SANTACRUZ MEDICAL SOCIAL ASSOCIATION

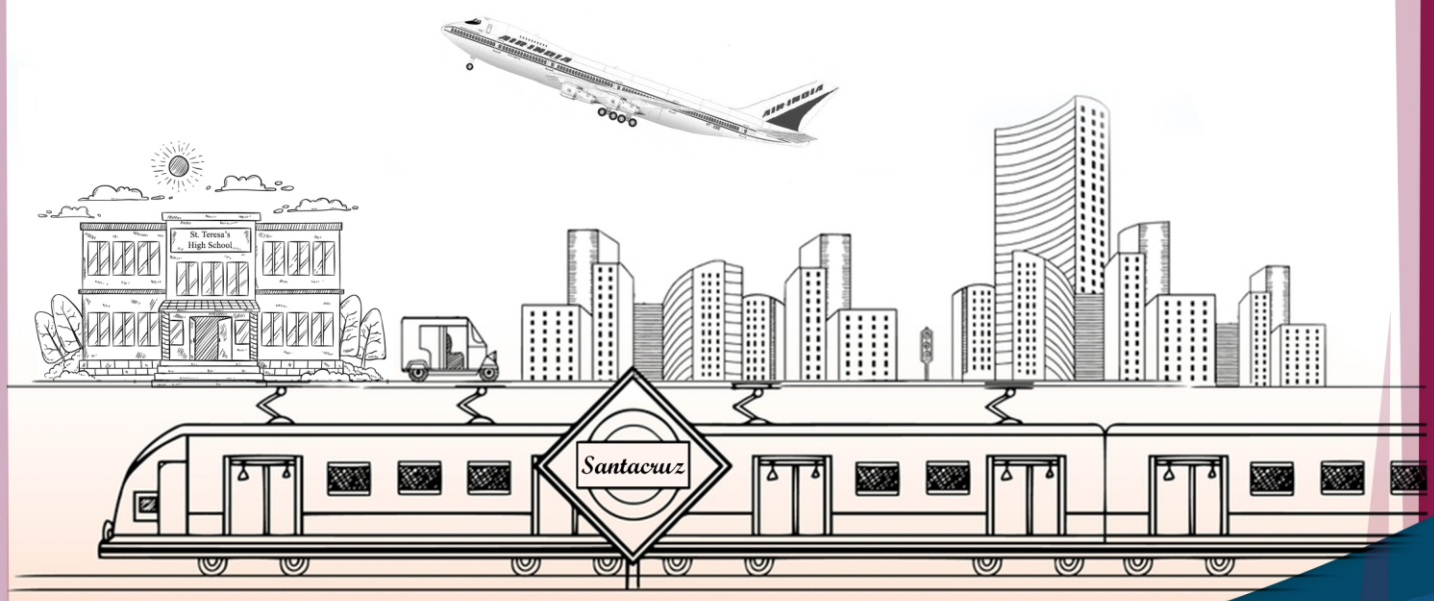
कामये दुःखतप्तानाम् प्राणिनाम् आर्तिनाशनम्

SMSA Samvaad

SMSA President, Secretary and the Managing Committee Present

MEDICAL BULLETIN

2024



1. Dear SMSA family,

Presenting Samvaad to you as a means of communication or “dialogue” has been a matter of labour & pride for us. It will have simplified medical updates from subject matter experts, new developments in different fields of medicine, some practical tips & pointers for clinical practice and good health and many other aspects that we as practising physicians sometimes struggle to keep up with. Importantly, your suggestions will be welcome and also advertisements for a nominal fee. We have a wealth of talent within SMSA and harnessing that itself has been a huge privilege. Hope you enjoy our first edition but we promise this novel concept of an e-Newsletter is evolving.

• Dr. Purvi Chawla, Consultant Diabetologist & Director of Clinical Research, President SMSA - ‘23-‘24

2. Dear Readers,

As the SMSA secretary, I’m thrilled to welcome you to this edition of the medical newsletter. Your health matters! So, dive into this medical newsletter for a wealth of information on preventive care, treatment options, and lifestyle choices that can positively impact your well-being. I hope you find this newsletter insightful and valuable in your pursuit of optimal wellness.

- Dr. Nisha Chaturvedi - Dermatologist, Secretary SMSA, ‘23-‘24

3. It gives me great pleasure to contribute an article in the first issue of 'SMSA Samvaad', a medical bulletin brought out by the 2023- 2024 Managing Committee of the SMSA under the able guidance of President, Dr Purvi Chawla and Secretary, Dr Nisha Chaturvedi; both of whom are great academicians. In our busy clinical practice, it is essential to remain abreast of relevant knowledge required for the practice of evidence based medicine. The concise nature of these articles makes for easy reading. Kudos to team SMSA for this important step in our Continuing Medical Education efforts.

• Dr. Rekha Ambegaokar - Obstetrician & Gynaecologist, Past President & Trustee, SMSA

4. Newsletter is a brilliant idea. There are so many new drugs & updates coming in that it will be very helpful to everyone, more especially to the seniors.

- Dr. Shaunak & Dr. Smruti Hora, Family Physicians & Past Presidents & Trustees, SMSA

5. Being updated on the latest information and developments is important in every field. This need is highlighted in the field of medicine as it deals with precious human life and the Corona pandemic was a perfect example of how we needed to be updated by the hour. Being active in the field of medicine gives us an advantage of reaching out to someone in the related specialization, but sometimes it can become necessary to have the most authentic and official information also. Am glad to know that SMSA has not only thought of but is beginning with an e-newsletter to keep us members aware of anything that could be important for us to function as good doctors. Every system needs some time to evolve and hence as was taught to us in childhood ‘make hay while the sun shines,’ I am happy that our association has taken a right decision at the right time. I congratulate the committee members for this wise decision and wishing them all the best for this new venture.

- Dr. Atul Pednekar - Homeopathic Physician &
Yoga Psychologist, Past President, SMSA

6. In today’s day and age where clinical advances happen every second, a newsletter will serve as a good avenue to be UpToDate with the relevant information from all fields.

- Dr. Mehul & Dr. Nikita Sheth, Family Physicians, SMSA

We welcome our Incoming President, Dr. Rahul Jeswani and Incoming Secretary, Dr. Genevieve Thakur and the entire team and wish them a fabulous SMSA year.

EVALUATION OF COUGH – WHAT A PHYSICIAN MUST KNOW!

Introduction:

Cough is a protective reflex and the main objective of Cough is to expel foreign particles and prevent them from entering into the lungs. This reflex involves a deep inspiration followed by the closure of the glottis and sudden opening of the glottis and contraction of diaphragm. It also stops food particles from entering the airway.

The types of Cough are primarily two:
1. Dry Cough
2. Wet Cough

The anatomical and pathological changes along the airway determines the type of Cough.

The symptoms of dry or wet Cough help the clinician to know the site of the disease process.

Let's see what causes Dry Cough:

Whenever the person coughs but there is no sputum, it is called Dry Cough. The causes of dry cough are largely the post-nasal drip and often missed, gastro-esophageal reflux. People who have rhinitis with symptoms of a running nose, the nasal mucus also trickles posteriorly along the posterior nasopharynx and then along the larynx. It causes mechanical irritation of the larynx and initiates a Cough Reflex. In such situations, the patient complains of running nose, sneezing and throat irritation. And with that, the patient often says that there is an irritating dry cough. In such a scenario, treating the rhinitis cures the cough.

Another common yet missed cause of dry Cough is gastro-esophageal reflux. Many people having eructations and heart burns, complain of dry Cough that arises out of mechanical irritation of the larynx and epiglottis. Treating the reflux
can actually treat the Cough.

An important cause of dry Cough is laryngitis following viral infections, post viral hyperactivity and allergic laryngitis. In many cases, we see patients who have fever and sore throat, complain of a lingering or persistent dry Cough lasting for more than few weeks. Cough suppressants like Dextromethorphan, Benzonatate, Levocloperastine give symptomatic relief in these patients. Other frequent inducers of dry Cough include smoking, occupational dust exposure, perfumes, incense sticks, smoke, pollution and avoidance of these allergens can reduce the intensity of Cough.

Let's now see what happens in the Lower Airways:

The bronchi are rich in mucus glands yet comparatively, the Bronchioles have sparse mucus glands. Logically, Bronchitis presents as Cough with copious sputum whereas Bronchiolitis presents with Dry Cough. One of the common reasons of Bronchiolitis are viral infections and allergen-induced damage. Clinically, bronchiolitis patients manifest with fine crepitations bilaterally.

Emphysema is a disease affecting the smaller airways and the alveolar sacs. Since the alveolar sacs are devoid of mucus glands, the Cough in emphysema is predominantly of the dry nature. But, the characteristic symptom of emphysema is exertional dyspnea. If an elderly person with dry Cough and exertional dyspnoea presents to you, emphysema should be on top of your mind.

Yet another important cause of dry Cough is interstitial lung disease (ILD). As the name suggests, this disease is in the Interstitium, hence there is no expectoration. It generally occurs in the age group of 40 to 55 years. With the advent of CT scans, it is much easier to diagnose ILD at an early stage with the most common form known as hypersensitivity pneumonitis.

Asthma, as we are aware, is a disease affecting the smooth muscle and sub-mucosa and often causes acute onset wheezing with a dry Cough.

Also, pleural pathologies may cause dry Cough so always look for pleural effusion if you are dealing with a patient having dry Cough.

If a patient specifically has dry Cough while lying down and associated with dyspnoea, then fluid overload could be a potential cause. In many patients, early CCF may present with dry cough in the supine position with orthopnea.

Just to Summarise:

*Dry cough can be acute or sub-acute or chronic.
*Age is very important
*Younger the patient, lesser the chance of ILD and emphysema.
*Always ask about occupational triggers
*Never forget reflux.

Let's see what causes Wet Cough:

The prototype of wet Cough is bronchitis. As the name suggests, it means inflammation of the bronchial mucosal glands. Such patients present with thick viscid sputum and get frequently infected. It may be acute or chronic in nature. Though smoking is considered as an important cause, non-smoking bronchitis is also equally common. Other frequent reasons are pollution, occupational dust, industrial gas exposure. Such patients have bilateral wheezing on examination.

However, acute fever, cough with purulent sputum is indicative of pneumonia. Hence an X-ray Chest is always helpful and a sure shot way of diagnosing a pneumonia. In fact, pneumonia can turn sinister if not diagnosed on time or if the patient has comorbidities like diabetes, alcoholism, kidney disease, HIV etc

In a country like India, tuberculosis or TB is very common and may present as dry or wet Cough. A Cough symptom of more than 2 weeks should be evaluated with an X-ray chest. Post TB sequelae like bronchiectasis is also common in which patients present with large amounts of expectoration and a long history of years. Again, a chest Xray is a good aid to diagnose bronchiectasis. In such patients, chest physiotherapy, mucolytics, expectorants are the mainstay of treatment.

Thus, if there is a patient with wet Cough and a long history, chronic bronchitis or bronchiectasis may be considered as the diagnosis.

Hemoptysis is a important symptom too and may occur in any respiratory disease. However, a large quantity of hemoptysis can be life threatening. Lung cancer, bronchitis, pneumonia, TB are few of the common causes of Hemoptysis. The less common ones are an AV fistula, fungal ball that may present with a torrential bleed.

Lastly, keeping an eye on the blood eosinophil count in patients with Cough is a good idea. High absolute eosinophil count with Nocturnal Cough may be a pointer to Tropical Pulmonary Eosinophilia.

Prof Dr Salil Bendre
Director
Pulmonary Medicine
Nanavati Max Super Speciality Hospital Mumbai

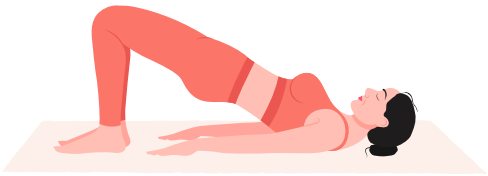
Back to Basics

Most of us have had back or spine issues at some time in our lives. Whether it's a simple postural ache or a severe sciatic pain, all spinal problems have the potential to put a spanner in the works of a perfectly planned schedule. The cause and subsequent treatment of most spinal problems is directly related to the tone or strength of the core muscles. Bed rest, while an effective measure to relieve back pain is, in fact, deleterious to the body if observed beyond 3 to 4 days. Early mobilization and stretching of the muscles ensures faster return to normalcy and less dependency on harmful painkillers. NSAIDS and other painkillers only postpone the pain rather than cure it, along with being harmful to the kidneys in the long run and habit-forming and addictive in nature. Their judicious use is the need of the day. There is also a misconception in the general public regarding the success of spinal surgeries. Spinal surgeries now are an established sub-speciality with minimally invasive techniques promising a smooth and quick return to routine activities. If correctly indicated and combined with a good exercise regime, a spine surgery is nothing to shy away from. Core strengthening not only delays the need for surgery in moderate or severe spinal pathologies but also guarantees a successful postoperative recovery and a faster return to function.

DR AMIT MEHTA.
MS, D.Orth, DNB. Orthopaedic & Joint Replacement Surgeon.

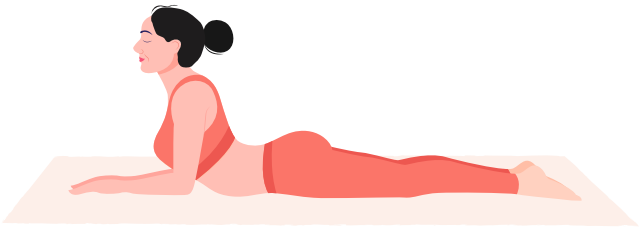
Exercises to Relieve Low Back Pam

TRUNK FLEXION STRETCH
On hands and knees, tuck in chin and arch back.
Slowly sit back on heels, letting shoulders drop toward floor.
Hold for 45 to 60 seconds.



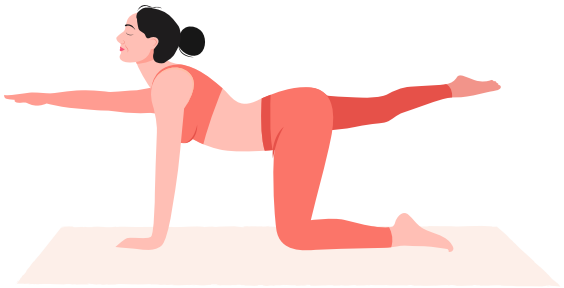
PELVIC TILT EXERCISE
Lie on back with knees bent, feet flat on floor, and arms at sides.
Flatten small of back against floor. (Hips will tilt upward).
Hold for 10 to 15 seconds & release.
Gradually Increase your holding time to 60 seconds.

CURL-UP EXERCISE
Lie on the floor on back.
Keeping arms folded across chest, tilt pelvis to flatten back. Tuck chin Into chest.
Tighten abdominal muscles while raising head and shoulders from floor.
Hold for 10 seconds and release.
Repeat 10 to 15 times. Gradually Increase your repetitions.

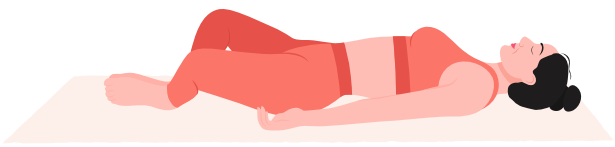


PRONE LUMBAR EXTENSION
Purpose: To extend your lower back.
Lie on your stomach & place your hands on the floor near the sides of your head.
Slowly push your upper body off the floor by straightening. your arms, but keep your hips on the floor. Hold for 10 seconds, then relax your arms, moving back to the floor.

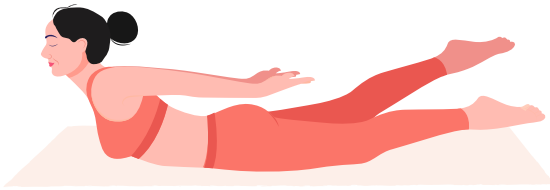
DOUBLE KNEE-TO-CHEST STRETCH
Lie down on back.
Pull both knees into chest until you feel a comfortable stretch in lower back.
Keep the back relaxed.
Hold for 45 to 60 seconds.



ALTERNATE ARM-LEG EXTENSION EXERCISE
Face floor on hands and knees. Raise right arm and left leg.
Do not arch neck.
Hold for 10 seconds and release. Raise left arm and right leg.
Do not arch neck.
Hold for 10 seconds and release.



TOWER TRUNK ROTATION STRETCH
Lie on back.



ALTERNATE LEG EXTENSION
Lie on vour stomach with your me folded undar unus chlo

A to Z of Hypertension Treatment

Q 1. What is the average age for hypertension that you are seeing these days?

Q 2. With the mercury being banned, are the automated BP machines accurate?

Q 3. Take home messages for BP Targets

Q 4. Take home messages for BP treatment

Answer 1. We are often seeing hypertension start in the 30s and 40s, more in men than in women.

Answer 2. Mercury-based BP instruments are still easily available. Either there is no real ban, or the ban is not being implemented. I personally trust mercury-based instruments the most. Digital BP instruments are my least favourite variety because of frequent errors. They are prone to show very low diastolic blood pressures inducing worry in patients. A decent alternative to mercury instruments is the aneroid BP instrument. I strongly recommend the expensive but excellent "Heine Gamma 5 Aneroid BP instrument" as an alternative for people who wish to move away from mercury.

Answer 3. Blood pressure treatment targets have experienced modifications in the past few years. This is what I follow...
1. In most patients, BP target is 135/85 or less.
2. In pregnancy-induced hypertension, BP target is 140/90 and not less than that.
3. In a pregnant patient with pre-existing hypertension, the target BP is < 140/90
4. In the elderly, postural hypotension is fairly common. I target the standing BP and do not allow it to go below 120.

A to Z.... Of Hypertension Management

ARB Dose Equivalence

Losartan 100 mg = Telmisartan 40 mg = Olmesartan 20 mg with Telmisartan being the preferred ARB

Beta Blocker Dose Equivalence

Atenolol 50 mg = Metoprolol 100 mg = Bisoprolol 5 mg = Nebivolol 5 mg

Calcium Channel Blockers

Of the dihydropyridine group – Amlodipine 5 mg = Cilnidipine 20 mg = Efnodipine 40 mg

Diuretics Used In Hypertension

Hydrochlorothiazide 12.5 mg = Chlorthalidone 6.25 mg = Indapamide SR 1.5 mg

Enalapril 5 mg = Lisinopril 5 mg = Ramipril 10 mg = Perindopril 4 mg; all of these commonly cause dry cough as a side-effect

First Dose Syncope due to postural hypertension is a worrisome side-effect of alpha blockers like terazosin and prazosin

Gout can be worsened or provoked by diuretics as they cause hyperuricemia

Hypertension should be treated straightaway with two drugs if BP on presentation is 110 diastolic or more

Isolated Systolic Hypertension is defined as systolic BP of 140 or more and diastolic BP less than 90

Justifiably use ACEi or ARB in those with diabetes with proteinuria even if there is no hypertension

K+ (potassium) levels in blood can rise dangerously if NSAIDs are used for long in patients on ACEi or ARB

Labetolol is the drug of first choice in pregnancy-induced hypertension

Moxonidine is a centrally acting drug used as an add-on therapy when multiple drugs fail to control BP

Nifedipine sublingual use should be totally abandoned in severe hypertension as it can cause cerebral and coronary steal syndrome

Obstructive Sleep Apnoea is an important cause of secondary hypertension and should be suspected in every patient with difficult to treat hypertension

Propranolol is useful as an anti-hypertensive in patients who have concomitant migraine or essential tremor

Quality of Generic Antihypertensives will always be suspect, and while one may allow them in non-affording patients, one must monitor the BP closely

Rebound Hypertension occurs especially when beta blockers or moxonidine are discontinued abruptly

Secondary Hypertension can be due to abuse of NSAIDs or steroids, especially NSAIDs used for orthopaedic reasons

Thyrotoxicosis can cause systolic hypertension while hypothyroidism can cause diastolic hypertension, both of which may resolve once euthyroid state is achieved

Unilateral or Bilateral renal artery stenosis can cause severe hypertension that can be often rectified by renal artery angioplasty

Verapamil and diltiazem are two calcium channel blockers that can cause severe constipation

White Coat Hypertension may necessitate a test called ambulatory blood pressure monitoring

Xerosis or dryness of skin is an important side-effect of diuretics, especially in the elderly

Young Adults are increasingly presenting with essential or primary hypertension because of a worsening lifestyle

Zero Tolerance should be adopted by physicians to any BP of 140/90 or above because of the very high morbidity

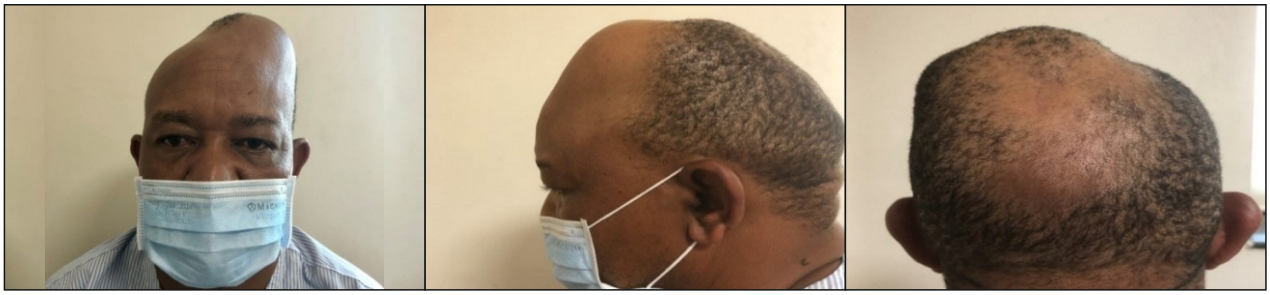
Dr. Tushar Shah, MBBS, MD (Med)
Consultant Physician, Author, Medical Quiz Specialist and Humorist

All In The Clinic

Unusual scalp swelling (A silent bomb)

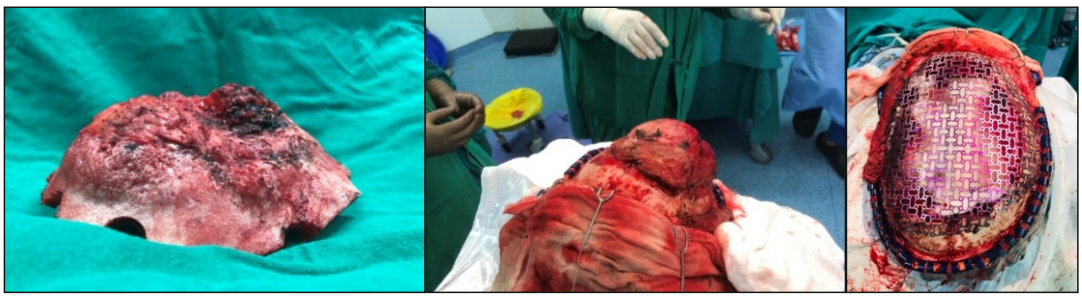
A 43 years old, African gentleman presented with a huge scalp swelling from 2007, which was gradually progressive in size but the growth, was quite rapid in his last three years. He had seen doctors in his country for which they tried some surgery in 2010, but could not achieve any resection of the growth. Finally when he presented to us, we did his full work up in the form of MRI brain with venogram (to check on the details of the swelling, compression on surrounding vital structures of brain, the dimensions, the extent of invasion, the nature of the swelling and the most important was to see the extent of swelling blocking the major veins draining the brain) and other pre-operative blood evaluation. His surgery was high risk in the form of possibility of large volume of blood loss as it was involving the major draining veins and chance of weakness of one side of body as the swelling was infiltrating the brain parenchyma. He was prepared for the surgery with reserving ample blood and blood products. Intra-operatively, we figured out that the swelling was growing on both the side of skull bone, involving the skull bone and growing outside (but the skin was free) as well as growing inside involving and pushing the brain down. We took out a large part of his skull bone (which had the tumor) and meticulously dissected the tumor from the surrounding brain parenchyma keeping the normal draining veins intact. The defect created due to removal of skull bone was reframed with titanium mesh to give support, contour and strength. The size of the skull bone removed was almost double what it would look in a normal person. Post-surgery, he had weakness of the right side of the body which improved with medication and physiotherapy over the next 4-5 days. He was then discharged after a week, where he was ambulating on his own and performing all his activities on his own, with no scalp swelling and free of the tumor. He has got a new look over his face and he could feel much lighther on his head.

A: Pre-Surgery



Pre-Surgery pictures in all three profiles, showing large swelling predominantly over the left side crossing the midline and occupying about 60% scalp area.

B: Intra-Surgery



B: During surgery, pictures showing the swelling arising from the bone with the cut removed part of the bone along the swelling and the reconstructed defect with titanium mesh.

C: Post-Surgery

C: Post-Surgery pictures in all three profiles showing almost normal scalp, with little post surgery swelling (which usually resolves in a week)

Dr. Mazda Turel
MBBS, M. Ch Neurosurgery, Consultant Neurosurgeon and Neuro-Oncologist

The Inside Story (Female Genital Itch)

Dr. Nisha Chaturvedi
Dermatologist, Secretary SMSA, '23-'24

Dermatoses in and around the genital area remain much neglected until late, due to the inherent hesitation and shame associated with revealing the "private parts" to outsiders, even doctors. Most women tend to suffer in silence, rather than voice their despair. Vulvar pruritus is a common complaint among young girls and women presenting to primary care or family physicians, gynecologists, and dermatologists. Female genital itch is especially disruptive because of its interference with sexual function and intimacy.

Causes of vulvar itch are vast and may be inflammatory, environmental, neoplastic, or infectious, often with several causes coexisting simultaneously. Diagnosis may be difficult because of the unique anatomy and inherent properties of genital and perianal skin.

Most women assume that all genital itching is due to yeast / candidial infection (commonest cause) but there are several other causes like
Inflammatory dermatoses- Lichen simplex chronicus, Lichen sclerosus , vulvar psoriasis,
Irritant and allergic contact dermatosis, Lichen planus
Infections-dermatophytosis , bacterial vaginosis, genital warts, pinworm infestations , trichomoniasis, Neoplasia - vulvar intraepitheilial neoplasia, Invasive vulvar cancer, Post menopausal - due to lack of estrogen, to name a few .

Diagnosis can be done by through history taking and careful examination of the vulva. Investigations like swabs, skin biopsy or a patch test may be needed to determine the exact nature.

Treatment is directed towards finding the cause and giving specific relief, like anti-fungal creams in case of candidiasis, tinea infection; topical steroids for inflammatory disease and surgery for neoplasia. General instructions include wearing loose-fitted, absorbent underwear and outer clothing, not to excessively clean the area, avoid using wipes for cleaning, or any other cleaning preparations. Ask the patient to apply bland emollients like petroleum jelly.

Some women may suffer from vulvar itch for years and may only receive temporary relief from treatment if not correctly diagnosed.

Thus, timely referral to a Vulvar specialist/ dermatologist, as needed is helpful for further management.

Human Papilloma Virus and HPV Vaccine: An Overview

Dr. Rekha Ambegaokar
Obstetrician & Gynaecologist, Past President & Trustee, SMSA

Question 1) What are the diseases caused by the Human Papilloma Virus (HPV)?

Answer: Almost all cervical cancers are caused by the Human Papilloma Virus (HPV).

HPV viruses are also responsible for vaginal, vulvar, anal, oral, throat and penile cancers.

India alone accounts for one-quarter of the worldwide burden of cervical cancers.

HPV infections are so common that nearly all sexually active men and women will get at least one type of HPV at some time in their lives.

Most HPV infections go away by themselves within two years. Around 5% of them progress to a state of persistent infection, which can cause cancer. Cervical cancer is often detected late due to lack of any significant symptoms in the early stages of the disease.

More than a 100 HPV types are known with 13 types implicated in causing cervical cancer or being associated with other cancers of the anus, penis, vulva, vagina and throat. Out of them, type 16 and 18 are the most common ones. In countries where the HPV vaccines are used in the national immunization programs, a significant reduction of diseases caused by HPV has been recorded within a few years of use.

Question 2) Which are the vaccines available against the HPV and what is the schedule?

Answer: 1. Bivalent (HPV2): this vaccine contains HPV types 16 and 18 (Cervarix).

2. Quadrivalent (HPV4): this vaccine contains HPV types 6, 11,16 and 18 (Gardasil, Cervarac)

3. Nonavalent (HPV9): this vaccine contains HPV types 6, 11, 16, 18, 31, 33, 45, 52 and 58. This vaccine is expected to broaden the protection against cervical cancer by around 15%.

In India, the Bivalent vaccine (HPV2) and the Quadrivalent HPV vaccine (HPV 4) are expected to prevent approximately 83% of cervical cancers, whereas the Nonavalent vaccine (HPV 9) is expected to prevent approximately 98% of cervical cancers.

All the 3 vaccines are very effective in preventing cervical cancers caused by the types contained in the vaccine.

Schedule:
*Girls 9 to 14 years:
Two doses to be administered at an interval of 6 months, 0–6 months.

*Girls 15 years and older:
Three doses recommended in the schedule 0–1–6 months for Cervarix and 0–2–6 months for Gardasil.

*In immuno-compromised individuals of any age:
Three doses recommended in the schedule 0–1–6 months for Cervarix and 0–2–6 months for the Gardasil. HPV9 is licensed in a 3-dose schedule of 0-2-6 months in females 9-26 years of age and males 9-15 years of age. The ideal age for starting the vaccine is 9-10 years. HPV vaccines can be given at the same time as the Tdap vaccine.

Question 3) Why is it essential to start the schedule at 9-10 years and not later?

Answer: 1. Young adolescents mount a superior immune response compared to older individuals.

2. Prevention of disease is better if started earlier.

3. Only 2 doses are necessary in this age group versus 3 doses beyond 15 years of age. There is no recommendation for any booster doses.

Question 4) Are the HPV vaccines safe?

Answer: These vaccines are generally safe. Mild to moderate local side effects are pain, swelling or redness at the vaccine site.

Some adolescents can get dizziness after the injection, hence observation for at least 20 minutes after administrating the vaccine is advocated. It is advisable to give the vaccine in lying down position.

Question 5) Who should not receive the vaccine?

* Pregnancy
* In any acute febrile illness, better to delay the vaccination
* Any allergy to known components of the vaccine

In India, only Nonavalent vaccine (Gardasil 9) is licensed for use in males.

CAUTION: Taking the vaccine does not make Cervical cancer screening irrelevant. All women HAVE to continue getting Pap Smears even if vaccinated.

-- By Dr. Rekha Ambegaokar
M.D. (Ob Gyn), Director of Obstetrics and Academics,
Nanavati Max Super Speciality Hospital

Spotlight: There's More To Diabetes In Women Than High Sugars!

It is now apparent that the pandemic perils will have a long-lasting impact on individuals at multiple levels including health. Women have been much worse affected in the pandemic; more poverty, low financial independence with less control over the household income, low education or awareness, more mental health problems, more responsibilities being household providers with less time for self-care, less physical activity, more consumption of left-over foods or easily-available food items, culturally unaccustomed to paying attention to oneself, or giving due importance to early signs/ symptoms of disease and seeking help or spending on tests, doctor visits or even accessing free healthcare.

While these are noteworthy social determinants of diabetes specific to women, they cause a delay in diagnosis and increase complications. Men and women are alike in many ways, with important pathophysiological and behavioural differences influencing clinical manifestation, disease progression/complications and response to treatment.

Typical symptoms of diabetes like increased thirst, hunger, frequency of urination, especially night-time are common to both sexes but the tell-tale signs of diabetes in women are frequent urinary tract infections, itching or discharge from the genital region and pain post-intercourse. Often, the symptoms may not be present or noticed by women, hence annual blood sugar testing (Fasting or random sugars, HbA1c) is recommended.

Since the lifecycle of a woman is so different than that of a man, diabetes can also be difficult in her with more physical limitations, significant comorbidities and socio-cultural prejudices. Studies have proven that women with diabetes are 3-4 times more prone to develop cardiovascular disease (coronary heart disease, heart failure, peripheral artery disease and stroke;) twice more likely to develop mental health issues like depression and anxiety; have increased sexual dysfunction and osteoporosis; increased risk of cancer than women without diabetes. The premenopausal protection from heart disease that women are privileged to have due to estrogen is lost in the presence of diabetes.

For preventing diabetes, we must recognise certain "pre-conditions" in women that increase diabetes i.e. polycystic ovarian syndrome (PCOS), pre-diabetes (HbA1c between 5.8-6.4%), GDM, overweight or obesity, sedentary lifestyle, premature menopause, and intervene with better lifestyle changes, medications and regular testing. Controlling co-existing conditions like hypertension and dyslipidemia is equally important.

Scientifically, it has been shown that GDM affecting 3-4 million Indian women every year, increases the risk of type 2 diabetes by 10-11 times in Asian Indian women in the 3-6 years post-delivery; increases heart disease and fatty liver too. Unfortunately, impressions of high sugars on the fetus in women with GDM, lead to higher fat and metabolic syndrome in these children at young age and also in their children, further propagating this cycle of diabetes and affecting multiple generations.

Fortunately, there is counter evidence that this vicious cycle may be broken and the risk halved, with a healthy lifestyle, intensive weight loss and maintenance after delivery, plenty of physical activity (>150 minutes/week), breast-feeding, consumption of a Mediterranean type of diet with a balance of moderate complex carbohydrates with protein and good fats, and testing blood sugars at 6-12 weeks and at 6 months after delivery, curtailing smoking or alcohol consumption, stress management.

Hence, physicians globally recommend that the spotlight should be on preventing diabetes and early detection/ management, with sustainable lifestyle changes as these chronic non-communicable diseases are heavily driven by unhealthy choices and overweight, especially in women.

Managing blood glucose optimally involves regular checking of blood glucose using traditional means like laboratory or home glucose meter measurements like fasting and post-lunch blood sugars, glycosylated hemoglobin A1c or with newer methods like continuous glucose monitoring (CGM) using sensors that last for 14 days and help determine glycemic variability and unrecognised hypoglycemia and hyperglycemia.

So, ladies and gentlemen, let us pledge on this International Women's Day, that we will engage in self-care and preventive health as our highest "dharma" to enjoy a great quality of life and prevent disease. Being the centre of the household, a positive change in a woman has a ripple effect in the family and society!!

- By Dr. Purvi Chawla
Consultant Diabetologist & Director of Clinical Research
• By Dr. Manoj Chawla
Consultant & Director Diabetology

LAUGH OUT LOUD
What do you call when the kid is asked to kneel down outside the class.

KIDNEY (KID KNEE)-
Dr. Hemal Bhagat - Consultant Laparoscopic Surgeon