

AFPI Karnataka State Chapter Newsletter

Quarterly Issue : Volume 9, Issue 2

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Dr Sowmya B Ramesh
President Karnataka

Warm greetings from the AFPI Karnataka Chapter.

This quarter has been quite productive, with the successful conduct of a conference in collaboration with BAPTIST HOSPITAL. Following that, we organized focused updates on topics such as herpes vaccines, pneumococcal vaccines, which are highly relevant to our current vaccination practices.

We are delighted to announce an upcoming full-fledged offsite meeting in Mysore on June 7th. The program details have already been shared, and we encourage all members to ensure their availability and actively participate to make the event engaging and impactful.

We are also excited to share plans for a rural conference in Atheni, North Karnataka, scheduled for November. In addition, we have several webinars and in-person events lined up, covering topics such as dog bite management, artificial intelligence in healthcare, and a rheumatology workshop.

We look forward to your enthusiastic participation and valuable contributions in all these initiatives.

Warm regards

Dr. Sowmya B Ramesh , President, AFPI Karnataka



Dr Hemavathi,
Secretary
AFPI Karnataka

Dear Members,

Greetings from AFPI Karnataka.

As part of our continued commitment to academic excellence and professional development, we are pleased to share that we have planned regular academic activities on a monthly basis for the upcoming quarter.

The sessions will cover a range of relevant and engaging topics, including Sarcopenia, Artificial Intelligence in Healthcare, and Management of Dog Bites, among others. These sessions are designed to enhance our clinical practice and keep us updated with evolving trends in family medicine.

In addition, we are organizing a Half-Day CME in Mysore, which will provide an excellent platform for knowledge exchange and interaction. We are also excited to announce the upcoming Rural State Conference in North Karnataka, focusing on addressing healthcare challenges and innovations in rural settings.

We strongly encourage all members to actively participate in these academic initiatives. Your involvement will not only enrich your own practice but also strengthen our collective mission of advancing family medicine across the state.

We look forward to your enthusiastic participation and continued support.

Warm regards,
Dr Hemavathi,
Secretary
AFPI Karnataka



Medicine is no longer a fixed rulebook—it is a living, evolving science.

What we learned yesterday may not fully serve the patient of today.

Guidelines remain our compass, but not our cage.

True clinical wisdom lies in knowing when to follow—and when to thoughtfully question.

As new evidence emerges, so must our thinking adapt with

humility.

Innovation often begins where rigid adherence ends.

Yet, progress demands responsibility, not reckless deviation.

We must stay curious, continuously learning, unlearning, and relearning.

Our patients deserve care that reflects both science and insight.

In these changing times, the best doctors are those who evolve without losing their core.

Dr. Amina Kausar Shah

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ACADEMIC COMMENTARIES



PEARLS OF DR. BADAKERE RAO

Do Not Die Before I Die

As I get old and conscious that not many years of reasonably competent professional life remains, I often think about what happens to my patients after my inevitable demise. These men and women have been my patients, often running to several generations.

The relationship and bond built over several decades is so subtle yet so strong that it is difficult to describe. Occasionally when this subject of inevitable mortality comes up during our talk, I tell them, “It is time you find another family doctor” This invariably leads to comments like, we will see when the time comes or “doc, you please suggest someone you think best” and the like. But what really exemplifies this bond is when this 70-year-old, Mrs. Yasmin told me the other day, “for heaven’s sake, doc, don’t go and die before I die’

Lets Get a Pearl out of Dr Rao now - A case of recurrent Bell’s Palsy !

Does Bell’s palsy have a genetic predisposition?

Both recurrence and genetic predisposition appearing in the same patient is uncommon.

Mr Sivasailam, A 60-year-old retired IT professional came with complaints of facial weakness, dribbling of saliva from one half of his mouth in the month of May 2017 which clinically was Bell’s palsy. He recovered well with a course of prednisolone and Physiotherapy in 3 months’ time. He reported on 2nd November 2035 with similar complaints, this time on the left side. He gave a history of his father suffering from similar symptoms and his UK based son having this in the month of July 2025.

Bell’s Palsy is generally a common condition, occurring in about 1 in 60 people over a lifetime, its occurrence across three generations of males in a single family and its recurrence in the same person are uncommon but well-documented phenomena in medical literature, suggesting a genetic predisposition in these specific cases.

Recurrence in the Same Person

- **Overall Rate:** Recurrence of Bell's Palsy is relatively rare in the general population, reported to be in the range of 2.6% to 15.2% of patients who have had a primary episode. A commonly cited average is about 7-10%.
- **Increased Risk with Family History:** The likelihood of recurrence is greater in individuals who have a positive family history of the condition.
- **Multiple Episodes:** While most people only have one or two episodes, some rare cases have reported as many as five or six episodes in the same individual.
- **Recurrence Pattern:** Recurrences can affect the same side of the face (ipsilateral) or the opposite side (contralateral).

Familial Occurrence (Across Generations)

- **Prevalence:** A positive family history is found in approximately 4% to 14% of all Bell's Palsy cases. In some studies, this figure can range up to 28.6%.
- **Inheritance Pattern:** Familial Bell's Palsy often follows an autosomal dominant inheritance pattern with low or variable penetrance, meaning that not everyone who inherits the genetic predisposition will develop the condition. In some rare case studies, high or complete penetrance has been noted.
- **Male-Only Pattern:** While the condition generally affects males and females equally, a presentation specifically in males across three generations would be considered a rare, but possible, manifestation of this genetic predisposition. Medical literature includes case series describing familial occurrences over multiple generations, but a strictly male-only lineage across generations would be an unusual and specific presentation.
- **Cause:** No specific gene has been definitively identified as the sole cause of Bell's Palsy; the prevailing theories suggest a combination of genetic susceptibility (possibly related to anatomical narrowing of the facial canal or immune response genes) and environmental triggers like viral infections.

In summary, having a case of Bell's Palsy run in a family for three generations and recur in the same individual points towards a genetic predisposition, which is a recognized, albeit uncommon, form of the condition.

The occurrence of Bell's palsy in three generations of the same family and with recurrence in the same person is considered rare but well-documented in medical literature. While most cases are sporadic (not inherited), a genetic predisposition is a known risk factor, and familial cases have a higher likelihood of recurrence.

Dr. B.C.Rao

AN UPDATE ON TUBERCULOSIS : DIAGNOSIS AND MANAGEMENT



Dr. S Subramanyam , Family Physician

Signs and symptoms of TB

Latent TB

Infected but no signs and symptoms. About 40% of Indian and 25% of global population are having latent TB out of which only about 5% may develop active TB under various immunosuppressive conditions.

TB can affect any system in the body from head to toe except hair and nail and the symptoms depend on the system affected. Common symptoms are fever, cough, loss of appetite and weight but symptoms can be acute or chronic, mild, moderate, or severe.

Whenever there is a diagnostic challenge, after ruling out all the other possibilities Tuberculosis must be considered and sometimes empirical treatment may have to be given for diagnostic / therapeutic purpose. Latent TB **SHOULD be** treated in high-risk groups, HIV and immunosuppressed

Classification :

Is now simplified as DSTB (Drug Sensitive TB) and DRTB (Drug Resistant TB).

Diagnosis

Tissue diagnosis is a must from the suspected material. Sputum / biopsy material to be subjected for histopathology, ZN stain and CB-NAAT (GeneXpert)

CB-NAAT picks up only MTB even in very low concentration and gives information whether there is **Rifampicin resistance**.

Those who are Rifampicin resistant are invariably resistant to INH also, and fall in to the category of DRTB. Rifampicin resistance is a strong surrogate marker for MDR-TB and often associated with INH resistance

It is mandatory to clarify DSTB or DRTB before starting treatment because DRTB is on the rise, is very dangerous, difficult to treat and often fatal.

Culture and sensitivity : If CB-NAAT confirms Rifampicin resistance, material should be sent for Liquid culture (Bactec) we get results in about 2 to 4 weeks.

LPA (Line Probe Assay) : LPA is a rapid technique based on polymerase chain reaction (PCR)

that is used to detect Mycobacterium tuberculosis (MTB) complex as well as drug sensitivity to rifampicin and isoniazid (INH)

Treatment of TB

Is simplified only two categories DSTB or DRTB. DSTB treatment is same for TB anywhere and any severity.

Drugs used are HREZ (INH, Rifampicin, Pyrazinamide and Ethambutol) for first two months (Intensive phase) and HRE for 4 months (continuation phase). Duration may be extended in special cases like CNS, Bone and joint TB, delayed response, and the like.

Dosing also made easy with FDC (Fixed Drug Combination) one tablet for 15 kg body weight.

Supportive treatment

Adequate nutrition and management of side effects is important..

Any Multivitamin containing Pyridoxine 10 mg is sufficient, it is observed that Pyridoxine is being prescribed in the dose of 40 mg without any indication.

DRTB (Drug Resistant TB)

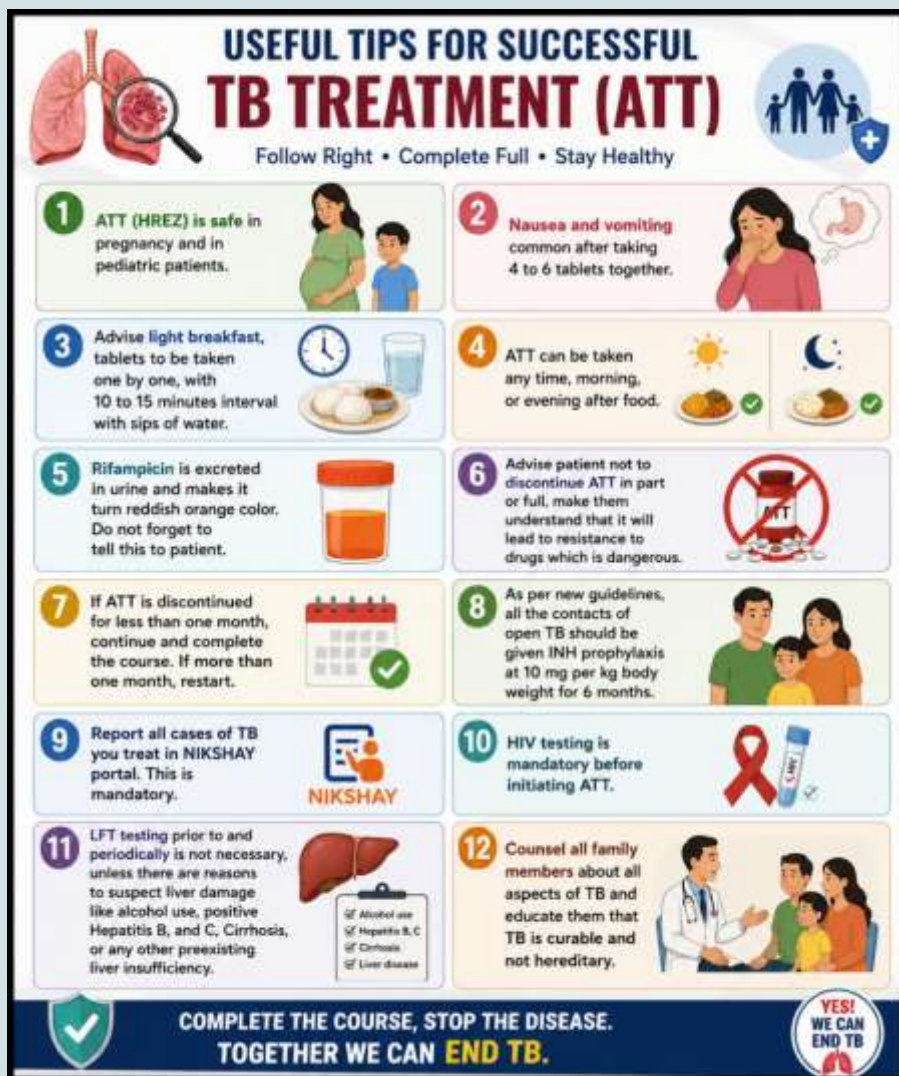
MDR,XDR and all resistant TB come under DRTB. Treatment of DRTB is based on the culture and sensitivity pattern.

Drugs used are toxic with lot of side effects, preferably treated by an expert in an institution under careful monitoring of the side effects.

The introduction of Bedaquiline has revolutionized the management of DRTB.

New regimens, do not have injectable and duration of 12 months, efforts are on to make it 6 to 9 months.

Primary care physicians are advised to manage DRTB in association with an expert from / in an institution.



Side effects of ATT

Common side effects are nausea, vomiting, burning stomach, bowel disturbance, giddiness, burning feet, skin rashes.

Most important and dangerous side effect is hepatotoxicity, if not attended in time can be fatal. Liver enzymes elevated up to 3 times with symptoms and up to 5 times without symptoms can be accepted and treatment continued.

Above that, treatment should be stopped and can be reintroduced after liver enzymes return to normal

Interestingly, most do not develop hepatotoxicity second

time, if they do, we have to revise the combination. Routine high-dose pyridoxine is unnecessary unless risk factors (diabetes, alcohol use, pregnancy, malnutrition) are present.

Some useful tips

First line ATT HREZ is safe in pregnancy and in pediatric patients

Nausea and vomiting common after taking 4 to 6 tablets together.

Advise light breakfast, tablets to be taken one by one, with 10 to 15 minutes interval with sips of water. ATT can be taken any time, morning, or evening after food.

Rifampicin is excreted in urine and makes it turn reddish orange color. Do not forget to Inform the patient. Advise patient not to discontinue ATT in part or full, make them understand that it will lead to resistance to drugs which is dangerous.

If ATT is discontinued for less than one month, continue and complete the course, If more than one month, restart.

As per new guide lines, all the contacts of open TB should be given INH prophylaxis at 10 mg per kg body weight for 6 months.

Report all cases of TB you treat in NIKSHAY portal. This is mandatory.

HIV testing is mandatory before initiating ATT.

LFT testing prior to and periodically is not necessary, unless there are reasons to suspect liver damage like alcohol use, positive Hepatitis B, and C, Cirrhosis, or any other preexisting liver insufficiency.

Counsel all family members about all aspects of TB and educate them that TB is curable and not hereditary.

There is an excellent system under NTEP (National Tuberculosis Elimination Program) for diagnosis and treatment, totally free of cost, make best use of it.

Family Physician is the first contact for most health- related issues, he has the advantage of early detection, management, prevention of spread, prevention of DRTB and he is the key in reaching the goal. Until family physicians are updated and committed in the TB elimination program, this program cannot be successful. It is the responsibility of the family physician to diagnose and treat all forms of TB unless the patient needs surgical intervention or hospitalization.

Guidelines keep changing, keep in touch with NTEP website and keep pace with the latest guidelines.

Dr S Subramanyam

Family Physician

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Are You GLP-1 Agonist Prescribing Ready?

Dr. Amina Kausar Shah

Things Every Physician Must Know

1. Shift in role: GLP-1 RAs are now obesity-first drugs, not just antidiabetics.
2. Disease model changed: Obesity is treated as a chronic relapsing endocrine disease, not lifestyle failure.
3. Best-in-class currently: Tirzepatide > Semaglutide for both HbA1c and weight loss.
4. Expected weight loss:
 - Semaglutide \approx 12–15%
 - Tirzepatide \approx 20–22%
5. Next-gen drugs incoming: Triple agonists (e.g., retatrutide) may achieve 25%+ weight loss (near bariatric outcomes).
6. Oral revolution: Oral GLP-1s (like Oral Semaglutide) are expanding access and compliance.
7. Cardiovascular benefit: ~20% reduction in major adverse cardiovascular events (MACE).
8. Renal protection: Slows CKD progression—now entering nephrology practice.
9. Not just metabolic: Emerging roles in fatty liver, PCOS, and possibly neurodegeneration.
10. CNS effects: Reduce food reward, cravings, and possibly addictive behaviours (alcohol, nicotine).
11. Common side effects: Nausea, vomiting, constipation—dose titration is key.
12. Newer red flags: Watch for -Vision changes (optic neuropathy- Evidence is weak / emerging), Mood changes / depression, Fatigue
13. Weight regain is common: Stopping therapy \rightarrow rapid regain (this is lifelong therapy for many).
14. Adherence problem: Up to ~50% discontinue within 1 year (cost + side effects).
15. Big clinical shift: GLP-1s are now multi-system disease-modifying drugs, not just glucose-lowering agents.

GLP-1 / GIP AGONISTS

PRACTICAL USE GUIDE – 2026



Lower HbA1c



Weight Loss



Cardiovascular Benefit



Improved Metabolic Health

1. DOSING & TITRATION

	STARTING DOSE	TITRATION	MAINTENANCE / MAX DOSE	FREQUENCY
 Semaglutide (Ozempic® / Wegovy®)	0.25 mg weekly for 4 weeks	0.25 mg → 0.5 mg → 1 mg → 2 mg (Ozempic®) 2.4 mg (Wegovy®) for obesity	Up to 2 mg (Ozempic®) Up to 2.4 mg (Wegovy®) for obesity	 Once weekly
 Tirzepatide (Mounjaro®)	2.5 mg weekly for 4 weeks	2.5 mg → 5 mg → 7.5 mg → 10 mg → 12.5 mg → 15 mg	Up to 15 mg weekly	 Once weekly
 Dulaglutide (Trulicity®)	0.75 mg weekly	0.75 mg → 1.5 mg → 3 mg → 4.5 mg	Up to 4.5 mg weekly	 Once weekly
 Liraglutide (Victoza® / Saxenda®)	0.6 mg daily for 1 week	0.6 mg → 1.2 mg → 1.8 mg (Victoza®) 3 mg (Saxenda®) for obesity	Up to 1.8 mg daily (Victoza®) Up to 3 mg daily (Saxenda®) for obesity	 Once daily



TITRATION PRINCIPLE
 Start low – Go slow
 Increase only if tolerated and additional benefit is needed.



Titrate every 4 weeks (weekly agents)
 Titrate weekly (daily agents)



If side effects occur, stay at the same dose longer before increasing.

2. WHEN TO REDUCE DOSE

- Persistent nausea / vomiting
- Excessive or rapid weight loss
- HbA1c already at goal
- Reduced oral intake / frail patient
- Other intolerance

Stop down one level at a time. Do NOT stop abruptly unless severe illness.

3. COMMON SIDE EFFECTS (WHEN TO EXPECT)



Early (first 2–4 weeks)
 Nausea, bloating, reduced appetite



During titration
 Nausea, vomiting, constipation / diarrhea, abdominal discomfort



Later / Long-term
 Gallstones (especially with rapid weight loss), mild tachycardia, rarely pancreatitis

4. STOP IMMEDIATELY (SEEK MEDICAL CARE)



- Severe abdominal pain (suspect pancreatitis)
- Persistent vomiting / dehydration
- Acute kidney injury
- Severe allergic reaction (swelling, rash, breathing difficulty)
- Suspected medullary thyroid carcinoma (rare) or MEN 2

5. CLINICAL PEARLS



Eat small, light meals. Avoid very fatty & heavy meals.



Stay well hydrated.



Reduce dose of insulin or sulfonylureas to avoid hypoglycemia.



Monitor weight, HbA1c, kidney function and GI symptoms.



USE WITH CAUTION / AVOID IN

- History of pancreatitis
- Severe gastroparesis
- Personal / family history of medullary thyroid carcinoma or MEN 2



GOALS ACHIEVED?

Maintain the lowest effective dose. Consider tapering if HbA1c < 6.5–7% consistently or excessive weight loss.



REMEMBER

These medications work best with lifestyle measures – healthy eating, activity, sleep and follow-up.



Start low. Go slow. Monitor closely. Stop early if needed.

Better Tolerance • Better Results • Better Outcomes



BEFORE YOU START A GLP-1 AGONIST



TAKE THIS 10-POINT QUIZ

For Semaglutide - Tirzepatide and other GLP-1 / Dual Agonists

1 IS THERE A VALID METABOLIC INDICATION?

- Obesity (BMI ≥ 30)
- BMI ≥ 27 with comorbidities
- Type 2 diabetes / Metabolic syndrome

BMI
 ≥ 30
 ≥ 27 with comorbidity

⚠️ Cosmetic-only use → rethink

6 HAVE I COUNSELLED THE PATIENT?

- Possible side effects (nausea, vomiting, early satiety)
- Slow titration
- Lifestyle changes are essential

DO NOT START IF

- Medullary thyroid carcinoma / MEN2
- Pregnancy
- Prior serious hypersensitivity

2 HAVE I ASSESSED BASELINE STATUS?

- HbA1c
- Weight / BMI / Waist
- Cardiovascular risk profile
- Relevant labs (RFT, LFT, Lipids)

BASELINE LABS

- HbA1c
- RFT
- LFT
- Lipids

7 DO I HAVE A TITRATION PLAN?

- Start low
- Gradual escalation
- Adjust based on tolerance and response
- Typical review at 4-8 weeks

GOAL
GO SLOW
START LOW

3 ANY ABSOLUTE RED FLAGS?

- Medullary thyroid carcinoma / MEN2
- Pregnancy
- Prior serious hypersensitivity

DO NOT START IF

- Prior pancreatitis
- Severe gastroparesis
- Gallbladder disease
- Retinopathy risk (rapid HbA1c reduction)

4 ANY CAUTION ZONE CONDITIONS?

- Prior pancreatitis
- Severe gastroparesis (not mild obesity-related)
- Gallbladder disease / gallstones
- Diabetic retinopathy risk (rapid HbA1c reduction)

PANCREATITIS **SEVERE GASTROPARESIS**
GALLBLADDER DISEASE **RETINOPATHY RISK**

5 HAVE I REVIEWED CURRENT MEDICATIONS?

- Insulin / Sulfonylureas → risk of hypoglycemia
- Other weight-loss drugs
- Polypharmacy / interactions

INSULIN **SU**

8 DO I HAVE A FOLLOW-UP STRATEGY?

- Monitor weight / BMI
- Glycemic response
- Side effects
- Labs as indicated

9 DO I HAVE AN EXIT / STOP PLAN?

- No meaningful response → stop
- Intolerable side effects → stop
- Achieved goals → maintain with lifestyle ± meds

STOP **REASSESS** **CONTINUE**

10 FINAL SELF-CHECK

- Right patient?
- Right drug?
- Right dose?
- Right follow-up?
- Shared decision with patient?

POTENTIAL BENEFITS

- Significant weight loss
- Improved glycemic control
- Cardiovascular benefits
- Metabolic improvement

HOW DID YOU SCORE?

8 - 10 YES

RATIONAL START
Proceed with confidence. Document and follow up.

5 - 7 YES

PAUSE & OPTIMISE
Reassess, optimise, and address gaps.

0 - 4 YES

UNSAFE TO START
Do not start. Reevaluate completely.

REMEMBER

- Not every patient needs a GLP-1.
- Not every GLP-1 is for every patient.
- Safe prescribing = Better outcomes.

GLP-1 IS POWERFUL. YOUR DECISION MATTERS MORE.



Use appropriate clinical judgment. Follow local guidelines and product labeling.



Higher Generation is Not Better: Choosing the Right Cephalosporin in Primary Care

Dr. Krithika Ganesh

A young adult with uncomplicated cellulitis walks in. You prescribe a third-generation injectable cephalosporin—just to be safe. It feels stronger. Broader. Better. But is it?

Cephalosporins are among the most commonly used antibiotics in primary care. Their classification into generations reflects drug development—not clinical superiority.

Misinterpreting this leads to overuse of higher generations, poorer targeting, rising resistance, and unnecessary cost.

Think spectrum, not generation.

First-generation (cefazolin, cephalexin):

Excellent Gram-positive coverage (Streptococcus, MSSA).

Best for cellulitis, impetigo, folliculitis, minor procedures.

Second-generation (cefuroxime, cefaclor, cefoxitin):

Expanded Gram-negative coverage (HEN PEcKS group).

Useful in respiratory infections, sinusitis, otitis media.

Cefoxitin adds anaerobic coverage.

Third-generation (ceftriaxone, cefixime, ceftazidime):

Strong Gram-negative action, good CNS penetration.

Weaker Gram-positive coverage—avoid for typical SSTIs.


Use in typhoid, meningitis, gonorrhoea, severe infections.

Fourth-generation (cefepime):


Broad-spectrum, beta-lactamase stable.

HIGHER GENERATION IS NOT BETTER CHOOSING THE RIGHT CEPHALOSPORIN IN PRIMARY CARE

By Dr Krithika Ganesh








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Cephalosporins are among the most commonly used antibiotics in primary care. Their classification into generations reflects drug development—not clinical superiority.


Misuse of higher generations leads to overuse, resistance, higher cost, and poor targeting.


THINK SPECTRUM, NOT GENERATION.


GENERATION	COVERAGE	BEST USE
1st GENERATION Cefazolin, Cephalexin	Excellent Gram-positive coverage (Streptococcus, MSSA)	 Cellulitis Impetigo Minor procedures
2nd GENERATION Cefuroxime, Cefaclor, Cefoxitin	Expanded Gram-negative coverage (HEN PEEKS group) Cefoxitin adds anaerobic coverage	 Respiratory infections Sinusitis Otitis media
3rd GENERATION Ceftriaxone, Cefixime, Ceftazidime	Strong Gram-negative action, good CNS penetration Weaker Gram-positive coverage	 Typhoid fever Meningitis Gonorrhoea / Severe infections
4th GENERATION Cefepime	Broad-spectrum, beta-lactamase stable	 Severe, nosocomial infections
5th GENERATION Ceftaroline	Covers MRSA and resistant organisms	 Use only when clearly indicated


RATIONAL PRESCRIBING IN PRIMARY CARE

 Identify site & likely pathogen


 Choose the narrowest effective drug


 Prefer oral therapy


 Send cultures before starting antibiotics

 De-escalate based on results

COMMON PITFALLS

 Routine ceftriaxone use

 Unnecessary injectables

 Failure to de-escalate

TAKEAWAY: In primary care, the goal is not escalation—but precision.

THE RIGHT DRUG, FOR THE RIGHT BUG, AT THE RIGHT TIME.

Reserved for severe, nosocomial infections.

Fifth-generation (ceftaroline):

Covers MRSA and resistant organisms.

Use only when clearly indicated.

Rational prescribing in primary care:

-Identify site and likely pathogen

-Choose the narrowest effective drug

-Prefer oral therapy

-Send cultures before starting antibiotics

-De-escalate based on results

Common pitfalls:

- Routine ceftriaxone use
- Unnecessary Injectables
- Failure to de-escalate

Takeaway- In primary care, the goal is not escalation—but precision.

Between Consultations



By Dr. Archana Prabhakar

On Being “Ready”: The Quiet Work of Showing Up!

Entering medical school felt extraordinary—and terrifying. Beneath the pride lived quieter questions: *Am I good enough? Will I manage? What if I fail?*

These doubts didn’t fade—they stayed. Through first year confusion, final year expectations, and into practice.

Looking back, one truth stands out: readiness never comes before responsibility.

Not before exams.

Not before rural postings.

Not before opening a clinic.

And yet, we show up.

Family medicine in India demands this daily. Patients arrive not with diagnoses, but with layered realities—social, emotional, financial. In ten minutes, we must listen beyond symptoms.

“Swalpa weakness” may mean anaemia—or burnout.

Here, readiness isn’t knowing everything.

It is staying present despite uncertainty.

Evidence supports what we see daily—empathy improves outcomes, adherence, and trust. Yet training often erodes it. Family medicine resists this by valuing relationships.


But empathy has a cost. Compassion fatigue is real. Sustainable care requires self-awareness, reflection, and boundaries.

Between Consultations


— By Dr. Archana Prabhakar —

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
Evidence supports what we see daily—empathy improves outcomes, adherence, and trust. Yet training often erodes it. Family medicine resists this by valuing relationships.


But empathy has a cost. Compassion fatigue is real.


Sustainable care requires self-awareness, reflection, and boundaries.




Pause.


Reflect.


Recharge.



Then, return.

Rural postings teach this best— where medicine strips down to listening, observing, and deciding when not to intervene.




“The art of medicine often lies in knowing when not to act.”


Choosing family medicine means choosing—




Continuity over certainty




Meaning over metrics




Relationships over rush




Readiness, then, is not a milestone. It is built quietly—




Through conversations




Through mistakes



Through reflection



Through return



“ Perhaps the question is not when we are ready— but how we **continue to show up**, even when we are not!!

Rural postings teach this best—where medicine strips down to listening, observing, and deciding when *not* to intervene.

Choosing family medicine means choosing continuity over certainty. Meaning over metrics.

Readiness, then, is not a milestone.

It is built quietly—through conversations, mistakes, reflection, and return.

Perhaps the question is not when we are ready—

but how we continue to show up, even when we are not !!

How AI Tools Can Reduce Medico-Legal Risk in Family Practice



Dr. Syed Mubarak

As family physicians, we work in a high-volume, high-trust environment. Most medico-legal issues in general practice do not arise from rare clinical errors, but from common gaps—poor documentation, missed follow-up, communication failures, and guideline deviation.

This is where AI tools, when used wisely, can quietly reduce risk in day-to-day practice.

Documentation: the first line of legal defense

In medico-legal cases, “if it is not documented, it did not happen.” AI-based ambient scribes and smart EHR assistants help create structured, timestamped notes during the consultation. They reduce missed details like red flag symptoms, counselling given, or safety-net advice. Better notes mean clearer clinical reasoning, which is critical when records are reviewed months or years later.

Clinical decision support at the point of care

Modern AI decision-support tools embedded in EHRs prompt differential diagnoses, highlight guideline-based investigations, and flag high-risk symptoms. In family practice, this is especially useful for chest pain, fever, abdominal pain, and chronic disease reviews. These prompts do not replace judgment, but they reduce the risk of “you did not consider” allegations, which are common in litigation.

Medication safety and prescribing errors

AI-driven prescription checks can flag drug–drug interactions, renal dose adjustments, duplicate therapies, and allergy conflicts in real time. Many medico-legal claims in primary care involve adverse drug events. Consistent use of AI checks strengthens prescribing defensibility.

Follow up and test result tracking

Missed lab reports and delayed follow up are classic legal traps. AI enabled task management systems

HOW AI TOOLS CAN REDUCE MEDICOLEGAL RISK IN FAMILY PRACTICE

Better Documentation **Safer Decisions** **Fewer Errors** **Lower Legal Risk**

1 DOCUMENTATION: FIRST LINE OF LEGAL DEFENCE

AI scribes & smart EHRs create structured, timestamped notes. Better notes = stronger defence.

2 CLINICAL DECISION SUPPORT AT THE POINT OF CARE

AI tools suggest differentials, flag red flags & guide investigations. Better decisions, fewer "missed" risks.

3 MEDICATION SAFETY & PRESCRIBING ERRORS

- ✓ Drug interactions
- ✓ Allergy alerts
- ✓ Dose accuracy
- ✓ Duplicate therapy

AI checks reduce prescribing errors & adverse drug events.

4 FOLLOW-UP & TEST RESULT TRACKING

AI tracks abnormal results, sends alerts & logs patient notifications. Clear audit trail = lower legal risk.

5 COMMUNICATION & PATIENT UNDERSTANDING

- ✓ Clear explanations
- ✓ Better understanding & adherence

AI generates simple visit summaries. Better communication, fewer disputes.

TAKEAWAY = Better Notes + Better Decisions + Better Follow-up + Better Communication = **LOWER MEDICOLEGAL RISK**

AI is an assistive layer, not a replacement for clinical judgement. Smart use. Safer practice. Stronger protection.

can track abnormal results, generate alerts, and document patient notifications. This creates a clear audit

trail showing reasonable systems were in place.

Communication and patient understanding

AI tools can generate visit summaries in simple language, improving patient understanding and

adherence. Clear communication reduces complaints and disputes.

In summary, AI in family practice is not about automation hype. It is about safer systems—better notes, better follow-up, and better clinical consistency. Used as an assistive layer, AI can quietly lower

medico-legal risk while letting us focus on the human side of care.

Dr. Syed Mubarak
 MBBS, PGDFM, PBDGM
 Project Director- Health & Wellbeing,
 Bosch Global Software

Career Pathways

GP Training in the UK: A Practical Overview



Dr. Ramya Naveen Methil

When I first started exploring GP training in the UK, it felt overwhelming. Too many steps, too many exams, and a lot of uncertainty. But once I broke it down and took it one step at a time, it became much more manageable—and definitely achievable.

The journey essentially begins with getting your **GMC registration**. For that, you'll need:

- English proficiency (**IELTS/OET**)
- **PLAB 1 & 2**
- GMC registration

PLAB 1 can be done from India, but PLAB 2 requires travel to the UK. That's usually the first big transition point for most of us.

Once registered, you have two practical options:

- Move to the UK, start in a **non-training job**, and then apply
- Or prepare from India, write the **MSRA exam**, and directly apply for GP training

The **MSRA** is now the key step—it decides your ranking and largely determines where you train.

What training actually feels like

GP training lasts **3–4 years**, and it's a mix of:

- **General practice (major portion)**
- **Hospital rotations** (medicine, pediatrics, psychiatry, etc.)

What really stood out to me was how important **psychiatry and pediatrics** are. In the UK, GPs manage a large part of these cases themselves, especially in early stages. That was quite different from my experience in India—and initially a bit intimidating—but incredibly useful in the long run.

Exams — but not the whole story

You will need to clear:

- **AKT (MCQ-based)**
- **SCA (simulated consultations)**
- **WPBA (ongoing assessments)**

But honestly, what shapes you more than exams is **day-to-day clinical exposure**—how you communicate, document, and think through cases.

Work culture — a big shift, One of the biggest differences is the work structure:

- Defined shifts (no 24–36 hour duties)
- Mandatory rest between shifts
- Protected **teaching and study time**

Once you move into GP postings, it's mostly:

- **Monday to Friday work**
- Some time each week dedicated to learning or portfolio work

It takes time to adjust—but it's a healthier system overall.

The reality check -Financially, GP training is reasonably well paid:

- Around **£52,000–£65,000 per year**

But expenses matter:

- **Rent** is the biggest cost
- **Childcare** can be expensive

- Visa and settlement costs add up



So planning ahead financially is important.

What I learnt through the journey

- It's okay to feel unsure in the beginning
- You don't need to know everything before you start
- Confidence builds during training—not before it

Most importantly: Don't look at the entire journey at once.

Just focus on:

- Clearing one exam
- Taking the next step
- Adjusting gradually

This is not the easiest path—but it is a **structured and achievable one**.

If you're willing to adapt, learn, and stay patient with the process, the system will support you, and the growth is worth it.



Dr.Priti Shankar, Afpi Secretary

This was in the early 90's about 5/6 years into my practice in my clinic!

One afternoon after a very busy morning (because other clinics were closed due to festival) was about to shutdown for the day when a big crowd barged into my chamber! Initial reaction was apprehension ! All unfamiliar faces -few women wailing and some shouting! Before I could react one of my patients who stayed close to my clinic hushed the others and started talking (much to my relief).

One man in the crowd was holding a 8 to 9 years boy's head with a cloth which was far from clean (dirty by all standards).

My patient explained that the boy had fallen into a well in the village and they had taken a bus and come to my patients home for help.

I looked at the wound 8 to 10 cms long a deep cut with the skull exposed !

All my neighbours and other patients knew that I do suturing of wounds and minor procedures.

But this was too much for me so I suggested to take the boy to a government hospital.

They said they had no money only a small change left.

Those days corruption at the hospitals was at the peak so they couldn't take to the hospital!

They didn't even have sufficient auto fare.

The relatives of the boy started crying and pleading for me to do something!The father said if we leave him like this he may die so whatever you can do please help!

They said we can't take him anywhere else without money!

I was known in the neighborhood to waive off the fees sometimes!

After assessing the situation once more I decided to help!

It's not only surgeons who pray before a major surgery! This was truly major for me .I was terrified and nervous initially but said a small prayer and with the blessings from God I proceeded after taking all the equipment ready!

Things were not going to be smooth as my clinic assistant almost fainted after seeing the wound!

One of the attenders had to give her water and take care of her .

Now I needed help while suturing and as I looked around a gentleman from the crowd (later came to know he was boy's relative) said he would help.

I was hesitant but with no other choice left I taught him to mop and cut the sutures etc.

When the boy arrived there was a gaping wound but no blood!

All vessels constricted.

Somehow with that man's help I completed the suturing!

I least expected it to look as neat as it actually did, much to my surprise. I dressed up the wound and told the parents to bring him again for dressing etc after 2 days and later for suture removal!

The father started crying and said he was a labourer on daily wages and he can't miss work and come.

I refused to take the small change he was paying me and ordered antibiotics and pain killers from the nearby chemist and sent them.

I heaved a big sigh of relief and had mixed emotions as they left!

Days passed, months passed and any enquiry from my other patients about the boy was fruitless.

My mind often in a turmoil whether the boy was doing well did he get sutures removed.

As I got engrossed in my practice and family with 2 children one toddler and one about 7 years the incident was pushed away from my forefront memory!

Those days telephone communication was not very easy only trunk calls !

Years later I was waiting at the bus stop for an auto to go to a social function with my in laws!

My mother in law waiting at the function!

One middle aged man tapped me from behind and said in Kannada "Do you recognise me Amma"

I am from Tamilnadu and my Kannada was just enough to understand him !

I said " Illa theriya illa"

Both Tamil and Kannada mix!

Then he pointed out to the a 15/16 year old boy next to him and said " Ivan gotthithiya - Do you remember or know him"

I again said Illa theriya illa.

He pointed out to that boy's head and said he had fallen in the well and you had sutured!

"Adhe huduga "

He had tears in his eyes and was very emotional and said you are like God to have saved him !

He was falling at my feet which I stopped him from doing.

Had a small conversation with him asking about the boys studies etc and then had to leave.

On the other side my mother in law eagerly waiting for me !

So I caught the 5th auto and left for the function.

All along the way to the function my heart was full and beaming!

Mixed emotions of gratitude to God and happiness that the boy was doing well and proud of myself (maybe selfish) that I managed that day!

The whole incident again flashed back of my assistant fainting and I had goosebumps!

God and Nature heal and I was very grateful that I made the decision on that day!

This is the Power of our profession - Satisfaction when we least expect it !

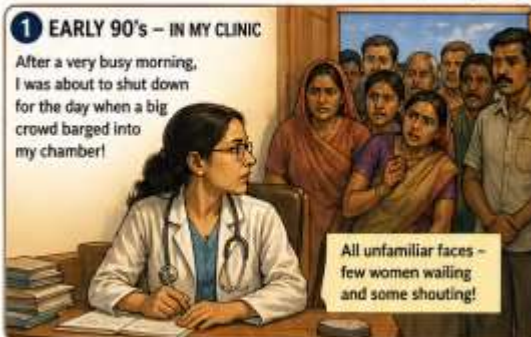
All my fears wiped out in those 5 minutes at the bus stop,!

The Power of Our Profession

A moment of courage... A lifetime of gratitude...

1 EARLY 90's – IN MY CLINIC

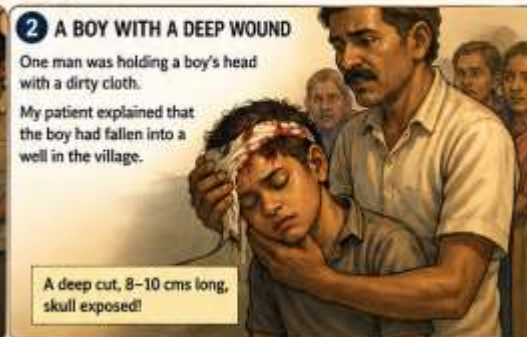
After a very busy morning, I was about to shut down for the day when a big crowd barged into my chamber!



All unfamiliar faces – few women wailing and some shouting!

2 A BOY WITH A DEEP WOUND

One man was holding a boy's head with a dirty cloth. My patient explained that the boy had fallen into a well in the village.



A deep cut, 8–10 cms long, skull exposed!

3 A DIFFICULT DECISION

I suggested taking him to a government hospital.

They had no money, only a small change left. Corruption was high, they couldn't go!

They pleaded for help. The father said, "If we leave him like this, he may die." Whatever you can do, please help!"



After assessing once more, I decided to help!

4 A PRAYER AND PREPARATION

It's not only surgeons who pray before a major surgery!

I said a small prayer and prepared myself.

My assistant fainted after seeing the wound!

One of the attenders had to take care of her.



5 AN UNEXPECTED HELP

I needed help while suturing.

A gentleman from the crowd (later came to know he was the boy's relative) said he would help.

I taught him to mop and cut the sutures etc.



6 THE SUTURING

When the boy arrived there was a gaping wound but no blood – all vessels constricted.

Somehow with that man's help I completed the suturing!

It looked much neater than I expected.



7 AFTERCARE AND GRATITUDE

I dressed up the wound and told them to come after 2 days for dressing and later for suture removal.

The father said he was a daily wage labourer and couldn't miss work.

I refused to take the small change, ordered medicines and sent them.



8 YEARS PASSED...

No news about the boy. My mind often wondered – Was the doing well? Did he get his sutures removed?

Life moved on... practice, family, two children...



9 A SURPRISE REUNION

Years later, at a bus stop, a middle aged man tapped me and said in Kannada, "Do you recognise me Amma?"

He pointed to the boy next to him.

"He fell in the well... you had sutured!"

He had tears in his eyes.



10 A HEART FULL OF JOY

He said I was like God to have saved him!

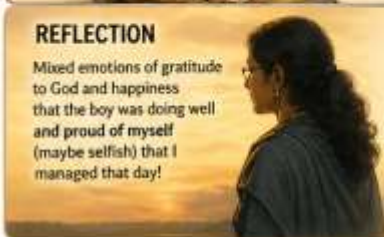
I stopped him from touching my feet.

Had a small chat and then left for the function. All along the way, my heart was full and beaming!



REFLECTION

Mixed emotions of gratitude to God and happiness that the boy was doing well and proud of myself (maybe selfish) that I managed that day!



God and Nature heal and I was very grateful that I made the decision on that day!

This is the Power of our profession – Satisfaction when we least expect it!

All my fears wiped out in those 5 minutes at the bus stop!



God is the Healer and we are mere instruments!!



Dr. Uma Madavachetty

Smart Financial Planning for Sustainable Practice & Personal Wealth

As family physicians, we dedicate our lives to caring for others—but often overlook our own financial health.

A well-planned financial strategy not only secures your future but also strengthens your ability to run a stable, stress-free practice.

This month, we focus on simple, practical financial planning strategies tailored for budding family physicians

1. Separate Personal & Practice Finances

Mixing finances is one of the most common mistakes.

Maintain separate bank accounts

Track clinic income and expenses clearly

Pay yourself a fixed monthly salary

Build a Stable Income Model

Family practice income can fluctuate.

Balance OPD consultations with preventive care packages

Introduce annual family health plans

Focus on follow-ups and continuity care

2. Protect Yourself with Insurance

Your income depends on your health

Health insurance for you and your family

Professional indemnity insurance

Term life insurance to protect dependents

3. Start Early Investments

Avoid delaying wealth creation.

Invest regularly (SIPs, mutual funds, fixed income options)

Diversify—don't depend only on clinic income

Plan for long-term goals (retirement, children's education)

4. Plan Clinic Expansion Carefully

Growth is good—but should be strategic.

Avoid over-borrowing

Invest in high-return services (diagnostics, preventive care)

Monitor ROI before major expenses

5. Tax Planning is Essential

Smart tax planning increases net income.

Work with a qualified accountant

Use available deductions and depreciation

Maintain proper records to avoid penalties

6. Build an Emergency Fund

Unexpected situations can affect both personal and clinic finances.

✓ Keep 6–12 months of expenses as reserve

✓ Ensure liquidity for emergencies



FAMILY PHYSICIANS - FINANCIAL PLANNING

by Dr Uma Madavachetty

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 - ✓ Use available deductions and depreciation
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- 7 Build an Emergency Fund**
 - ✓ Keep 6-12 months of expenses as reserve
 - ✓ Ensure liquidity for emergencies
- 8 Plan Your Retirement Early**
 - ✓ Create a retirement corpus goal
 - ✓ Consider passive income sources (rent, investments)
 - ✓ Don't rely solely on active practice income

COMMON FINANCIAL MISTAKES TO AVOID

- ✗ Over-expanding too early
- ✗ Ignoring insurance
- ✗ No savings discipline
- ✗ Poor record keeping
- ✗ Delaying investments

FINANCIAL HEALTH TIP OF THE MONTH

"Earn well, but plan better."

Even a well-running practice can face challenges without proper financial discipline. Small, consistent steps today can ensure long-term stability and peace of mind.

Strong financial planning helps us serve patients better—by ensuring continuity, investing in quality care, and reducing stress on healthcare providers.

Secure your future while caring for others.

Because a financially healthy doctor builds a healthier community

7. Plan Your Retirement Early

Medical professionals often delay retirement planning.

Create a retirement corpus goal

Consider passive income sources (rent, investments)

Don't rely solely on active practice income

Common Financial Mistakes to Avoid Over-expanding too early Ignoring insurance

No savings discipline

Poor record keeping

Delaying investments

Financial Health Tip of the Month

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MEDICO-LEGAL OPD CASES – WHAT WENT WRONG?

CASE 1 – Missed Cardiac Diagnosis (Chest Pain in OPD)

A middle-aged patient came with chest discomfort and mild sweating.

Doctor diagnosed acidity, gave antacids, and sent home.

No ECG or cardiac evaluation was done.

Patient later suffered myocardial infarction.

Legal principle aligned with: Jacob Mathew vs State of Punjab

What was NOT done

- No basic investigation (ECG)
- No risk stratification (age, symptoms)
- No documentation of ruling out cardiac cause

Legal POV

- Court checks: *Would a reasonable doctor have done an ECG?* → Yes
- Failure to rule out life-threatening condition = negligence

Key - *“Error of judgment is allowed—but failure to take basic precautions is not.”*

CASE 2 – Irrational Prescription → Adverse Drug Reaction

Patient with mild fever/URI given multiple drugs (antibiotic + NSAID + others) without clear indication.

Developed severe drug reaction (e.g., SJS).

What was NOT done

- No clear indication for antibiotic

- No documentation of reasoning
- No warning about drug risks

Legal POV

- Prescribing without indication = breach of standard care
- If harm occurs → direct liability
- “Patient insisted” is not a defense

Key - *“Unnecessary treatment that causes harm is negligence.”*

CASE 3 – No Documentation (OPD Visit)

Doctor evaluated patient correctly and gave appropriate treatment.

However, no written notes of history/exam/advice were recorded.

Patient later alleged wrong treatment.

What was NOT done

- No documentation of history/exam
- No record of advice or follow-up instructions

Legal POV

- Courts rely on records, not recollection
- Absence of documentation = presumption against doctor

Key - *“If it is not documented, it is considered not done.”*

DOCTOR IN SPOTLIGHT

DR SWAPNA BHASKAR



From Fragile beginnings to Fearless journeys : My Life in Family Medicine

Dr Swapna Bhaskar, MBBS, DNB (Family medicine), PGDMCH, FRACGP Consultant GP - Plaza Medical Centre, Kalgoorlie , Western Australia Former HOD Family Medicine, St Philomena's Hospital, Bangalore, India. Former President - AFPI Karnataka.

“ You are a smart young efficient doctor, why waste your career doing DNB Family Medicine ?” “ What is family medicine and its scope for doctors like you” “ Aren't you wasting your time and career by choosing a non existent speciality with no clarity on

your future ” These were a few questions that kept coming my way multiple times from well-wishing elders ,teachers, and friends during my post graduation and early years as a family physician. I am certain these are thoughts that cross the minds of many young doctors in the field of Family Medicine. Chapter 1 - Uncertainty, Sustainability, and the Courage to Continue With dreams of specializing in Internal Medicine or Ophthalmology, I landed in Bangalore as a young mother in 1999. Not wanting my son to be reared by a caretaker, I was mostly a “stay-at-home mom” for four years, spending only a few hours with a local pediatrician as his clinical assistant. Many of my friends were specialists and had set up busy practices by then. Determined to become a specialist, I tried and miserably failed multiple entrances, finally managing to borderline pass the NBE one.

After a hospital based test and interview, I was elated to be among the shortlisted candidates. The receptionist at the office then gave us the backdoor information that the Gen Medicine seat was already given to an internal candidate, and graciously offered the opportunity of joining a new field called “Family Medicine”. This would train you primarily in internal medicine, along with other subjects she mentioned. In my confused state, it seemed like a pretty good deal, becoming a specialist without having to battle more entrance exams. So, without much choice I became a “Family Medicine” trainee by chance! We were proudly (and somewhat nervously) the first

batch to take on this then unknown three year speciality training in Bangalore, though a few senior doctors had already secured the degree through an exit exam.

Being a PG felt like an endless grind, looking forward to the day it would finally be done.! The most intimidating part of our training was the uncertainty. Neither the faculty nor my three peers knew what we were expected to learn or teach, where we should be posted, what our roles were in those postings, how the final exams would be structured, or what future opportunities awaited us. We were routinely used to fill gaps across departments under the pretext of needing training in all departments. .Despite the lack of overt recognition, Family Medicine doctors slowly proved themselves to be an indispensable part of the hospital when required

Through those three grueling years, I found myself on the verge of quitting my training more times than I can count.. Giving up on my training would have meant letting down my family, whose encouragement gave me the strength to persevere. In the middle of that, we also welcomed our second child. Amid the struggle, one saving grace was my medical director's promise of a faculty position, a flicker of light at the end of the tunnel. That assured my journey would not be in vain.

Gradually, the challenges of training brought clarity and confidence. I became equipped to provide care across all ages, organ systems, and genders, going beyond the narrow focus of many specialised PGs.. The difficulties of handling patients and relatives, doing procedures, communicating with patients while balancing work, family and finance made me a really strong and competent family doctor by then.

Passing the DNB exams remains an enigma to me even now. Yet it marked a turning point, enabling me to become one of the first Family medicine qualified faculty to establish a department which was all this while led by Internal Medicine and Community Medicine specialists. The first few months were the usual OP/IP routine. Then I slowly started what we never had during my training: actual teaching for Family Medicine PGs As the department expanded, I had the good fortune of working with some wonderfully energetic bunch of peers who helped build the department with pride. I watched my students flourish in many directions within Family Medicine, some building successful clinics of their own, some dedicating themselves to teaching, and others pursuing sub-specialties such as Infectious Diseases, Transitional Care, and Palliative Care During my initial two years, I also started a small evening general practice clinic near home, with minimal investment, mainly to improve my difficult financial situation. I began with just a small room and a waiting area, quietly hoping that at least 3–4 patients would walk in to see a new, inexperienced doctor. There was no grand inauguration, no newspaper advertisements, and no marketing team, just quiet determination. I did not take a single holiday, ensuring no patient would return unattended. Gradually, patients began to trust my care, and word-of-mouth became my most powerful form of publicity. Soon, I started

receiving referrals from general practitioners and specialists in the area, all while maintaining ethical practice without compromise.

Life moved on with its share of highs and lows, while I continued to do my best, often imperfectly but sincerely, as daughter, sister, wife, mother, teacher, and Family Doctor.

Although I reckoned I knew what family medicine was, my entry into the Academy of Family Physicians of India around 2015 changed many perspectives about this wonderful field. Here I got a chance to work and interact with esteemed faculty of Vellore CMC, GPs from America, UK, Australia and many other countries. Holding the position of the Karnataka chapter President for 3 years gave me the opportunity to host the National conference, state conferences, and collaborate with esteemed organisations like NTI, Niti Aayog, State health Department, RGUHS to name a few. AFPI became an important catalyst in my growth, giving me the opportunity to take on dynamic roles such as DNB examiner, thesis evaluator, and OSCE preparation team member. My heart swelled with pride whenever I shared my speciality with family, friends, and well-wishers who had earlier doubted my choice. A special mention to my guru, Dr B C Rao, a guiding father figure whose energetic and inspiring presence always reminded me of my potential, and who always made me believe I was capable of achieving and envisioning.



Here I was, heading a department and the AFPI state chapter,

sculpting many family physicians, spearheading activities related to health education, medical education and primary care of a country which needs it! I am extremely proud of what I achieved in those 16 years, and I thank God for the CHANCE given to me, depriving me of my CHOICES. Still, something within me felt missing, and I knew I needed to explore further.



At the inauguration of FMPC 2019 as president of AFPI Karnataka



Dr Ramya Raman (far right) and I with some of Kalgoorlie's Plaza Medical team (L-R), Dr Swapna Bhaskar, Practice Principal Dr Kylie Sterry, Practice Manager Robert

Hearing from some undergraduate friends about how highly valued GPs were abroad gradually planted the idea of stepping out of my comfort zone. I also grew curious about how training and medical practice might differ in a developed country. But a lingering question remained... Was it still possible at my age?

August 2023 - the page of RACGP president Michael wright



Receiving FRACGP from the vice president of RACGP - Dr Ramya Raman

Chapter 2

When dreams beckon midway and change your path. In 2022, I took a tough yet crucial decision to migrate to Australia. Why Australia? Maybe it was my friends already working there as GPs, the chance to skip the hospital route and go straight into general practice, less lawsuits against doctors, or even the better pay, honestly, there wasn't one clear reason. After clearing a few exams, completing numerous documents, and nothing to lose, my husband and I landed in Kalgoorlie, a small town in Western Australia with a population of about 30,000, smaller than even a few crossroads in Bangalore. Leaving behind my boys, parents, lovely friends, colleagues, and important responsibilities, I once again landed in uncertainty, which, looking back, felt almost funny in its irony.

I found myself back in student mode after 18 years, learning the Australian approach to general practice, as well as new cultures, guidelines, music, dance, sports, cuisine, and much more. In those two years, the thought of quitting crossed my mind again a dozen times, weighed down by endless assessments, paperwork, and supervision demands. But perseverance paid off, and seeing my name in the FRACGP register last year was a moment I had only ever dreamed of. In this small town today, I am known for the care I provide.

A four-year-old calling out “That’s my doctor” in a crowded supermarket, a salesperson going the extra mile to find me the perfect shade of paint, or an 80-year-old arriving with a homemade cake to celebrate my fellowship, these simple moments mean more than words can express. Looking back, across all the places I’ve been and the challenges I’ve faced,

I realize this journey was never just about degrees or achievements. It was about growing, starting over, and learning how to truly care for people.

As words often attributed to Theodore Roosevelt remind us: “No one cares how much you know until they know how much you care.” And in the end, that is what I believe matters the most.

FUN CORNER !



THE DETECTIVE HAT- What Would You Do Next?"

CASE 1 – Persistent Fever

A 30-year-old with fever for 4 days, mild headache, platelets 1.3 lakh, WBC slightly low, vitals stable, no focus.

Best next step?

- A. Start antibiotics
- B. Start antivirals
- C. Observe + repeat labs + warning signs
- D. Admit immediately

CASE 2 – Borderline UTI Symptoms

A 28-year-old female with mild burning urination, no fever, no flank pain, symptoms since 1 day.

What would you do?

- A. Start antibiotics immediately
- B. Encourage fluids + observe
- C. Urine culture first, then treat
- D. Start IV antibiotics

CASE 3 – Subclinical Hypothyroidism

A 38-year-old female, TSH = 8, normal T3/T4, mild fatigue.

Best approach?

- A. Start high-dose thyroxine
- B. Start low-dose thyroxine
- C. Observe + repeat TSH in 6–8 weeks
- D. Ignore completely

ANSWER

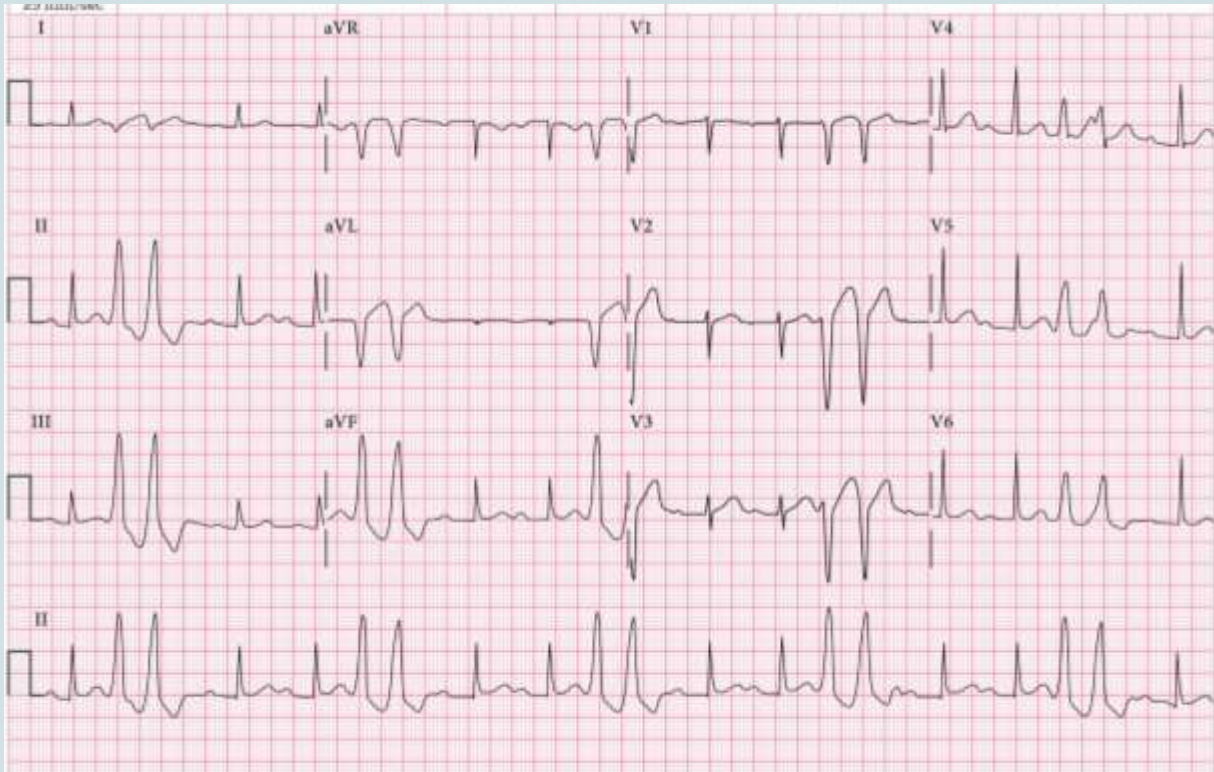
C | B | C

Clinical Pearls

- Case 1: Viral patterns (dengue-like) → don't jump to antibiotics
- Case 2: Very early mild symptoms → can observe before labeling UTI
- Case 3: Not all TSH elevations need treatment immediately

Case

A 48-year-old male presents with **intermittent palpitations**.
No syncope. Vitals stable.



1. **What is the rhythm abnormality?**
2. **Which ECG feature helped you identify it?**
3. **Is this benign or potentially serious?**
4. **What is your first-line management in OPD?**

How to Diagnose

Look for these 4 clues:

1. **Two consecutive early beats**
Not just one → that's why it's a *couplet*
2. **Wide, bizarre QRS complexes**
>120 ms, abnormal shape
3. **No preceding P wave**
Confirms ventricular origin
4. **Compensatory pause after the pair**

Differentiate from:

- **NSVT (Non-sustained VT)** → ≥ 3 beats
- **SVT with aberrancy** → usually has preceding P / pattern

2 beats = couplet
≥3 beats = think VT

Why couplets matter more than single PVCs

- Higher **arrhythmogenic potential**
- Can progress to **VT**
- More concerning if:
 - Frequent
 - Symptomatic
 - Structural heart disease

Treatment Approach

If asymptomatic + normal heart

Reassure – Lifestyle advice

- Reduce caffeine
- Improve sleep
- Stress control

If symptomatic (palpitations, anxiety)

Start **Beta-blocker : Metoprolol 25–50 mg OD** (titrate as needed)

If high-risk features- DO NOT ignore — evaluate further

Red flags:

- Syncope / presyncope
- Known CAD / cardiomyopathy
- Frequent couplets / runs
- Family history sudden death

Do:

- **Echo**
- **Holter monitoring**
- **Electrolytes (K, Mg)**
- Refer cardiology

X ray - What is your diagnosis ?

- Look for a **bright white (radio-opaque) density** along the **urinary tract path**

- Trace from **kidney** → **ureter** → **bladder**
- Correlate with **pain side** and symptoms

Keep in mind -**Calcium stones** → usually visible **Uric acid stones** → often NOT seen on X-ray

Case - A patient presents with **chronic low back pain ± radicular symptoms**



1. **What abnormality do you see?**
2. **How will you grade the severity on X-ray?**
3. **Who can be managed in OPD?**
4. **When will you ask for MRI?**

Answers

1. Diagnosis - Forward slip of one vertebra over another (commonly L5 over S1)

2. Grading (OPD practical – Meyerding)

Based on % slip of upper vertebra over lower:

- **Grade 1:** <25%
- **Grade 2:** 25–50%
- **Grade 3:** 50–75%
- **Grade 4:** >75%

Quick visual rule: Mild | Moderate | Severe | Near complete slip

3. Who can be managed in OPD

- Grade 1–2
- No neurological deficit
- Mild to moderate pain

Management:

- Analgesics
- Core strengthening
- Activity modification
- Weight reduction

4. When to ask for MRI

Do NOT order MRI routinely

Indications:

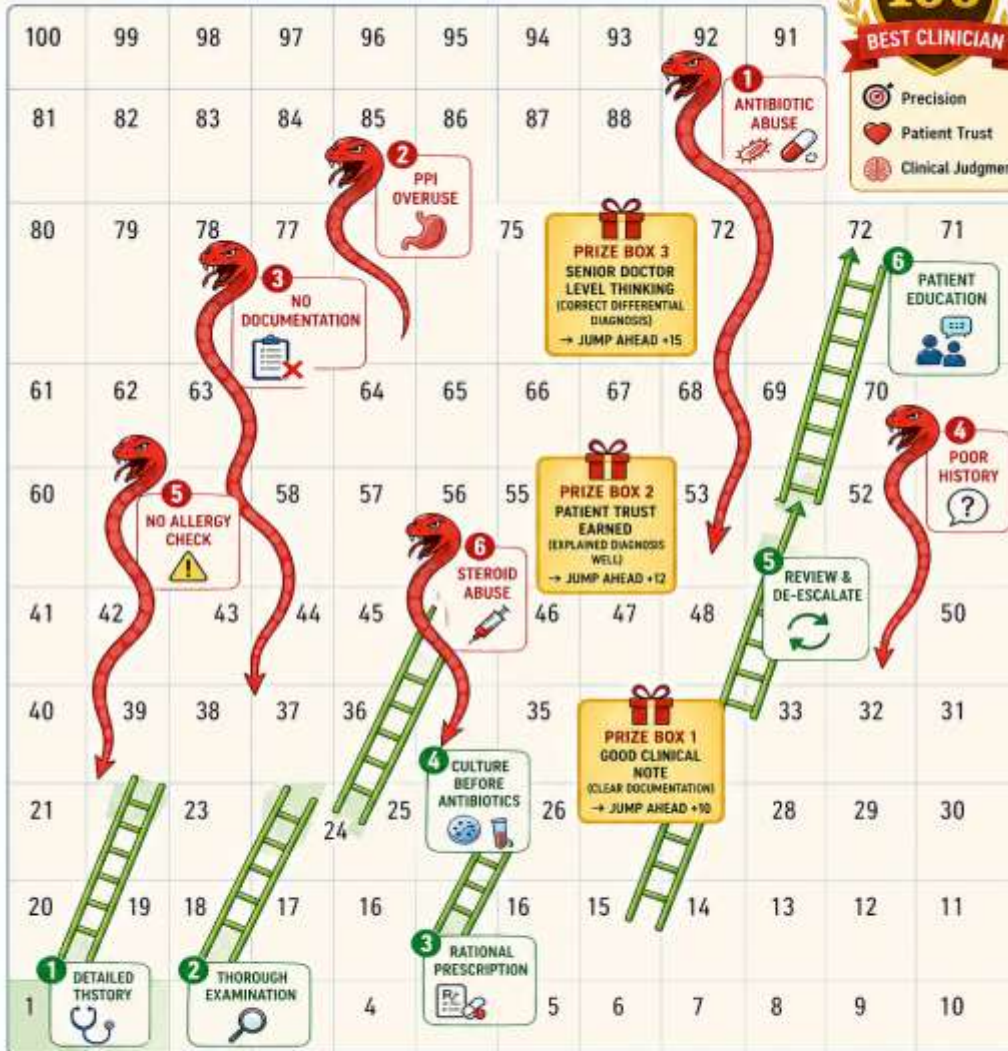
- Radicular pain (leg symptoms)
- Neurological deficit
- Suspected nerve compression
- Severe or worsening symptoms
- No improvement after 4–6 weeks
- Planning surgical referral

Red Flags (Immediate referral + MRI)


- Motor weakness
- Bladder/bowel symptoms
- Progressive neurological signs


CLINICAL LADDER TO 100

★ RIGHT CHOICES. BETTER CARE. BEST OUTCOME. ★



- Precision
- Patient Trust
- Clinical Judgment

 **SNAKES – BAD PRACTICES THAT PULL YOU DOWN**

 **LADDERS – GOOD PRACTICES THAT LIFT YOU UP**

EVERY DECISION MOVES YOU UP... OR PULLS YOU DOWN.



Practice In Family Medicine Is Like Snakes & Ladders — Every Step Matters.

Contact the editor for any queries or suggestions@doctoraminaa@gmail.com.