

Saturday, January 11, 2014, Day-2

In association with
American Association
of Physicians of
Indian Origin (AAPI)

Physicians of
Ahmedabad



Organized by

GMERS
Medical College,
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Care Institute
Medical Society
for Research
and Education

Editorial Board

Scientific Editors :

Dr. Keyur Parikh

Dr. Parloop Bhatt

Today's Highlights

- ▶ Plenary Lectures
- ▶ Lifetime Achievement Award & Father of Echocardiography Award:
- ▶ CIMSCON Oration
- ▶ Clinical Case CD Reviews

Sponsored Satellite Session

- ▶ Symposium-A : Hypertension Management
Venue : Hotel Radisson Blu
- ▶ Symposium-B
Venue : Hotel Inder Residency
- ▶ Symposium-C
Venue : Hotel Four Points by Sheraton
- ▶ Symposium-D
Venue : Hotel Four Points by Sheraton

TODAY'S WEATHER



Sunrise : 7.23 AM

Max
26°C
Min
11°C

Sunset : 6.12 PM

DON'T MISS TODAY !

11:50 AM

Life Time Achievement Award & CIMSCON Oration

03:25 PM

Clinical Case CD Review by

Dr. Keyur Parikh, Dr. Milan Chag,
Dr. Urmil Shah, Dr. Hemang Baxi,
Dr. Anish Chandarana, Dr. Ajay Naik,
Dr. Satya Gupta, Dr. Vineet Sankhla,
Dr. Raj Makkar and
Dr. Dharam Kumbhani



Making A Record History With 2600 Delegates



A full house on Day-1 of Conference



CIMS
ECMO
Team

VT Substrate and SVT Intervention Determines Therapy and Outcomes

THCC and CIMS arrhythmia center data of VT ablation and SVT Intervention and Outcome

Year	VT procedures	Success	SVT	Success rate (96.6%)
2001	1	1	2	2
2002	3	3	30	28
2003	4	3	64	60
2004	3	3	60	57
2005	4	2	89	85
2006	4	3	92	88
2007	2	2	103	99
2008	3	2	104	100
2009	8	6	116	112
2010	14	12	113	110
2011	20	18	176	173
2012	9	8	168	165
2013	6	4		
Total	81	67	1117	1079

VT Ablation

Reasons for recurrence / non-success:

- Papillary muscle origin of VT (closely mimics ILVT, Fascicular tachycardia)
- Structural heart disease, scarred ventricle.
- Deep focus of VT, hypertrophied muscle.
- Epicardial origin of VT with focus close to epicardial coronary arteries.

Summary

- Arrhythmia management is a highly refined science and art
- EP and RFA is a “curative” procedure with high success rates and low complications in skilled hands.

SVT Intervention

Reasons of recurrence / non-success:

- Structural heart disease (Ebstein's anomaly, IVC interruption)
- Arrhythmogenic focus in close proximity to important conduction tissue (e.g. Mid-septal Accessory pathways, AT close to AVN, Junctional tachycardias)
- Multiple accessory pathways, especially in Right Free Wall region.
- Atypical Flutters

Summary

- Arrhythmia management is a highly refined science and art
- EP and RFA is a “curative” procedure with high success rates and low complications in skilled hands.

Dr. Ajay Naik

Mitral Annular Plane Systolic Excursion: Potential in Echo Guidance in Cardiac Failure

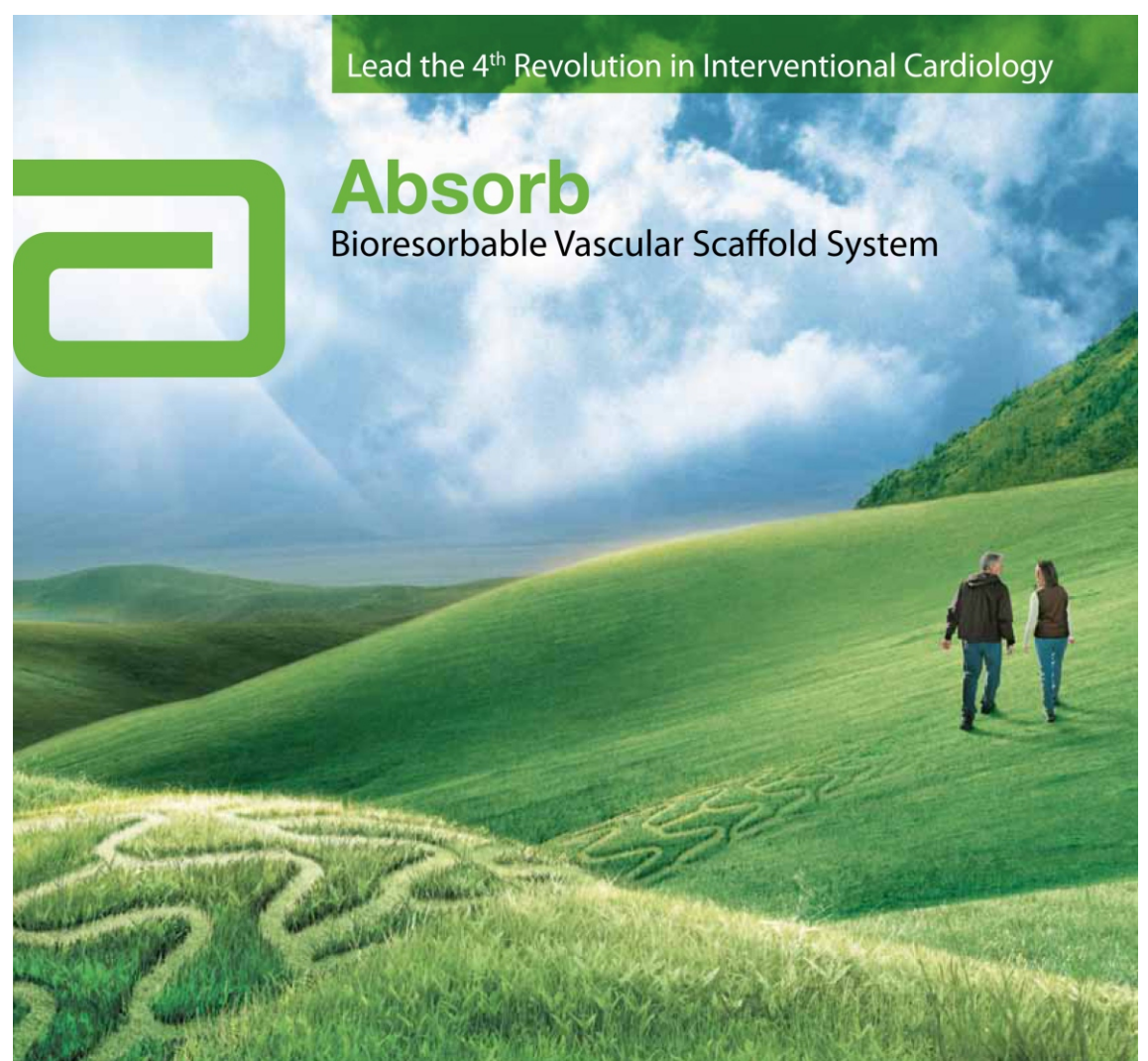
NGOY T.M.B; KINTOKI V.E.; LUTETE K.M.; KINTOKI F.; MUPEPE D.; LEPIRA B.F.

Pulsed-wave (PW) Doppler tissue velocities of the mitral annulus correlate well with Left Ventricular (LV) diastolic(D) and systolic(S) functions. But for taking care of cardiac patients in countries where Doppler cardiac studies is unavailable request alternative solution.



A series of 91 patients, most of them suffering of dilated cardiomyopathy have been monitored with echocardiography to determine the most appropriate treatment. Exploratory analysis allowed us to extract the most relevant cardiac measurement variables. Repeated measures on 11 patients allowed us to edit plots suggested by the measured mitral valvular excursion after performing a one way ANOVA on repeated measures.

With measured Mitral annular systolic plane excursion (MAPSE) we stabilize accurately 70 patients (79.5%) in less than 5 days, 10 (11.4%) exhibited no change and 8 patients (9.1%) got a worse evolution. After Varimax rotation, we extracted 7 components explaining a cumulative variance of 70.4%. MAPSE inertia contribution to first component was 83.4%. Successive one way ANOVA on 3 measures of MAPSE, TAPSE, Systolic and diastolic Vg dimensions and Ejection fraction didn't show significant results but we could be able to edit plots showing tendencies. MME used for assessment of MAPSE is a useful method for guiding treatment of heart failure patients in our country. Our study couldn't accurately determine the precise extent but revealed tendencies on plots emphasizes on the potential usefulness of echoguidance in treatment of cardiac patients in our countries.



It's easy to move forward when you leave nothing behind

The dream of a bioresorbable scaffold has now become a reality. Absorb defines a new paradigm – Vascular Reporative Therapy (VRT). The goal of VRT is to restore the vessel to a more natural state, capable of normal vascular function to enable long term benefits. Leaving nothing behind* promises a bright future for interventional cardiology. Together, we can lead the revolution in patient care.

*Small platinum markers at scaffold edges remain for fluoroscopic landmarking.

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Management of Massive and Submassive Pulmonary Embolism : Catheter Directed Thrombolysis

Dr. Sanjiv Parikh

Patients with massive PE, who present with signs of severe right ventricular dysfunction (RVD) and cardiogenic shock, are routinely treated using aggressive strategies.

Whether similar treatments should be performed in submassive PE patients, who also present with signs of RVD albeit being hemodynamically stable, remains a topic of debate.



Based on the clinical evidence reviewed, submassive PE is associated with poor prognosis when treated conservatively; patients may develop long-term sequelae (i.e., chronic pulmonary hypertension and RV failure) if the thrombus is not resolved and RV dysfunction reversed by an effective treatment. Our experience demonstrates that catheter-directed thrombolysis can be safely administered to patients with acute PE and USAT is an accelerated form of CDT which holds the promise of becoming the first-line treatment for both acute submassive and massive PE.

Can We Detect Vulnerable Plaque? Newer Imaging Techniques

Dr. Vineet Sankhla



Many of the currently available imaging tools for clinical use still provide minimal information about the biological characteristics of plaques, because they are limited with respect to spatial and temporal resolution. Moreover, many of these imaging tools are invasive. The new generation of imaging modalities such as magnetic resonance imaging, nuclear imaging such as positron emission tomography and single photon emission computed tomography, computed tomography, fluorescence imaging, intravascular ultrasound, and optical coherence tomography offer opportunities to overcome some of these limitations.

Principles of Aortic Valve Repair and Starting a New Aortic Valve Repair Program

Dr. Meong Gun Song

Principles of Aortic Valve Repair

The real time characteristics of aortic root in a normally beating heart



was understood through our vigorous research by looking at the histological characteristics and movement of aortic root in relation to the pressure changes in the left ventricle and aortic compartments; the ratios between the diameters of STJ, sinuses and annulus, and height of aortic root and leaflets are constant at a certain time in the cardiac cycle, although the diameter, height and shape of each part change

with the opening and closing of the aortic valve.

Therefore, with the new technique addressing the four main components of the aortic root, sino-tubular junction (STJ), aortic root wall, annulus and aortic leaflets, almost all kinds of aortic root and valve diseases can be repaired.

Practically the CARVAR procedure is composed of two processes; evaluation and surgery. The evaluation process is to determine the necessity of correction of four main components; the leaflets, aortic sinus wall, annulus and STJ, and determination of the optimal diameter of the STJ. And the surgery process consists of correcting the four main components: annulus reduction, aortic sinus procedure, aortic leaflet procedure, and STJ reduction. However, it doesn't mean that every patient needs all four procedures, but only the needed procedures according to the disease status.

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In Stage 2 HTN with High CV Risk

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CHeckmate...CV Risk

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Zyrova D3 Forte

Rosuvastatin 10mg + Vit. D3 1000 IU

Restores D3, Reduces CV risk

Zydus CND

Long Term Results of Homograft Valve and How to Setup Homograft Bank

Dr. Sridhara Iyengar



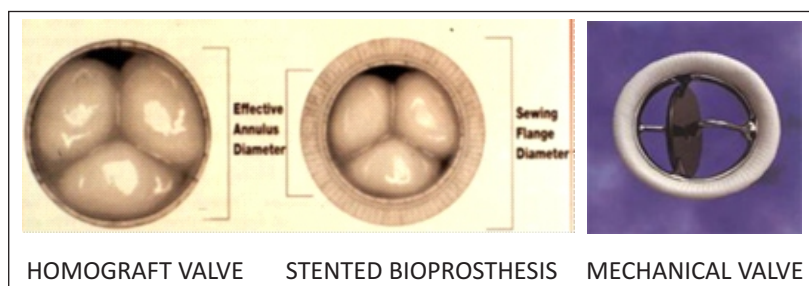
Homograft valves are human heart valves either donated or explanted from cadavers.

Human heart valve transplants are a better alternative to replace diseased heart valves in both adult and pediatric age groups. Complications such as

thromboembolism, durability and hemolysis that are seen with prosthetic valves are uncommon with homograft valves.

Mechanical valves demand lifelong anti-coagulation, and patients need periodic monitoring for therapeutic levels of anticoagulant. The increased incidence of structural failure makes bioprosthetic valves less durable – especially in younger patient populations, warranting repeat operations. Another important negative factor related to both of these types of prosthetic valves is the reduced effective orifice area due to rigid sewing in smaller annulus.

The advantages of homograft valves are: (i) anticoagulation is unnecessary; (ii) larger effective orifice area compared to same sized prosthetic valves; (iii) relatively better resistance to infections; (iv) because of the viable cells in a cryopreserved valve, they are known to grow with a growing child; (v) with advancing technology, in the future, a failed homograft valve may be treated by a percutaneous approach.



- Proven Long-term Durability:
 - 80% Freedom from Structural Deterioration at 15 Years
 - 97% Freedom from Structural Deterioration at 10 Years
- Excellent Hemodynamics:
 - Low Pressure Gradients
 - Large Effective Orifice Area
- Less Complications
- Less Incidence of Endocarditis
- Low Risk of Thromboembolic Events
- Makes future percutaneous valve replacement easier.

Sutureless Valve Replacement With Edwards Intuity Rapid Deployment Valve

Dr. Vinayak Nilkanth Bapat

Rapid deployment aortic valves offer a method by which surgeons can more easily perform minimal invasive AVR and these devices should lead to increased surgeon acceptance and more widespread adoption of minimal invasive AVR surgery. In addition, rapid deployment valves represent an important addition to the surgeon's armamentarium when dealing with patients who will benefit from a reduced myocardial ischaemic time, i.e. patients with left ventricular dysfunction or those requiring complex multivalve or combined procedures. Implantation of rapid deployment valves is relatively easy with a short learning curve.



As stated above, however, proper sizing is absolutely critical for these devices. In addition, the surgeon must ensure that the annulus is roughly circular after the removal of the calcified cusps. A large block of calcium that extends deep into the aortic annulus can pose a problem for rapid deployment valves, and a conventional AVR may be more appropriate for such patients. A markedly hypertrophied interventricular septum does not pose a problem, however, and rapid deployment valves can also be implanted following a myectomy procedure. The case demonstrates a minimal invasive implantation of an EDWARDS INTUITY rapid deployment valve (Edwards Lifesciences, Irvine, CA, USA) and highlights important steps in its implantation. Tips and tricks will also be discussed.



Leaders in diabetes & cardiac care

Presents



Telmisartan 20/40/80 mg Tablets



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Dr. Sanjay Shah Shares An Interesting Trauma Case



A 9 year old child with massive haemorrhage due to penetrating injury with cardiac arrest, GCS-E1M4VT, pupil dilate not reacting to light was operated.

Diagnosis and management: Left common carotid artery and left intra jugular vein were dissected; avulsion of left superior

thyroid artery at its origin, transaction of left facial artery rent in left internal jugular vein was repaired primarily. Patient was given multiple blood component (12 products), IV fluids, Inj.vit.K, Inj. Tranexemic acid and other supportive care. He was kept on ventilator support. Inotropic support was tapered and stopped. He regained consciousness after 14 hours and was extubated. He was mobilized independently. Post operative colour doppler suggested normal flow in LCCA, LECA, LICA and left IJV.



Fig. 1: Multiple Hemostatic Forceps applied to Control Bleeding



Fig. 2 Recovery after Procedure

Outcome: Patient came with poor haemodynamics and in cardiac arrest with extuberant external bleeding. An effective CPR along with aggressive resuscitation and invasive monitoring was done in ER. Timely intimation before transferring such patient allowed us to activate whole trauma team, ER department, operation theatre staff and blood bank. This event was managed successfully because of team work and the bold decision to go ahead by trauma surgeon inspite of very poor prognosis. Discharge medications included antibiotics, antacids and analgesics.

Sudoku

	2		6		8			
5	8				9	7		
				4				
3	7					5		
6								4
		8					1	3
				2				
		9	8				3	6
			3		6		9	

Answer on Page-8

When Is It too Late for Aortic Valve Surgery?

TWO RISK-ASSESSMENT SCORES

- The EuroSCORE : it overestimates the dangers of isolated aortic valve replacement in the patients at highest risk
- The STS score: reflects more closely the operative and 30-day mortality rates for the patients at highest risk undergoing surgical aortic valve replacement

Limits related to comorbidity

Patients can be refused surgery because of severe comorbidities like :

- Concomitant cardiac surgery
- Neurological Dysfunction, Dementia, CV stroke
- Chronic lung disease or end stage lung disease
- Liver Cirrhosis (Child-Pugh class B and C)
- Renal Dysfunction
- Emergency surgery
- Porcelain Aorta.
- Redo Surgery.
- Hostile chest.

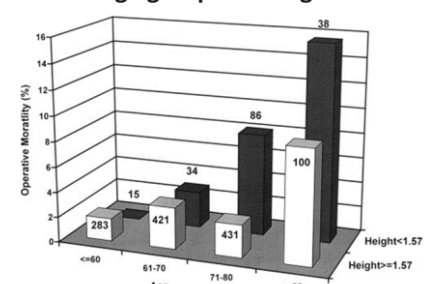


Dr. Dhiren Shah

Categories of Aortic Stenosis

	Aortic sclerosis	Mild AS	Moderate AS	Severe AS
Aortic jet Velocity (m/s)	< 2.6	2.6-3.0	3-4	> 4
Mean gradient		<30	30-50	>50
AVA (cm)		>1.5	1.0-1.5	<1.0
Velocity ratio		>0.50	0.25-0.50	<0.25

Operative mortality according to age group and height



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Treats constipation... naturally

TERLOC INJECTION
Teripressin 1mg / 10ml
Stops GI Bleed, Saves Life

POLYCAPTM
Simvastatin 20mg, Ramipril 5mg, Atenolol 50mg, Hydrochlorothiazide 12.5mg and Aspirin 100 mg (Enteric coated) Capsules
TIPS to add years to Life

HAEM UP Inj. FAST GEMS
Sure Way to Haem UP !

Cadigard
Piperacillin 4gm + Tazobactam 500mg Injection
Overpowers Tough Infections

Trazodac Fast 100mg
The Effective Pain Reliever

Faciloc
Enoxaparin Sodium Injection 4000 mg
Locks Factor Xa... Saves Lives

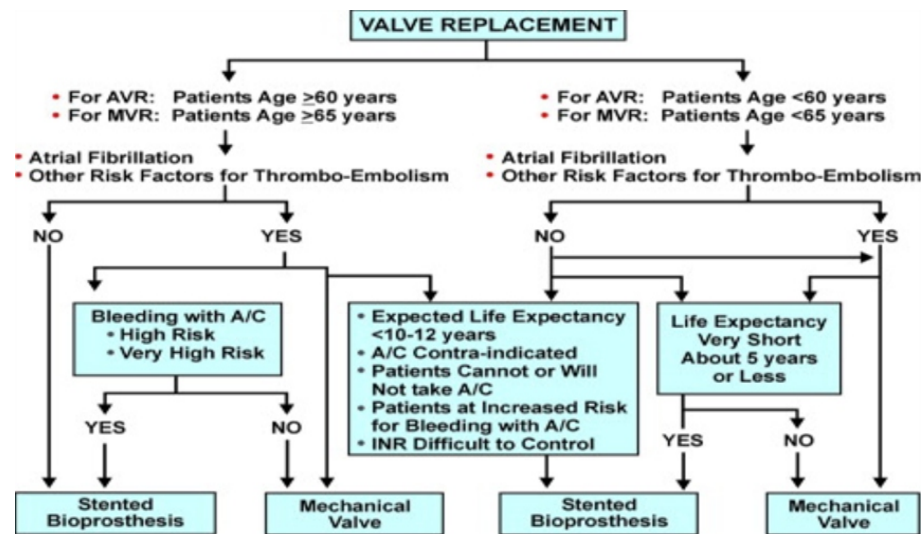
Humstard 30/70
Premixed Human Insulin 40 IU/ml
Better Compliance, Better Control

FibroBAN
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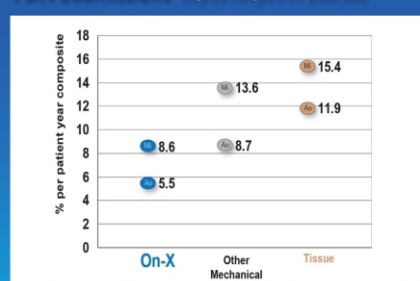
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Dr. Dhaval Naik Defends Mechanical Valve



Comparison of Prosthetic Valve Performance
FDA Submissions Weighted Averages of Composite Rates*



AATS Report: Prospective Randomized On-X Heart Valve Clinical Trial (PROACT) Provides Evidence of Reduced Complications

On-X aortic valve trial is the first to formally study patients maintained at levels of anticoagulation below those currently recommended by professional society guidelines, helping to lessen anticoagulation-related complications

Cultural Bridge Award to Dr. Sudhir Parikh by Dr. Anish Chandarana and Dr. Mahendra Vegad



The No.

prescribed DPP-4^a inhibitor worldwide¹

Janumet
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Once-daily **Januvia**
sitagliptin

POWER: Powerful HbA_{1c} reductions in a broad range of patients¹⁻⁷

PROOF: Clinical data up to 2 years duration^{1,8}

EXPERIENCE: Approved in over 107 countries with more than 54 Million¹ prescriptions dispensed

Before initiating therapy, please consult the full prescribing information.

Approved in over 107 countries with more than 54 Million¹ prescriptions dispensed

INDICATIONS: For patients with type 2 diabetes mellitus, JANUVIA is indicated as an adjunct to diet and exercise to improve glycemic control, as initial monotherapy, as initial therapy in combination with metformin, as adjunct to metformin, sulfonylurea or PPAR γ agonist when the single agent alone does not provide adequate glycemic control, in combination with metformin and a sulfonylurea or Metformin and a PPAR γ agonist (i.e., a thiazolidinedione) when dual therapy with these agents does not provide adequate glycemic control, and in combination with insulin, alone or in combination with Metformin. CONTRA-INDICATIONS: Hypersensitivity to any components of this product. WARNING AND PRECAUTION: JANUVIA should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. There is an increased risk of hypoglycemia when Januvia is added to an insulin secretagogue (e.g., sulfonylurea) or insulin therapy. Consider lowering the dose of sulfonylurea or insulin to reduce the risk of hypoglycemia. UNDESIRABLE SIDE EFFECTS: JANUVIA was generally well tolerated in controlled clinical studies as both monotherapy and combination therapy with side effects mild and transient in nature. While the overall incidence of adverse events were similar to that observed with placebo, the nature of adverse events included hypoglycemia, urinary tract infection, abdominal pain, nausea, vomiting, diarrhea and headache. The following additional adverse reactions have been reported during post-marketing use of JANUVIA: Upper respiratory tract infection, nasopharyngitis, constipation, vomiting, headache, arthralgia, myalgia, pain in extremity, back pain, acute pancreatitis (hemorrhagic or necrotizing), acute renal failure, sometimes requiring dialysis, serious allergic and hypersensitivity reactions including anaphylaxis, angioedema, rash, urticaria, cutaneous vasculitis and exfoliative skin conditions, including Stevens-Johnson syndrome. Because these reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure. In such cases promptly stop Januvia, assess for other potential causes, institute appropriate monitoring and treatment and initiate alternative treatment for diabetes. For additional adverse experience information, see the product circular. Before initiating therapy, please consult the full prescribing information.

Photographs used are for pictorial presentation only and are not actual patients

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Dr. James Stoller Addresses Questions Related to Practical Use of Supplemental Oxygen

Supplemental oxygen is commonly prescribed, with great associated expense. This presentation will address four questions that regard the practical use of supplemental oxygen:



Table 1 reviews the indications for supplemental oxygen according to the American Thoracic Society.

PaO ₂ mmHg	SaO ₂ %	LTOT indication	Qualifying condition
≤55	≤88	Absolute	None
55–59	89	Relative with qualifier	"P" pulmonale, polycythemia >55% History of oedema
≥60	≥90	None except with qualifier	Exercise desaturation Sleep desaturation not corrected by CPAP Lung disease with severe dyspnea responding to O ₂

Available delivery systems for supplemental oxygen include compressed gas, liquid oxygen, and oxygen concentrators (which extract oxygen from the atmosphere). With compressed gas cylinders being least expensive and available in a variety of tank sizes but bulky and capable of providing oxygen for limited durations. Liquid oxygen systems offer convenience when services are available but are expensive and feature evaporative loss. Oxygen concentrators are

self-sufficient and free patients from dependence on delivery services but provide decreasing FIO₂ values at higher flow rates (e.g., FIO₂ is <0.90 at flows > 5 liters/minute and incur electricity costs for users (of approximately \$300/year in the United States). Various oxygen-conserving strategies are available, including reservoir cannula devices, transtracheal oxygen, and demand oxygen delivery systems. As such, when patients undergo oxygen titration to determine the patient's oxygen needs, the titration should be done with the patient's own device, especially if it is a demand oxygen system.

Despite current practice, many important questions regarding supplemental oxygen lack rigorous supportive evidence. These include the benefits of supplemental oxygen for COPD patients with only mild hypoxemia (e.g., SpO₂ 89 - 93%), the benefits of supplemental oxygen for patients with exercise or nocturnal desaturation only, and the benefits of oxygen for patients with interstitial lung disease or other hypoxic disorders. Ongoing research (e.g., the NIH Long-Term Oxygen Treatment Trial [LOTT]) is addressing some of these issues.

Transporting a Critically ill...

Dr. Vipul Thakkar

Intra and Inter- hospital transport is common due to



need for specialized diagnostics, treatment or care, yet has inherent risks. It needs adequate risk-benefit analysis and diligent planning to be effective and successful. It should be done by experienced,

specialized retrieval team and vehicle well-equipped with dedicated, well-adapted equipment-support systems. The process should be well-orchestrated for given patient and scene by preparation, prediction-prevention, and management of expected or unexpected-untoward event with proper and timely communication with receiving-relevant facilities. Whole process should be well-documented for continuity of care, legal and quality improvement purposes. Aeromedical evacuation is getting popular for specific patient population, need special knowledge & experience of different working conditions with altered physics and physiological effects. For safe transportation practices, simulation training may be beneficial with focus on medical as well as technical problem and its resolution.

► Answer

1	2	3	6	7	8	9	4	5
5	8	4	2	3	9	7	6	1
9	6	7	1	4	5	3	2	8
3	7	2	4	6	1	5	8	9
6	9	1	5	8	3	2	7	4
4	5	8	7	9	2	6	1	3
8	3	6	9	2	4	1	5	7
2	1	9	8	5	7	4	3	6
7	4	5	3	1	6	8	9	2

Infection Control in Intensive Care Unit

Dr. Dhanashri Atre Singh

Nosocomial infections affect 5 to 15% of hospitalized patients and can lead to complications in 25 to 33% of those patients admitted to ICUs.



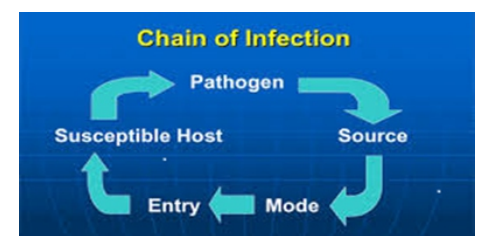
Q : What are the causes of increased infection rates in ICU?

A : The causes for increase infection rates in ICU patients are multifactoral: these patients are the sickest with multiple underlying comorbidities, malnourished; their care is usually long term and invasive with multiple indwelling devices and catheters and usage of broad spectrum antibiotics.

Q : Which are the most common infections in the ICU ?

A : The most common infections are ventilator associated pneumonia,(VAP)

catheter associated urinary tract infection (CAUTI), central line associated blood stream infections (CLABSI), skin and soft tissue infections (SSTI), intrabdominal infections post trauma or surgery.



Recent studies strongly confirm that these strategies may only be effective over prolonged periods if they can be integrated into the behavior of all staff members who are involved in patient care. Accordingly, infection control measures are to be viewed as a priority and have to be integrated fully into the continuous process of improvement of the quality of care.

Upper GI Bleed: Causes and Management

Dr. Bhavesh Thakkar

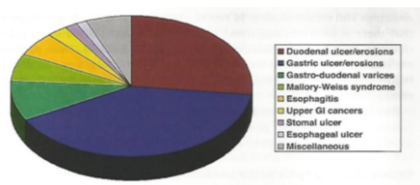
Upper GI Bleed (UGIB) commonly presents as hematemesis and/or melena. In cases of severe UGIB, hematochezia can be present.



Variceal bleeds (constitutes 15-20% of UGIB) due to portal hypertension can be from esophageal, gastric fundal or ectopic variceal bleed.

Causes of non variceal bleed includes peptic ulcer disease (about 50% of UGIB), Mallory-Weiss tear, Portal hypertensive gastropathy, Arterio-venous malformations, Dieulafoy's lesions, Esophageal or Gastric malignancy, Gastric Antral vascular ectasia(GAVE), Aorto-duodenal fistula, Duodenitis, Gastritis and Erosions, etc.

Management of UGIB depends of acuteness of presentation and rapidity and



severity of blood loss. Initial hemodynamic assessment and clinical judgment plays important role. ABC of resuscitation has to be maintained. Endoscopy plays important role in acute bleeding condition and has to be performed within 12 hours of presentation, preferably within 6 hours of hospital admission. Management can be guided various scoring systems like: Rockall score, Glasgow-Blatchford scoring system.

A. For Variceal Bleed:

Pharmacotherapy: Terlipressin, Somatostatin, recombinant Factor VIIa.

Endotherapy: Variceal band ligation, Sclerotherapy, Glue injection.

Balloon Tamponade: Sengstaken-Blakemore Tube.

TIPS: Transjugular Intrahepatic Porto-systemic Shunt.

Surgery: Gastric Devascularization.

B. For Non-Variceal UGIB:

Pharmacotherapy: Injectable PPI, Somatostatin, Octreotide

Endoscopic Injection Therapy.

Endoscopic Thermal Therapy and Mechanic Techniques.

Do not miss Today

Prize Distribution

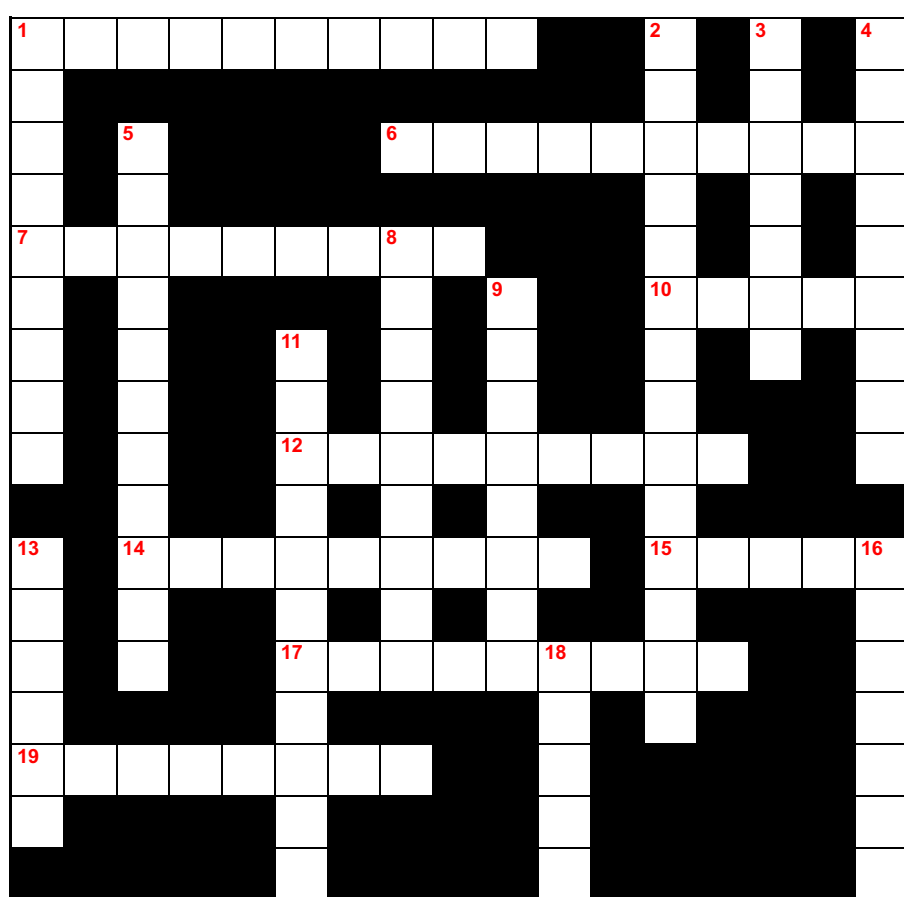
of Poster Presentation

at 12.30 PM,

Tagore Hall



Crossword



ACROSS

1. Conducting nerve impulses in a direction opposite to normal. (10)
6. Located outside the alimentary tract. (10)
7. Filled with vascular sinuses and capable of becoming distended and rigid as the result of being filled with blood. (9)
10. Make a great effort at a mental or physical task. (5)
12. Capable of responding to stimuli. (9)
14. Especially of muscles; drawing away from the midline of the body or from an adjacent part. (9)
15. A medicine that strengthens and invigorates. (5)
17. Moving of a body part away from the central axis of the body. (9)
19. Filled with vascular sinuses and capable of becoming distended and rigid as the result of being filled with blood. (8)

DOWN

1. Drawing a limb towards the body. (9)
2. Maintaining a generally constant physiological state in a cell or organism. (14)
3. Supplied with oxygen by respiration. (7)
4. Controlled by individual volition. (9)
5. Controlled by the autonomic nervous system; without conscious control. (11)
8. Not supplied with oxygen. (9)
9. Of two or more muscles; having equal tension. (8)
11. The effect of a stimulus (on nerves or organs etc.). (11)
13. Without volition or conscious control. (6)
16. Regulation or maintenance of a function or action or reflex etc. (7)
18. Of sexual organs; stiff and rigid. (5)

Answer on Page-10

Dr. Surabhi Madan Resolves Meningitis Syndrome

The syndrome of meningitis ranges from acute to sub acute to chronic; may be community acquired or health care associates and may be caused by a wide variety of



infectious agents

including bacteria, viruses, fungi, protozoa and helminths.

Bacterial meningitis- The management algorithm for suspected community acquired bacterial meningitis includes immediate collection of blood samples and lumbar puncture or CT Scan to determine whether CSF formula is consistent with the clinical diagnosis. The choice of empirical antimicrobial therapy depends on the patient's age and various conditions that may have predisposed the patient to meningitis.

Tuberculous meningitis – A score called THWAITE'S SCORE differentiates tuberculous and bacterial meningitis with a sensitivity of 90-99% and specificity of 79-82%. TB culture is very crucial as it is the gold standard diagnostic modality.

Molecular tests like GenXpert, LPA Hain, TB PCR help in fast diagnosis. The duration of treatment with the first line drugs should be minimum 12 months, and all patients of TBM should be started on adjunctive corticosteroids regardless of disease severity at the time of presentation.

Cryptococcal meningitis- Presentation is usually sub acute to chronic. WBC count in CSF ranges from <20-500 cells/dl. India ink staining, CSF cryptococcal antigen and culture are diagnostic. Induction therapy with amphotericin B and flucytosine followed by consolidation and maintenance therapy with fluconazole is the therapeutic regimen of choice. Unlike TBM, there is no proven beneficial role of steroids.

Post-neurosurgical meningitis- The principles of management for post-neurosurgical meningitis are similar to those for the treatment of community-acquired meningitis; however, surgical management including removal of the infected foreign implants is vital for the successful outcome of patients with post-neurosurgical meningitis.

Bronchial Thermoplasty

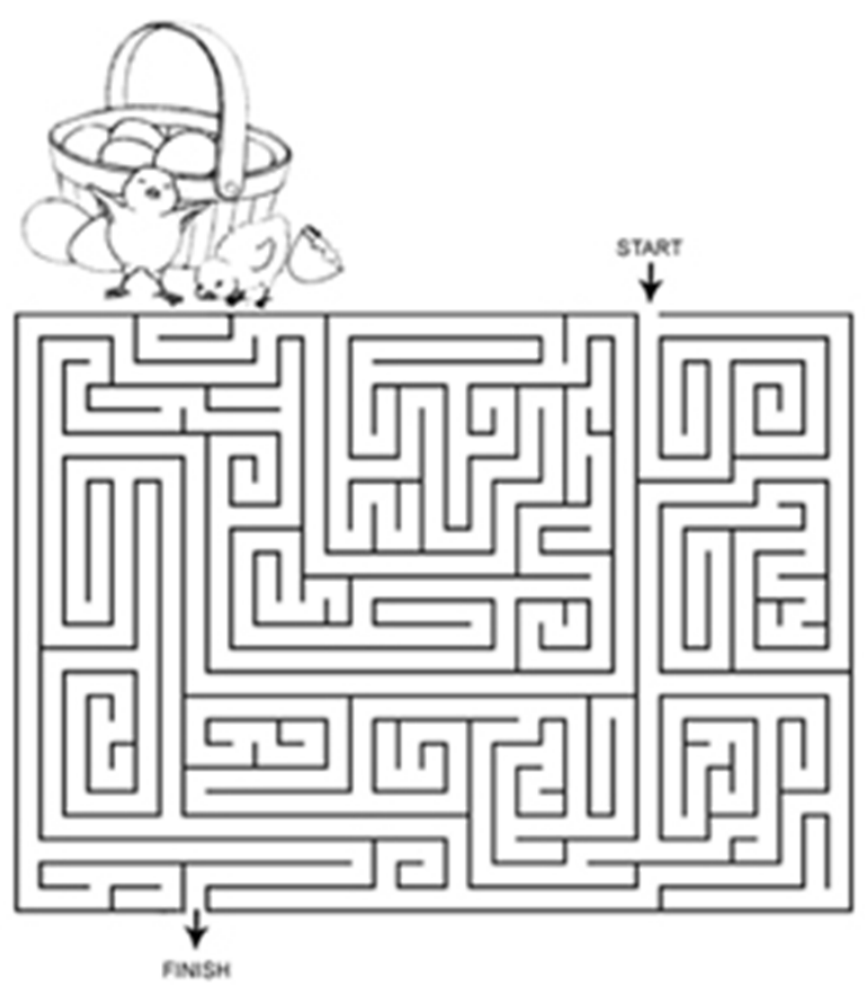
Dr. Atul C. Mehta,

Bronchial Thermoplasty (BT) refers to the use of heat to induce structural changes in the bronchial smooth muscles. It is performed using a specially designed catheter and a radiofrequency (RF) generator. The energy delivered at each treatment site is substantially lower than the energy used for ablation of the endobronchial lesions.

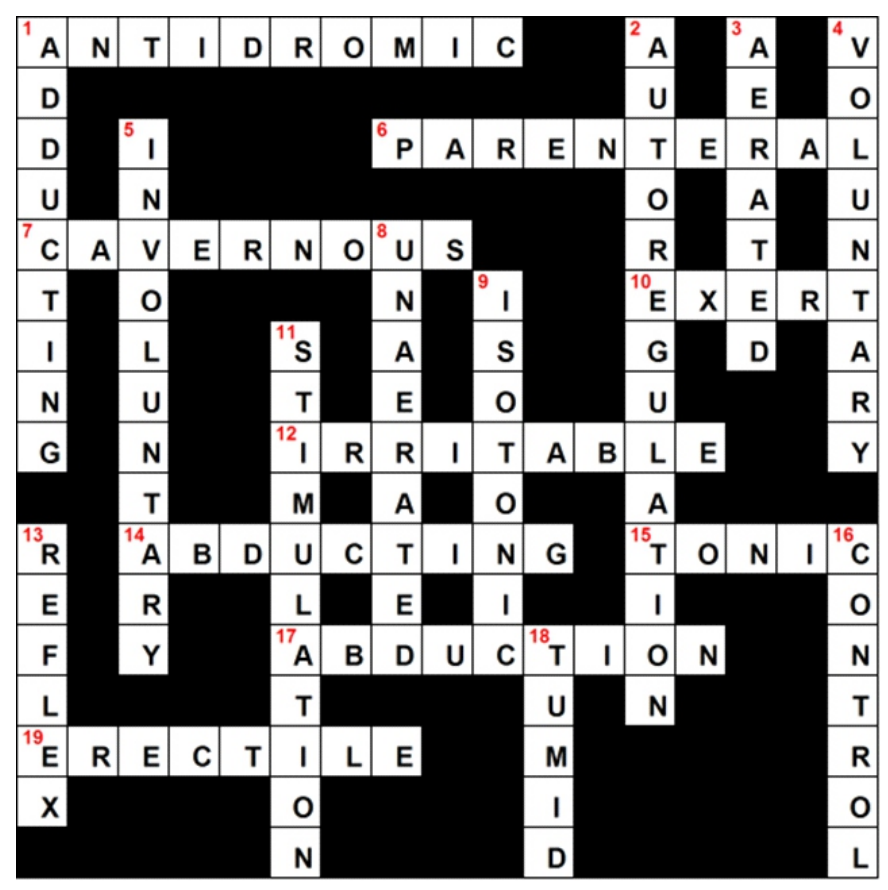


When passed through the working channel of a therapeutic flexible bronchoscope (FB), the wire basket at the end of the catheter is expanded to touch the airway wall under direct vision. Once contact is achieved, a 10-second pulse of RF energy is delivered, and the wire basket is collapsed and moved approximately 5 mm proximally to the next treatment site. The BT system was developed over a series of pre-clinical studies and was first applied in the canine airways. During the pre-treatment trials in dog model the thermal effects were found to be dependent upon the temperature reached in the airway wall. Histological examination of treated sites revealed that smooth muscle was replaced with connective tissue elements. Long-term studies at 3 years showed no evidence of scarring and the effect on reducing muscle mass was stable. Functionally, airways treated with BT contracted less following methacholine instillation than untreated sites and this effect was related to the degree to which muscle was reduce, yet the relaxation was not impaired.

Find your way through this Easter maze



Answer of Crossword



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The Aging Physician - Impact on Patient Care...

Dr. Kaj Johansen



All of us grow older, and the implications of advancing age are ever-evident to each of us. For physicians, in particular, the advantages and hindrances of advancing age have implications not only on how we practice but also have real impacts on patient outcomes. Age affects physician and surgeon performance, particularly in the context of knowledge, judgment and psychomotor performance. Based on comparative studies of other professionals dependent on maintenance of both visuospatial and cognitive skills Dr. Kaj Johansen shared his thoughts about how to maximize the benefits, and minimize the deficits, which accompany advancing physician age.

Decortication in Empyema: Indications, Timing and Role of Video Assisted Techniques

Dr. Pranav A Modi,



Decortication of the lung is the process of peeling or stripping a constricting membrane from the pleural surfaces. Decortication departed from the classic approach of aspiration, open drainage and thoracoplasty for the treatment of chronic empyema and fibro thorax. Further refinements of the initial procedure included intercostal incision, wide exploration of the pleural cavity, full mobilization of the lung, removal of the fibrous peel (but not the visceral pleura), and suction drainage of the complicated pleural space. Advent of video assisted techniques and emergence of multidrug resistant species have greatly changed the concepts of scientific management of pleural space infections.

JIC FINALE - MANEKCHOWK AT TAGORE HALL
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What Physician Should Know About Radiation Oncology

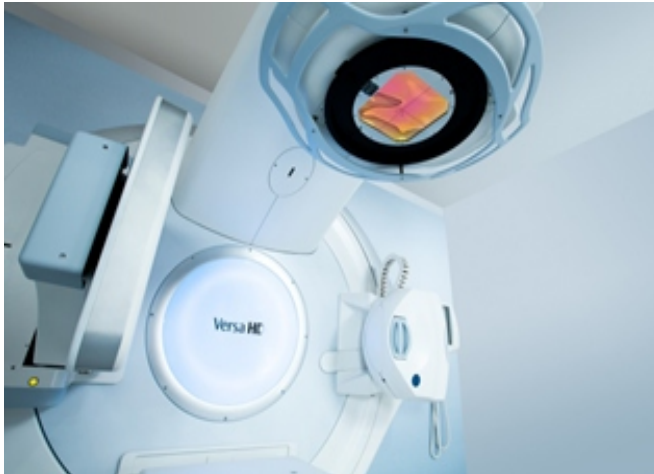
Dr. Devang Bhavsar, Dr. Kinjal Jani,



Radiation therapy remains an important component of cancer treatment

with approximately >70% of all cancer patients receiving radiation therapy during their course of illness; it contributes towards >50% of curative treatment for cancer.

The main goal of radiation therapy is to eradicate cancer cells of their multiplication (cell division) potential. IMRT is an advanced approach to three-dimensional treatment planning and conformal therapy. It optimizes the delivery of irradiation to irregularly-shaped volumes and has the ability to produce concavities in radiation treatment volumes. IMRT can be delivered using linear accelerators with static multi-leaf collimators (MLC, step and shoot IMRT) or dynamic leaf MLCs, tomotherapy machines or volumetric arc modulated therapy (VMAT). With success of IMRT (fig 4), some limitation is seen when you are reducing margin around tumor, so next generation linear accelerator comes with Image Guided Radiotherapy (IGRT) (fig 5) and recently one more weapon added in field of radiation oncology and going to make treatment more effective and fast, Stereotactic Radio Surgery (fig 6), from



conventional 6 –7 weeks of radiation can be delivered in only one day or in 4-7 fraction. Stereotactic radiotherapy enables the delivery of exquisitely conformed radiation in large fraction sizes, which also enables improved tumour control while limiting the normal tissue toxicity. Due to the exquisite dose sculpting, robust image-guided technologies (gating or chasing) have to be coupled with the radiation delivery systems.

Stereotactic radiotherapy can be delivered using linear accelerator systems or Cyberknife® (Accuray Inc, CA, USA). This technique is currently widely used for treating intra-cranial lesions, . There is increasing evidence supporting its use for the radical treatment of stage I lung cancer, renal cell carcinoma, hepato-cellular carcinoma, spinal tumours and prostate carcinoma (as a primary treatment or a post-treatment boost). It can also be used for treatment of lung and hepatic metastases).

In conclusion we will like to mention that radiation play major role in all solid tumor management (curative, adjuvant or palliative). Evolution in field of radiation oncology make delivery of therapeutic doses feasible with minimum side effects, multi-modality or tri-modality (radiation, chemo and surgery) make organ preservation and cure even in locally advanced stages.

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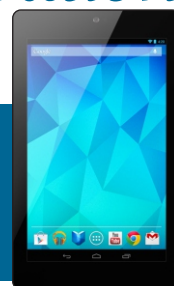
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Don't Miss JIC 2014 Tracks

Cardiovascular Thoracic Surgery (CVTS) Track

Date : January 11-12, 2014
Venue : CIMS Hospital

Critical Care & Pulmonary Track

Date : January 11-12, 2014
Venue : The Grand Bhagwati

Joint Replacement Track

Date : January 11, 2014
Venue : The Grand Bhagwati

Trauma Care Track

Date : January 12, 2014
Venue : The Grand Bhagwati

Clinical Cardiology Track

Date : January 12, 2014
Venue : Tagore Hall