IAP GOA E-Bulletin

BULLETIN *November 2017*

Activities from

July 2017 to November 2017

Issue 3

GOA STATE CHAPTER

For Private Circulation

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From the Desk of President IAP Goa

- **Dr. Harivallabh Pai**

Dear Members,

Greetings from IAP – GSC!!

We had a Fruitful year 2017 with CMEs being held virtually every Month in the whole year.
We also observed important days and weeks during year viz,
IAP Rational ATIBIOTIC DAY,
IAP ANTIMICROBIAL AWARENESS WEEK,
CHILD & ADOLESCENT HEALTH CARE WEEK,
TEENAGE DAY,
DAUGHTER'S DAY,
HEALTHY LIFESTYLE etc.

Now the organizing committee of ***Goa PEDICON 2018*** *is delighted to extend a very warm hearted to you.*
At the Conference we have very ***renowned faculty*** *and I am very sure that all of you take advantage of this opportunity of interacting with the High Profile Child Health Professional.*

Looking Forward once again to Greet you all at Pedicon 2018.

JAI HIND!!!
JAI IAP!!!!

Editors Write…

Greetings to all the readers….

A warm welcome to everyone, yet another Bulletin is being released and it give me immense pleasure to present before you this last Bulletin for this year 2017.
After a series of Festivities amidst the joyful recitation of Aartis to Noise of fire crackers and Glow of Diyas we, are here presenting before you our **THIRD Bulletin** full for knowledge and some new discoveries in a way that we can come to know our mentors and members in a better manner.

As always I owe a BIG Thanks to my strong supportive team, forever encouraging and consistently giving me Positivity to keep me going. They deserve a Big Applause.
I thank Dr. Harivallabh Pai, Dr. Kalpana, Dr. Swapnil, Dr. Santosh Usgaonkar for continuous guiding me. I should make special mention here Dr. Swapnil Usgaonkar for patiently responding to all my queries inspite of his busy schedule.

This Bulletin is very special as it contains a special article about a member, Dr. Avdhut Borkar ; I am thankful to his family for sparing time to share a details about him. I am thankful to Dr. Purnima Usgaonkar for helping me gather the information and comply the article.
I specially thank Dr. Vishal Sawant, Dr. Sushma Kirtani, Dr. Shilpa Joglekar, Dr. Anneley D'lima for their contribution.

From July to November multiple activities have been conducted by our dynamic members and each one have meticulously followed the WHO days as per the schedule.

Month of November has been specifically busy with many activities held during this period.

We haven't altered the Quiz this time and have kept the same questions as last time please do attempt.
It was disappointing that no one replied to the Quiz.
Let's see who will crack the Quiz this time.
Ok then!! Chal then let's get started with the bulletin.
Hope you like it. Please do send us your feedback.

Happy Reading

Warm Regards,
Dr. Siddhi Nevrekar, Dr. Vinda Arlekar, Dr. Anagha Dubhashi

A MAN , GENRE APART: Dr. AVDHUT BORKAR

'Discipline is the Bridge between Goals and Accomplishments', says Jim Rohn; and a Perfect example of same is

'Dr. Avdhut Gopinath Borkar'

Have known Dr. Borkar since my childhood , a good friend of my father and a frequent visitor at place, we would frequently meet him at social gatherings too.
A man of composed genre with a great personality which by itself speak volumes about him.
His Prime Concern as I always recollect was **' Environment' – A Safe, Lively, Green Nature to Live in….**

Dr. Avdhut Borkar, was born on 22nd October 1947, at Nuvem, Guirim at his maternal Grandmother's house. 2nd in order out of 5 kids, born to **Mr. Gopinath Atmaram Sinai Borkar** and **Mrs. Shantabai Gopinath Shenvi Borkar**.
Full of kindness and patience, same values and virtues were passed on to Dr. Borkar and his siblings
Dr. Borkar has an elder brother and a younger brother and 2 younger sisters.

Even though journey of Life sailed through turmoil with varied challenges and hurdles to tackle, there was always a sense of pleasantness and positivity maintained in the house. Keeping Positive outlook and approach all difficulties were achieved.
Inspite of being under constant stress, Dr. Borkar was always encouraged by his family members and teachers to be a part of academic oriented activities.

Amidst all these chaos, varied functions, annual traditions were being carried on and Festivals being celebrated enthusiastically with loads of galore, pomp and joy. Dr. Borkar thoroughly enjoys festivals especially Ganesh Chaturthi and Navdurga Jatra as these are the times for family reunions and family celebrations where they have lots of fun and have a Blast!!
Sir, would also enjoy taking part in keeping up the family traditional tasks along with his parents who had taken up the responsibilities of doing there once the extended family had to move out for better Job prospects.

Though basic education starts at home, Dr. Borkar's Formal education started at People's High School and then went on to Dhempe College of Arts and Science, Panaji. Further on, joined Goa Medical college to complete his MBBS and later his DCH under efficient guidance of Dr. Sunita Gaunekar.
Likewise Dr. Borkar believes he owes a lot to Mr. Jagdish Surlekar, Mrs. Kumud Kamat and Mrs. Pinto as they have been particularly influential in his life during his formative years

Besides studies, his childhood memories are full of wonderful time spent with friends , he remembers his old friend Mr. Dilip Desai from school days; so also he has fond memories of his time spent with his cousins playing cricket with Cricket being his favourite game…. A pakka Sportsman at Heart, Dr. Borkar liked sports a lot and would enjoy cycling; It's not surprising to hear that Dr. Borkar was beyond imagination thrilled when his uncle Dadu gifted him a Bicycle.
Being a booklover at heart, Dr. Borkar would spend time reading book and that made, Daji; his cousin Shri. Suresh Borkar presented him with books.

Being very sincere, hardworking and having good academic performance, **his uncle Mr. Jaiwant Borkar** fondly called as DADU and his cousin sister**, Mrs. Kunda Usgaonkar** were the most important and note - worthy People who encouraged him to actually enter Medicine inspite all odds.
It was very natural for Dr. Borkar to enter the medical field as he has always been caring in nature with a heart and inclination to work social wherein he could help and reach out to people and provide his services to them. While studying medicine there have been many different memories, but for Dr. Borkar being in this profession means that it had to be a profession where ethics and social concern should be your top most priority.
Dr. Borkar shares special bond with his roommate Dr. Jayant Kamat, so also with Dr. Devidas Shirodkar. He is still in contact with them.

After completion of post-graduation, he joined health service initially for a short duration, therafter he served a tenure of almost 21 years at MPT Vasco.

He resigned voluntarily to take up half time private practice so that he could devote more time for social cause. Even whilst he was working MPT. Dr. Borkar was very active on the human welfare front wherein in 1981, he played a pivotal role in starting **Mobile Medical Service** ; Providing free regular camps , along with which Health education verbally and in form of literature was provided to the people. So also the poor and needy were helped by dispensing free medicines and treatment if need be. One such Camp held at Aksan they got to detect a major chunk of Koch's cases.

Dr. Borkar prepared educational Slides under a WHO Project which was initially in Konkani. Later the same were translated in **9 other languages** and reused by others to propagate the same.
An innovative idea was sorted, such that Calendars were distributed amongst the Anganwadi workers, in which the Photos published contained HEALTH EDUCATING MATERIAL on essential topics like Hygiene, Care of newborn, Child health etc… 1st was published by Government of Social welfare and 2nd one by MPT.

A compilation of same, wherein all the photographs with the messages capturing guidelines towards various Health issues was made and published by the name **'BHURGUIM, BHALAIKI ANI JATNAY' (Child health and Child care)**

Alongside these active social project Sir, provided **Honorary services to Matruchaya** and **Shree Ramnath Devasthan** as and when need be.

Dr. Avdhut Borkar has been felicitated by **Param Pujya Vidhyadhraj Swamiji** for **selfless services to the community**.

Also he has been the founder member of IAP GOA Branch along with our other key members.

Sure enough, a multitalented man with lots of ideas, Dr. Borkar architectured and self-designed his Residential house at Madkaim by using raw materials – Laterite. He would personally supervise and be a helper to men at work when it was being done.
His intellectual inputs were used to suffice all the needs in the house such that **The house is a perfect example of Green House – with less use of steel and cement, conservation energy and water, biogas is used to treat sewage and kitchen waste and Natural light is used as source of Light.**

Sir has done various Experimentation with composting, vermi-composting and Tree plantation.

A Visionary with dreams in eyes , Dr. Borkar had start ed a journey towards a new cause, as mentioned before Dr. Borkar would do private practice at Goa Velha. It was an unfortunate day in 2000 when he met with an accident whilst waiting for a bus and had a long course of recovery at Goa Medical College for almost 2 to 3 months.

All through this process there is, was and shall always be a **Silent yet Strong** support that stood by Dr. Borkar right through out right from the time she entered his life. We just can't miss to mention **Mrs. Gulab Borkar**, married to him in 1980 she has been with him all through thick and thin and says "Dr. Borkar is a Visionary in real sense. I have learnt a lot from him. He is a teacher, guide and philosopher to me."

As its said '**आशेचे , निराशेचे असे अनेक प्रसंग येतात, पण विचारांचा भक्कम पाया असणारी माणस कुठ्ल्याही प्रसंगी ठामपणे उभी राहतात** '

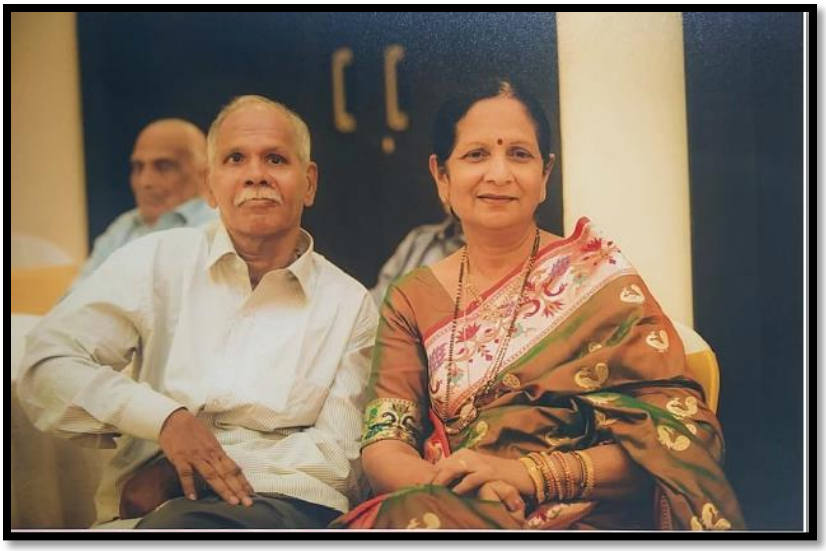
Mrs. Borkar was very composed during these testing times and knew that she had to be strong to keep the situation intact. She trusted her instincts and just followed what was happening the way it was. Once it was declared that Dr. Borkar 's condition was status quo and he could be taken home, they opted to take him to MPT instead as it was his SECOND HOME. At the doors of MPT he was warmly welcomed embraced by the staff , doctors and his colleagues in MPT, making Mrs. Gulab feel emotional, yet strong and secure within… she was surer now that things will be fine… She was at Home…

Dr. Borkar showed a lot of Improvement in a Known and Homely environment better, as in when his close friend Dr. Shaila Borkar interacted with him he made a Positive attempt to reply to her.

To help him improve, once Sir started sitting he was made to sit in his previous clinic at MPT and allowed to examine the babies. As a part of therapy, to improve his fine motor grip he was made to write prescription for the babies after examining them. Mrs. Gulab still remembers those days. She still has those prescriptions treasured with her.

With positive inputs and fruitful suggestions from friends and well-wishers like Dr. Govind Kamat(Vasco) ..there was lots of improvement and Dr. Borkar came home walking. Music as suggested by Dr. Kamat played a pivotal role in help Dr. Borkar heals better.

17 years post this tragic incident, he started his private practice again at Madkaim at home itself with the help of his wife Mrs. Gulab; who would assist him. Patients who would revere and had full faith in Dr. Borkar were happy to get treated by him and some insisted to get vaccinated also.
Dr. Borkar continued his practice till 2012 then he retired as physically it wasn't possible for him.
Truly hats off to such a **Wonderful Man**….rather I should say Hats off to such a **WONDERFUL COUPLE**.



Mrs. Gulab Borkar, presently working as Associate professor in G.V.Ms Commerce College, Farmagudi (M.A. MPhil) has been definitely a very Bhakkam support to Dr. Borkar
Mrs. Gulab being a nature lover took active interest in Environmental conservation and Preservation and hence both together opted for Rain water Harvesting At Keri 1992 to take care of Water shortage.
Mrs. Borkar as mentioned earlier had a huge responsibility when the incident took place, it appreciable how well she managed to raise the then teenage boys whilst continuing the ongoing projects her husband had started as they were his **Dream projects**.
Now, Mrs. Borkar has started a **Nature club in her college called ECOVISION** under which they carry out various nature related activities.

The Nature club conducts seminars and paper presentation at State and International level to PopulariseTechniques of **Rain Water Harvesting And Waste Management**. Special workshops are held for students.
As a member of Nirmal Vishwa, activities of preaching conservation continue with introduction of innovative programme **'Learning with nature' in Lokvan**.

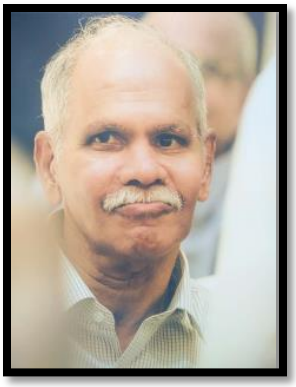
All through the up and down hills, there have been Happy moments too, moments to celebrate and rejoice.
One such moment was in 1981, when the Borkars were blessed with a baby boy whom they named **Anirudh** , to day he makes his parents proud. His **a Praticing Lawyer** with his online legal advice portal named www.legalmadesimple.in- 1st of its kind in Goa**. Mr. Anirudh** is married to **Dr. Ankita Joshi**, MS (OBG) Sr. Resident in GMC.

Birth of **Abhijit** marked another day of celebration in the family in 1983, an engineer by profession, he has started his own firm by the name **Dimensions in Bethoda**. Mr. Abhijit is married to **Mrs. Vibha Kurade** (M.Pharm), who presently works for Watson .
Senior Borkars were promoted to the post of grandparents in 2012 when their grandson **Anvay** arrived and 5 years later he has been joined by his little sister **Amaira**, 2017.
Dr. Avdhut always considered that helping his children grow into responsible Human being is of prime importance. Both his sons consider him to be more of a friend than a Father. He gave his children perfect freedom to choose what they wanted to do in life especially when it came to Career.

Dr. Borkar was very attached to his grandmother and would be very angry if anyone would argue with especially when she got bedridden. As a family man, Dr. Avdhut always had his family and extended family on priority list wherein as mentioned earlier festivals and get togethers meant special to him as they mean FAMILY TIME. He enjoys family outings and does believe that its necessary to have them on regular basis. **For him HIS FAMILY IS HIS STRENGTH.**

Some special moments with Family and friends……

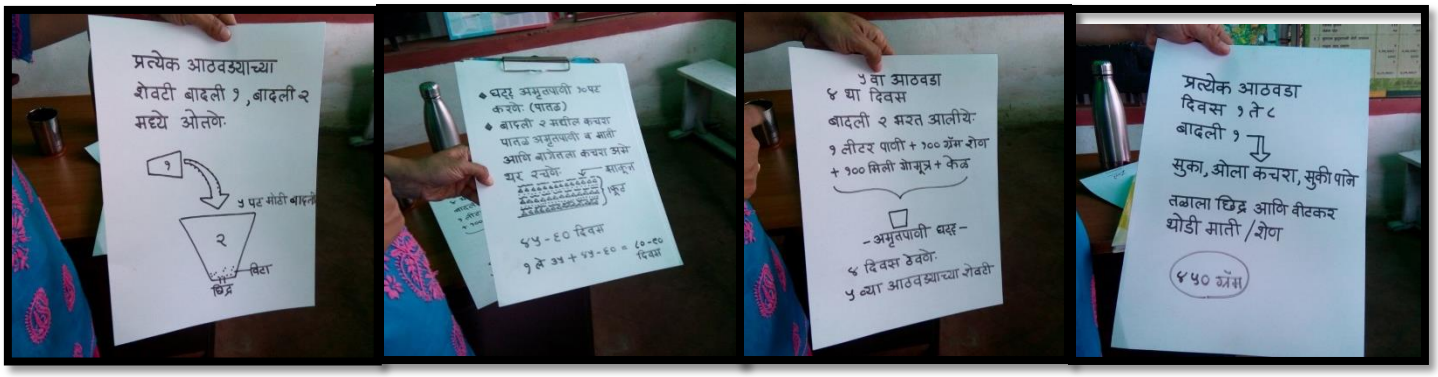
As a doctor, Dr. Borkar is very much satisfied with what he has done but wishes he could work more. He is happy that his patients have faith in him, respect and loves him still and that those patients who have grown up respect and remember him still. He always wants people to remember as a **CARING DOCTOR** and he is happy to have achieved it.



His Message to younger generation is ***'Whatever You May Choose to Do, Put All Your Best In It.'***

His greatest fear still remains to be Environment degradation causing health hazards
His accident is definitely a loss to our Society. We would have definitely benefitted by his Evolved ideas. Our dream for Safe Goa would become much easier if we have people like Dr. Avdhut Borkar and Mrs. Gulab Borkar amongst us.
I am thankful to Mrs. Gulab Borkar specifically for spending time with us and answering on behalf of Dr. Borkar. It was really a touching moment to be there and listen to the wonderful work done by this **Awesome MAN.**
God bless your Family Always!!!!!

<u>COMPOSTING TECHNIQUE:</u> Thanks to Mrs. Gulab Borkar for sharing the Technique.



NON KETOTIC HYPERGLYCINEMIA: A CASE REPORT & BRIEF REVIEW

Das Kokil, Caro Siya, Dubhashi Anagha
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INTRODUCTION

Non ketotic hyperglycinemia (NKH) is an autosomal recessive inborn error of glycine metabolism, resulting in accumulation of large amounts of glycine in body fluids and severe neurologic disturbances immediately after birth. This metabolic disorder is due to defect in liver enzyme complex, termed glycine cleavage system which is a complex of four proteins: P, T, H and L(3). Most cases (>80%) have deficiency of P protein activity (4) the gene for which is present on the short arm of chromosome 9. Cases of later onset NKH have been thought to have defects in H or T proteins (1).Deficient activity of GCS leads to accumulation of large quantities of glycine in the CNS. This allosterically activates N-methyl-D-aspartate (NMDA) receptors, located in the hippocampus, cerebral cortex, olfactory bulb and cerebellum to produce excitoneurtoxicity leading to intractable seizures(4). In the brainstem and spinal cord however it acts as an inhibitory neurotransmitter explaining the apnea, hiccups and hypotonia(5)

Most glycine encephalopathy cases occur during neonatal period.the neonatal form manifests in the first few hours to days of life with progressive lethargy, hypotonia, myoclonic jerks, hiccups and apnea which often lead to coma or death. Outcome is usually poor, with mortality up to 50% during the 1st week of life. Surviving infants have profound intellectual disability and intractable seizures.Atypical forms include milder disease, with onset from late infancy to adulthood, which presents various neurological symptoms: seizure, motor and/or cognitive impairments, aggressive behavior, and impaired work or school performance (13). A rare transient form has been described in which newborns have elevated cerebrospinal fluid and plasma glycine, which is biochemically and clinically indistinguishable from the classic form. In the rare form, glycine levels normalize over time without pharmacologic intervention and often have few or no neurologic sequelae (14)

CASE REPORT

A male baby weighing 3kg was born at term after uneventful antenatal period to a 35yr old gravida 4 mother. He was a product of 3rd degree consanguineous marriage. She had two livingfemale children who were well. She also had one abortion. This baby did not have any perinatal asphyxia. Apgar was 8 at 1min and 10 at 5min of life.

Baby presented at 18hours of life with weak cry,decreased activity and decreased sucking. On examination, baby was normothermic, pink with HR : 142/min and RR: 46/min and normal peripheral pulses. There were no gross congenital anomalies. The sensorium was depressed with minimal spontaneous eye opening and limb movements. There was response to painful stimuli.

There was no focal neurological deficit. Neonatal reflexes were sluggish. Baby was investigated for the possibility of sepsis, meningitis, electrolyte imbalance, inborn errors of metabolism.

Haematological investigations revealed TC: 29,700 DC: N57 L31 M7 E4 B1, CRP: Negative, RFT : normal, electrolytes: normal, blood culture: Sterile. ABG: Ph: 7.35 PCO2 : 39 PO2: 59 HCO3: 22.1. Serum ammonia: 160, urine for reducing substances: negative, urine for ketone Bodies: negative .cranial USG: normal, lumbar puncture: normal. Metabolic screen showed increased glycine leves- 1061 (normal< 800) suggesting non-ketotic hyperglycinemia. However we were unable to do the confirmatory tests due to economic constraints by the parents.

Baby was initially kept under observation and kept on tube feeds of expressed breast milk via NG tube. At 36 hours of life baby‘s sensorium worsened, he became lethargic with shallow respiratory efforts. Baby was started of IV fluids and connected to CPAP. ABG revealed respiratory acidosis. In view of worsening respiratory acidosis baby was connected to assisted mechanical ventilation. Patient was also started on sodium benzoate (250-750 mg/kg/d) to lower plasma glycine levels, dextromethorphan (25–30 mg/kg/d)with the intent to reduce the excessive stimulating activity of glycine on N-methyl-D-aspartate receptors. Subsequently on ventilator baby’s activity improved. Tube feeds were restarted, but feed intolerance was observed. Baby was extubated to NIPPV on 10^{th} NND and to CPAP on 11^{th} NND. However baby’s sensorium worsened again on 12^{th} NND. Baby expired on 12^{th} NND.

DISCUSSION

NKH is a relatively frequent metabolic cause of overwhelming illness in infancy (15). Over 150 cases have been reported. The exact prevalence is not known, though it is estimated to be 1 in 250000. It is common in Northern Finland, where the prevalence is 1 in 12,000(15) and is transmitted as an autosomal recessive trait. In the present family, only the male child was affected with previous 2 unaffected female children suggesting that a sex linked mode of inheritance may also exist. In one study in India it was found to be the 4^{th} most common inborn error of amino acid metabolism after homo-cystinuria, alkaptonuria and maple syrup disease (2).

NKH presents as a life threatening metabolic encephalopathy in the neonatal period. Most infants appear normal at birth, remain asymptomatic for a brief period, seldom longer than 48hours (16). They present with rapidly progressive neurological symptoms such as lethargy, poor feeding, seizures, high pitched cry and generalized hypotonia. Hiccups are frequently observed. Most patients lapse into coma and die within a few weeks. Survivors usually have severe psychomotor retardation, spasticity; microcephaly and uncontrolled seizures (l5, 16).In the present case baby presented at 18hours of life and went into a coma like state requiring assisted ventilation by 36 hours of life. No seizures were observed.

The pathophysiologic effects of hyperglycinemia are attributed to the inhibitory property of glycine at post synaptic strychnine sensitive receptors particularly in the spinal cord and brain stem, and over stimulation of the excitatory gluta-minergicNMethyl-D-aspartate (NMDA) receptors, particularly in the forebrain(lO)

NKH is diagnosed by elevated levels of glycine in urine, serum and CSF in the absence of any organic aciduria and ketoacidosis. It is essential to rule out organic acidurias as in these conditions glycine levels may be elevated because of suppression of the GCS by abnormal metabolites. In the classical neonatal NKH levels of CSF glycine and the glycine index i.e., CSF/ plasma glycine ratio are very high but are low in the later onset, milder or atypical types.3 Plasma glycine level up to 2000 μmoles/L and CSF glycine levels up to 500 μmoles /L have been reported in the classical forms of neonatal NKH.6 A glycine index of more than 0.08 is considered diagnostic. Disease severity has been directly linked with the glycine index. Enzymatic confirmation of NKH requires estimation of the GCS activity in liver samples which is not available everywhere.

Other findings reported in patients with NKH are transient hyperammonemia(7)which was also present in our patient, high serum creatine kinase levels(1) carnitine deficiency(8)high levels of lactate in fluids andcreatine in fluids and brain(9). Various findings reported on neuroimaging include arachnoid cyst(1) intracranial haemorrhage(7)agenesis or hypoplasia of the corpus callosum, delayed myelination of cerebral white matter, gyral malformations, ventricular enlargement, cerebellar hypoplasia(10) hydrocephalus(11) and subcortical hypo intensity on MRI(12).A burst suppression pattern seen on EEG is highly suggestive but is not diagnostic of NKH.

No effective treatment is available. Based on the hypothesis of NMDA receptors activation by glycine, glycine decreasing agents i.e., sodium benzoate and NMDA antagonists ketamine and dextromethorphan have been tried. The outcome is usually poor (4, 13) though occasional satisfactory results have been reported (4, 7). Sodium benzoate and dextromethorphan were tried in our patient, but failed to respond to these modalities. Additional anticonvulsant therapies include diazepam, which is a glycine competitor, phenobarbitone and felbamate(14)which were not used as seizures were not observed in this case . Antenatal diagnosis is possible by estimation of GCS activity in chorionic villous sampling at 8-16 weeks of gestation. DNA analysis shows two prevalent mutations: S564I in the gene encoding P protein and H42R in the gene encoding T protein. Presence of these mutations is an unambiguous diagnosis of NKH.

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SIDEROBLASTIC ANAEMIA - A CASE REPORT

Arpitha K. R., Anjali Shirodkar, Vaishali Joshi, Lorraine D'sa
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INTRODUCTION:

Sideroblastic anemias comprise a heterogeneous group of acquired primary or secondary and congenital disorders which have anemia, generally refractory to therapy, ineffective erythropoiesis and the presence of large number of ring sideroblasts in the marrow. Increased levels of tissue iron and varying proportions of hypochromic erythrocytes in the blood are associated features. Acquired causes are much more common than the hereditary forms. Acquired causes include drugs(isoniazid, linezolid, penicillamine), pyridoxine deficiency, zinc poisoning, alcohol consumption, myelodysplastic syndrome.

CASE REPORT

A 5yr old female child born out of non consanguineous marriage , native of Orissa & hailing in Goa presented to us with history of noticing pallor by the mother along with history of fatigue, exercise intolerance for 15 days and facial puffiness and pedal oedema for 2 days. No history of noticing yellowish discolouration of eyes or urine. No history of orthopnoea, PND, chest pain. No history of bony pain or noticing bluish patches over the body. No history of any drug intake or exposure to heavy metals. She is non-vegetarian by diet with normal dietary pattern.

History of hospitalization in the past at 3 yrs of age with similar complaints. Child was transfused with packed cells in view of severe anemia, in failure. No family history of receiving blood transfusion.

On examination, there was severe pallor, knuckle hyperpigmentation, bald tongue, pedal oedema and liver was palpable 2cm below the right subcostal margin. There was no icterus or generalized lymphadenopathy, hemolytic facies. Weight < -3SD, height < -3SD, weight/height < -3SD, Suggestive of acute on chronic malnutrition. Rest of the systemic examination was normal.

Hematological Investigations revealed anemia with very high levels of serum ferritin, (table 1) indirect hyperbilirubinemia with normal liver enzymes and complete haemogram with peripheral smear was suggestive of high RDW with severe hypochromia, severe anisocytosis, moderate polychromasia, presence of micro and macrocytes with basophilic stippling and cabot rings. Serum iron- 239, with very high serum ferritin levels (1120) vitamin B12 levels were low (83) with normal folate levels. Bone marrow aspiration revealed erythroid hyperplasia, increased iron stores (4+ to 5+) with presence of >15% ringed sideroblasts confirming the diagnosis of sideroblastic anaemia.

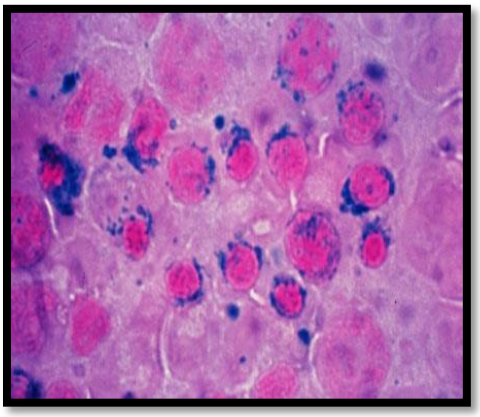

Figure: Bone marrow picture with Prussian blue staining demonstrating ringed sideroblasts

Hb	TC	RBC	MCV	MCH	RETIC	IRON	FERRITIN	B12	RDW
3.7	6300	1.66 Million	68.2	22.2	1%	239	1120	83	66.8

Table 1: Hematological profile

Child was transfused and started on vitamin B12 1mg weekly injections with pyridoxine supplementation. Subsequently at regular follow up visits hematological profile was monitored and was found to show consistent improvement in haemoglobin levels.

DISCUSSION

Sideroblastic anemia is a refractory anemia defined by the presence of many pathological ringed sideroblasts in the bone marrow. Sideroblastic anemia have microcytic hypochromic anemia with the presence of : (a) large number of pathologic sideroblasts in the marrow, which characteristically display abnormal mitochondrial iron accumulation in a circumnuclear position in erythroblast, these are referred to as ringed sideroblasts (b) ineffective erythropoiesis (c) increased levels of tissue iron (d) varying proportions of hypochromic erythrocytes in the blood. Sideroblastic anemia is diagnosed when 15% or more of marrow erythroblasts are ringed sideroblasts.

They are characterized by ineffective erythropoiesis, defective cytoplasmic or nuclear maturation. Erythroid hyperplasia of the bone marrow is accompanied by normal or slightly increased reticulocyte count. An almost constant feature is an excess of total body iron which is not reversible. The serum iron concentration is increased upto the point of complete transferrin saturation and serum ferritin level reflects the degree of iron overload.

CONCLUSION

In developing countries like India where malnutrition and iron deficiency is prevalent , iron deficiency anemia is the most common cause of microcytic hypochromic anemia. Hence it is a common tendency to assume any microcytic hypochromic anemia as iron deficiency and prescribing iron therapy. Our case illustrates sideroblastic anemia as a cause of microcytic hypochromic anemia even though it is a relatively rare cause, especially in children. Since iron deficiency anemia and sideroblastic anemia are treated differently, it is important to evaluate a case of microcytic anemia with iron overload considering sideroblastic anemia as one of the differentials.

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2. Bhandari P, Hamal R, Shrestha A, Srivastav S. Sideroblastic anemia. Journal of Pathology of Nepal(2016)volume 6;959-961.
3. Nusbaum N J. Concise review- Genetic basis of sideroblastic anemias. Am J Hematol 1991;37:41-44.
4. Darole P.A., Agarwal B, Ramteke V, Padwal N J, Kamath S.A. Drug induced sideroblastic anemia- a case report

Child Rights Week– Revising child rights in its true sense.

- **Dr. (Mrs.) Sushma P. Kirtani, Chairperson, Goa State Commission for Protection of Child Rights**

20th November is celebrated as the Universal Children's Day (International Child Rights day) all across the world. Children are future of every nation. No nation can reach its development goals unless appropriate steps are taken to ensure the growth and development of children who are an important national resource.

They are unfortunately the weaker section of society and hence vulnerable to exploitation and abuse. Globalized India has worsening level of basic health, nutrition and shelter. Children suffer the most as a result of social sector cutbacks and policies. India is a signatory of the UNCRC and participated summit in 1990 which adopted a declaration on survival, protection and development of children. All individual below the age of 18 years are entitled to rights as guaranteed by the UNCRC and the Indian constitution.

Children are guaranteed certain rights by the constitution of India.

1) Right to free & compulsory education for all children between 6 to 14 years.

2) Rights to be protected from any employment that can harm the development of a child up to the age of 14 years.

3) Right to be protected from being abused and forced by economic necessity to work that is not suited to their age or strength.

4) Right to equal opportunity & facilities to develop in a healthy manner and in conditions of dignity that ensured freedom from all form of exploitation.

5) Right to equality.

6) Right against discrimination.

7) Right to children form weaker sections to be protected from all forms of injustice and exploitation.

8) Right to express themselves without fear.

Child Rights opposes the Child Labour and Child abuse so that children get their **Full right for survival and developing and enjoy their childhood**. Children should be cared and protected and should not become victims of violence, abuse. Trafficking and Illegal activities. They should lead a happy and healthy life, proper schooling and learning.

Child rights day is celebrated in India every year to make sure that children are getting rights and respect. They should fully develop and be secure and the stakeholders follow all the laws, regulations and aims of the child rights. These Child Rights Strategies should be promoted to all sections of the society across India. One needs to safeguard Child Rights and prevent violence and Child Abuse and promote their legal and social rights in the society for the children and their bright future and to also see that child rights policies are implemented in the country.

GASTRO ESOPHAGEAL REFLUX IN CHILDREN - REVIEW

Dr. Vishal Sawant
Paediatric Surgeon
Healthway Hospital, Old Goa

Introduction:

Gastro oesophageal reflux is retrograde movement of gastric contents in the lumen of oesophagus. Regurgitation is common in infants and Children and has a varied presentation from simple regurgitation (GER) to severe oesophageal and extra oesophageal complications (GERD). GERD occurs when reflux causes troublesome symptoms and/or complications. Clinicians need to use their clinical experience and judgement to differentiate GER from GERD so that unnecessary investigations and treatment is not ordered and at the same time GERD is adequately treated.

Pathophysiology:

The high amplitude peristaltic wave facilitated by gravity helps in prograde movement of food bolus from the oesophagus in to the stomach. At the distal end of the oesophagus is a lower oesophageal Sphincter(LES).
The mechanism which helps in preventing reflux at the LES are:

- Intraabdominal length of the oesophagus which is subjected to positive intra-abdominal pressure unlike negative intra thoracic pressure on the thoracic oesophagus
- Angle of His (Acute angle between the Lower end of the oesophagus and the fundus).
- Mucosal fold of the stomach.
- Pinch cork effect of the Crura of Diaphragm
- Effective gastric peristalsis
- Effective oesophageal clearance.

If any of these mechanism is not fully functional or is altered by any factor, reflux occurs. Chronic exposure of lower oesophagus to acid results in changes of oesophagitis. Vomiting and regurgitation are typical symptoms of GER.
LES relaxes to allow passage of food into the stomach during swallowing. It has been found that there is transient lower oesophageal sphincter relaxation (TLESRs) that occur without swallowing. These relaxations are increased in patients with GER.
In most of the premature almost 50 to 100 percent reflux episodes are caused by TLESRs. Rest are associated with increased intra-gastric pressure.

Position of the baby during and after feeding is also known to influence reflux. **Left lateral position has been found to decrease the incidence of reflux by reducing the TLESRs.**
Right lateral position though helps in improving gastric emptying, the benefit of left lateral position outweighs the benefits of right lateral position. Reflux is also less in prone position.

Incidence of reflux is also less in exclusive breast-fed babies compared to partially breast-fed babies.

Use of Xanthenes is known to increase GER by increasing TLESRs.

Factors responsible for increase Reflux events:

- Oesophageal Dysmotility
- Increased TLESRs
- Hiatal Hernia
- Delayed gastric emptying due to some partial obstruction in the outlet
- Medications like xanthenes
- Small capacity stomach
- Nasogastric tubes
- Surgical: Gastric or Oesophageal surgeries like TOF repair or EA
- Omphalocele gastroschisis, malrotation, absence of diaphragmatic crura
- CDH repair
- Gastrostomy tube placement.

NATURAL COURSE OF GER IN PEDIATRIC AGE GROUP:

Regurgitation is a common phenomenon in New born (80%), that decreases to 10 % by one year of age. Various factors like liquid nature of feeds, recumbent position and immaturity of the LES mechanism is responsible for this in the new-born period. As the child grows and semisolid feeds are introduced and the sphincter mechanism improves the regurgitation episodes decreases.

CLINICAL FEATURES:

It is important to differentiate children with pathological reflux. Physiologic reflux is common in New-borns and infants particularly in early infancy. GERD occurs when reflux of gastric contents causes symptoms that are troublesome, affects quality of life or cause pathological complications.

The list includes:

- Failure to thrive
- Crying, fussiness during or after feeding,
- Emesis and / hematemesis
- Irritability
- Bad breath, gagging or chocking at the end of feeding
- Sleep disturbance and frequent night waking
- Abdominal pain
- Dental erosion
- Sandifer syndrome
- Dysphagia Apnoea
- Respiratory symptoms, aspiration, recurrent pneumonia, chronic stridor and wheezing

The above symptoms are nonspecific and may be present in certain conditions like Cow's milk protein allergy, pyloric stenosis, malrotation, overfeeding, tracheoesophageal fistula, and constipation.

A detailed history and examination is necessary for diagnosis and treatment. Infants are unable to verbalise and hence certain symptoms like heartburn which is common in older children and adults with GERD may be represented by symptoms such as irritability and back arching.

This symptomatology varies with age. the main symptoms in children from 2 years to 12 years is vomiting feeding difficulties and abdominal pain and those above twelve years symptoms are similar to those of adults.

Predisposing conditions

- Neurological impairment,
- Obesity
- Operated tracheoesophageal fistula
- Congenital diaphragmatic hernia
- Family history are commonly associated with reflux.

- **Food allergy and GER:**

Cow's milk protein allergy (CMPA) also presents with vomiting and regurgitation. Many infants who do not respond to anti GER management may be having CMPA. GER is frequently diagnosed and treated with H2 blockers or PPI, causing decreased gastric acid. Decreased gastric acid may in turn affect digestion of proteins causing new protein molecules which are absorbed and may produce specific IgE, resulting in allergy.

Food allergy needs to be considered in the differential diagnosis of GERD as the presentation is similar and both may be associated (16 to 55%). Recent studies have shown that in some of the patients GERD is not only associated with CMPA but is induced by it (Borelli et al)

- **Respiratory symptoms:**

Respiratory symptoms are common in children. GER can induce respiratory symptoms by either aspiration of gastric contents, vagal stimulation by presence of food in the oropharynx or centrally mediated response. Both acidic and alkaline reflux can induce respiratory symptoms. Hence PPI may fail to cure symptoms in a subset of patient with alkaline reflux.

A large study has shown higher incidence of symptoms like sinusitis, laryngitis, bronchiectasis and asthma in patients with GERD. Although relation between asthma and GERD is advocated, cause effect relationship is not convincingly confirmed.

- **Extra intestinal symptoms-**

Children tend to have more extra intestinal manifestation compared to adults who present with classic features of GERD. Symptoms like dystonia, Sandifer syndrome, opisthotonus, tick and sleep disorder occur in children with GERD.

INVESTIGAITONS

❖ **Objectives of the tests-**

Tests are done to confirm diagnosis, look for anatomical malformation, predisposing factors and complications.

No single test is sufficient to make a diagnosis of GERD and it is the clinical assessment and combination of various diagnostic test which helps in achieving the above objectives.

- Radiology- **Upper GI series**

Barium studies helps in assessing the anatomy of oesophagus, GE junction, angle of His, presence of hiatus hernia, oesophageal stricture caused by acid reflux and any gastric outlet obstructions. So, it gives very good anatomical information about the GE junction.

- **Endoscopy**

Helps in assessing the degree of oesophagitis if any including biopsy to rule out other conditions. It also helps in identifying the hiatus hernia and gives information about the integrity of LES. However, the major disadvantage is the need of General anaesthesia.

- **Scintigraphy**

Though recommended for evaluation of GER for identifying reflux episodes and gastric emptying, it lacks standardisation in normal values and acquisition techniques.

- **pH monitoring**

In this a pH probe is positioned in the lower oesophagus and PH is recorded over 24-hour period. Child can continue with his normal feeding pattern. pH below 4 is considered significant and the number of such episodes and their duration as well as the duration of the longest period below pH 4 is considered to decide on the need of treatment.

24-hour pH monitoring though considered by many as gold standard in the evaluation of GERD is not very useful in isolation in children and infants due to its inability to detect alkaline reflux. However, the test is simple to perform.

- **Oesophageal Manometry**

Its value lies in identifying oesophageal motility disorders and helps in precise placement of impedance probe in Multiple Intraluminal Impedance study which is now a gold standard in the evaluation of GERD often in combination with pH monitoring. However, it is recommended by some authors before considering surgery for GERD.

- **Combined Multiple Intraluminal Impedance and pH monitoring**

This consists of a catheter with different sensors along the length of the catheter which measures changes in the impedance values. Reflux episode is characterised by precipitous drop in the impedance. Multiple sensors help in detecting the extent of reflux. The catheter also has a pH probe at 2 places. Hence it records both acid and non-acid reflux events. It also allows study of patient while continuing feeding.

Its major disadvantages the cost and the complexity of interpretation. Its main advantage is to establish correlation between GER and symptoms.

- **PPI tests**

Empirically putting patient with suspected GERD on PPI for 4 to 6 weeks and see if there is improvement in their symptoms can be used as a therapeutic trial. However recent studies do not favour use of it in children due to side effects and it may not be useful in children with alkaline reflux.

TREATMENT

Treatment could be either conservative or surgical

Conservative

The conservative management is important in New-borns and Infants, where regurgitation occurs mostly due to physiological immaturity of the Lower oesophageal sphincter.

It is mostly sufficient in addressing majority of reflux and regurgitation symptoms.

- This includes small frequent feedings, thickening of feeds (adding rice cereal to the formula, usually 4 gm in 30 ml)
- Keeping the baby upright before and after feeding. The child is kept upright for 30minutes after the feed to facilitate oesophageal clearance and gastric emptying. The head end of the bed is elevated to 30degress during rest of the period.
- Left lateral position is recommended as it reduces the frequency of TLESRs.
- Prone position though useful is not recommended due to risk of SIDS.
- Milk Protein allergy needs to be considered in children on formula feeds and formula needs to be changed before labelling the child as GER.
- UTI's commonly manifest as vomiting in infants and need to be considered in the differential diagnosis.
- Medical management is considered when there is no relief with above measures or GERD diagnosis is certain
- Medicines used are Antacids, PPI, H2 blockers and Prokinetic agents. They are commonly prescribed but should be used with caution due its side effects.
- Antacids neutralises acid and are useful in children with mild symptoms and helps in diagnosis as well as relieving symptoms. However, children should not be overloaded with antacids as they contain Aluminium and Magnesium.
- H2 receptor antagonists- They decrease acid production by blocking receptors on the basolateral membrane of parietal cell.
- PPI decrease acid production by irreversibly inhibiting H+/K+ATPase on the apical aspect of parietal cell.
- Prokinetic agents helps in promoting gastric emptying and thereby reducing reflux episodes.
- Erythromycin, Metoclopramide and Domperidone are most commonly used drugs.
  Erythromycin is known to cause hypertrophic pyloric stenosis.
  Metoclopramide is known to cause irritability, dystonia and tardive dyskinesia. Cisapride is banned due to its risk of cardiac arrhythmias.

- PPI should be dosed 30 minutes before feed and not in presence of antacid and H2 blockers. Nocturnal breakthrough can be treated with H2 blockers.
- Adverse effects of acid blockers- due to decrease in the level of gastric acid it increases the colonisation of gut and bacterial translocation resulting in increased risk of gastroenteritis and community acquired pneumonia. It has also been found to increase risk of NEC and late onset sepsis in new-borns.

Surgical management

Most of the patients can be safely and effectively managed conservatively and only few require surgery.

Indications of Surgery

- Severe reflux with failed medical treatment
- Failure to thrive in spite of maximal medical treatment
- Recurrent respiratory events or ALTE associated with gross emesis
- Operated patients of oesophageal atresia with trachea oesophageal fistula
- Patients with hiatus hernia

Types of operations and the principles.

The basic consideration in correcting GER is to restore the anatomical and physiological function to as normal as possible.

This is achieved by :

1. Increasing the length of the intra-abdominal portion of the oesophagus
2. Restoring the angle of His
3. Crural closure
4. And creating a wrap of fundus around the e lower end of oesophagus

❖ Various surgical options are available. They are carried out either by conventional open surgery or laparoscopically.
❖ They are classified basically into the ones with complete wrap and the ones with partial wrap.

❖ Nissen's fundoplication in which a 360-degree flap is created around the oesophagus is the most commonly performed operation. However, the wrap needs to be sufficiently loose to prevent dysphagia and gas bloat which are the commonest problems implicated to this operation.

❖ Other procedures like Toupet, Boix Ochoa use partial wrap.

❖ In a neurologically impaired child with severe dysmotility of oesophagus just a gastrostomy may be sufficient to reduce the symptoms

- Surgical management is not without problems- commonest problem encountered specifically to the procedure include dysphagia gas bloat breakdown of wrap dumping syndrome and oesophageal stricture, intra thoracic migration of the wrap. Though more and more procedures are carried out laparoscopically nowadays, the success of laparoscopic procedure depends on the experience of the Surgeon in these procedures.

Suggested Reading

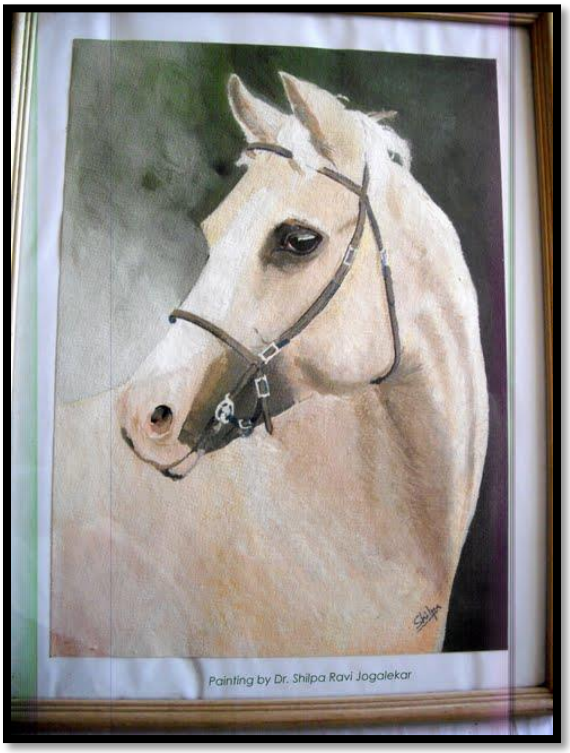
1. Manual of Neonatal Surgical Intensive Care, Third edition. Anne R Hansen, Mark Pudder
2. Gastro- Esophageal Reflux in Children, Int J Mol Science- 2017 Aug; 18(8): 1671.

Passion Beyond Profession

Dr. Shilpa Joglekar

Artistic Paediatrician…..

As a child everyone has a passion for drawing but to possess it and pursue it as a Talent and continue it as your Passion that too when you are busy in your daily chores and professional life is Amazing.



The above Fantabulous art says it all. Dr. Shilpa Joglekar, Says she did small paintings with water colours as a kid with her 1st big achievement being District level award from 6000 entries. She was encouraged to enter the world of oil and acrylic painting by her senior teacher in ophthalmology. She is very dedicated towards her work and it's very addicted to same such that she paints till mid night and even during lumch break once she starts the same. Madam is so passionate about her Artistic work that once when she fractured her hand she had to quit her job, so to keep her occupied she chose painting.

Slowly she ventured into various medium of art materials viz, oil, acrylic, fabric, charcoal, coloued pencils, crayons,.
Besides painting on Canvas she also would love to do pot painting, statues, and also her home interiors.
Participation in exhibitions or any competitions wasn't her priority as she always limitied it to her Private Passion but that she has a collection of > 50 painting and with encouragement of all well wishers she feels she should look forward to hold an Exhibition in near future. Madam never got a chance to take any formal training persay and You tube has been her formal guide to help her get self trained.
Definitely madam should hold an exhibition soon

A Paediatrician – Mini Cook: Dr. Annely D'lima

COOK – EAT – BE HAPPY… Tummy Full…

Dr. Annely D'lima when asked what cooking means to her pat comes the answer' **STRESS BUSTER'** . A Calorie and Diet Conscious Human being she **Devours Desserts**… Can you imagine that!!!!. She loves to spend time in the kitchen to experiment on new recipes especially Desserts.

Cooking has always been more than just satisfying hunger. She loves to feed people more than herself and enjoys the look on the face of others once they enjoy her delicacies.. Indeed she is a superb cook. She say" It gives me immense sense of satisfaction when you achieve something that you thought was difficult. Especial when you try a recipe for the first time and it turns out to be WONDERFUL and everyone just loves it. ***You are over the Moon!!***."

She wishes that whenever time permits she could learn finer techniques and skills involved in Pastry masking and is quite keen on joining classes in near future. Even though she didn't think of participating in any competitions or nor did she judge any she would definitely would want to do it someday.

Dr. Mimi Silveira is her biggest inspiration, as we all know she is really an Amazing cook and her desserts are to die for. Her Savory treats are class apart. Madam cooks with so much of flair and passion that it really makes you feel to follow her league.

Really its greats to know that we amongst us have Awesome talented people who have hidden creativity within them and give some time to this passion of their in-spite of all the Professional burden.

Hats off to you people!!!!!

Branch Activities

1. **CME on Cardiovascular system was conducted on the 16th July 2017, Congenital heart Disease being the main topic. Guest speakers were Dr. Shirish Borkar and Dr. Manjunath Deasai.**
   Dr. Borkar addressed on the Surgeon prespective of the CHD whilst Dr. Manjunath soke regarding the topic in terms of 'Limitations of Stethoscope and Conevntional Clinical Medicine. It was a very informative CME indeed.

Dr. Borkar, Dr. Manjunath addressing the crowd and actively replying to all the queries asked

Mr. , advocate who guided us regarding the medicolegal aspects……

2. **Month of August began by rigorous training of paediatricians with ALS course held at GMC organized efficiently by our coordinator Dr. Lorraine D'sa. Held on the 5th and 6th August 2017.**

3. **Monthly CME was conducted on Respiratory system, speakers for the day were Dr. Suhas Kulkarni and Dr. Harshad Kamat. Dr. Suhas spoke on Respiratory emergencies and also on the topic Paediatric Tuberculosis, Dr. Harshad Kamat briefed everyone on Bronchiolitis.**

Dr. Suhas Kulkarni and Dr. Harshad Kamat are seen addressing the crowd……

4. **In the month of September, the CME was concerning 'Common Paediaric Diseases' with Speakers being, Dr. Santosh Kondekar and Dr. Dhanesh Volvoikar. Dr. Kondekar addressed the topic of Funtional constipation and Loose motions and Dr. Dhanesh Volvoikar spoke on the topic Paediatric allergy and its impact.**

Dr. Dhanesh Volvoikar, Dr. Santosh Kondekar spoke to the attending crowd about Common Paediatric problems…..

5. **CME for the month of October was on the topic ' Vaccinology', Guest speakers being, Dr. Nitin Shah and Dr. R. K. Malik. Dr. Shah spoke on Combination vaccines with Hexaxim being the prime vaccine in question. Dr. Malik brief the gathering on Influenza vaccine and its advantages.**

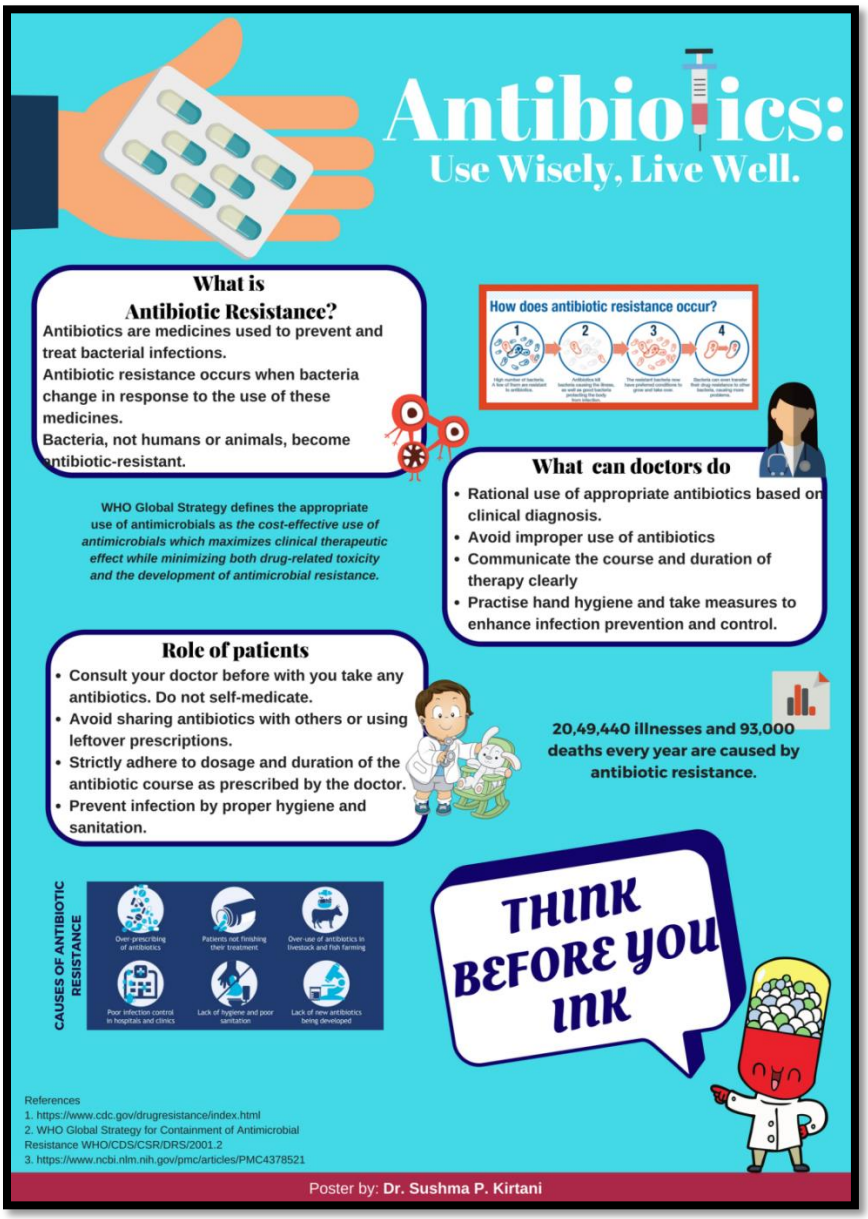
Vaccinalogy CME – Full house, Queries being efficiently answered by the speakers….

6. **November 2017 we had CME on topic Pnuemococcal disease and Prevention, wherein the speaker was our very own Dr. Harshad Kamat who efficiently addressed the topic and guided us.**

Dr. Harshad Kamat speaking on the topic Pnuemococcal disease and its Prevention…..

……..Continued

7. **Poster and Essay writing was conducted to observe IAP Antimicrobial Awareness Week and celebrate IAP Rational Antibiotic Day.**



Poster by Dr. Sushma Kirtani

B) <u>Essay submitted by Dr. Anish Bakhle</u>

Can you imagine a world without antibiotics? Antibiotics is the kind of magic that lets us run our lives very comfortably on a day to day basis in-spite of its literal translation meaning against life. It's become so essential in clinical practise that all of us would be handicapped one way or the other without it.
The era of antibiotics was started by Sir Alexander Fleming in 1928 with Penicillin. This pushed medical science further substantially and was followed by many other compounds that could be used orally or parenterally. And yet here we are with the question, "ARE WE MOVING FROM PRE ANTIBIOTICS TO NO ANTIBIOTICS ERA???"

Antibiotic resistance is a serious problem that was even recognized by the United Nations. It has taken the world by storm. The times are such that we are looking for a new and stronger Antibiotic because a majority of the ones invented less than 50 years ago are now almost useless against a slightly stronger bug, be it a bacteria, a fungus or a virus.

To point out a couple of reasons as to why we have reached this day, here is a list of things that could've contributed to the current state of affairs in the world of antibiotics. There are 3 main culprits in this unforgivable crime and they are the doctors, the patients, and the drug dispensers /providers or other health care individuals in addition to the microorganisms who seem to be getting smarter by the day.
Now let's look at our culprits one by one. The DOCTORS.
1. Inadequate dosage of the drugs
2. Inadequate duration of therapy
3. Improper indication for starting antibiotics
4. Not maintaining the 1st line 2nd line etc of the protocol of antibiotics
5. Rampant use of antibiotics because the patient demands it
6. Unethical benefits from Pharmaceutical companies are few that easily strike us.

The PATIENTS
1. Lack of understanding or poor compliance to therapy
2. Self medication
3. Pressurizing the doctor for antibiotics
4. Stopping therapy upon getting a sense of well being

Lastly we have the rest of the world who is doing their bit in adding to the nuisance that antibiotic resistance has become. On the common practices is the rampant use of antibiotics in live stock that we eat. The non medical personnel who prescribe medication without complete knowledge of the devastating effects of their decisions.

Sadly the whole world is bearing the brunt of this. Who would have thought of a day when TB wouldn't respond to rifampicin? Or the precious Vancomycin that was our best friend when it came to dealing with Staphylococcus would be ineffective? These are just to name a few. The impact of this is quite solid. Appearance of MDR /XDR TB, resistant strains of staphylococcus or even HIV have starting becoming a common phenomenon in out day to day clinical practise. The increasing number if deaths due to communicable diseases.The day is not far when well reach the era of superbugs and no antibiotics might just be the reason for the apocalypse.

So here are a few simple things we could do to stop the resistance.
1. Read before use of medications.
2. Follow proper protocol for use of medication.
3. Avoid use of antibiotics whenever possible.
4. Stop over the counter dispensing of antibiotic drugs without valid prescription.
5. Better doctor patient counseling and communication.

So lets us be the superheroes that the world needs to curb the antibiotic resistance and take the world back to where life is beautiful with no antibiotic resistance.
By:
Dr Anish Bakhle
1st year PG
Department of Pediatrics
Goa Medical College

8. **Adolescence week programme activities were done in full swing by our members.**

a) **Adolescent health camp with dispensing of health education was done at Moira Panchyat.**

Health camp conducted at Moira- Dr. Anant Kini, Dr. Swapnil Usgaonkar, Dr. Sushma kirtani, Dr. Nazareth, DR. Damodar Narvekar are seen in the photographs…..

b) **Adolescent Children were addressed and educated at KV High School, Ponda on 7th November 2017 By Dr. Sushma Kirtani, Dr. R. C Dev. Dr. Sushma and Dr. Dev both spoke on Family Life Education. Dr. Dev also spoke to the PTA members highlighted important aspects in Adolescent care.**

Activity under Mission Kishore addressing to the present students regarding Health education and Family Life Education

c) **On 13th November, Daughter's Day was celebrated ; Dr. Kini, Dr. Sushma, Dr. Swapnil, Dr. Damodar Narvekar gave talks to the children at Vidhyaprabhodini High School, Porvorim. Topics like HPV, Adolescent vaccination, adolescent nutrition were covered.**


Health Talks were given to Adolescent girls to celebrate Adolescent week and Daughter's Day……

d) **Adolescent Health check up was done at Vidhyaprabhodini High School, Porvorim; Dr. Kini, Dr. Swapnil Usgaonkar, Dr. Sushma Kirtani, Dr. Chetna Khemani, Dr. Nazareth were present.**


Health camp at VidhyaPrabhodini High School, Porvorim

e) **Dr. Purnima Usgaonkar gave a Talk on Health and Hygenie to Adolescent girls from Swami Vivekanand Higher Secondary School, Borim. The talk was organized by Mudra Pratisthan. She also donated books authored by her on Nutrition in Adolescence and Family Health to the School Library.**


Dr. Purnima educating students of Vivekanand High School, Borim

f) **On 22nd November 2017, Dr. Kini, Dr. Nazareth and Dr. , examined 80 children at People's High School, Camurli. Anaemia, Ear infection, Dental caries, undernutrition, Scabies were detected and adequately treated.**

Camp held at People's High School, Camurli

DHS Activities:

1. **Breastfeeding week was celebrated with lots of enthusiasm. Various kinds of activities were conducted by each wing of DHS.**

Activities being done to create Awareness and Encourage Breast Feeding……..

Various activities conducted at various centres to create Awareness and Encourage Breastfeeding

Walk for Breastfeeding- Hospicio conducted a Run to create Awareness regarding Breast feeding

2. **To promote HEALTHY FOOD HABITS… 'TIFFIN BOX' competition was conducted at Sub district Hospital Ponda**

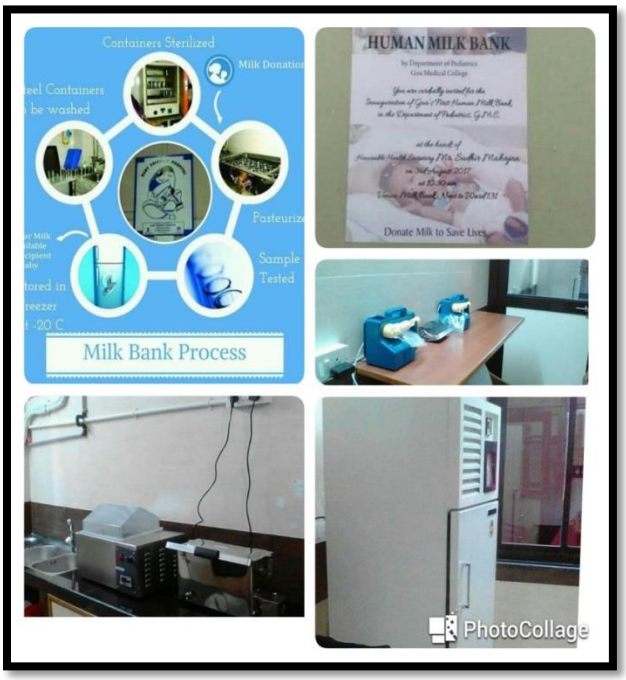
3. **Dr. Chetna Khemani from Asilo Hospital was faculty at The National Paediatric Rheumatology Conference (NCPR) at Kolkota, 28th and 29th October 2017.**

4. **Dr. Chetna was also one of the panelist at DMARDs in JIA**

5. **Dr. Priety Shetye gave a talk on 'Optimal infant Feeding Practices at a Workshop in College of Home Science. It was organized by Community Food extension unit, Ministry of Women and Child Developlement Unit, Government of India.**

Activities at GMC:

1. **Breastfeeding week was marked by Starting of the 'Milk Bank'.**



Another feather to the cap…MILK BANK…. Seen in the picture is Dr. Mimi Silveira addressing the gathering….

2. **Paediatric Quiz was conducted for Undergraduate on 2nd August 2017 and Post Graduate on 9th August 2017 By Department of Paediatrics.**

Paediatric Quiz being conducted at Department of Paediatric at Under graduate and Post Graduate levels.

3. **World Prematurity day was celebrated at Goa Medical College on the 17th November 2017. It was a fun filled program organized by the enthusiastic residents along with an event manager for the NICU graduates, comprising of various games, music and a cake cutting ceremony. This was followed by a formal function in the Lecture Hall of Goa Medical College. The dignitaries who attended this function were Hon Minister of Health Mr Vishwajit Rane, Dean of Goa Medical College Dr Pradeep Naik, Medical Superintendent Dr Shivanand Bandekar, OSD to Health Minister Dr Rajananda Desai and Professor and HOD of Department of Pediatrics Dr Mimi Silveira. Health talk delivered by Dr Aparna Wadker for the parents on care of the premies post discharge from NICU, followed by Dr Siya Caro's presentation on the GMC NICU statistics, outcome and future aspirations and upgradation for better outcome. Our residents then presented a wonderful poignant skit on the course of a premie in the NICU through their parents' perspective which left the audience teary eyed.**

World Prematurity Day being celebrated in Goa Medical College…..A proud Moment …….

Activities by our members:

1. GSCPCR with COOJ mental health foundation had a symposia on suicide prevention under the campaign called "YELLOW BARDEZ" on 27th september. At the the seminar hall of secretariet. All the stakeholders were invited for this symposium. The collector for North Goa Smt. Neela Mohanan was the chief guest and Dean GMC Dr Pradip Naik was Guest of Honour. Dr Peter Castellino founder Director cooj presented the talk on WHO theme, 'Take a minute and change the life'; explaining risk factors and magnitude of this problem.
Dr. Sushma Kirtani, chairperson, GSCPCR spoke on way forward. She presented the various measures government should be adopted to prevent suicide as young lives are lost every day.

2. Dr. Sushma was invited as a faculty in the capacity of Chairperson of Child Rights Commission to speak in Medicolegal CME. Topic being ' Child Rights in the Era of Gloabalisation – Role of UN'

3. Dr. Sushma Kirtani has donated money for 'AkshayaPatra Foundation'; Run by ISKCON. The donation is used to feed 9 kids – mid day meal for one year. The donation wqs done on 17th October- It being Dr. Sushma's birthday.

4. ORS week was observed at Dr. Sushma Kirtani's Clinic.

Dr. Sushma Kirtani educating parents about the importance of ORS and how to prepare and use the same…

1. Dr. Purnima Usgaonkar carried out her Regular camps (every Wednesday) at Matruchaya in the month on August onwards which is being continued till date. New inmates were examined and investigated. Deworming was done for all the inmate girls along with proper Health care guidance provided to the Caretakers.
During one of the camps a case of Hepatitis was diagnosed and managed with due care.

At Matruchaya, Dhavlim Ponda…..

2. On 29th August onwards, Dr.Purnima Usgaonkar undertook couselling session for the new admission students of Dr.K.B.Hedgewar Vidyalaya Ponda . Around 80 students who were examined at the health camp held on 30/7/17. These children are further on called for Personal Counseling in batches.

Personal Counselling of the New entrants of K. B. Hedgewar high School, Ponda in progress….

3. Mobile clinic camps of Snehmandir were conducted from month of July onwards. Dattagad, Konshe, Chirputem areas were covered. Around 40 – 50 patients were examined. Their health status, queries, deworming status and vaccination along with any other ailments were identified and referred to their respective specialities.

Dr. Purnima examining children and guiding the parents at Sneh-mandir Mobile Camp, held every Tuesday.

1. Dr. Anjana Pradeep on occasion of ORS week on 28th July, conducted an Interactive Session at WOW Kids – Play school, Panjim. Topic being ' ORS- ONLY RATIONAL SOLUTION FOR DIARRHEOA.

Dr. Anjana Pradeep explaining the importance of ORS to the parents and teachers at WOW Kids, Panaji

Activities from SETHU:

It has been raining trainings at Sethu all through the monsoon months.

- **July started off with a clap of thunder, with the Behaviour Management workshop organized by Sethu in collaboration with resource persons from the Autism Team of Ummeed Child Development Centre, Mumbai on 7th and 8th July. 50 parents and professionals attended the two day program to learn the principles of behavior modification, including the importance of analysing behavior to identify the triggers and appropriate treatment.**

- **On 21st July, Dr. Nandita de Souza delivered a talk on Learning and Behavior Matters at the Annual PTA meeting of Mary Immaculate High School, Panaji. Around 300 parents and teachers of the school were present. She spoke about the influence of emotions on learning and behavior.**

- **On 29th July, Dr. Nandita de Souza conducted a workshop on Childhood Sexuality for the parents of Std 1 students at Shiksha Niketan, Alto Torda. An early start to sexuality and safety education can go a long way in building self esteem and preventing abuse.**

- **Tarang is Sethu's preschool program for Inclusive Education which has been in operation since 2006. The training component was flagged off during this academic year on 19th August with an orientation program for 29 Heads and senior teachers on Inclusive Education. Sethu has launched an intensive training for schools with 2 components that address the needs of School Heads and teachers. 12 Heads of schools attended a 2 day Educational Leadership for Inclusion training on 22nd and 23rd September, where they created their own road map for inclusion. The teachers from these schools are undergoing an 8 month Certificate Course in Inclusive Education. So far, 3 sessions on Welcoming Diversity, Curriculum Based Assessment, Universal Design for Learning and Teaching Reading have been completed.**

- **In August, Sethu launched the IAP Fellowship in Developmental Pediatrics. Dr. Aparna Wadkar has been deputed from the Pediatric Neurorehabilitation Centre at Goa Medical College, to undergo the one year training.**

- **On 30th August, Paradise School, Quitla, Goa invited Sethu psychologists Silvia Mascarenhas and Aileen D'Souza to conduct a workshop for their staff on Learning Disabilities and Management of Classroom Behavior.**

- **Sethu staff conducted a series of 3 workshops at Chubby Cheeks Spring Valley School, including topics like Behavior Management (7th September), Creativity in Teaching (28th September) and Collaborative Learning (16th November).40 teachers from primary, middle and high school sections benefited from this training.**

- **On 8th September, which was World Physiotherapy Day, Dr. Nandita de Souza spoke to the parents and teachers of Sanjay School for Special Education on Holistic Approach to Students with Special Needs. She emphasized the critical role that parents play in implementing home programs to achieve the goals of therapy**

- **The new Asha program based on Teaching Social Skills to Children with Autism by Brookes Ingersoll and Anna Dvortcsak started at Sethu on 19th Sept with 8 families. Over a course of 12 weeks, these families will be trained in social communication, use of visual supports and behavior management**

- **Sethu has been working to develop a comprehensive program for the treatment of Attention Deficit Hyperactivity Disorder. 'From Disorder to Order' a 4 session, once weekly training program in Konkani, for children with ADHD and their parents was held over 4 Friday afternoons during October and November. 10 parents from 8 families and 7 children were trained.**

- **On 10th October special educators from Sethu conducted a session on Coping with Inclusive education at Holy Cross HS Bastora**

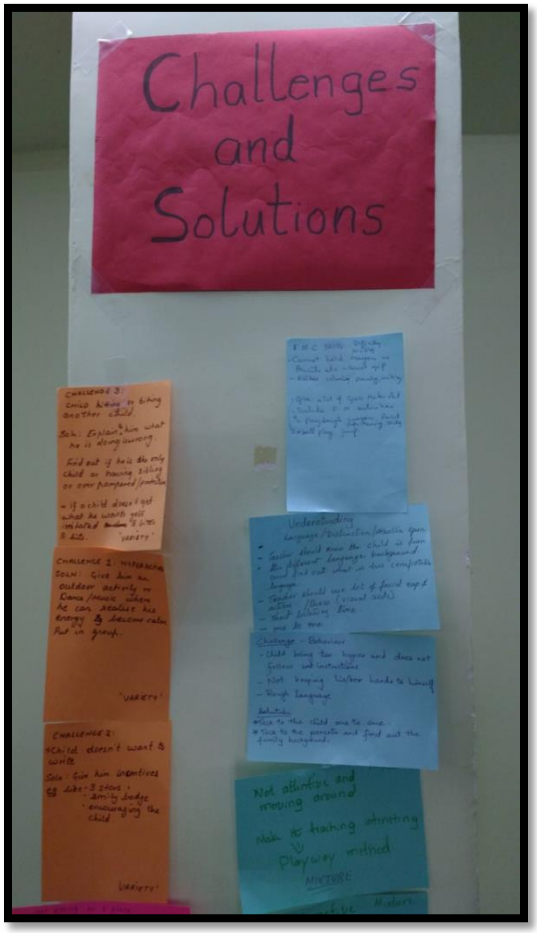
- **MRF organized a workshop on Healthy Living, in a world influenced by social media on 28th October. The Sethu psychologist who was the resource person discussed ways to keep children safe online.**

- **Children's Day was celebrated with a difference this year - Sethu organized an inclusive feast of fun and frolic as 48 children gathered together with their family members to be together and raise the spirits of children high. Thanks to the community participation and support of Bastora Panchayat, we were able to conduct the program with great success.**

- **Sethu's Child Protection Policy has been finalised and is in operation. It has a special section on the safety of children with special needs.Professionals interested in knowing more about this resource may contact Sethu's Child Protection Officer Silvia Mascarenhas on silvia.mascarenhas@ sethu.in.**

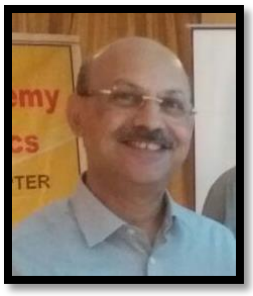
A parent resource person addresses the parents of children with ADHD

Heads of schools in Goa talk about their commitment to inclusive education at the Tarang Educational Leadership workshop



Teachers attending the Certificate Course in Inclusive Education, list out the challenges and the solutions for ensuring learning in class

Let's Know Him Better: Dr. Harshad Kamat



1) When is your birthday?
   - 16th April 1966

2) What does you name mean?
   - One who spreads Happiness.

3) Why Paediatrics?
   - Because it was an end speciality with no further specialization. Easier to establish your practice.

4) What do you like most about your profession?
   - Most gratifying to see children getting well and the smiles, pleasure and respect of the entire family that ensues.

5) If not a doctor, what would you have been?
   - Food critic and connoisseur of haute cuisine(I hope to still be one)

6) Your favourite hobby? Would you like to pursue it as a Profession?
   - Travelling and Dining out.

7) What is your favourite cuisine and eat out place?
   - I love experiencing all cuisines. Black sheep Bristo

8) Besides Goa if you had been given an option to live somewhere else it, where would it be?
   - Mediterrean Riviera

9) Your most treasured memory?
   - Birth of my two daughters

10) Your worst night mare?
   - My wife's illness

11) Your 5 most cherished possessions?
1) My family- wife and two daughters
2) Parents, Siblings and their family
3) My pediatric training which enables me to be what I am.
4) My friends who constitute my extended family.
5) Car and Home

12) What creatures/ things scare you?
- None

13) What irritates you most?
- Inaptitude

14) Your strongest personality trait?
- Temperament- I am generally calm in adversity

15) What is your Definition of a) Being Famous and b) Being Successful?
a) Being famous is the result of excelling at your chosen calling. That is how the world perceives you.
b) Being successful, is what one should aim for because that is how you perceive yourself. That gives you a sense of purpose, feel good factor and happiness.

16) What are you most thankful about in your life?
- That I have a life

17) If you were given power to change what would you change in a] World b] India c] Pediatrics?
a) Inequality caused by dominance of a few. All to have equal opportunity
b) Restrict population, education, health and ensure reservation is restricted to one generation only. Politicians to be vetted and only clean and educated individuals to be our representatives
c) Clean and ethical practice

18) Your best childhood memory?
- Time spent in Daman

19) Your most favourite game in Childhood?
- Cricket

20) Who inspires you most, in other words Who is your Idol?
- Dr Y K Amdekar

21) What comprises of an ideal Vacation?
- New locales, relaxed itinerary, delectable cuisine and wonderful company

22) What you prefer:
- Messaging/Calling up - Calling
- Watching a movie or watching Drama in theatre- Theatre
- Vacation at a Hill station or Beach or Safari- Hill station
- Read a book/ Watch TV- Book
- Facebook/Whats App/Twitter/Snapchat/Instagram- Whatsapp
- Travel by car/plane/bus/train/cruise- Plane

23) If you could go back in time, which year would it be?
- April 2014 – wonderful vacation in Provence- south France

24) If a Genie granted you 3 wishes, what would you ask for?
- Health for the entire family.
- Happiness for the entire family.
- Wealth

25) Do you have a Bucket list? What hits the list?
- Travel the world

26) Do you talk to yourself?
- All the time

27) Is crying or venting out your feelings a sign of weakness?
- Not at all

28) Advice to GenX Pediatricians?
- Remain updated
- Ethical practice
- Spend quality time with family

29) What is your favourite quote?
- BELIEVE YOU CAN AND YOU ARE HALFWAY THERE

30) How do you want People to remember you?
- As a good human being and a very good doctor

QUIZ:

1. **A 4-year-old child presents with fever for 3 days followed by bullous eruptions over the body. He also complains of burning micturation and defecation with difficulty in eating. He has received medicines for fever and cold – details not known. There is H/o child being admitted 15 days ago for seizure under investigation and is presently put on**
   Oral Carbamazepin. No seizures since then. Mother doesn't give history of varicella contact.
   On physical examination, that child was sick looking with vestibular lesions and mucosal ulcers.
   There was associated non-purulent conjunctivitis. What is the most probable provisional diagnosis?

2. **What are the 5 I's of Urticaria?**

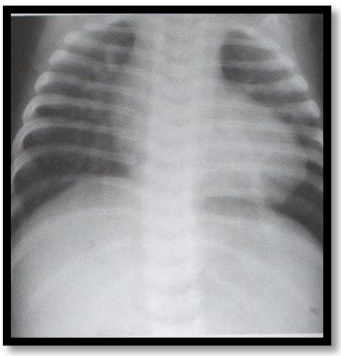
3. **Are pyridoxine supplements given to all patient who are in INH? In case no, who are to be adviced and why?**

4. **What is the most standard site for temperature assessment?**

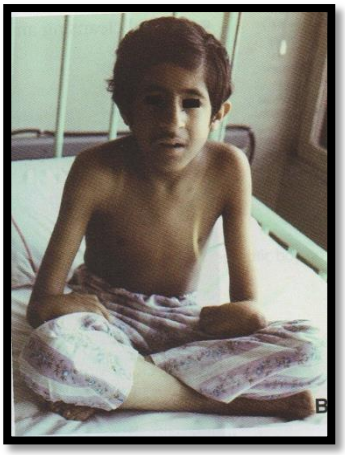
5. **What size needle gives lesser local reaction whilst giving a vaccine?**

6. **In a case of meningitis for how long should the patient be kept in respiratory isolation after starting the treatment?**

7. **Identify the Cardiac lesion in this child:**



8. **Spot diagnosis: What is the child suffering from?**



9. **Arrange in chronological order (Just write the alphabets)**
   Eruption of Primary dentition
   a) **Central incisors**
   b) **Canines**
   c) **1st molar**
   d) **Lateral incisors**
   e) **2nd Molars**

10. **Mostellars formula is used for?**

Send your answers without Googling or using any search aids to the siddhi.usg@gmail.com within 1 month of the bulletin release. Winners will be decided on Basis of First E-mail First Serve order.
The First one to send the all correct answers will win exciting Prizes.
Remember Honesty is the Best Policy. All the best!!!