it in urban, rural or farthest-to-reach areas of our country.

Home-based primary care is a very powerful strategy that facilitates exploring challenges in the patient's most comfortable environment. In our practice setting, we identified a cluster of influencers contributing to the patterns of outcome for an individual that can be looked at addressing through multidisciplinary home-based primary care team (Fig 4)

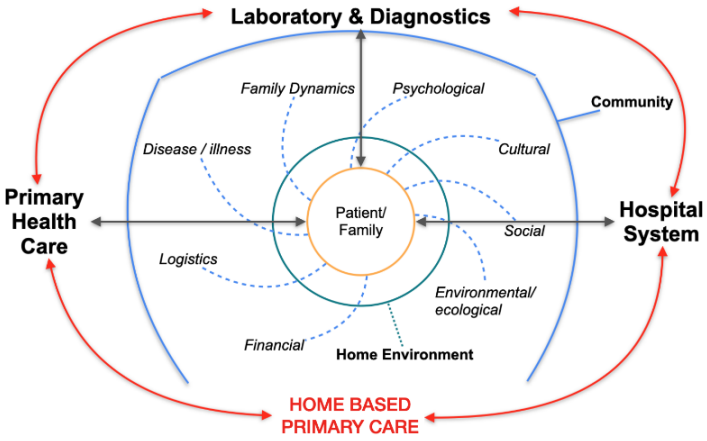

Fig 4: Factors contributing to patients' outcome

As we see in the above case of Mrs K, we find several layers of challenges attributing to patient outcomes and quality of life. The fear and loss of a close family at an early age, responsibilities of parenting 3 young children by herself was a lot complicated. Additionally, there were several challenges associated with Mrs K (hallucinations, agitation, restlessness, physical exertion) in managing her progression of dementia. Instances of her insisting that this is not her home and wanting to walk out of the house can be both physically and emotionally draining the carers. The family at their end would do the best smiling all time but had their own challenges (individual aging, family dynamics, engaging in activities, burnouts, financial, infrastructure & logistics). This was overcome by appropriate sensitization and preparedness empowering the family to provide comfort to the patient. Titration of medications based on the needs of the individuals is crucial as several patients with dementia are unable to express their feelings of discomfort or pain. Thus making bed-side clinical diagnosis and shared decision making a critical aspect in the majority of these cases.

Lastly, doing all that can be done with no gratification or acknowledgement from the patient to the carers can be emotionally challenging. This can be overcome by integrating the right support system with availability of the

competent team. We also learnt that empathy, patience and humility are the core components of the care for dementia/chronic conditions. We believe that the home based primary care setting is an ideal environment for such patients to feel safe and holistically understand and address these challenges at an individual level.

Conclusion:

We believe that everyone has a story to tell, and some of us need our story to be heard". Dementia is a progressive condition and does affect the Quality of Life (QoL) not only of the patient but more so of the family (the primary caregivers). Empowering families and providing a system for continuous support by a family doctor and team is of utmost importance to keep the patient comfortable and enhance the QoL. Bereavement counseling should be continued for the mental health of the family after the demise of the patient.

Seeing several patients requiring symptom relief in our daily practice, we believe the principles of palliative care lies at the core of every setting. Creating mechanisms to empower existing health systems as multidisciplinary teams to provide palliative care in the comforts of people's homes is an emerging field of practice. It also enables clinicians to be skilled to manage symptoms to comfort individuals through their life spans and various disease conditions.

Lastly, early integration of home-based or community-based palliative care can improve the quality of life of the patients and caregivers along with reducing their financial burden. There is an increasing demand for the role of primary care physicians to play a key role in palliative care.

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Update

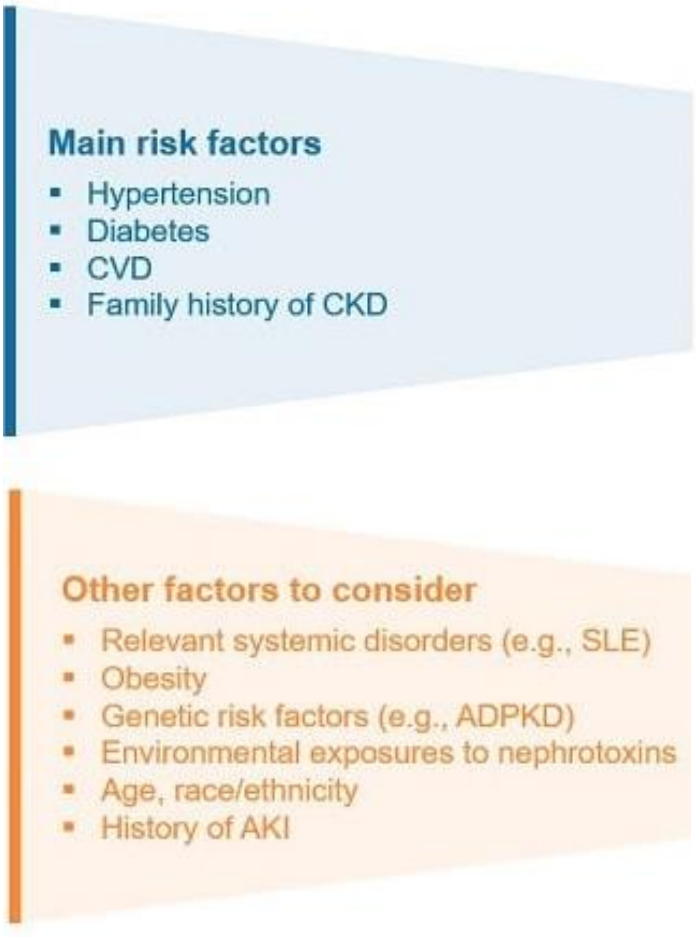
Chronic Kidney Disease

Around the world, CKD is a leading cause of morbidity and mortality, and its negative impact on global health is increasing. Deaths due to CKD are predicted to nearly triple from 2016 to 2040 as CKD becomes the fifth leading cause of years of life lost in 2040 (up from 16th in 2016). Despite this impact, CKD remains underdiagnosed and undertreated. Early-stage CKD is primarily asymptomatic, making it difficult to identify. Primary care physicians may be surprised to learn that CKD is more prevalent in women than men: globally, CKD affects approximately 417 million women and 336 million men. Data from the United States also suggest that the proportion of patients with stage 3 to 4 disease is higher in women than men (7.8% vs 5.9%). The false perception that men are more often affected by CKD than women may arise from the fact that, globally, there are more men on dialysis (1.7 million vs 1.3 million) and more men receive kidney transplant (0.4 million vs 0.3 million).

Early detection of CKD allows for earlier initiation of prevention strategies to reduce the risk of CKD progression and cardiovascular disease (CVD). Recognizing CKD at an early stage can be accomplished using relatively simple tests. Effective treatment options are available that can slow CKD progression and reduce morbidity and mortality, underscoring the importance of identifying CKD early.

Screening for CKD is recommended for patients with risk factors for CKD. The main risk factors for CKD are hypertension, diabetes, CVD, and a family history of CKD (Figure 1). Other factors to consider include demographics, obesity, genetic and environmental factors, and other comorbid conditions. Note that older adults, who have a higher risk of CKD, should not be excluded from screening efforts for CKD as they may also benefit from early intervention.

Figure 1. Risk Factors for CKD.[11]



ADPKD, autosomal dominant polycystic kidney disease; AKI, acute kidney injury; SLE, systemic lupus erythematosus.

Screening for CKD involves measuring kidney function (serum creatinine or eGFR) and kidney injury (albuminuria or UACR). A diagnosis of CKD can be made based on either eGFR or UACR. For measuring kidney function, calculating eGFR is recommended, preferably in combination with cystatin C for more accurate staging. For kidney injury, the preferred method is UACR. However, it is recognized that UACR testing is not universally available. If UACR is unavailable, a dipstick to determine albuminuria may be used as an alternative. If albuminuria is detected by dipstick, then a follow-up test for UACR is recommended to quantify urinary albumin excretion

Patients with risk factors for CKD but no laboratory evidence of CKD do not require treatment but should be monitored regularly, at least once per year. The frequency of retesting should be individualized based on the overall clinical picture and factors such as trends in renal test results, the number of risk factors present, degree of control of comorbidities, and patient preference.

A diagnosis of CKD can be made based on eGFR or UACR. A patient with eGFR < 60 mL/min/1.73 m^2 or UACR ≥ 30 mg/g (3 mg/mmol) meets the criteria for CKD. In this case, the patient currently meets both criteria. However, testing from a single time point is not sufficient for diagnosis, and the test must be confirmed before a diagnosis can be made. Trends in eGFR and UACR are also important: an unexplained, progressive decline in eGFR ≥ 5 mL/min/1.73 m^2 within 1 year is also a sign of high risk

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The goals of therapy for CKD are to slow the progression of CKD, manage comorbidities, and reduce the risk of death. Interventions may include lifestyle modifications, such as smoking cessation, exercise, and changes in diet. Medical interventions include optimizing the control of comorbidities, including hypertension, diabetes, and CVD. For example, intensive blood pressure control has been shown to improve kidney outcomes and reduce mortality in patients with CKD. Optimizing lipid-lowering therapy with statins can reduce CVD risk in patients with CKD.

For patients with diabetes, intensive glucose control has been shown to reduce the risk of CKD progression. Clinical trial data support the use of the SGLT2 inhibitors canagliflozin, empagliflozin, and dapagliflozin in patients with CKD and type 2 diabetes. As such, the International Society of Nephrology-Kidney Disease Improving Global Outcomes (ISN-KDIGO) guidelines recommend first-line combination therapy with metformin and an SGLT2 inhibitor for patients with CKD and type 2 diabetes and eGFR > 30 mL/min/1.73 m^2. In the UK, the National Institute for Health and Care Excellence (NICE) generally recommends adding an SGLT2 inhibitor to standard therapy (an angiotensin-converting enzyme [ACE] or angiotensin receptor blocker [ARB] inhibitor) for patients with CKD and type 2 diabetes if the UACR is > 30 mg/mmol. SGLT2 inhibitors can also be considered in patients with a UACR of 3 mg/mmol to 30 mg/mmol.

Recent data suggest that the SGLT2 inhibitor dapagliflozin may also improve renal outcomes in patients with CKD without diabetes In the UK, NICE recommends offering dapagliflozin as add-on therapy to standard care for patients with CKD and an eGFR between 25 to 75 mL/min/1.73

From Netscape

Analysis of pioglitazone efficacy in the treatment of NASH

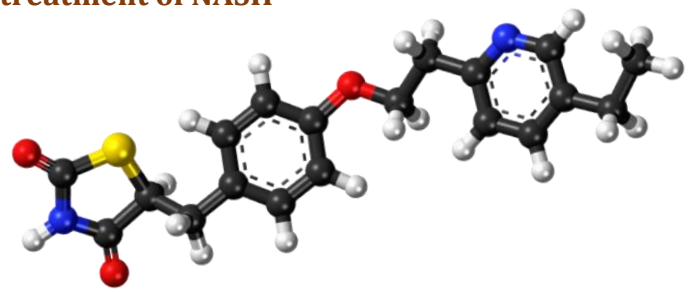


Fig 5: Pioglitazone molecule

In this meta-analysis, pioglitazone has a certain effect on patients with NASH. It can effectively improve the degree of NASH, liver function and blood glucose. Also, there is no major adverse events in the study. The change of each index comes from different mechanism. As demonstrated in the meta-analysis, the total effective rate of the experimental group for NASH patients rose by about 78% compared with that of the control group. The main reason may be that pioglitazone can improve the sensitivity of target tissue to insulin, reduce insulin resistance and regulate blood lipid.[43] Most other parameters are lower in the experimental group than those in the control group. But there is no significant changing difference in weight or BMI. The main reason for the decline of FPG level may be that pioglitazone regulates the genes' transcription related to insulin, so it may control the generation, transportation and utilization of the blood glucose. Pioglitazone downgrades fasting glucose by enhancing insulin-induced suppression of gluconeogenesis and glycogenolysis rather than by glucagon reduction.[44] The main reason for the decline of HbA1c and TG level may be that pioglitazone can also increase uncoupling protein 1 expression in adipocytes and promote the energy consumption.[45] Moreover, pioglitazone can significantly reduce ALT, AST, and GGT. All results indicate that pioglitazone can control the liver enzyme spectrum caused by fatty liver.

Considering the mechanism on reducing the steatosis and inflammation of liver, pioglitazone can promote the differentiation of white adipocytes, increase the number of small adipocytes and reduce the number of large adipocytes after activating PPAR γ in the body. Small adipocytes are more sensitive to insulin, which can promote glucose uptake, promote energy consumption and reduce the storage of excess energy in adipose tissue.[46] A declining of FNS and HOMA-IR indicates that pioglitazone does not promote the secretion of islet β cells, however, it can increase the tissues' insulin sensitivity. The main reason for the decline of FNS and HOMA-IR level may be that pioglitazone can down regulate the expression of tumor necrosis factor-α, leptin and resistin genes, and these cytokines are closely related to insulin resistance, which may be 1 of the mechanisms of pioglitazone enhancing insulin sensitivity.[47]

Limitations

Although the 15 articles included in this meta-analysis prove that pioglitazone is useful, there are still some limitations: Firstly, there are some differences in the condition and basic treatments of NASH among the studies, which is also the reason for the heterogeneity of some indicators. Secondly, only Chinese and English literatures are included, and other languages are not involved. Language restrictions may lead to inappropriate results. Thirdly, all clinical studies have small sample size which may affect the reliability of the analysis results. Finally, the RCTs included in this study are biased in research design, methodology and result reporting. The details provided, such as randomization method, allocation concealment and blind method, are insufficient. Therefore, the evidence strength of the results is affected.

Applications prospects

In recent years, NASH becomes a serious public health problem. Its symptoms and related

complications seriously affect the quality of patients' lives.[48] Pioglitazone is an insulin sensitizer that selectively activates PPAR-γ.[49] PPARs are the main regulators of genes related to the glucose metabolism and the fat metabolism.[50] Pioglitazone can promote the uptake and the storage of fatty acids and up-regulate the expression of the insulin receptor substrate-1.[51] It can reduce the level of serum fatty acids and improve the insulin sensitivity of liver, muscle and adipose tissue. So, pioglitazone can achieve the purpose of treating NASH.[52] The liver damage caused by NASH is mainly manifested by the abnormal biochemical indexes of liver function. ALT, AST and GGT are commonly used in clinical practice to reflect the liver function.[53] Among them, ALT mainly exists in mitochondria of hepatocytes, and the intracellular concentration is 1000 to 3000 times higher than that of serum.[54] The concentration of AST in normal human serum is very low.[55] GGT mainly exists in the intrahepatic bile duct epithelium and the cytoplasm of hepatocytes. When the intrahepatic and extrahepatic bile duct obstruction can lead to the increase of GGT in serum. When the liver lesions are serious, a large number of hepatocytes and serious damage, GGT will increase.[56] In this meta-analysis, liver function indexes are significantly different before and after the pioglitazone treatment. ALT, AST and GGT are significantly decreased. However, some studies have shown that weight gain is common in patients taking thiazolidine 2 ketone drugs, which can cause fluid retention and congestive heart failure.[57] In addition, studies on the effect of pioglitazone withdrawal also show a significant rebound in the ALT.[58]

Go to:

Conclusion

Pioglitazone intake is effective in NASH management, including the total effective rate and other related clinical indexes. The treatment of NASH needs to be further verified.

This drug which is an adjunct drug which was primarily promoted in the treatment of type 2 Diabetes, where it helps tissue utilization of Insulin there by reduces Insulin resistance. Used extensively in the past it is now used selectively when other agents fail due to its safety profile. How ever as one can see I the meta-analysis report published above that it is a useful drug in treating Fatty liver [NASH]

Adverse effects, some of them can be serious.

The important ones are

Fluid retention in the limbs and abdomen. Can worsen the existing heart failure or may precipitate one.

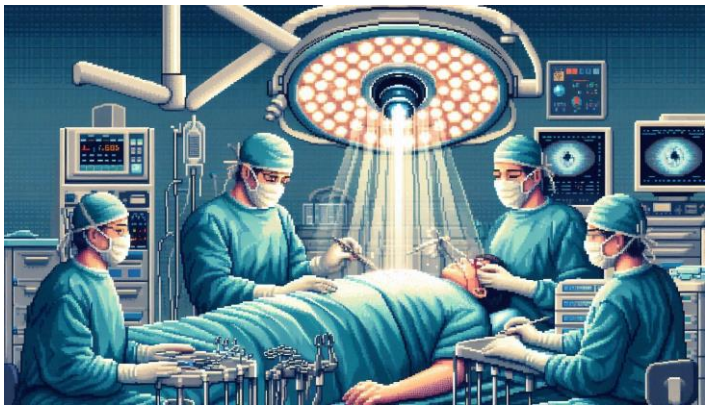
It causes reduction in bone mineral density and increase in the adipose tissue, especially in the femoral neck and hip bones, this is more in women than women. It should be therefore used with caution or not at all in post-menopausal women. Also, there are reports of increase incidence of bladder cancer

Ophthalmic Plastic Surgery

I often get asked this question when I tell them what I am specializing in. Most people are not aware that such a speciality exists including majority of medical doctors. They ask me how can you be an Ophthalmologist and a Plastic surgeon at the same time? It is a tedious exercise explaining it to people what my work comprises and one which makes my wife make fun of me when I explain because she has heard it so many times. I thought it would make sense to pen it down. Here it goes....

Ophthalmic Plastic Surgery is a sub-speciality of Ophthalmology which deals with the orbit (eye socket), eyelids, tear ducts, and the face. It also deals with the reconstruction of the eyelid, the eye socket, and surrounding structures. As is obvious, trauma care involving the eye tissues and the bone surrounding the eye come under

the purview of this sub-speciality. Lately as a natural progression this branch has been getting into Facial Aesthetics in a big way in the form of brow lifts, facelifts, Botox injections, fillers and other forms of facial rejuvenation.



Oculoplastic surgeons have perfected, refined, and pioneered new techniques of lacrimal surgery, ptosis repair & blepharoplasty, orbital surgery, lid malpositions, and flaps & grafts. With the close relationship of this speciality with ophthalmic cancer and reconstruction of eye structures after removal of various tumours, oculoplastic surgeons are also de-facto Ophthalmic oncologists.

The subspecialty of ophthalmic plastic surgery was born in the mid-twentieth century in the United States at the conclusion of World War II. The art of oculoplastic surgery, however, is centuries old, bearing its roots in antiquity in India, the Far East, and Europe.

The various procedures that have evolved over centuries can be divided into several general categories: reconstructive, restorative, and cosmetic. Oculoplastic surgeons have perfected, refined, and pioneered new techniques of lacrimal surgery, ptosis repair and blepharoplasty, orbital surgery, lid malpositions, and flaps and grafts. With the close relationship of this speciality with Eye Cancer and eye reconstruction after removal of tumours, Oculoplastic surgeons are de-facto Ocular oncologists. Since the treatment of the above conditions often requires multidisciplinary approach, the possibilities of this field are endless. It also requires good working relationship with other specialties and to create a valuable team to treat the patients.

Oculoplastic surgery became recognized as a unique subspecialty of ophthalmology at the end of World War II. Numerous orbital and periocular injuries were treated by general ophthalmologists without prior training or exposure to ophthalmic plastic surgery. Often, trial and error were keys in developing these procedures. Among the earliest pioneers was Dr John M. Wheeler who established a full practice based on oculoplastic surgery. He is known as the father of oculoplastic surgery. His student Wendel Hughes was the next major force in this field. Further Hughes' students Alston Callahan, Byron Smith and Crowell Beard propagated this field across the world. This group of Oculoplastic surgeons went on to found the American Society of Ophthalmic Plastic and Reconstructive Surgeons (ASOPRS) in 1969. This was the first such society in the world for oculoplastic surgeons. Later more such societies got formed in other parts of the world. Europe (ESOPRS), Canada (CSOPRS), Asia-Pacific (APSOPRS) and even India (OPAI).

It is a relatively less known specialty. (I did not know about it till I joined residency). There lies the challenge in this field and the greatest opportunity to grow. The specialists in this field are there in it only for passion since the other sub-specialities in Ophthalmology are much more rewarding monetarily. This sub-speciality is quite hard to master yet it is incredibly satisfying. I am honoured and privileged to count myself among these stalwarts. Like I said the possibilities are endless and there is so much work to be done....

Who is an Oculoplastic Surgeon?

An oculoplastic surgeon undergoes a full residency program in Ophthalmology followed by additional years of fellowship training in

Ophthalmic Plastics and Ophthalmic Oncology. The fellowship encompasses specialised training in the treatment of the diseases and function-including surgery of Eyelids, Orbits, Lacrimal Surgery, Facial Trauma, Reconstructive Surgery and Aesthetic surgery of the face especially around the eyes. The oculoplastic surgeon uses his/her microsurgical skills gained during residency in ophthalmology armed with knowledge of the intimate anatomy of the eye and the face to provide the best outcome for any condition in and around the eyes. Sometimes the treatment of the above conditions often requires multidisciplinary approach where other specialists like Neurosurgeons, Otorhinolaryngologists, Head and Neck Oncologists, Maxillo-facial surgeons, Radiologists, Radiation and Medical Oncologists. The oculoplastic surgeon has a good working relationship with other specialties and to create a valuable team to treat the patients in best possible way.

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Masala

Doctor mom and son Advaith

Silence broken by Advaith.

'Mom, what is steroid?'

Mom, 'why don't you browse and tell me?'

After browsing, Advaith tells, 'steroid is a substance to build muscles, but it has bad effects.'

Mother, 'It is also life saving'.

Advaith is quiet for a while, then he asks, 'Mom, why earth is so fat?'

Mom, 'Hmmm, don't know'
'It is because it swallowed an asteroid, A steroid,' Advaith tells.

Another time

Advaith, 'Mom, what are the seven easy steps to stay healthy?'
Mom after some thinking, asks Advaith, 'son, you tell me.'
Advaithi, 'H E A L T H Y.'
Mom, 'What?'
Advaith, 'Step one H, Step 2 is E, Step 3 is A……..
Mom,' Advaith, 'Don't you have any home work to do?

Dr Sowmya Vivek

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