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Editor: Dr. Saurabh Misra MS, FICS, FIAGES Sr. Consultant – Minimal Access & Bariatric Surgery
President – ABCF (Apollo Bangalore Consultant Forum)

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Dead doctors don't lie!

This is the title of a CD that is being sold in the USA by a doctor who claims that his alternate medicine is more effective than the traditional medicine or the Allopathic medicine as is widely practiced! His explanation was that, "if the traditional medication was that effective, then the doctors would be living more than their patients with all the knowledge and resources at their disposal!" According to him, an average American physician lives 5 years less than their counterparts in the other professions".

Actually, he was wrong! According to Frank E, an analyst, an average American physician lives longer than the general population to about 73 (White), 68.7 (Black) years compared to lawyers at 72.3 and 62 years and general population at 70.3 and 63.6 years .

The trouble begins when we see the Indian figures. According to the IMA Pune, the average Indian physician lives 10 years less than the general population! At an average age of 55 years, the great Indian healer lives the least!

So what makes us different and more vulnerable than our western counterparts? There is no doubt that that the Indian doctors are rated as the best in the world. Having said that, the comparative reimbursement is far from even! To make up for the revenue gap, most of our colleagues will unknowingly resort to the 'the number game' at the cost of their free time, family time and their health.

'Stress' is another killer in our times! Some our colleagues who have worked in the west, have never seen our bosses ever talk to their patients on the phone! It is a strict 'no-no'. Work culture in our country mandates otherwise.

Practice here requires availability and not picking up a phone call after working hours or otherwise is considered impolite! Thus the phone calls further eat up into our free time making things more complicated. The other stress in our practice is the patient's expectations for a world class results by paying Indian prices! They may be correct in their expectations but they also need to realise that medicine is becoming increasingly equipment dependent for example a PET scan or a CyberKnife, which comes at great price and all costs have to be recovered!

As the Indian patient is becoming increasingly violent, the trust gap is increasing, inciting the physicians to increasingly practice defensive medicine, where, patients and the insurance company are footing the bill! The system is suffering with no one benefitting! So how do we take care of ourselves in this environment of mistrust, violence, decreasing reimbursement and increasing expectations?

I tried to compile the various strategies which could be really effective:

1. Protect your Telomere: 'Telomere' is the limbs of your genes which decay over time, the length of which decide your age. Proper diet and exercise are the only two ways to delay the decay.
2. People who live long are conscientious, i.e. take corrective decisions based on facts about you!
3. Make friends, be more social!
4. Quit smoking and curtail alcohol.
5. Have a siesta, if possible.
6. Make sleep a priority (at least 7-8 hrs).
7. Lose weight.
8. Get spiritual.
9. Have a group practice with like minded individuals.
10. Practice a phone free day in a week!
11. A diet full of nuts and proteins (Mediterranean diet) with fewer carbohydrates are an obvious choice. A weekly exercise target of 150 minutes can certainly help!

So, go for it guys! Go to tonight's party instead of waiting for the next patient! Do things that you love and love what you do! After all, your profession is just a small part of your life and not everything about yourself!

Dr. Saurabh Misra

Revision Knee Replacement for Infected Total Knee Replacement - A Case Report

Introduction:

The total knee replacement surgery gives consistent and durable long term results for patients suffering from total knee replacement, in the form of relieving pain and improving the mobility and function.

However the complications are also known to occur in this surgery such as improper ligament balancing resulting in a tight knee or a lax knee resulting in instability and pain. The infection of a total knee is a serious complication in terms of its management, its social, economical and psychological implications that it has on the patient and family. The infected knee replacement can be salvaged by a revision knee replacement by proper management in a centre which has the facilities, expertise and experience in performing revision joint replacement surgeries.

An infected total knee replacement if not adequately and promptly treated can result in long term disability and pain to the patient and often patient may end up with either fusion of the knee, were the mobility is lost or amputation, were the limb is lost.

With proper technique and expertise, the revision of such a problem to give functional and lasting knee is possible. We report such a case of management of infected knee by revision surgery at Apollo Hospitals, Bangalore.

Case Report:

A sixty five year old lady had undergone knee replacement surgery 5 years ago (in another hospital), and had infection in the knee since a year. She underwent two surgeries which failed to remove the infection from her knee. We performed a two stage procedure for the infected knee.

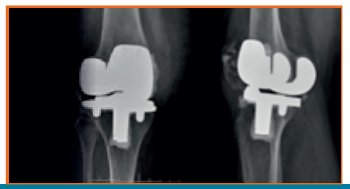

Fig 1 - X-ray showing infected TKR with loosening of implants.

She had pain and was not able to walk for the last six months. The x rays showed loosened implants.

Stage one was removal of the implant and debridement and we inserted an antibiotic impregnated bone cement as a spacer. (Fig 2) The patient was on intravenous and oral antibiotics for period of eight weeks. The infection was controlled well. The ESR and CRP values touched the normal range at eight weeks.

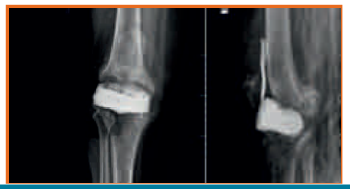

Fig 2 – X-ray sowing the removal of infected TKR implants & antibiotic impregnated cement spacer in situ.

As the wound was well healed, stage-two surgery was performed with removal of the cement spacer and debridement and implantation of the revision implants was performed. Patient sustained the procedure well. As there was certain amount of bone loss, a special implant for revision called LCCK was used. (Fig 3)

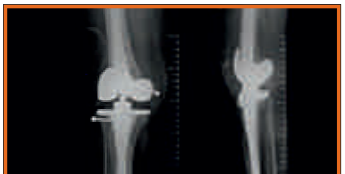

Fig 3 – X-ray showing the revision implants (LCCK) in situ after the revision surgery.

At the present follow up patient has a good function in the knee without pain.

Conclusion:

Infected knee replacement is a serious complication can result in significant pain, disability and loss of function. Often these patients end up in either a knee fusion or amputation.

With good control of the infection, technology and expertise, revision of the infected knee and implantation of revision implants is possible to give a good function of the knee and pain relief to the patient.

Dr. Raviraj A
MBBS, D ORTHO, DNB (Ortho), M.Ch Ortho, MNAMS
Fellow in Joint Replacement Surgery
Sr. Consultant Joint Replacement & Arthroscopy
Apollo Hospitals, Bangalore

Antidepressants Are Not Addictive

Antidepressants are an effective treatment modality for Depression - third commonest medical condition in world. WHO estimates that it will climb to No. 2 by 2020 and No. 1 by 2030! Further they have reported that about 60% of individuals who consult general practitioner (GP) have stress related psychological problems. This makes the GP's at the forefront of prescribing effective medicine in an informed manner.

Antidepressants are proven to be effective in treatment of depression and anxiety disorders including OCD. Research has established that combination of antidepressant and psychotherapy (talk therapy) is more effective than either on their own.

WHO has added that treatments are available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. Perhaps this may be due to stigma and misperception about mental illness, but I think equally due to misinformation related to antidepressants and its alleged addictive nature.

Let's make it clear. Antidepressants Are Not Addictive. It's a common misconception that they are. Unlike commonly used tranquillizers (Diazepam, Alprazolam, Lorazepam), alcohol and nicotine (cigarette and chewing tobacco), antidepressants are not addictive. This means that they do not cause physical dependence which is characterised by Tolerance (needing to take increasing dose to get the same effect), Withdrawal effect on reducing dose or abruptly stopping after regular uses for more than 6 weeks (features include anxiety, nausea, tremor & sweating in milder cases to convulsion & delirium in severe cases), and compulsive use to abate craving etc.

Confusion arises as antidepressant discontinuation leads to withdrawal effects. These effects are seen in 1/3 of individuals who 'abruptly' stop taking antidepressants (SSRI like paroxetine, sertraline and citalopram, and SNRI like venlafaxine). They effects are characterised by flu like symptoms - aches and pain, stomach upset, anxiety, dizziness, insomnia, vivid dreams, electric shock sensation in the body. In most people these withdrawal effects are mild, but for a small number of people they can be quite significant.

Some individuals report that, after taking an SSRI for several months, they have difficulties in managing without medicine and so feel addicted to it – when assessed most of these people have reverted of the original condition, thereby requiring re-instatement of previous effective medication.

The Committee of Safety of Medicines in the UK reviewed the evidence in 2004 and concluded **'There is no clear evidence that the SSRIs and related antidepressants have a significant dependence liability or show development of a dependence syndrome according to internationally accepted criteria.'**

Advisory: Please prescribe sensibly and deliver needed treatment. As you all know winning trust is first step to patient engagement. Avoid combination (multiple drugs in the same tablet) medicines where antidepressants are mixed with addictive tranquillizers, as it is harder to reduce dose or stop them. Where discontinuation of antidepressant in indicated go for slow tapering down off the dose over a period of 2-4 weeks or longer, rather than abrupt stopping. Ideally this is done under expert psychiatric supervision.

Dr. Roshan Jain
Sr Consultant Psychiatrist and De-Addiction Specialist
Apollo Hospitals Bangalore
www.roshanjain.com
email: roshanjaindr@gmail.com

Kudos!

Dr. Saurabh Misra

Activities undertaken for July, August and September 2016

- Conducted a Live workshop on rare procedure known as Laparoscopic Rives Stoppa technique for repair of Ventral hernias at KIMS Hospitals, Bangalore on 23rd July 2016.
- Invited as Faculty in KIMS Hospitals for a guest lecture on 'Complications of Laparoscopic surgery and how to avoid it?' on 24th August 2016.
- Invited as a Faculty by HSI (Hernia society of India) at Aurangabad, Maharashtra, on 2nd Sept and chaired a session on 'Best video', session.
- Invited for a guest lecture on "Self fixating meshes" at the same conference.

Dr. Sunil N Dutt

Invited/Guest Faculty (Programme Committee): 14th International Symposium on Cochlear Implantation and Other Implantable Prosthesis (CI2016) –Toronto, May 11th -14th, 2016.

- Chairperson/Moderator: Session on Paediatric Issues
- Poster presentation: Role of TT EABR in I Candidacy
- Reviewed 40 abstracts in CI Surgery

Invited/Guest Faculty and Regional Coordinator (India): 1st World Congress for Cochlear Implants in Emerging Countries, Dubai, UAE, May 24th to May 26th, 2016.

- Regional Coordinator for India
- Invited lecture: Hearing Preservation CI Surgery
- Instructional Course: TT EABR in CI Candidacy
- Panellist in Round Tables: a) Newborn Hearing Screening b) Tips and Pearls in Surgery c) Revision CI Surgery d) Remote Mapping and Consensus
- Moderator: Round Table on Revision Surgeries

Invited/Guest Faculty: 10th International Cholesteatoma Conference, CHOLE2016, Edinburgh, UK, 5th to 8th of June 2016.

- Invited lecture: Bone Anchored Hearing Aid Technology: Evolution in India
- Indian Society of Otology lecture: Removal of Cholesteatoma Matrix: Difficult Situations
- Contributor: Consensus document on Definitions, Classification and Staging of Cholesteatoma

The Department of ENT has started a Postdoctoral Clinical Otology Fellowship under the aegis of RGUHS beginning July 2016.