Cross Specialty Scientific CME

CROSS CONNECT 2017

Venue	ITC Mughal, Agra, Uttar Pradesh
Date	28 July 2017
Total Participants	150

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Cross Connect 2017 was conducted at ITC Mughal, Agra, Uttar Pradesh. The CME was organized by CME Foundation of India (CMEFI).

The sole objective of the CME was to update the doctors from across India and specially from in and around Agra in cross specialty i.e. endocrinology, cardiology, urology, neurology, rheumatology, psychiatry, with their level of morbidity and mortality and its associated spectrum of complications, as these diseases are now highly visible across all societies within India.

The session was open with an introductory session by CME Foundation of India and followed by the welcome address by the course director Dr. Hemant Thacker.

Welcome address – Dr. Hemant Thacker
Course Director

The scientific program was broadly classified into 06 symposiums with their topics and speakers respectively

Symposium 1

Diabetes: how technology is shaping up management of diabetes
Dr. Banshi Saboo

Symposium 2

Cardiology: J shape curve in hypertension: is lower better
Dr. Arati Dave Lalchandani

Symposium 3

Urology : Incontinence and urinary retention, cutting the gordian knot
Dr. Shailesh Raina

Symposium 4

Neurology: Significance of Tias
Dr. S. M. Katrak

Symposium 5

Rheumatology: interpreting common investigation reports in rheumatology Disorders
Dr Lata Bichile

Symposium 6

Psychiatry: Handling depressed patients and anxious relatives
Dr. Nilesh Shah

Summary

"How technology is shaping up management of diabetes" explained by Dr. Banshi Saboo with following highlights:

Technology is emerging as a major game changer in the way diabetes is being managed worldwide In the recent past, diabetes management has witnessed many changes at various levels ranging from understanding of diabetes to management strategies. Diabetes treatment has changed considerably over the years with the development of new medical technologies. From talking meters to continuous glucose monitors. Lots of exciting things have happened in the field of diabetes research. The Latest technology is known to all by now. After many decades, this technology has brought joy to the doctors across the world. Though, the technology used is showing great benefits in terms of glycemic control, weight reduction, and blood pressure reduction!

Symposium 2

"J Shape Curve In Hypertension: Is Lower Better" was discussed by Dr. Arati Dave Lalchandani with following remarks

The J-curve phenomenon is defined as the shape of the relationship between BP and the risk of CV morbidity and mortality, which means that the risk of CV events may increase at both too high and too low levels of BP. The current national and international antihypertensive treatment guidelines recommend a BP goal of <140/90 mmhg, and <130/80 mmhg in patients with CAD, chronic renal disease and other CVD. However, the recent large clinical studies have shown the J-curve phenomenon in patients with a DBP <80 mmhg as well as in patients with a SBP <130 mmhg, and the studies demonstrated no significant differences in the risk of cardiovascular complications between aggressive antihypertensive therapy and standard therapy. Yet the J-shaped curve does not appear for stroke patients, and this shows a relationship consistent with the principle "the lower the better"

"Incontinence and urinary retention, cutting the gordian knot" was described By Dr. Shailesh Raina with following summary

Urinary incontinence is loss of bladder control. Symptoms can range from mild leaking to uncontrollable wetting. It can happen to anyone, but it becomes more common with age. Women experience ui twice as often as men.

Most bladder control problems happen when muscles are too weak or too active. If the muscles that keep your bladder closed are weak, you may have accidents when you sneeze, laugh or lift a heavy object. This is stress incontinence. If bladder muscles become too active, you may feel a strong urge to go to the bathroom when you have little urine in your bladder. This is urge incontinence or overactive bladder. There are other causes of incontinence, such as prostate problems and nerve damage.

Treatment depends on the type of problem you have and what best fits your lifestyle. It may include simple exercises, medicines, special devices or procedures prescribed by your doctor, or surgery. Any patient with incontinence deserves proper evaluation and treatment as most forms of incontinence are treatable even in the elderly patients.

Urinary retention is the most common urologic emergency, affecting 1 in 10 men age 70 and older. Benign prostate hyperplasia (BPH) is the most common underlying condition, but multiple etiologies may cause UR. Medications are frequently implicated Initial management of UR involves prompt bladder decompression. We suggest initial treatment with a Foley urethral catheter, rather than a suprapubic catheter for grade 2b. A suprapubic catheter may be indicated when obstruction precludes a urethral catheter, and may be preferred in patients who are expected to require longer term decompression. Clean intermittent catheterization is likely not practical for patients with acute urinary retention. We recommend complete initial drainage of the bladder rather than limiting the volume of initial drainage for grade 1c.hematuria, transient hypotension, and post obstructive diuresis are common, but rarely clinically significant. Hospitalization is indicated for patients who are uroseptic, or who have obstruction related to malignancy or spinal cord compression. Emergency surgery for relief of prostatic obstruction is rarely indicated, and carries an increased risk over elective surgery. The majority of patients can be managed as outpatients once bladder decompression is accomplished. Removal of the catheter after a period of time results in successful spontaneous micturition in up to 40 percent of patients with UR, though recurrent UR is common. We suggest a trial of catheter removal in one to two weeks for grade 2c in men with presumed BPH, we recommend use of alfuzosin 10 mg daily, to be initiated at the time of initial catheterization for grade 1a.the majority of men who have BPH and UR will ultimately require definitive intervention for their BPH. We suggest ongoing treatment with an alpha blocker and 5 alpha reductase inhibitor to delay the recurrence of

AUR for grade 2b. A urodynamic evaluation is suggested prior to prostate surgery for patients who have experienced UR.

Symposium 4

"Significance of TIAs in stroke prevention" was elaborated by Dr. S. M. Katrak with following summary of discussion

Diagnosing transient ischemic attack identifies a patient who is at risk for subsequent stroke. The risk of stroke after transient ischemic attack is somewhere between 2% and 17% within the first 90 daysstroke is a syndrome that can have either an ischemic or hemorrhagic cause. It is now clear that transient ischemic attack and minor ischemic stroke are highly predictive of a subsequent disabling ischemic stroke within hours or days. The critical clinical problems for physicians and nurse practitioners who evaluate these patients are to identify that the patient has had a stroke or transient ischemic attack and to stratify risk to determine if the patient requires rapid intervention to prevent recurrent stroke. Antithrombotic therapy may play a distinct role in this acute pathophysiology. Effective therapies in those with TIA could significantly reduce the overall burden of stroke if initiated immediately.TIA is a unique, important type of cerebral ischemia characterized by substantial instability, in which acute treatment is potentially highly consequential. Currently, the treatment choice ranges from immediate hospitalization and initiation of intravenous antiplatelet agents or heparin to outpatient evaluation and treatment with aspirin.

"Interpreting common investigation reports in rheumatology disorders" Dr. Lata Bichile deliberated the topic with following highlights

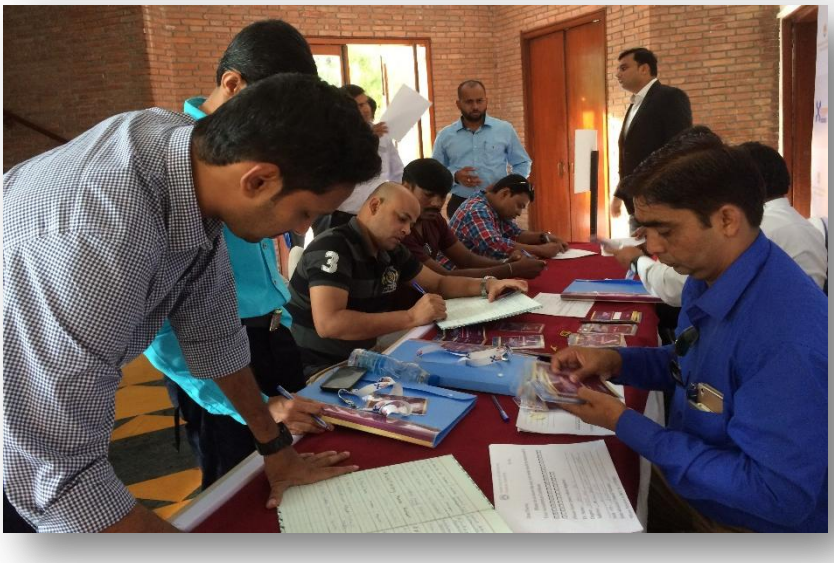
Antibody tests are useful for confirming a rheumatological diagnosis. However, there are major pitfalls in relying on them to diagnose or rule out a disease. Most antibody tests are reported either as absolute values in international units or as a titre. A titre gives a value for the number of dilutions before activity is lost. The higher the titre, the greater the concentration of the antibody. To avoid pitfalls when referring a patient with inflammatory arthritis, suspected connective tissue disease or vasculitis, it is important to know exactly which tests to request to confirm or exclude a specific diagnosis. Selection of appropriate auto antibody tests in patients with suspected rheumatologic disorders should be guided by clinical impression • Before request, be sure of indication & anticipated response to result.

Begin with sensitive tests and if positive use more specific tests to help confirm diagnosis. Most auto antibody tests need not be serially repeated - exceptions canca & ds DNA. CRP is usually preferable to ESR for detecting acute phase response - exceptions SLE Cancer referrals. Computer based interventions may help to guide requesting.

Dr. Nilesh Shah took the session on "Handling depressed patients and anxious relatives" and closed it with following points

Anxiety and depression are experienced by nearly everyone, to some degree, in their lifetime. Whether these issues are direct or indirect occurrences of one's life, they can become a salient part of our day to day living. Encouraging outdoor activities, even when patient doesn't feel like doing them, is an excellent way to combat depression. A healthy diet and a regular eating schedule helps to recognize any changes in eating patterns. New hobbies helps realizing fun activities they can engage in to be entertained, even though they may not be able to do everything they could once do. Accept their feelings toward the rest of the world. Trying to reason with them may make it seem like you are just another person who is against them or doesn't care about them. Reassure them of depression treatments and how effective they are. Let them know that treatment has high success rates helping a depressed patient not feel so worthless, and sometimes even lift their spirits. Talking to patients about their feelings is a good first step in dealing with their depression. Being sympathetic helps them know that you understand their feelings rather than judge them for how they feel. Let the patients relative know everything that you are doing and why you are doing it. Most people's fear of the hospital comes from being in an unfamiliar environment and not knowing what to expect. Before you enter the room, make sure you are prepared. Bring in any new medication hand-outs, understand and be able to explain the rationale behind administering all of them. Prepare patients relative on what to expect with any procedures that will be done for that day or the next day.

Session @ Glance

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