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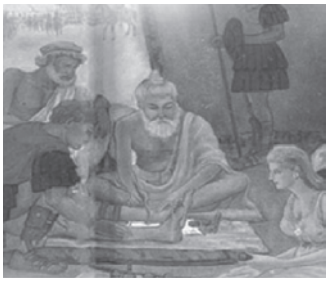

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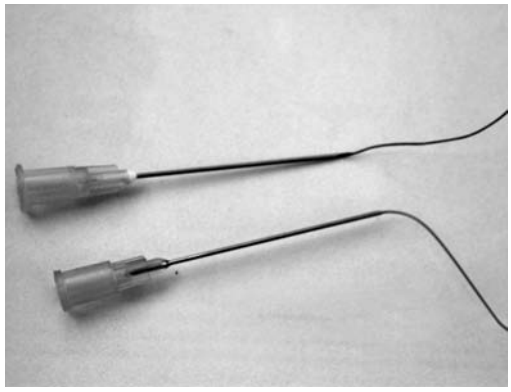
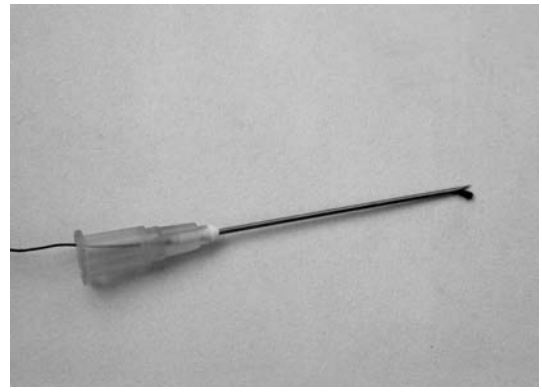


Figure 1



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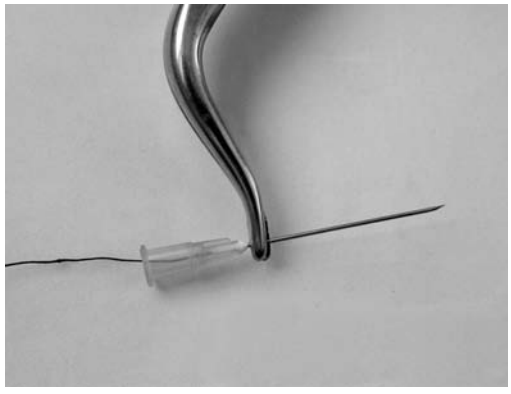

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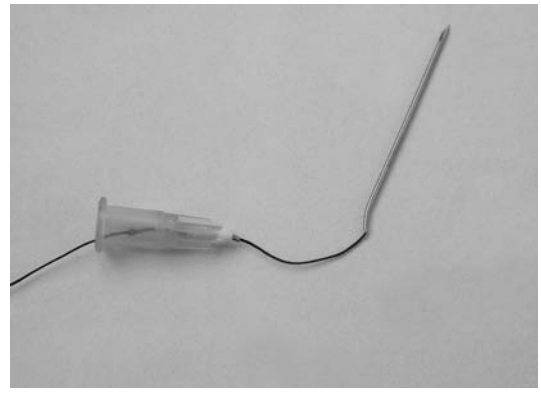

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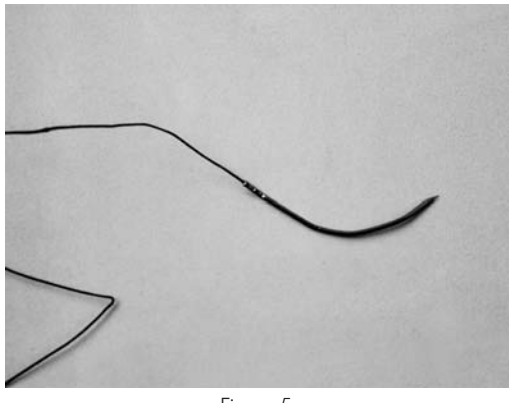

Figure 5

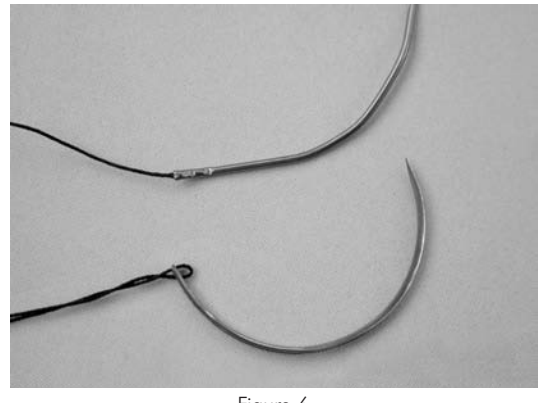

Figure 6

Financially Atraumatic Sutures

Dr R P Usgaocar*, Dr Bossuet Afonso**

Sutures are an integral part of surgery and are also becoming an integral and substantial part of the bill presented to the patient thereafter.

This is because of the high costs of 'atraumatic sutures' available commercially. Atraumatic sutures have become widely prevalent in surgery, and deservedly so. This is because the concept of fusing thread to needle ensures a sharp needle every time, and also tissue trauma is much less with there being significantly less bulk than the eyed broad needle with the two strands of thread at the eye.

However one finds that an exorbitant price is often paid (particularly for non absorbable polymer sutures), for the little piece of sharpened steel at the end of the suture forming the needle - often near 100 times more. Of course the sutures are dyed as well as packed neatly for presentation to the surgeon during surgery.

A simple technique is presented for in house preparation of atraumatic suture; this can suffice for a wide range of purposes, but is not a substitute for specialized suture/needle combinations.

The technique is:

1 The suture thread is passed through the bevel of a new hypodermic injection needle of suitable size and the thread withdrawn from the hub end.

2 The trailing end is withdrawn till it just disappears through the bevel.

3 The portion of the hollow needle next to the hub is crushed/clamped down on to the thread with a heavy needle holder or bone nibbler type of instrument. For sutures prepared in advance an ordinary nose plier is excellent.

4 The needle hub is broken off by twisting sideways and withdrawn from the thread.

5 If required, the needle can then be gently bent into a curve with the needle holder so that the bevel faces inward.

6 For materials like silk and nylon, threads can be swaged on needles in advance of surgery and autoclaved. Individual paper envelope packs can also be made.

One thereby gets a sharp single use new needle which being siliconised also glides easily. The cost saving is tremendous. Needle with eyes are unnecessarily traumatic as they tend to get blunt soon. Also procuring them is now difficult as the world of surgeons turns to atraumatic sutures available commercially.

Consultant Plastic surgeon, Consultant General Surgeon**, Manipal Goa Cancer and General Hospital, Dona Paula, Goa*

This issue has been sponsored by Mr. Suheim Sheikh, Secunderabad

Computers and the rural surgeon, A to Z ways in which it helps

Hui Wen-Jie*, Justin Charles Daniel**, Dr. J. Gnanaraj ***

Introduction

Computers have invaded all walks of life and are no more considered luxury but necessity. We describe the various ways in which the computers have been used at Burrows Memorial Christian Hospital (BMCH) in rural Northeast India and what difference it has made.

The C3MDS Software

This locally designed software is used for hospital management. It is doctor-oriented software that helps the mission hospital to function efficiently and profitably. It helps the staff pay attention to details, spend quality time with patients, provide adequate explanations to patients of their conditions and have adequate knowledge and do all these quickly and efficiently. The C3MDS (Christian Comprehensive Computerised Mission Development Service) was developed as doctors, administrators and computer personnel worked together to use the computer in helping them do what they always dreamed about. It made the "If only I had…" dream come true.

The Operating Room System

The computers here help in recording and broadcasting surgeries and procedures from the operating room. They also help in editing, making videos and running the BMCH television channel.

The Highlights of C3MDS Software

The software combines data, accounts and analysis to generate patient charts. All aspects of hospital activities like surgery posting and statistics, work allocation, the log book for vehicles and the generator, library software, information necessary for purchases and more are available.

The Advantages

a) The most significant impact of the software is seen at the Pharmacy and the stores. Figure 1 shows the profits from the Pharmacy after the installation of the software in the year 2004.

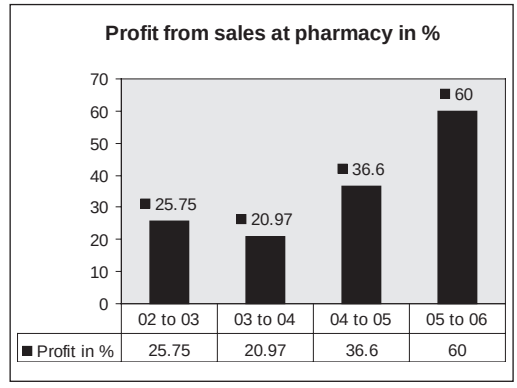

Figure 1: Profits from the Pharmacy

The doubling of profit was possible because of the following reasons:

1. **Accurate information is available and thus there is no wastage**. The computer calculates the order quantity using the formula "Order quantity = (Maximum stock - current stock)" for medicines that have gone below the minimum stock.

2. **ABC analysis and all information are available online and by default the order goes to the best buy**. The information and deals given by medical representatives and companies are often forgotten when actually placing orders and ABC analysis helps to concentrate on the medicines that give the best profit while bargaining and having control. The computer automatically calculates the profit ration "Profit ratio = {(Maximum retail price - Purchase price) / Maximum retail price} x 100" and by default generates orders for the best.

3. **It helps avoid cheating by dealers and suppliers**, who often supply medicines that are not ordered, give a little more than was ordered, sell short expiry date medicines, slowly increase the price, bill at higher prices than agreed upon, etc. With large orders and manual checking these often get overlooked.

4. Another headache for the surgeon is when medicines and disposables go out of stock especially since the geographical location of the hospital makes them difficult to procure. C3MDS prevents this.

b) The computer helps to **reduce the workload of the surgeon**. The nursing staff enters the vital signs and preliminary history. For each symptom the computer gives the clarifications that need to be asked. Some of the experienced staff could make the provisional diagnosis and order the predefined set of investigations.

c) Computers **reduce the time** that the patients spend at the hospital as every detail of the laboratory report, Pharmacy expenditure etc can be prepared even before the patient arrives.

d) Computers **save money** in printing charts and reduce time taken to make them. The charts are also more accurate. For instance, the consent form is specific for surgeries and lists the probable complications of that particular procedure. Once the diagnosis is made, predefined prescriptions with all the necessary instructions are printed at the click of a button.

e) The **standard of care is greatly improved** as predefined investigations ensure no one is forgotten as clinical signs and CME notes are only a click away and a diagnosis is made for every patient.

f) **Research is simplified**. Data of any surgical procedure, diagnosis, finding, etc could be obtained.

g) **Administration of the hospital is made easy** with the accounts, work allocation and monitoring, log book, salaries, minutes and correspondence etc sections of the software.

h) The non availability of senior help and guidance is a major drawback to the rural surgeon. The recordings of all the laparoscopic surgeries are edited and fed into the C3MDS software. It is possible to quickly retrieve any particular part of the surgical procedure and view how difficult circumstances were managed. When seniors visit periodically, advice is sought from them and this too is entered for quick retrieval in future. Internet facilities and speakerphones in the operating room help communication with seniors at Christian Medical College and elsewhere when required.

i) The compact disks recorded with patient's surgical procedure are sold to them and this revenue has helped the hospital purchase its computers.

j) In most hospitals relatives of patients have nothing to do. We use them to produce health education and hospital advertisement videos using just a video camera and related computer software. Relatives are very eager to help, and buy the CD with the clip that they acted in.

k) Health education regarding the disease is recorded before the surgical procedure and is given to the patient as a VCD. Friends and relatives who have watched these and then had investigations came for surgical procedures here. The CDs acts as publicity for the hospital.

l) The BMCH channel plays health education programmes selected by the hospital.

During morning rounds the patients and relatives are photographed and the videos are played on the network. Everyone loves seeing their faces on television.

m) **Disease specific health education material** is generated by the software and is addressed directly to the patient hence people are more likely to read it.

n) The **log book section** of the software helps the doctors keep tract of procedures they are doing and the materials they are reading and preparing.

o) The **CME section** helps junior doctors prepare for the PG entrance exam. They can access questions related to a particular topic at any time and practice their tests online.

p) The **drugs information section** displays details about the various medicines allowing searches by symptoms.

q) The **Discharge Summary section** helps to quickly prepare summaries of inpatients and outpatients. It contains all the relevant information like clinical presentation, vital signs, investigations, procedures or surgeries carried out with findings, recommendations, automatically generated dates for repeat visits, etc

r) It is possible to **view the relevant videos (either CME or surgery)**, helping greatly in consumer protection court.

s) The computers **relay the surgeries live** from the operating room. This makes it easier to explain minimally invasive procedures, like when electro vaporization of prostate causes hardly any bleeding with no tissue remaining to show the patient what he had just undergone. Many watch the "live show", creating a platform for staff to give health education messages and it convinces other patients and relatives to have the surgical procedures. Patients agree for diagnostic laparoscopy and once the relatives see pus inside the abdominal cavity they in-turn readily agree for definitive surgical procedures.

t) **Following up patients is easy**. Computers generate birthday greetings; follow up enquiry letters to patients, etc.

u) **Computer games** keep the staff in their seats and entertained even when there is no active work.

v) The **curriculum section** helps elective students and junior doctors know what they are expected to do and learn during their posting at the hospital.

w) The **wise search** facility available in many places helps to speed up searches. For example to search for laparoscopic Cholecystectomy it is sufficient just to type "c c" to search and find it while posting for surgery.

x) **Monitoring the hospital progress** is easy. About 42 different ratios of the hospital can be calculated.

y) Computers made the **nursing education and continuing medical education** more interesting.

z) Last but not the least it **does away with paper medical records** and gives more space for hospital usage while preventing loss of records. The back ups in external hard disks save space.

Future Possibilities

The exciting new possibilities:

- Using voice commands to open various pages and do the typing
- Using a pad for writing for those who are not used to typing
- Recording a patient's history in

different languages and have it translated to English for the doctors and for the patients to receive the instructions in languages they know to read and write.

Summary

The computers have invaded all walks of life and are here to stay. They make the life of the rural surgeon comfortable, easy and help him to get more profits to help the poor and needy.

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Journal scan

Lichenstein or mesh plug hernia repair. Is there a difference in recurrence?

Albert B. Lowenfels: Br J Surg 2007:94:36-41

595 patients of inguinal hernia were randomly assigned to one of the two procedures and reviewed after one year. Follow up was complete in 85% patients who showed no difference with respect to recurrence or postoperative complications. In mesh plug group operation was shorter, re-operations within first year were less frequent (4 Vs 14) but seromas were more frequent. Follow up was only for one year and patients are being followed for review at five years.

Unusual diagnoses presenting as incarcerated inguinal hernias.

D. Burnten R. Hoslem: Int J Clin Pract 2006:60(12):1681-1682

In this case report of sigmoid diverticular abscess presenting as left incarcerated inguinal hernia, authors review the literature to list the unusual causes as Meckel's diverticulum, inflamed or perforated appendix, ovulating ovary, liposarcoma of spermatic cord, spermatic cord haematoma, pancreatic pseudo cyst, blood from ruptured spleen and splenic gonadal fusion in a child.

Magnitude and severity of colonoscopy complications.

David A Johnson: Ann Intern Med. 2006:145:880-886

This retrospective study of 16318 colonoscopies shows incidence of serious complications as 5/1000 procedures including perforation, bleeding requiring patient observation or blood transfusion or surgery and unusual complications like snare caught on a large polyp and diabetic ketoacidosis. Only one death was directly linked to colonoscopy. The incidence of complications was higher (7/1000) in scopies with biopsy than in those without biopsy (0.9/1000)

Surgery boosts survival in patients with squamous cell carcinoma.

Thomas S May (personal interview, International journal of Surgery)

Survival is significantly increased in patients with squamous cell carcinoma when treated with surgery plus adjuvant hormone and/ or chemotherapy as compared to patients receiving radiation plus adjuvant therapy. The chances of survival were found to increase by two and half times.

Compiled by Dr.Medha Vaze
Rural Medicare Centre, Mehrauli

Haemangio- Pericytoma: A Case Report

Dr. Sitanath De

Introduction

Haemangio-Pericytoma is a rare tumour arising from Pericytes of Zimmerman located toward the outside of blood vessel lumen. It usually occurs in adults and is often deep seated in the pelvis, mediastinum and orbit. Sometimes it is superficial and the thigh is a common site. It has a tendency for local invasion. Its potency for malignant transformation with pulmonary and bony metastasis is known. The microscopic findings that correlates with its aggressive feature are:-

Prominent mitotic activity, increased cellularity, Hemorrhage, Necrosis

For postoperative management of these cases, the help of the histo-pathologist is enormous. The histopathological findings and diagnosis might strongly indicate the future course of treatment. The objective of reporting this case is to focus to the handicap the rural surgeon has in his long physical and mental distance from histo-pathologist colleagues. From rural areas the specimen is sent to a collection centre, then via a district centre and finally to the city centre - to a histopathologist. It takes a minimum 14 days to report, then another week for its delivery from the collection centre. It is almost impossible to meet the diagnostic pathologist personally for the discussion; the best available option is the mobile phone. In these circumstances, the doctor is hardly likely to remember the slide in question and promises to ring back. After few days, when asked about the possibility of malignant change, he agrees that the patient should have chemotherapy. The rural surgeon is then faced with the problem of recalling the discharged patient for further treatment.

Key words

Haemangio - Pericytoma, Treatment in rural area.

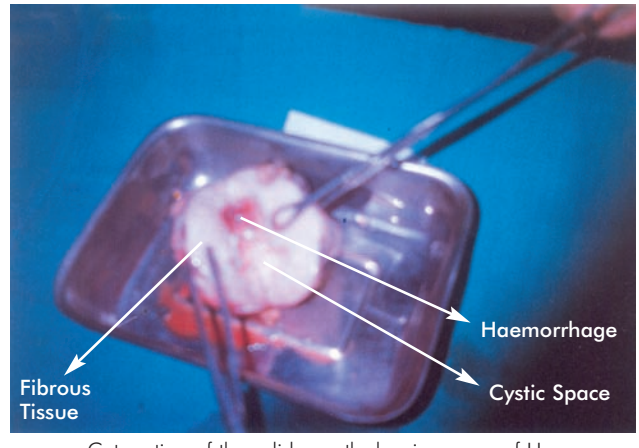
Case Report

On 13.09.06 a female of 35 presented with a swelling in upper left thigh, which is gradually increasing in size.

On examination, the swelling measures 10cm / 8cm, firm in consistency, not attached to skin, free from deeper structure except at one place at the point of entry of blood vessels (also confirmed during operation). The inguinal nodes were not enlarged.

On 15.09.06 Eneucleation with ligation and excision of the root vessels under ketamine anaesthesia was performed, and the patient was discharged home next day. Specimen was sent for histopathological examination on 15.09.06. The cut section showed area of necrosis. Stitches were removed on 23.09.06.

The biopsy report was brought to me on 5.10.06 by one of the relatives. It states- section shows histology suggestive of Haemangio-Pericytoma.



Cut section of the solid growth showing areas of Hg, cystic space and fibrous tissue

Discussion

As I was not familiar with the tumour, it was necessary to refer to my pathology text book. I also phoned my histo-pathologist who agreed that there was potential for malignant change. He was kind enough to send me a Xerox copy of the subject *(Ackerman's Surgical Pathology, Chapter 25, "Soft tissues", p.1582)* for updating my knowledge. I was very grateful for this assistance.

I wrote a letter to the patient requesting her to come for review. On 5.12.06 she came for a check up. She was advised to attend the oncology OPD at a teaching medical institution for further management.

The difficulty in obtaining the reports of any diagnostic test in rural area in time could be detrimental to patient's treatment. This may be true in the case of an X-ray, USG, CT scan, some pathological and all histo-pathological reports. The time lag is due to the fact that most specialist pathologists live and practice in the larger cities. The rural surgeon has almost no chance to meet and talk to them. There is a need for closer academic interaction with our pathologist colleagues and also other diagnostic specialists for our own professional benefit as well as our patient's welfare.

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A matter of concern

It has been brought to the notice of the Gov. Body that a few of the members of ARSI are charging hefty fees from their own colleagues for training them in some of the surgical procedures. ARSI Gov. Body highly objects to this practice and requests members not to indulge in such practice. ARSI is committed to help its fellow colleagues, practicing in Rural India in every possible way including imparting necessary surgical skills and knowledge.

Management of Dysmenorrhoea
(Based on Evidence)

Dr. S.K. Baasu

Dysmenorrhoea is painful menstrual cramps of uterine origin. Primary Dysmenorrhoea is defined as a history of painful menstrual cycles and exclusion of organic causes by physical examination. Dysmenorrhoea affects about 40% to 70% of women of reproductive age, and is a frequent cause of time lost from work or school as well as interfering with daily living. It is not unusual for a Primary care physicians, in their daily practice, to come across with such patients.

One may get easily confused about various therapies that have been put forward for relieving Dysmenorrhoea ranging form dietary therapies, herbal supplements, hormones, vitamins, herbs, minerals, proteins, and fatty acids. Unfortunately few of them have adequate experimental backing. Perhaps one of the rational treatment modality for Dysmenorrhoea is treating the patient with NSAIDs and minor analgesics. This is based on the findings that prostaglandins are implicated in the pathogenesis of dysmenorrhoea. NSAIDs are peripheral prostaglandin synthetase inhibitors, but paracetamol is not.Let us see what evidences suggest.

Two different well designed systemic reviews[1,2] from randomized double- blind trials (one from Cochrane Review collected from the Cochrane Menstrual Disorders and Sub-fertility Group trials register, Cochrane Central Controlled Trials Register, MEDLINE, and EMBASE) was taken into account to find out the effectiveness of the NSAIDs for primary dysmenorrhoea.

Outcomes analysed were pain relief, absence from work or school, restriction of daily activities, and adverse effects. Adverse effects were also examined. Most trials were either parallel or cross-over design, predominantly comparing the test analgesic with placebo.

Compared with placebo, naproxen (550 or 275 mg four times daily), ibuprofen (400 mg four times daily) and mefenamic acid (250-500 mg four times daily) had numbers needed to treat(NNT) of between 2.4 and 3.0, with overlapping 95% confidence intervals, indicating no real difference between them. Five trials of aspirin (650 mg four times daily) had a much higher NNT of 9.2, with no overlap of confidence intervals with the NSAIDs. One comparison between paracetamol (650 mg four times daily) and placebo showed no difference between them.

Adverse effects

Overall NSAIDs caused significantly more adverse effects than placebo (1030 women), but there was no significant difference between NSAIDs and placebo for gastrointestinal effects (432 women) or nervous system adverse effects (229 women). The median withdrawal rate was 10%. Women withdrew for reasons including lack of efficacy or adverse effects, but numbers for these were not available. Adverse effects were mainly nausea, dizziness and headache. There was a suggestion that naproxen caused more adverse effects (mainly nausea), but the power of studies to detect this was low and confidence intervals wide.

Clinical bottom line:

Naproxen, ibuprofen and mefenamic acid are all effective in the treatment of primary dysmenorrhoea, with numbers-needed-to-treat of 2.4 (2.2 to 2.7), 2.6 (2.2 to 3.2) and 3.0 (2.4 to 4.0) respectively for at least 50% pain relief. Ibuprofen appears to have

fewer adverse effects, and is therefore the drug of choice. Dosing regimens for these levels of efficacy are naproxen 550 or 275 mg, ibuprofen 400 mg and mefenamic acid 250 to 500 mg, all four times daily for three days.Aspirin is less effective than these drugs, and paracetamol, based on a single trial, was not effective in primary dysmenorrhoea.

Does Vitamin E has any role for dysmenorrhoea?

A literature search showed that at least three randomised trials had been performed over 50 years. The search was confined to PubMed and Cochrane library. All the studies were randomised and double blind, investigating vitamin E at any sensible dose or duration of use, in women with primary dysmenorrhoea, and use pain or some related measure as an outcome. All of them studied young women, for between two and four months, using different doses of vitamin E (ranging from 150mg to 400-500 units). While in one study treatment was given for 14 days in each cycle, two other studies used it for 5 days starting 2 days before the period. All three studies found that menstrual pain was diminished by vitamin E more than placebo, and the two longer studies found that maximum effect occurred by about three months. The two longer studies had dichotomous outcomes, of pain reduction by a useful amount[3], or non-use of analgesics[4].

Whether vitamin E could be harmful?

A meta-analysis of vitamin E supplementation trials indicated a small increase of mortality in people taking vitamin E[5]. The size of the increase was not great (39 per 10,000 persons), was barely statistically significant, applied only to high-dose studies (400 IU/day or more), used for long periods, and mostly in small studies in older patients with chronic diseases. Other meta-analyses[6] using only larger studies found no difference in mortality. So any move to using vitamin E for treating dysmenorrhoea needs to be cautious, and young women thinking of self-treating should be advised to use small doses for a few days before and during their period, and no longer.

Does combined oral contraceptive has a role?

Use of oral contraceptives for treating dysmenorrhoea has been advocated sincee 1960s, though experimental backing has been lacking. The evidence is not overwhelming, but there may be an additional benefit of pain relief for one women in five taking oral contraceptive pills and this may be sufficient to consider OCP for dysmenorrhoea when contraception is also required. Five randomised trials were found[7], all dating from the late 1960s or early 1970s. None was particularly large, and for the four that had combinable data there were only 320 women. Trials used different types or doses of oestrogen or progestagen. Combined data suggest that overall 52% of women were benefited with OCP, compared with 31% with placebo (95% confidence interval 3 to 10). This may be sufficient to consider OCP for dysmenorrhoea when contraception is also required.

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"The data we have are not the data we want. The data we want are not the data we need. The data we need are not available" -Finagel's Laws

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Community health Status of Rural Punjab

Dr. A.K.Banerjee, MS Dr. Madhumeeta, MD

Introduction

No rural medical practice is complete without comprehensive knowledge about the surrounding community; i.e., its health, problems, traditions, beliefs and awareness level. Only thereafter, a sustainable cost-effective combat strategy can be devised so that whatever limited resources are available can be utilized optimally and evaluated further. We present hereunder a community health data to reflect the health standard of some villages representing rural Punjab. The data is collected through doorstep field survey covering almost every household of the villages during "Jan Jagran Abhiyan" conducted by community health unit of Bengal institute of health sciences in 2005. We compare the data with earlier data of rural Punjab and India which were collected in 2000 by MICS (Multi Indicator Cluster Survey, UNICEF) and NFHS (National Family Health Survey) in to evaluate progress made in last 5 years.

A close perusal shows that though Punjab has higher prevalence of addiction at all age group and for all substances, other indicators of community health awareness are better in Punjab than in rest of India. However, Punjab is lagging behind, albeit slightly, in ensuring improved source of water in every household. Rural community also needs to be educated about the necessity and choice of contraceptive methods and institutional deliveries. A rural doctor can play a significant role in these spheres.

INDICATOR	RAJGARH	GOBINGARH	JALANDIWAL	PUNJAB	INDIA
TOTAL ADULT POPULATION	807	1163	3758		
1. Addiction					
Addicted people identified	81 (10.03%)	82 (7.05%)	210 (5.58%)		
Age-wise addiction prevalence					
Less than 30 years	26 (32.09 %)	26 (31.70%)	47 (22.38%)		
30 to 40 years	28 (34.56%)	23(28.04%)	76 (36.19%)		
40 to 50 years	15 (18.51%)	32(39.02%)	59 (28.09%)		
50 to 60 years	13 (16.04%)	1 (1.20%)	27 (12.85%)		
Substance-wise prevalence					
Alcohol	39(45.14%)	46(56.09%)	145(69.04%)		
Opium	14(17.28%)	3(3.65%)	12(5.71%)		
Doda	14(17.28%)	80(21.95%)	36(17.14%)		
Post		6(7.31%)	10(4.76%)		
Others	3(3.70%)	7(8.53%)	10(4.76%)		
Bhukki		20(24.39%)	51(24.28%)		
Drugs & Medicines		8(9.75%)	3(1.42%)		
2. Place of Deliveries conducted					
Total house surveyed	167	218	489		
Home delivery	92(55.08%)	127(58.25%)	290(59.30%)		
Govt. Hospital	5(2.91%)	1(0.45%)	25(5.11%)		
Trained Dai	53 (31.73%)	69(31.65%)	140(28.62%)	56.5%	34.2%
Private Hospital	65(38.92%)	66(30.27%)	168(34.35%)	30.5%	26.3%
Note: Multiple deliveries were sometimes conducted at different places	00	5(2.29%)	04 (0.81%)		

INDICATOR	RAJGARH	GOBINGARH	JALANDIWAL	PUNJAB	INDIA
3. Methods of contraception used					
Total number of eligible couples	140	218	489		
Safe period / withdrawal	23(16.42%)	13(5.96%)	18(3.68%)		
Oral pill	12(8.57%)	14(6.42%)	22(4.49%)		
Copper-T	3(2.14%)	12(5.55%)	16(3.27%)		
Condom	16(11.42%)	18(8.28%)	48(9.81%)		
Vasectomy	3(2.14%)	5(2.29%)	7(1.43%)		
Tubectomy	27(19.28%)	61(27.98%)	188(38.44%)		
Nil	56(40%)	95(43.57%)	184(37.62%)		
4. Source of treatment commonly used for house-hold ailments					
Total house surveyed	167	218	489		
Allopath doctors	139	161(73.85%)	345(70.35%)		
Homoeopathy	(83.23%)	9(4.12%)	19(3.88%)		
Ayurvedic	6(3.59%)	00	2(0.40%)		
All	4(2.43%)	19(8.71%)	61(12.47%)		
Don't Know	13(7.78%)	29(13.30%)	62(12.67%)		
	13(7.78%)				
5. Source of drinking water					
Total housed with improved source	167(100%)	218(100%)	487(99.6%)	99.3%	83.7%
Tube-well	23(13.77%)	18(8.25%)	142(29.03)		
Jet pump	98(58.68%)	127(58.25%)	270(55.29%)		
Hand Pump	45(26.94%)	68(31.19%)	46(9.40%)		
CHN storage tank	4(2.43%)	5(2.29%)	31(6.33%)		
Houses without improved source					
Well	00	00	2(0.4%)		

Address for correspondence: Talwandi Rd. Raikot -141109, Punjab, E mail: sadbhavna100@yahoo.com

Steps of Caesarean section (Based on evidence)

Dear Dr. Basu,
I have gone through your paper titled "Steps of Caesarean section (Based on evidence)". I have got my own queries and observations that I am putting before you.

Left lateral tilt:

As is conventionally taught and mentioned in all the textbooks of obstetrics and anaesthesia, left lateral tilt is recommended to avoid inferior venacaval compression to avert the risk of supine hypotensive syndrome. But to me, as I always stand on the right side of the patient; it becomes cumbersome to operate when the patient is tilted leftward. I used to give a right lateral tilt for my convenience against the established norm but I find that there is hardly any difference.

(Reply: Whereas clinicians often give "experience" as the basis for a particular practice, the truth is probably closer to "habit"--the way it has always been done. I am sure if you try in couple of cases with left lateral tilt position (just 10-15 degree) you will be able to do so comfortably and not feel it cumbersome any more. The relative merits of right and left lateral tilt during Caesarean section had been assessed by various studies with otherwise normal placental reserve. The incidence of hypotension (revealed aorto-caval occlusion) before and after induction of anaesthesia, was significantly greater (P<0.001) with the "right side down" posture. The clinical and biochemical status of the fetus were generally more favorable with left lateral tilt, as were the maternal-to-fetal blood gas gradients and relationships. - S.K.B)

Incision:

The vertical midline incision must be condemned and should be abandoned completely not only for caesarean section, but also for tubectomy as well as hysterectomy due to the increased risk of incisional hernia. Unfortunately, at my place, most of the surgeons and gynecologists are giving vertical incision for all the above indications: probably they don't experiment in changing their habits of operating, leading to disastrous outcome.

I will definitely like to know from you what the Joel-Cohen incision is, which I have neither heard nor found in the textbooks as well as Dorland dictionary.

(Reply: I totally agree with you that the vertical midline incision must be abandoned. CS should be performed using a transverse abdominal incision because of much lesser risk of incisional hernia, less postoperative pain and an improved cosmetic effect compared with a midline incision. If you are convinced that transverse incision is better, try to convince others. You have to understand that many clinicians still fear uncertainty and resist changes. It is said that "Habit is stronger than reason" and "Bad habits are like a comfortable bed, easy to get into, but hard to get out of." But I may tell you that more and more clinicians are accepting evidence based practice and the standards of practice are gradually changing. The Joel Cohen incision is a straight skin incision 3 cm below the line that joins Anterior superior iliac spine and therefore more cephalad than Pfannenstiel incision. I am convinced that it is more physiological,

associated with shorter operating times and reduced postoperative febrile morbidity. The Pfannenstiel incision consists of a curved skin incision, two fingers breadths above the symphysis pubis. - S.K.B.)

Retraction of bladder:

Do you incise the utero-vasical fold and retract the bladder downwards and then give the incision on the uterus on the lower uterine segment or open it directly all the time directly 1 am above the bladder fold? I usually slide the bladder but open it directly in case of patients having previous repeated caesarean sections. But when we go above, the uterine wall is thick and causes some difficulty in apposing it.

(Reply: No I don't incise U-V fold of peritoneum any more particularly for primary CS delivery. Omission of the bladder flap provides short-term advantages such as reduction of operating time and incision-delivery interval, reduced blood loss, and need for analgesics. However I become extra careful in prior cesarean delivery cases at the time of doing repeat cesarean delivery to prevent bladder injury. If the uterine incision is made slightly above the vesicouterine peritoneal fold, the loose connective tissue between the uterus and the urinary bladder allows the spontaneous descent of the bladder. Some obstetricians may feel that the uterine incision may be too high in a thicker portion of the uterus. However the incision is made essentially at the same level in the lower segment below the uterine physiologic retraction ring. On the contrary the omission of the bladder flap prevents the incision from being made too low. Low uterine incision should be avoided when the cervix is fully effaced and dilated to prevent rupture of the cervix. - S.K.B.)

Use of suture:

I always use vicryl no. 1 suture with 50 mm half circle needle to close the uterine incision in single layer. This saves the extra suture material and time devoted to do it in double layer.

I am really thankful to you for highlighting some of the conclusive messages that you have tried to convey through your paper. Sometimes, we do not discuss about the basic aspects of the commonly performed procedures and continue to perform in our own way as trained locally and commit the mistakes for the whole life; hence the role of the evidence based medicine.

Sincerely,
Dr. Jayadeva Sinha

Non-operative fracture Treatment- a Forgotten Option

I am very much pleased to go through the paper of Dr. Gabriele Holoch titled "Non-operative fracture Treatment- a Forgotten Option". It has been rightly emphasized the role of stabilization instead of rigid immobilization of the fracture to unite. There is need of introspection into modern trend towards open reduction and internal fixation, more so with the advent of newer methods of fixation like interlocking nailing and use of plates with locking head screw.

The problem is that the younger surgeons start their training with these internal fixation techniques and I doubt many of them are not familiar with the conventional techniques of

closed treatment of fracture shaft of humerus including # surgical neck and # shaft of tibia. Her observation is very correct regarding the special role of closed treatment for the fractures of these two bones. We must use the best technique suitable to the individual patient, rather than making the patient suitable to the technique. Lot of unnecessary internal fixations are being done particularly in humerus and tibia in the name of early return to work as the demand of the modern era leading to disastrous consequences, like osteomyelitis, breakage of implants, etc.

From my experience, I am mentioning some of the fractures most amenable to closed reduction:

i) Only sling treatment for most of the fractures of proximal humerus including # surgical neck, leading to minimal shoulder stiffness, which is very notorious in such fractures.

ii) UL slab for # shaft humerus still gives the best results regarding union with negligible deformity.

iii) # Shaft tibia needing above knee plaster cast for 1 ½ month followed by sermiento cast allowing full movement of the knee, as mentioned in the paper.

Sincerely,
Dr. Jayadeva Sinha

Query on use of mosquito net instead of mesh (Letter from Ethiopia)

Dear Dr.Baasu,

Through contact with the German Society for Tropical Surgery I have been following the publications of "Rural Surgery" with interest. I had been especially amazed at the prospect of being able to use mosquito net instead of mesh, as mentioned in the January issue 2006 in relation with the Antia Finseth award 2005. Unfortunately at that time internet access was near to impossible from my rural posting in Ethiopia and I never received answers to my emails, in fact I believe my emails never actually reached.

My question is: How do I sterilise mosquito net?

I would very much appreciate your help, as I of course grew up with using mesh and believe it could transform the local practice, in certain cases for the better, I think.

Looking forward to hearing from you

Faithfully
Susanne Reinoehl MRCS (Ed)

(The letter was forwarded to Dr. R.R.Tongaonkar for reply)

Dr. Tongaonkar's reply

Dear Susanne,

Your query regarding sterilisation of mosquito net was forwarded to me because after Dr. Brahma, the recipient of Antia- Finseth Award, introduced the cloth way back in year 2000, I did the analysis of the mesh, used the mesh myself and we collectively published an article in Indian Journal of Surgery and later I popularized the cloth across India.

I collected data from 23 centers in India who were using this cloth with total number of patients in whom the cloth is successfully used amounting to over 3000. I was invited to present my work in the 10th World Congress of Endoscopic Surgery held in Berlin in Sept.2006 as a Faculty.

Coming to you query, you can sterilise the cloth by Autoclaving or by ETO sterilisation.

If you need any further information about the cloth including its microscopic studies, and histopathology reports in cases that had recurrence, please be free to contact me.

Thank you,

Yours sincerely,
Dr. R. R. Tongaonkar

(Past President, Association of Rural Surgeons of India.)

Congratulations!

Rural Medicare Society Award (2006)

For

The best paper published in "Rural Surgery" bulletin

Angiography and vascular surgery in a remote coal mine hospital

By

Dr. Sanjeev Golash Vol.2 No 1 January 2006

The Award money of Rs 3000/- in cash will be presented to Dr. Sajeev Golash at the ARSICON Pune 2007 conference

Mountain Diary
Kamla

Dr. Sushil Sharma

It's four in the morning. The dogs bark frantically to warn of an unusual presence outside. Our house is in the middle of the forest and it is pitch black outside. It could be the leopard that has been prowling around and has also made a go for Beta - an unusual cross between a Doberman and a Himalayan mastiff. I wait with my ears pricked. The sound of voices and the familiar "Dak sahab" and I know that some one is ill. Wrapping a shawl around myself, I get down from the attic which is our bedroom and put on the lights to open the door. It is a cold wintry night. There are three bleak, dark faces standing outside. Their faces, lit with the dancing light of the kerosene torch they hold in their hands, are a mix of helplessness and desperation.

Kamla is ill. She had delivered a baby boy two days ago and has been bleeding since then. The Dai who had done the delivery was happy at having done a good job and had gone back home. The three men, including the husband had walked through the forest from the village of Kaphura, an hour's journey from our house. The situation was desperate and I tried to convince them to get Kamla to the hospital. She could be assessed and treated there - we had all the facilities to take care of such problems, I said. In case we could not handle the situation, we would send her to the Civil Hospital at Almora. It would not take too much time to get our driver and at the least, the lady could be resuscitated. No, was the plea - we will not be able to get the people to carry her to the hospital at this hour. We do not have a "doli" (a chair stretcher). Just please come and have a look.

Why did you not come earlier? We thought this was usual and only since the last few hours she has been swooning and is not responding. This too is usual...

I pick up my emergency kit, a torch and a knife for protection on my way back alone and we set up at brisk pace through the forest. It is 5.30 in the morning. The first light of dawn has painted the tips of Trishul and Nanda Devi a light pink. The air is crisp and invigorating and the distant sound of a cock crowing brings in the first sign of morning. We reach Kamla's house and I sense the sombre atmosphere. The chilling sound of helpless wailing of women greets us.

As we walk through the front room and into the bedroom, I take time to adjust to the dim lighting. There is no electricity in the house. A single open kerosene lamp is the sole source of light. The smoke from the lamp adds to that coming from the fireplace, around which some men are huddled. A still form lies on the dirty rug in one corner of the room. It's Kamla - covered with a quilt and still as only death can be. The lovely boy she has brought into the world, lies crying in his grandmother's lap. Although her lips are blue and the face a pallid brown, the features show a pretty, young girl. She is beautiful. Was…

I make the cursory check of her pulse and look for signs of respiration. Steth on the heart.. declared dead... more wailing. We all sit stunned. Including the kids, there must be some twelve people in that tiny room. Through all the grief, some woman has remembered to make tea for everyone. Rural hospitality is amazing. The tea is sickly sweet but welcome.

Kamla's gone. A nineteen year old from the neighbouring village of Chapad. Studied till the eighth standard and married at eighteen - not unusual for her family of seven, where her father had to work hard to make both ends meet. Her death too was unwarranted.

As was custom, the Dai had delivered the baby and walked off, thinking that she had done a great job. She had actually, under the circumstances. What she left out, or rather left in, was the placenta. Kamla just bled to death.

She needn't have, I said to Ajay as we sat sipping our filter coffee in the new south Indian restaurant in Connought Place. The coffee was good and genuine. 'But how long will you all try and sustain this work through the organisation; you must use the system; it seems that sometimes NGOs carry on their work only to sustain themselves; such efforts are just not sustainable,' said Ajay. I'm a bit confused. `Do you really know what you want to do?' he went on.

I thanked him for his time and offered to pay for the coffee. Its expense account, I'm told expansively with a special smile for my pretty companion. We walk out into a stream of yuppies buzzing in to catch their mid - day meal, chatting away on their mobiles. Life does look good. We part ways as Ajay saunters off to his office with the satisfied stride of having justified his morning listening to us.

I feel the need to take a deep long drink from a clear mountain spring. I think I'm caught in a reality warp. There will be many more Kamlas that I will see in the years to come. Gopal, her husband will find a wife for himself and Kamla will soon be forgotten. How many more Kamlas…

23 Feb, 2007

Dr. Sushil Sharma, a member of ARSI, is a practicing Anaesthesiologist based in the village of Satoli in the Kumaon Himalayas for the last nineteen years. In addition, he coordinates the effort of Aarohi, an organization established in 1992 for the development of rural areas of the Himalayas. Aarohi is a web of hundreds of like minded people from all over the globe. He can be contacted at aarohi2000@gmail.com

Invited as a speaker

Dr.J.K Banerjee, President of ARSI was recently invited to "First International Conference of Rural Cardiac care", held in Kerala, as a faculty member. Besides chairing a session Dr. Banerjee spoke on the topic "Rural healthcare, opportunities and challenges"

As a president of ARSI he has also been invited to a two day workshop on

"Human Resource and health (HRH)", organised jointly by the Ministry of Health, Govt. of India and WHO in Delhi.

Sushrut Award and Dr Anandibai Gopal Joshi Gourav Puruskar

Dr. R.R. Tongaonkar, past president of ARSI, has been unanimously selected by 'Mumbai Medical Foundation' for this year's prestigious Senior 'Sushrut Award'. Every year the Foundation gives two Sushrut Awards - one to a senior surgeon and second to a young Surgical Teacher. Dr. Tongaonkar has also been selected by the State Govt of Maharashtra for the prestigious "Dr. Anandibai Gopal Joshi Gourav Puruskar (Award)" as the best doctor in the year 2006-07 in the category of individual Non-Govt. doctor. This award is decided after strict regional and State level scrutiny. The award consists of Rs. 50,000/- cash, a trophy and a certificate.

The award giving ceremony will be held at Pune on 7th April in the presence of Chief Minister and other many Ministers of State of Maharashtra.

Heartiest congratulations to Dr R.R. Tongaonkar!

National Award

Dr.K.C.Sharma, Chief consultant surgeon Udhampur, an active member of ARSI and Chairman, Award Committee (Dr. Antia- Finseth innovation award) has been selected for "National Achievement award for health excellence" by National Association for Economic Growth and Social Development. The award will be conferred at a high level function in New Delhi on April 25th. He is being awarded for his research contribution in the field of medical sciences. Dr. Sharma was recently honored with State Award by J&K Govt. for his social and medical services to the rural people.

Heartiest congratulations to Dr K.C. Sharma!

Attention please

A group tour for ARSI members has been planned to attend
2nd International Conference of Rural Surgery in Tanzania.
For query regarding itinerary please

Contact:
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From the diary of a rural obstetrician

Conviction

Dr. Gio Gnanadurai

I was doing the routine scans for the day, when my wife, Karuna, rang me up and told me that there was a patient with a hand prolapse. As she wanted to make sure it was the elbow and not the knee, she suggested that I do a scan. The patient was only 24 weeks, and had already drained all the liquor. It was a very difficult scan, and I could not make out if the bone going down was from the upper or the lower limbs. So I did a pelvic examination and ascertained it was indeed a hand prolapse. The foetus heart beat was at a very slow pace.

I knew there was very little place for an *Internal Podalic Version*, in the modern day obstetrics. But all the same, I suggested to Karuna to wait till her *full dilatation*, before we decide on the next move. She agreed to this proposal. We finished the morning OPD, and went home for lunch.

I just woke up from my short afternoon nap, when Karuna informed me that she had been told from the labour room that the cervix was fully dilated. She hurriedly went down to the labour room, even as I started to get ready also.

I started wondering. Why should I attempt a vaginal delivery? For the sake of the professional satisfaction and for the accolades I might receive? Should I risk the life of the patient and end up with litigation? Then suddenly I was clear in my mind. If I would attempt it, it was for the sake of the patient, whose family would save a few thousand rupees, and not for the fame I would receive. So I prayed to God to give me the wisdom to take a right decision, for the sake of the patient. By this time I was informed that the patient had been shifted to the operation theatre. As I rushed down, I prayed once again to protect me from *Professional Pride*.

Under IV Pentathol, and gas/oxygen mask, administered by our nurses, (there is no anesthetist), we started attempting the maneuver. We gave a liberal episiotomy, and I tried to locate a leg to pull out. Though it was slightly difficult, I had one leg out in no time. Now we had one leg and one hand out - not an easy position either. Getting at the other leg was a little more difficult than the first, and might have been riskier, but I managed it. In the process, the femur was fractured, but it did not matter, as the baby was already dead. It was then we realized, that the baby also had a gross anomaly - no anterior abdominal wall, and the entire contents of the abdomen lying exposed - **exampholos**. I had completely missed it during the ultrasound.

We checked for any possible rupture of the uterine wall, and thankfully, there was none. We just had to suture up the episiotomy and we were through. I moved to the OPD straight. After half an hour Karuna informed me that the patient was fine.

Next afternoon, when I reached home after the morning OPD, I came to know that the patient had absconded without paying anything. After listening to the incidence I was completely in peace. I realized that neither I would be poorer nor the patient would be richer by this act. I rather thanked God for saving me and the patient from more trouble that either of us could have faced. We indeed have everything to be thankful for, nothing indeed to worry over. If God brings me to the point of treating this patient again, I desire His grace, in helping me to treat her as if nothing has happened.

Stop struggling for perfection, and recognize the perfection you already are
You need just this: devotion to the essential.

In Trial, Drugs Equal Benefits of Artery Stents

By BARNABY J. FEDER (From Newyork Times)

NEW ORLEANS, March 26 - Many heart patients routinely implanted with stents to open arteries gain no lasting benefit compared with those treated just with drugs, researchers reported Monday.

Hopes for a Plaque-Fighting Drug Dim (March 27, 2007) The researchers said patients with stents to prop open coronary blood vessels in addition to being treated with statins and other heart drugs in a five-year trial had better blood flow to the heart than patients treated only with drugs.

The nearly 2,300 patients in the trial all had a relatively stable form of coronary artery disease that generally progresses slowly.

Previously, doctors had assumed that stents performed much better than drugs at relieving symptoms over the long run. Studies have shown that angioplasty and stenting can save lives when used in heart attacks. The procedure is also recommended for many patients whose symptoms of poor blood flow to the heart are not relieved by rest or drugs.

For such patients, the debate is not whether to use stents in addition to drugs but whether stents are used in too many seriously ill patients who might live longer with bypass surgery.

Angioplasty with stenting generally costs $25,000 and up. The latest drug-coated stents cost $2,200 apiece and are especially effective at preserving the channel created by angioplasty.

Sales of the drug-coated stents have been falling in the United States since last spring because of studies that showed that potentially deadly clots formed in a small percentage of patients long after the stents had been implanted. Recipients of drug-coated stents are now told by most doctors to take anticlotting drugs indefinitely. The new clinical study adds questions about the effectiveness of stenting to the safety debate, at least in the patients studied in the trial, named Courage, for Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation.

(Abstract from the original article)

RNI No. DELENG/ 2005 / 16240

Dr. Antia- Finseth
INNOVATION AWARD- 2007

Association of Rural Surgeons of India offers Antia- Finseth Innovation award of Rs. 10,000/- for any innovation that is useful for rural health care. Innovation may be equipment, procedure or even a concept.
Innovator may be medical, paramedical or non-medical person. Apply about the innovation with following details:

1. Brief abstract of the innovation (About 300 words)
2. Novel features of the innovation
3. Advantage over the known alternatives
4. Detailed description accompanied by diagrams, drawings, photographs neatly labeled
5. Complete bio-data of the innovator along with photograph
   One copy of the application has to be sent to Hon. Secretary and Chairman Award Committee each

Terms and conditions:

1. Awardee has to present his work at the annual conference of ARSI and receive award
2. Award will not be given in absentia.
3. Decision of the selection committee shall be final

Last date of submission of application for the award is 31st July 2007

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