

## Curing with compassion Meet on rheumatoid arthritis

**C**ontinuing Medical Education Seminars (CMEs) are conducted by Rabindranath Tagore International Institute of Cardiac Sciences, Kolkata on a regular basis. These are held for our fraternity of family physicians to impart knowledge and perception in the field of modern medicine, by the way of direct participation and interaction.

April saw the first anniversary of our CME. To commemorate its first birthday a symposium was held on the debilitating disease Rheumatoid Arthritis. The celebrations were held on the 30<sup>th</sup> April to coincide with the sixth Foundation Day of Rabindranath Tagore International Institute of Cardiac Sciences.

The symposium witnessed the congregation of some of the most eminent professionals of the medical field. The session commenced with the welcome address from our Clinical Director Dr. Ashutosh Raghuvanshi followed by the release of a CD by Prof Sukumar Mukherjee which contained a number of compilations of CME lectures 2005-2006.

Among the eminent invitees were Prof. Alakendu Ghosh who chaired the session and Prof Sukumar Mukherjee who delivered a guest lecture on Art and Science in the management of Rheumatoid Arthritis. Dr. Vikash Kapoor waxed eloquently on the surgical aspects of Rheumatoid arthritis while our Deputy Medical Superintendent delivered the vote of thanks.



**Dr. Mrinalendu Das**



**Dr. A. Raghuvanshi**



**Dr. Sukumar Mukherjee**



**Dr. Vikash Kapoor**



**CD release**

The symposium sought to shed light on Rheumatoid Arthritis, a crippling disease which is one of the most common causes of physical disability at a young age. Prof. Sukumar Mukherjee, articulated upon the important clinical parameters are relevant investigations required for the proper diagnosis of the disease. He opined that early treatment with effective medication could halt the development of various deformities. He also spoke on differential diagnoses of rheumatoid arthritis and how to differentiate between various forms of arthritis.

Dr. Vikash Kapoor enumerated the various surgical options of treating this disease to provide pain-free joints. Early intervention would probably prevent a lot of the disability associated with the onset of Rheumatoid Arthritis.

Prof Alakendu Ghosh nicely conducted the session with poise and e'lan. An interactive question and answer session with enthusiastic audience participation followed up the seminars. The CME was brought to a close with the final comment from the speaker who observed that early diagnosis of the disease and its guide referral to a specialist could defer the disabling deformities, which are a common sequel to the disease.

The programme started at ten in the morning and ended at about one in the afternoon after a light luncheon. Around 80 delegated including doctors from RTIICS and ACTC participated in the CME.

The symposium was a great success and all the delegated felt it was a beneficial and enriching experience. Certificates of participation were awarded after the completion of the programme.

**Dr. Mrinalendu Das**

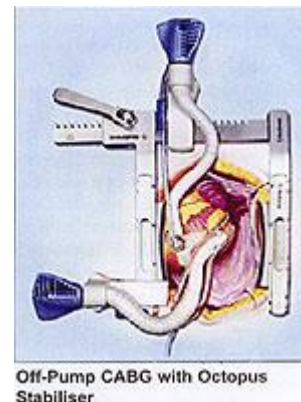
**Sr. Consultant Cardiac Surgeon, RTIICS**

We thank Dr. Babul Chakraborty, M. B.B.S. (Cal), renowned Family Physician in Child Care & Immunization, for sending us this very encouraging letter (reproduced below). Such words of support help us to strive towards higher goods....

"I had the opportunity few days back i.e. on 30/04/06 to attend the annual CME on "Rheumatoid Arthritis" by eminent Dr. Sukumar Mukherjee that had helped me very much at your centre. Your arrangements are praiseworthy specially. Your audiovisual arrangements you've provided during Prof. Mukherjee's Lecture & the Interaction later on. I've come to know that it was your 6<sup>th</sup> Establishment day. On 30/04/2000 you've started your journey. Now the Centre is 6 yrs. Old ! My heartiest congratulations for this. Besides this your publications (periodicals, newsletter) that you've provided us - are very informative. I think in future also, in the pursuit of knowledge, education and excellence, your centre will create an example to serve the medical fraternity & the ailing humanity."

## CABG: the promises and paradox

Perhaps in the history of applied science there is no single procedure that has enamoured human attention and admiration as has coronary Bypass surgery since its inception in 1966. Is it not paradoxical that an unassuming Argentinean resident, Rene Favoloro - rose above the towering figures in Cleveland Clinic and in the autumn of 1966 proclaimed to have devised the first aortocoronary bypass for myocardial ischemia. In the same institute a few years earlier Soanes had discovered coronary angiography by sheer accident entry in the coronary ostia....Medicine has never been the same again.



Combination of coronary angiography and bypass surgery was a proverbial super hit combination that dominated the façade of medicine for the next four decades.

The result of relief from angina and reduction of myocardial infarction was dramatic, so much so that CABG overtook appendicectomy as the most commonly performed operation. But what were the principal indications for CABG in the boom era of 75-85?

Discrete coronary stenoses, good, L.V. function and non-diabetics formed the bulk of the patients. The prima donna surgeon would not cast a second glance at the diabetics with diffuse disease and the poor LV functions. IT was a New York that a small step in surgery proved to be a giant leap for mankind....Dr. Green's adoption of the left internal mammary artery for bypassing the left anterior descending coronary artery. The epochal work of Loop et al from

Cleveland Validated the benefits and since then it has remained as the gold standard for revascularisation---yet to be beaten with 90% 10 yr patency rates.

The ensuing refinement in cardiopulmonary bypass and myocardial preservation saw the gradual broadening of the surgical spectrum to the post infarct compromised LV functions, diffusely diseased arteries and complex repairs of L.V. aneurysms.

Some workers were dabbling with the extended use of arterial grafts but LIMA and vein grafts remained the staple procedure. Through the Eighties and Nineties there were volumes of literature on long term LIMA and vein graft patency rates...a wealth of statistical data that was to be the backbone of surgical analysis.

By the dawn of the Nineties CABG had attained a success rate in excess of 95% with equal measure of relief form angina.

Like most fairy fables the story was too good to last ! A little known German - Andreas Grunzweig was devising with his kitchen table kit a funny catheter that would spoil the party in a big way. Angioplasty found its way from the kitchen table to the cath lab and became a valid technical alternative to the hitherto unchallenged CABG. The surgeon did breathe a sigh of relief once the high re-stenoses data found their way out in print.

This relative disadvantage was off set with the sophistication of stent technology.

The dream run had ended...surgery had a competitor...could it rise to the challenge?

### **Rise to the challenge we did...**

Dutch workers and the ingenuity of Enrico Bufalo from Brazil, ushered in the era of Off Pump CABG that obviated the routine use of cardio pulmonary bypass for CABG.

IT meant a dramatic reduction in morbidity and cost. It was coupled with the fact that safe reuse of disposables was a boost in the arm for the surgeons in Asia and South America. In the next few years more than 75% of all CABGs in India were being done on OFF Pump technique. This has ushered in an era where Indians and South Americans have inclined towards the off pump style, whilst northern hemisphere remains conservative with the proportion of Off Pump work scarcely exceeding 25%.

## **The journey of CABG...**

The surgical fraternity has more than equalled the challenge not only in the acceptance of newer methodology but also in its capacity to deal with complex cases: - poor coronaries, valve + coronaries. L.V. aneurysms, post infarct VSD and redo CABGs.

We seldom appreciate the fact that the last decades have been a game of moving goalposts!

What used to be the indications for CABG in 80's form the crux of PTCA today...and the primary contra indicators of the 80's are the vast majority of today's surgical populace. There is no comparable surgical practice where there has been such an avrupt paradigm shift in the clinical scenario from the sublime to the stern ! It is a tribute to the tenacity of surgical and critical care practice that over the decade the results of excellence have been maintained-even though the challenge is many time longer.

IT is considered common place for 30-40% ejection fraction patients to be operated on with < 2% mortality... 20% of all patients are in chronic renal failure... 10% are complex and redo cases. IT will remain the holy grail of coronary surgery to tread where angels fear to step in... Tougher hurdles have to be overcome in quest to provide effective therapy in the complex disease spectrum.

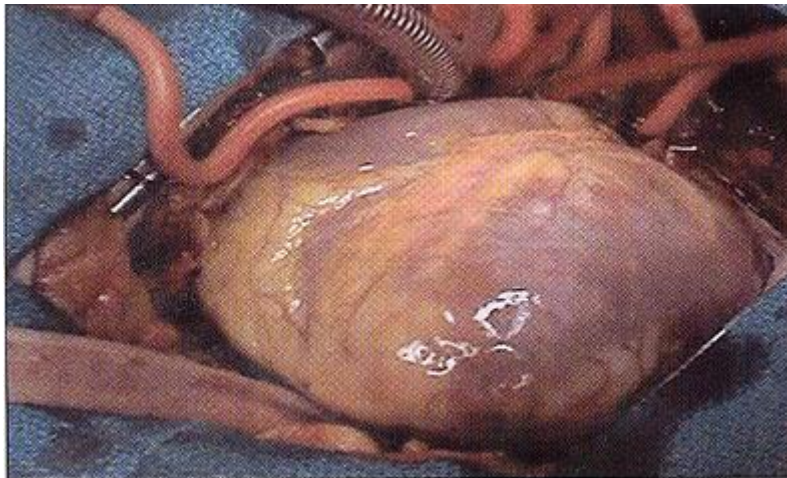
## The Great Divide

Another aspect of stark difference between the surgical practice is the north south divide between the affluent and non affluent economies. The surgical numbers have dramatically shrunk in the US, UK, Europe whilst the Asian and South Americans record an increasing trend. To appreciate the phenomenon without over simplification we need to empathize with the facts :-

...The developed world is beginning to feel the benefit of preventive cardiology programmes with the overall incidence of coronary artery disease and diabetes being on the decline.

...The developing (deprived?) society is still struggling with the disease burden and still the resources are inadequate to cope with the needs.

...CABG in India and Brazil, the two most active spots outside of G7, has remained cost effective and restrained as far as the cost to the patient is concerned.



**LV Aneurysm surgery**

A standard CABG in India is at least 40% less expensive than a double vessel angioplasty with drug coated stents, whereas in the USA CABG is 50% more expensive.

This is primarily attributed to the distorted and inflationary cost structure. Expressed simply.... bad strategy. It is a rather harsh simile to use but our colleagues in the west are-'shooting themselves in the foot'.

Majority of the treatment recommendations from the health cost providers in the west-favouring PTCA over CABG-is based solely on immediate cost considerations.

The sooner our western brethren address this hard facet of life-the better.

The surgical practice in India has not only been equal to the clinical challenge but also contained its own greed, managing to keep it alive as an attractive economic option with better long term results.

The evolution of surgical practice in RTIICS in the last five years has been more of a revolution! From a modest 300 cases in 2001 to 1000 in 2002 and in excess of 1500 cases over 2005 - it has been a staggering growth in numbers... Perhaps not equalled by any other institute in the country. There is clinical demand for us to perform at least 2200 cases annually with more than 1500 CABG's .. the constraint has been our built up super structure, which I believe is being addressed. RTIICS had been working to >95% occupancy and OT utilisation for more than last three years. We are overwhelmed by the response from the community and peer group. All this with less than 1% mortality in elective CABG and a strict commitment to coat and transparency.

If we have dwarfed all other surgical practices in the region...It is because of the unflinching commitment of each member of the RTIICS family, including the supportive, paramedical, nursing and medical staff. If some of us have acquired a stature of some height, it is because we stand on many shoulders...

In attempting to outline the state of affairs in coronary surgery today... I have spun a yarn of reality...Which not only has its twists and turns but also reminds the clinician at every juncture that it is his primary endeavour to render efficient and honest medical advice. The techniques and technology will change...but the ethos of medicine remains unwavering...should we end with Tagore:-

.....father, in your festival of lights let me light my small lamp.

## Open the artery, sooner the better

A 65-year-old diabetic male patient presented in emergency with uneasiness followed by extreme weakness since the last 8 hours. The referring physician excluded hypoglycaemia and could efficiently pick up subtle ST changes in ECG. On admission in the hospital's Emergency Traige, he was found to have a pulse of 65/minute and a BP of 90/60 mm Hg. He has mid-line obesity, mild pallor and pedal oedema. Heart sounds were soft, chest bases were clear, JVP was unremarkable, ECG revealed 1<sup>st</sup> degree AV block and ST elevation in lead II,III, avF, V3R and V4R, Trop T was positive, RBS 300 mg/dl, Hb 11.5gm/dl, serumcreatinine 1.3mg/dl. A diagnosis of acute inferior and right ventricular ST elevation myocardial infarction was made. The patient received 325 mg of Aspirin and 600 mg of Clopidogrel immediately and was transferred to the Critical Care Unit. Within the next 10 minutes, he developed complete AV block and his blood pressure was unrecordable. Echocardiography rules out any pericardial effusion, and showed hypokinetic inferior wall RV, postero-basal hypokinesia and an EF of 40%. Endotracheal intubation and inotrope infusion (dopamine, dobutamine,noradrenaline), volume infusion were started and an IABP (intra-aortic balloon pump) was inserted immediately.

After-discussing with the relatives, he was taken up for coronary angiography and possible revascularisation. Coronary angiogram revealed minor disease in the left anterior descending artery, normal left circumflex and occluded right coronary artery. Right coronary artery was crossed with coronary wires. Direct stenting of the proximal RCA was done and a TIMI III flow achieved. The patient developed non-sustained ventricular tachycardia and remained hypotensive despite IABP and inotrope support.

After 3 hours, his left pedal pulse was found to be feeble (IABP through left femoral artery). Fearing ischaemic complications of the peripheral artery, the IABP was removed and the inotrope was continued.

Other treatment included Eptifibatide and insulin infusion. His intra-arterial blood pressure remained 90/60 mm Hg despite optimum inotrope support for the next 2 days. Gradually, the inotropes could be tapered and stopped, and he was out from ventilation after 60 hours. He was shifted to the general ward on the 5<sup>th</sup> day and discharged from the hospital on the 10<sup>th</sup> day. HE came for a follow-up after 3 weeks with no cardiovascular symptoms but complained of inability to follow the dietary restrictions.

Primary coronary angioplasty in the setting of ST elevation MI is a life-saving procedure, if performed in early period. The rule is "Time is Muscle". We could perform coronary angioplasty within 90 minutes of admission. On the contrary, thrombolysis in the setting of cardiogenic shock, as in this case, is mostly unsuccessful and associated with worse outcome (SHOCK trial). Of course, doing a primary angioplasty in these sick patients needs a complete team effort of doctors and paramedical staff.

**Dr. Sunip Banerjee, Consultant  
Interventional Cardiologist, RTIICS**

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## Physiotherapy workshop: Focus on Neurodynamics

Prof. D. Dastoor, Vice President, Asia West Pacific Region, World Confederation of Physical Therapists (WCPT) and elected Executive Member of WCPT representing the Body from 2003 to 2007, qualified in physiotherapy at the KEM Hospital of Mumbai has been associated with teaching and examineship at Seth G. S. Medical College and KEM Hospital, Mumbai since 1960.

To share her invaluable expertise and experience in the field of physiotherapy, Prof. Dastoor visited our Institute on 23<sup>rd</sup> April. The physiotherapy Department of the hospital along with Indian Association of Physiotherapy, West Bengal branch organised a CME-cum-workshop at the Conference Hall of the Utility Building of the hospital to avail of Prof Dastoor's lecture.

The topic of discussion was Neurodynamics.



Prof. Dastoor at the workshop



Participants follow instructions

Although the attendees were required to pay for the lecture-sessions, there were as many as 50 enthusiastic candidates at the CME, who had arrived from all parts of West Bengal.



Attentive participants

Around 9.30 am the programme started with the lighting of the inaugural lamp, followed by encouraging speeches delivered by Dr. Kunal Sarkar and Dr. Vikash Kapoor. Prof. Dastoor started her lecture by explaining the theory of Neurodynamics, and proceeded to speak on Neural Tests. The post lunch session was that of hands-on demonstration and practical training. This was a very interactive and lively session.

The CME was highly informative and educative for all the attendees.

The Department of Physiotherapy is grateful to the hospital's Administrator Dr. Milind Inamdar and Dr. Mrinalendu Das, Sr. Cardiac Surgeon, RTIICS for their valuable guidance and relentless support.

**Department of Physiotherapy**  
**RTIICS-ACTC**

## Hepatocellular jaundice

Recap : Jaundice, a yellow colouration of the sclera, skin and mucus membrane results from the accumulation of bilirubin. It can be haemolytic, hepatocellular or obstructive type.

In the previous issue, we discussed haemolytic jaundice. This issue deals with hepatocellular jaundice.

Hepatocellular jaundice can be due to various causes and the most common of them are due to hepatitis virus. Again the hepatitis viruses can be hepatotropic (like Hepatitis A, Hepatitis B, Hepatitis C, Hepatitis D and Hepatitis E) or non-hepatotropic (like CMV, varicella-zoster etc.) Of all the hepatotropic viruses, Hepatitis A and Hep. E are the most common (taken together) cause of epidemics of viral hepatitis. Both these viruses are acquired through feco-oral route and behave almost similarly. After the virus (which is excreted in the fecal matter of the patient) gets into the host's body via contaminated food or drinks, it takes at least 2-6 weeks to manifest symptoms. During this period of incubation, there are absolutely no symptoms pertaining to the infection, but soon non-specific symptoms like fever, body ache, lethargy and anorexia (loss of appetite) appear.

Once the icterus (jaundice) appears, which is usually detected as yellow urine or sclera, fever generally subsides but anorexia, nausea and vomiting continue. At this stage, the victim gets alarmed and consults the physician.

The diagnosis is mostly done by the symptoms and presence of jaundice and enlarged liver. This is confirmed by blood tests like liver function test. However, the etiological virus is detected by specific blood examination.

The most important point to be noted is that the treatment of these conditions requires only adequate calorie intake and physical rest. No specific drugs so far have been helpful in eliminating the virus from the body. So dietary supplementation is the mainstay of the therapy. It is rather unfortunate that people impose so many unscientific restrictions in the diet of these patients. It is important to note that the calorie content of the food taken by these patients should be more than that necessary for normal persons and the quality of food should be as per the choice of the patient. Eating digestible carbohydrates like sweets and ice-cream not only provide quick and adequate calorie-content to the body, but are also enjoyed by the patient!!

With proper management, these patients improve smoothly in 4-6 weeks. Only rarely, the disease may last up to 8 weeks. In the acute phase, however, some of the patients may have a fatal complication like fulminant hepatic failure. Fortunately, these patients do not have chronicity. Once cured, they are completely normal and there is no residual damage to the liver.

Of Hep. A and E, A is more commonly found in children and mostly, it is subclinical, i.e. the symptoms are minimal and sometimes may even go unnoticed. The good aspect again is that a patient, who has had exposure to Hep A once is immune to the disease throughout the rest of life. Such patients do not need Hep. A vaccination. Otherwise children, before going to school, should be given Hep. A vaccine. Hep. E, on the other hand, does not have any vaccine.

(In the next issue we shall continue with other types of Viral Hepatitis)

**Dr. N P Bohidar**

**MD, DM (Gastro-AIIMS) FICP**

**Consultant Gastroenterologist, ACTC**

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## Hematuria: Urologists' nightmare

Hematuria in medical diseases is associated with proteinuria, RBC casts, hypertension, dysmorphic RBC on electron microscopy and final diagnosis achieved by Renal Biopsy. Hematuria in patients on anticoagulants cannot be assumed secondary to anticoagulation unless there is systemic bleeding and always warrants full investigation to rule out co-existent pathology. Surgical causes of hematuria, especially stones, tumours, TCC bladder, need to be carefully investigated and evaluated. Small lesions may be missed by traditional investigations and may require RGP studies, cystoscopy, URS and urine cytology to arrive at a conclusion. Rare cases of hematuria like porphyria, myoglobinuria, drug induced colour change of urine mimicking hematuria have to be kept in mind.

Latrogenic hematuria, following surgery to renal tract, PCNL, TURP/TURBT (secondary hemorrhages), are not usually encountered by the Casualty officers. Catheterisation trauma while inserting or removing Foley's catheter is also a less frequently encountered problem. Urethral bleeds, urethral rupture secondary to RTA, accidents, penile fractures with associated urethral injury, malsexual practices and infections might also present with hematuria.

Hematuria is a bewildering subject of varied aetiology and concerns all clinicians in all fields of practice and is a daily encountered problem for the Urologists.

**Dr. Suresh Bajoria, Sr. Consultant, Department of Urology, ACTC**

## Camp at Jamshedpur

On 23<sup>rd</sup> April, in association with Brahmananda Sewa Sadan, our hospital held a Free Health Check-up Camp in Cardiology, Orthopaedics and Neurosurgery at Tamolia, 15 Km away from Jamshedpur.

On 22<sup>nd</sup>, Dr. Sunil Lhila, Dr. Pratap Kr. Pani and Dr. Nirmal Jajodia reached Jamshedpur by train. Mr. Rajdeep Khan and Mr. Athar Harim from the hospital's Marketing Department were at the station to receive the team of doctors.

On 23<sup>rd</sup>, the well-organised camp started at 9.30 am. The organisers took ECGs of the patients. A total of 124 patients were seen by our doctors, out of which 40 were for Cardiology, 49 for Orthopaedics and 35 for Neurosurgery.



**Mr. Athar Harim, Department of Marketing, RTIICS**

## ACTIVITIES OF THE ACADEMIC FORUM

On 7<sup>th</sup> April Dr. Sujit Sarkar made a slide presentation on Lap CBD Exploration. In his lecture, Dr. Sarkar explained that Lap CBD Exploration has now become a common procedure for the treatment of Common Bile Duct stones. Cholecholescope and the other conventional instruments used are very expensive and have some limitations in case of large, multiple and impacted duct stones. Rigid nephroscope used for the treatment of renal stones is a cheaper alternative to cholecholescope, with advantages in management in complex common bile duct stones.

On 14<sup>th</sup> April Dr. Pankaj Singh made a slide presentation on 'Pre-operative cardiac assessment in cases undergoing non-cardiac surgery'. In his lecture, he started that pre-operative cardiac evaluation of the patients undergoing non-cardiac surgery decreases the risk of peri and post-operative morbidity and mortality. In general, the indications for cardiac testing are the same as those in a non-operative setting, but there, the timing is important with regard to non-cardiac surgery, specific risk factors and specific surgical conditions. Pre-operative testing should be limited to circumstances in which the result will affect the patient's treatment and outcomes.

He started that initially, the patient's clinical history of illness, physical examination and electrocardiogram (ECG) should be taken to look out for potential cardiac disorders (CAD, prior Myocardial Infarction), heart failure, symptomatic arrhythmias and valvular heart disease. Other risk factors include age, functional capacity of the patients and comorbid condition such as diabetes mellitus, peripheral vascular disease, chronic lung disease and type of surgery. Based on history, physical examination, ECG, patients are divided into high risk, intermediate risk and low risk categories. Further cardiac evaluation can be done by assessment of left ventricular function, 24 hour holter monitoring in cases of symptomatic arrhythmias, exercise stress testing, pharmacological stress testing (Dobutamine Stress Echocardiography,

Dipyridamole or Adenosine with thallium myocardial perfusion imaging) and coronary angiography. Coronary revascularization before non-cardiac surgery to enable the patients to get through the non-cardiac procedure is appropriate only for a small subset of patients at very high risk. A conservative approach to the use of expensive tests and treatment is recommended.

The clinical lecture on Hematuria, delivered by Dr. Suresh Bajoria on 21<sup>st</sup> April, covered the basic clinicopathological facts on the symptomatology, clinical presentation, urinalysis (dip stick and microscopic) to come to a definite diagnosis. Dr. Bajoria stated that microscopic hematuria vs macroscopic, initial, terminal or entire urine hematuric, loin pain, dysuria, other associated features and a strong degree of clinical suspicion is required to get to the bottom of the diagnosis.

On 29<sup>th</sup> April in his lecture on 'When to ask for radiology', Dr. Lokesh Kukatla stated that with the availability of multiple modalities for diagnostic and therapeutic purposes, healthcare has taken a big leap forward for the fast, early and good treatment of patients.

Also, it exerts a lot of stress on the clinician to ask for an appropriate investigation on patient-to-patient basis, which is economical and provides maximum information.

He emphasized that the optimal use of these modalities is the key to cost-effective management.

Then the speaker enumerated the advantages and disadvantages of the various modalities of treatment available.

1. X-Rays: These are good for skeletal imaging, chest pathology, acute abdomen and trauma, but suffer the disadvantages of lack of characterization, sensitivity and specificity.
2. Contrast studies: Most of these studies have become obsolete due to endoscopy and other types of scopes, except for in small bowel enema.
3. Ultrasonography: These are good for small parts, abdomen and obstetrics. No radiation.
4. Doppler Study: This is very useful for all regions. This is a non-invasive study.
5. CT Scan: This is useful in trauma, acute conditions, staging of tumours, diffuse lung diseases, bones, 3D imaging and angiography.
6. MRI: This is good for the brain and the spinal cord, staging of tumours, musculoskeletal imaging and angiography.
7. Mammography: This is the Gold standard for breast cancer screening.
8. Bone Mineral Densitometry: This is good for detecting osteoporosis.
9. Interventional Radiology: This is the most sought-after branch of study now. This modality is very useful in both vascular and non-vascular interventions, but requires a capable interventional Radiologist.

## Live Workshop

Dr. Aaron Frimerman, Interventional Cardiologist from Hillel-Yaffee Medical Centre, Hadera, Israel, visited our hospital on 3<sup>rd</sup> April, and conducted a live workshop here. Prior to the workshop, there was a very lively two-hour session of discussion and mutual interaction among the delegates constituting our own cardiology faculty members as well as the invited interventional cardiologists from all over the city.

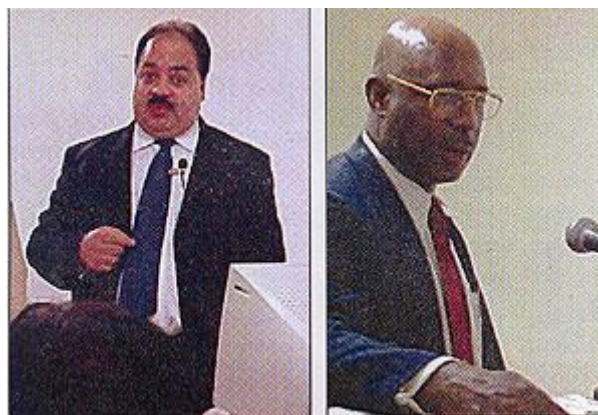


The live workshop that followed, included three cases of coronary intervention namely bifurcation treatment, total occlusion and peripheral interventions. On the whole, it was an active exchange of ideas and techniques practiced.

**Dr. J Naik, Director,  
Interventional Cardiology Services, RTIICS**

## Emergency Meet: Use of Point-Care-Systems

In this Fast-Track World, in the department of Emergency our hospital is not far behind. When a central laboratory is used to measure biochemical cardiac markers in cases of acute coronary syndrome and unstable angina, results should be available within 60 minutes, preferably 30 minutes.



**Mr. Ashok Kumar**

**Mr. Jim McClain**

Point of Care systems, if implemented at the bedside, have the advantage of reducing delays due to transportation, processing, labelling, data entry, spinning, storage of sample, calibration and specimen degradation in a central laboratory.

Elevated levels in cTnI convey prognostic information beyond that supplied by the clinical characteristics of the patient. The Cardiac Marker Kit used in our department of Emergency and Critical Care Unit is a ready tool for simultaneous qualitative detection of myoglobin. CK-MB and Troponin I are enabling healthcare providers to easily and accurately access and diagnose chest pain patients at the decision point, providing time-critical diagnostic information within 15 minutes.

The Reader gives the caregiver option of reporting quantitative results for myocardial infarction.

We thank Mr. Jim McClain from New Jersey and Mr. Ashok Kumar from Princeton BioMeditech, USA, who presented an interactive session on the use of Point-Care-Systems in the department of Emergency and Critical Care, sharing their valuable experience in the Western countries.

The meeting ended with high tea.

**Dr. Sujoy Ranjan Deb, Dy. Medical Superintendent, RTIICS-ACTC**

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## World Health Day Celebrations: Focus on health-human resources

World Health Day was celebrated on 7<sup>th</sup> April by the students and faculty of College Of Nursing, Asia Heart Foundation, at the premises of the College, on the RTIICS, ACTC grounds. This year, the theme for World Health Day was Health-Human Resources.



Health screening programme



Ms. Asima Chakravarty

Ms. Pratima Chatterjee

Keeping this theme in view, the students and faculty of the College had arranged a programme in the morning session as appended below:

- Health Screening Programme conducted by the students of Cardiovascular Thoracic Training (CVT)
- Stress Management Programme conducted by B.Sc. Nursing (Generic) students.
- Self breast examination by B.Sc. Nursing (Condensed Course) students.
- The overall programme was very educative and interesting. The Hospital Administrator Dr. Milind Inamdar graced the occasion and encouraged us further in our efforts. Most of the employees of RTIICS and ACTC attended and benefited from the programme, and immensely enjoyed themselves.

The evening session saw a discussion arranged by the Clinical Instructors of the Institution. The session was inaugurated by Ms. Pratima Chatterjee, Registrar, West Bengal Nursing Council. The inaugural speech was delivered by Ms. Abha Roy, Principal, College of Nursing, Asia Heart Foundation. In her speech she unfolded the theme for the day which was : Legal Issues in Nursing.

The brain-storming session was very thought-provoking. Some of the burning questions in the said issue came to the fore and all the delegates, who had arrived from different hospitals all over the city, actively participated. There was lively exchange of ideas. Ms. Pratima Chatterjee, Registrar, W.B.N.C., and Ms. Asima Chakraborty, Principal, College of Nursing, B M Birla Heart Research Centre also spontaneously came forward to share their experience and ideas with the delegates and the organisers.

The lively discussion ended with Vote of Thanks by Ms. Kuntal Mandal.

The programme was coordinated by Ms. Ishita Mundle, Ms. Nargis Ahamed anchored the entire session.

**Ms. Jayanti Chatterjee, Faculty,  
College of Nursing,  
Asia Heart Foundation**

### **SURGERIES DONE SUCCESSFULLY WITH THE HELP OF THE GUEST SUPPORT CELL**

- Helping the poor with quality healthcare has always been a mission for our Chairman Dr. Devi Shetty. Time and again he has made his contributions, sometimes by floating health insurance schemes and often by coming up with projects especially for the benefit of the lower middle class. Dedicating himself to the cause of the poor, he has recently saved the life of 16-year-old Kalita Sardar, whose father, a daily labour at Mukundapur, could barely provide for his three daughters. The eldest Kalita suffered from a heart disease that required a Glenn Shunt Open Heart Surgery. As the surgery was to be performed immediately, Dr. Shetty gave his consent to get it done free of cost. This earned him and the hospital the blessings of the poor, ill-fated family. The surgery was successfully performed at our hospital, by our Clinical Director Dr. A. Raghuvanshi.
- Nilratan Halder had been suffering for the past three years. Doctors had advised him a valve replacement surgery, the cost of which was way beyond his reach, as he was a poor painter cum caretaker in a house, with his own family to fend for. With the help of his landlord, under the guidance of the Guest Support Cell, he could gather only about Rs.50,000. But our Clinical Director Dr. A. Raghuvanshi did not want him to wait further and suffer more, and performed the AVR surgery on him whatever amount he had managed to collect.
- Four-year-old Ajoy Saha would often suffer from breathlessness. Our Paediatric Cardiologist Dr. Biswajit Bandyopadhyay advised the child an angiogram. For the poor father who worked as a driver the required amount was difficult to collect. Dr. Bandyopadhyay guided the child's father to our Cell and the procedure could be done on Ajoy with the meagre sum that the family was able to gather.
- Shikha Khatya had been suffering from jaundice for the past 10 years. Her husband was affected with paralysis and so there was no source of income for the family, and Shikha's condition worsened day-by-day. Our Consultant General Surgeon Dr. Manas Roy advised her a Lapchole Lap CBD Exploration Surgery. AS the surgery costs were definitely out of reach for Shikha, Dr. Roy went out of his way to extend a helping hand to her. Not only did he perform the surgery at a concessional package, with the small sum that they could collect from the funding agencies as directed by the Guest Support Cell, but even did not charge his fees.
- As she sat beside the crutches her father was holding for support, bright-eyes Arpita showed no signs of the pain she had been suffering for the past few months. After several bouts of vomiting and pain in her stomach, she was advised to undergo an immediate Choledochal Cyst Surgery. Her father, who worked in a grocery shop, had himself been hit by a motorbike that had left him with a fractured leg. Barely able to walk with the help of crutches, he could suppress his share of pain but could not

tolerate his little daughter's misery. For the surgery that was to be a major one and urgent too, Dr. Ishika ghose guided them to the Cell. Ultimately, the complex surgery was performed with the aid from SICW, a funding agency and with concession allowed on the package cost.

Surgeries done successfully with the help of the Cell for the month of April: RTIICS:Surgery-36, Cathlab Procedures-13. ACTC:8

**Ms. Baidehi Banik,  
GRE, Guest Support Cell.**

**Dear Readers,**

RTIICS has completed six years in the city...six eventful years, that have seen it reaching up and touching new heights. Our success would never have been possible without the love, support and the faith that the people of Kolkata have in us. We take this opportunity to thank all our well-wishers.—Editor