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Tamil Nadu State Chapter

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Editor's Note

Dear members of API TNSC,

Seasonal Greetings!

We are pleased to present this issue of "The Journal of the Association of the Physicians of Tamil Nadu" 2024, featuring a collection of original research articles and case reports that highlight diverse and relevant topics in the field of medicine.

In our Original Articles section, we begin with a fascinating case report on Actinic Reticuloid which delves into the challenges of diagnosing and managing this rare photodermatosis. Following this, the article on body weight and reproduction explores the complex relationship between them. We also feature an important article on Brucellosis shedding light on this often-overlooked zoonotic infection, and its implications in clinical practice. The next article on Euglycemic Diabetic Ketoacidosis, a rare but life-threatening complication in diabetic management. The final original article on Pregnancy Complicated by Serious Infection, addresses the complexities of managing severe infections during pregnancy.

In the Case Report section, we have included two emergency medical situations, under the title Emergencies: A Series – 8 & 9, which provides practical insights into the management of acute medical crises.

We thank all the authors for their invaluable contributions and look forward to more collaborative efforts in future issues.

Please note that the election nomination form is included in this Issue.

With warm regards,
Dr. Vijay Viswanathan
MD., Ph.D., FICP., FRCP (London & Glasgow)

Contents

Original Article

Case report

"ASSOCIATION OF PHYSICIANS OF INDIA TAMILNADU STATE CHAPTER"
Sri Sakthi Vinayakar Multispeciality Hospital & DR. V.Palaniyappen's Diabeles Specialities Centre, 95, 95A, Near Bus Stand,
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CIRCULAR 1/2024

Election of Association of Physicians of India – Tamil Nadu State Chapter Executive Committee Members for 2024 – 2025 are invited for the following Posts.

1. **One General Secretary**
2. **Two Vice Chairmen**
3. **Two Joint Secretaries**
4. **One Treasurer**

Nominations shall be made on prescribed forms stating the office for which nominations are filled. The nomination shall be proposed by one valid life member and seconded by another valid life member and duly signed by them and shall also be signed by the candidate signifying his/her willingness to stand for election and serve on the Executive Committee if elected. Separate nominations must be submitted for each post.

Every Executive member is supplied with a nomination form. The nomination form completed in all respects should reach the API TN Office not later than 23rd September, 2024 along with a passport size photograph. For every post on the Executive Committee, the nomination must be accompanied by a sum of Rs. 5000 + 18 % CGST / IGST = Rs. 5,900 (Rupees Five Thousand and Nine Hundred only) in favour of "Association of Physicians of India Tamil Nadu State Chapter" in the form of Demand Draft only payable at Chennai. The nomination paper not accompanied by the Bank Draft of Rs. 5,900 will be deemed invalid. The fees for nomination is Non Refundable.

Rules Relating to Qualification for Election to Executive Committee

1. Vice Chairman / Hon. Gen Secretary: To contest for the post of Vice Chairman / Hon. General Secretary, the candidate should be a life member of National & Tamilnadu State Chapter API for at least 5 Years and should have completed at least one continuous full term of 3 years in any elected position in the Executive Committee
2. Hon. Treasurer / Joint secretary: To contest for the post of Hon. treasurer / Joint Secretary, the candidate should be a life member of National & Tamilnadu State Chapter API for at least 4 Years and should have completed at least one continuous full term of 3 years in any elected position in the Executive Committee
3. A member shall not contest simultaneously for more than one post.

They are requested to send a passport size photograph, short biodata not more than 200 words. The candidate will have to certify and sign that the information provided in his / her biodata is correct.

The results will be declared and announced in subsequent issue of TAPIJ. The report will be placed before the Next API TN State Chapter Executive Committee Meeting.

Dr.V. Palanlappan MD., FICP., FRCP (London)
Hon. General Secretary
Date: 04.09.2024
Place: Guziliamparai

DEADLINES OF ELECTION PROCEDURE

Last date to receive the nomination at API TN SC office	23.09.2024
Last date for withdrawal	30.09.2024

The Association of Physicians of India - Tamilnadu State Chapter
Nomination Paper for all Elections

Office for which the
Candidate is nominated _____

Name of the Candidate _____

Address of the Candidate _____

_____

Life Membership No : _____

Tel.Nos.Resi. _____ Office _____ Institution _____

Mobile : _____ email : _____

Name of the Proposer _____

Address of the Proposer _____

_____

Life Membership No : _____

Date Signature of the Proposer

Name of the Seconder _____

Address of the Seconder _____

_____

Life Membership No : _____

Date Signature of the Seconder

DECLARATION BY THE CANDIDATE

I hereby declare that the information given above is true and I have read all the instructions and criteria carefully. I hereby declare that I will abide by all the rules & regulations as per the constitution of ASSOCIATION OF PHYSICIANS OF INDIA TAMILNADU STATE CHAPTER. I, Further declare that I will not indulge in any activity which may harm the honour & prestige of API TNSC.

D.D.No:……Amount:……

Undertaking

I hereby undertake that I have held the following posts / not held any post of the Excutive committee of API TN State Chapter.

	Post	Period
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Date

Form is available on website: www.tnapichapter.org

Signature of Candidate

Original Article

The Journal of the Association of Physicians of Tamil Nadu,
Vol. 3, Issue 1, English Quarterly, January – March 2024

Actinic Reticuloid – A Case Report

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Abstract:

Actinic reticuloid (AR) is a persistent, immune-mediated photo dermatosis induced by ultraviolet (UV) radiation, either by UVA, UVB or visible light and is considered an entity of Chronic actinic dermatitis (CAD). CAD consists of a spectrum of diseases including Actinic reticuloid (AR), photosensitive eczema, and persistent light reactivity. In addition to photosensitivity, most patients also show contact sensitivity to several allergens. It is characterised by pruritic, eczematous and lichenified plaques over the photo-exposed sites.[1] [4]

Keywords: *Chronic actinic dermatitis, Actinic reticuloid, Photosensitive eczema, Photosensitivity dermatitis.*

Introduction:

Chronic Actinic Dermatitis (CAD) is an immune-mediated photodermatosis, first described by Ive et al. in 1969.[2] About 75% of patients have contact sensitivity to several allergens in addition to severe sensitivity to UVB, UVA, and/or visible light, which may be a factor in the etiopathogenesis of CAD. Mild cases of AR are eczematous whereas the most severe ones resemble cutaneous T-cell lymphoma.[2][5] ACD or allergic contact dermatitis, frequently coexists with CAD and often precedes photosensitivity.[4] Diagnosis is made based on clinical, histopathologic, and photobiologic findings. Photo testing and patch testing also become essential in making a diagnosis and the treatment includes detailed advice on sunlight and allergen avoidance, topical corticosteroids, and emollients. Systemic immunosuppressives such as azathioprine or systemic prednisolone for acute exacerbations may be explored when these therapies alone prove ineffective. Systemic treatment may be necessary for more than a few weeks.[3]

Case Report:

A 62-year-old male patient, who is a farmer by occupation presented to our Dermatology OPD with an eczematous, pruritic eruption on the face (Figure 1), back, chest and both hands (Figure 2). The patient gives a history that the rash first appeared on the face 3 years back. The rash appeared during summer only during the initial stages but the seasonal variation disappeared with the progression of the rash to a more severe form. The rash later spread to other exposed areas like the hands, upper back and chest. The patient has no known allergies. A clinical diagnosis of Actinic reticuloid was made. The patient was advised of the following treatment:

- Clobetasol ointment once a daily external application for the lesions on the body.
- Tretinoin 0.025% cream for external application on the face at night.
- Liquid paraffin for external application all over the body.
- Tablet levocetirizine 5mg HS.

Figure 1: *Pigmented, thickened, plaques with accentuated skin markings seen on the face.*

Figure 2: *Multiple pigmented, scaly papules and plaques are seen over the nape of the neck, back, and dorsal surface of both the hands and the chest.*

- Photoprotection and allergen avoidance are advised.

Improvement was noted in the lesions at 1-month follow-up (Figure 3).

Figure 3: *Improvement in the lesions was noted after 1 month of treatment*

Discussion:

Chronic Actinic Dermatitis (CAD) is a chronic or recurring dermatitis mainly affecting the photo-exposed sites. It is considered to be the second most common immunological photodermatosis after Polymorphous light eruptions.

It includes four previously documented conditions:

i. Actinic reticuloid (AR): Pseudolymphomatous changes in patients with broad-band photosensitivity.
ii. Photosensitive eczema: Dermatitis in sun-exposed sites

iii. Photosensitivity dermatitis / actinic reticuloid: Features of both photo-exposed site dermatitis and actinic reticuloid are seen.

iv. Persistent light reactors: Patients having photo contact allergy.[1]

It is predominantly noted in elderly males usually associated with atopy, particularly in patients with skin phototypes IV-VI.

Dermatitis of different types acts as a predisposing factor for CAD. It is a sporadic disease with no genetic factors involved.[1][2][3]

CAD is characterized by lichenified, pruritic, eczematous plaques that are primarily found on sun-exposed sites like the head, neck and limbs. There may have been pre-existing dermatitis in some patients, which makes them unaware of the association with sunlight.

In Actinic reticuloid there are pseudo-lymphatous and prurigo nodularis-like changes. CAD can also present as an unexplained erythroderma.

Close differential diagnoses for this condition include:

- Airborne contact dermatitis
- Photo-aggravated atopic or seborrheic eczema
- Drug-induced photosensitivity
- Cutaneous T-cell lymphoma [1]

The diagnosis is usually made based on history and clinical findings. Phototesting, patch and photopatch testing can be used to further substantiate the diagnosis. On Histopathological examination, there is epidermal spongiosis with acanthosis and dermal perivascular inflammatory cell infiltrate is noted. In the chronic phase, pseudolymphomatous changes with epidermotrophism are seen which makes it difficult to differentiate from mycosis fungoides.[5]

Management of this condition involves:

- Avoidance of UV rays and visible light, when necessary, by using hats, broad-spectrum sunscreens.
- Potent or very potent topical corticosteroids.
- Topical tacrolimus or pimecrolimus.
- Topical retinoids.
- Systemic glucocorticoids or Azathioprine 150mg used in cases of acute flares.
- Other systemic immunosuppressives can be tried.[3][6]

Conclusion:

This condition is not commonly reported in the literature. This case has been presented here for its rarity and it is important to do further research to be done in this direction to improve the quality of lives of the affected patients.

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The Journal of the Association of Physicians of Tamil Nadu,
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Body Weight and Reproduction

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Introduction:

The role of lifestyle factors, particularly excess weight gain in the genesis of metabolic diseases has been studied extensively. The results of these studies have always been consistent. If there is a dispute, the primary reason behind this is that statistics always involves a group of people and there will be some outliers. We fail to understand that the hormonal milieu and their activity varies from individual to individual. The reproductive hormones are extremely sensitive to changes in weight. It is a well-known fact that the onset of puberty is earlier in overweight and obese girls.[1] Obesity may also lead to central precocious puberty in girls.[2] Obesity often leads to delayed puberty in boys. Likewise, significant weight changes can also affect the reproductive function in both men and women. Subfertility may ensue in couples where considerable weight gain has led to sexual dysfunction in men and irregular or absent menstruation in women.

Body weight and reproduction in women:

Significant weight gain results in oligo/anovulation by inducing various hormonal changes (Fig 1). Women present with irregular or absent menstruation or subfertility. Spontaneous ovulation and resumption of regular menstruation have been noted with lifestyle modification and weight reduction alone.[3] Similarly, significant weight loss as in anorexia nervosa leads to hypothalamic amenorrhea.[4]

Body weight and reproduction in men:

Sexual dysfunction is commonly seen in overweight and obese men. Erectile dysfunction is seen in 30-50% of men with obesity.[5] Most of the studies have not shown an association between obesity and semen parameters like sperm concentration or motility.[6,7]

The Body mass index:

The body mass index (BMI) is currently considered the most accurate (available) anthropometric measure of an individual's ideal body weight. It is calculated by the formula, BMI = kg/m^2 (kg is a person's weight in kilograms and m^2 is height in meters squared). According to the BMI, an individual can be classified in one of these categories:

Underweight	-	<18.5 kg/m^2
Normal	-	18.5-24.9 kg/ m^2
Overweight	-	25-29.9 kg/ m^2
Obese	-	≥30 kg/ m^2

According to the Revised Consensus Statement for diagnosis of Obesity in Asian Indians, the cut-off for Indian women is even lesser. A BMI of 23.0-24.0 kg/ m^2 and ≥25 kg/m^2 is considered overweight and obesity, respectively given higher obstetric risks in women belonging to these categories.[8]

Polycystic ovary syndrome (PCOS) was always linked to either overweight or obesity in earlier literature.[9] In our practice, we noticed that women presented to the fertility clinic with

oligo/anovulation and PCOS irrespective of their BMI. They were almost equally distributed in the categories of normal BMI and overweight, whereas the number of women with obesity was comparatively lesser. While trying to explore the reason behind this pattern of distribution not corresponding to BMI, we found that almost all of these women had a history of significant weight gain after adolescence.[10] Similar findings of increased incidence of Diabetes mellitus and heart disease even in Indians with normal BMI have been noted.[11] This proves that BMI is not a very good indicator of good health or a predictor of disease, at least in Indian men and women. Moreso, this also conveys that there has to be a common factor involved in the pathogenesis of PCOS and other metabolic diseases in lean individuals and individuals with a higher BMI. Excess weight gain is probably the factor. All weight gain in adult life, except during pregnancy or bodybuilding is abnormal and may have metabolic and reproductive consequences.

Why is it so? What could be the reason behind this?

As we had mentioned in the previous section, significant weight gain during any part of an individual's lifetime can result in various hormonal changes. Although Insulin resistance (IR) has been implicated in the pathogenesis of PCOS and other metabolic diseases like DM, the exact mechanism has not been identified yet.[12] Tools for assessing IR are no longer considered clinically relevant due to their non-standardization and inability to correlate with clinical outcomes.[13] The practice of testing women with PCOS for higher serum insulin levels and IR has also been withdrawn from routine clinical practice due to the inconsistent results obtained.[14] From the available evidence, it could be discerned that the common factor behind these metabolic or hormonal derangements may not be insulin resistance after all.[12] 'Insulin' can still be considered as the primary instigator of these changes, where relative hyperinsulinemia due to excessive intake of carbohydrates could result in lower circulating sex-hormone binding globulin levels and thereby increased serum free testosterone levels resulting in hyperandrogenism and the other changes associated with PCOS. (Fig 1)

Revisiting Barker's hypothesis:

Dr David Barker's hypothesis on Fetal Origin of Adult Diseases (FOAD) claimed that the compromised nutritional state during early in-utero development had a profound impact on the risk for the development of diseases like coronary artery disease, hypertension, obesity, and insulin resistance later in adult life.[15] This was also earlier implicated to IR, whereas scientists have re-looked into this concept and believe that the actual reason behind this is the rapid 'catch-up' growth that happens after birth and during growth. An individual's weight is decided in utero depending on their genetic makeup and the nutrition they are provided with. The various systems in the body acclimatize to this and the memory is maintained. *The human body does not have a BMI chart or a calculator*. It was tuned to function for a particular weight and it falters when it is exposed to nutrition which is exponentially more than what that individual's body was actually made for and requires. This results in PCOS in women and sexual dysfunction in men, to begin with, and later leads to all the other metabolic diseases.[16]

Weight gain – Carbohydrates and activity:

The article focuses on the primary aetiology behind hormonal-cum-metabolic disorders affecting fertility, as treating the cause

provides better results and prevents long-term health complications in these conditions.

நோய்நாடி நோய்முதல் நாடி அதுதணிக்கும்
வாய்நாடி வாய்ப்பச் செயல்.

The above verses are from Thirukkural, a classic Tamil language text written by Thiru Tiruvalluvar in 300 BCE. This Kural emphasizes that it is crucial to identify the cause of a disease and treat the cause. In PCOS or erectile dysfunction due to weight gain, lifestyle particularly diet modification is the foremost and the only effective available treatment without side effects.

Although ovulation induction provides good results in women with anovulatory cycles, literature evidence suggests that these women are still at a higher risk for miscarriage, gestational hypertension, gestational diabetes and neonatal complications.[17] The rationale behind this is that the underlying cause, which is weight gain was not addressed or rectified.

Carbohydrates form the major source of energy required for the functioning of all systems. Yet, the consumption of excessive carbohydrates or the addition of more refined carbohydrates to the diet has been shown to have health implications. Comparatively, whole grain intake was found to be a better alternative in reducing the risk of metabolic diseases.[18] In the South Indian population, the glycemic load and glycemic index of the ingested food also seemed to play a role in the risk of developing Type 2 diabetes mellitus (Type 2 DM).[19] Considering PCOS as the predecessor for Type 2 DM, consuming food containing high calories or a high glycemic index can be considered the major risk factor for the development of PCOS, too. Even though wheat was considered as a substitution for rice a few years ago, recent studies have shown that the glycemic index with both diet patterns is not different.[20] The surging epidemic of diabetes and other lifestyle diseases in India is primarily due to the excessive intake of ultra-processed food rich in added sugars.[21] Unfortunately, health drinks, beverages, chips and biscuits have become part of the regular diet in most households in India.[22] The above-mentioned items contribute to the 'empty calories' ingested without much nutritional value and they also prevent intake of well-balanced nutritious food.

Therefore, the first-line management of lifestyle disorders affecting reproductive function is similar to that suggested by physicians for metabolic diseases. A diet comprising of lesser refined carbohydrates and more complex carbohydrates has been shown to reduce the postprandial rise in serum glucose and thereby insulin secretion in response to dietary load. Foods with high fibre content and low glycemic index promote early satiety and reduce hunger. Vegetables contain high quantities of fibre, minerals, vitamins and antioxidants. Non-starchy vegetables are low in calories and carbohydrates. Over the centuries, eating habits have changed-with more refined food. Modern processing also leads to the loss of essential nutrients in the diet. It is important to ensure adequate intake of fibre, especially soluble (as in vegetables and fruits). Some studies also insist that the quality of a plant-based diet plays an important role in improving markers associated with adiposity.[23]

Physical activity and exercise are also vital to achieve the desired outcome.[24] Physical activity not only improved body dimensions and modulated hormone levels in women with PCOS, but it also improved their psychological wellness.[25] The risk of developing cardiovascular disease in

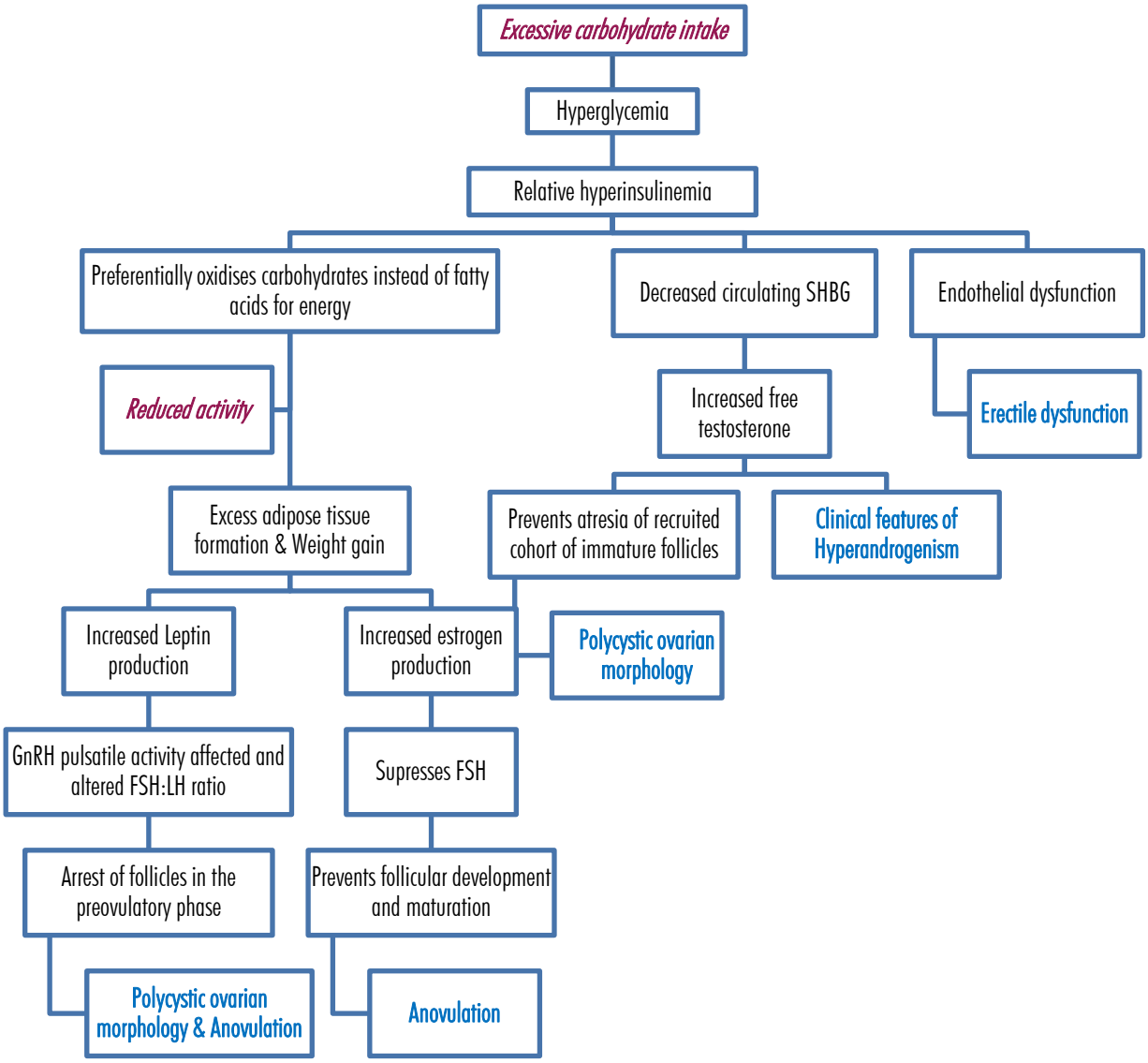

Fig 1: Pathogenesis of PCOS and Erectile dysfunction due to excessive refined carbohydrate intake, reduced activity and excessive weight gain

women with PCOS was less in those who followed regular intensive aerobic exercises.[26] This beneficial effect is due to the fall in adiposity and thereby rectification of the hormonal imbalance associated with it.

Lifestyle modification in the form of reducing refined carbohydrate intake and increasing physical activity improves the chance of spontaneous ovulation and thereby pregnancy rates in women with PCOS and anovulatory cycles.[3,27] Similarly in men, sexual function improves with lifestyle modification.[28,29]

Conclusion:

Non-communicable diseases are the leading cause of death in Tamil Nadu and many parts of the country.[30] Similarly, the incidence of PCOS is high in Indian women with it being the commonest cause of infertility. Although there

may be a genetic predisposition to these conditions, the development of disease as such is triggered by excess carbohydrate intake or reduced physical activity. Therefore, the major focus in the management of all these metabolic diseases should be lifestyle modification. This requires persistent efforts from the physician and the patient. PCOS in women and sexual dysfunction in men can be considered as the 'wake-up call' to prevent further development of other lifestyle disorders like diabetes, hypertension, cardiovascular disease or cerebrovascular disease.

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Dr. Vijay Viswanathan took over from Dr. SN. Narasingan who served the API Chennai Hon Gen Secretary very successfully. Dr. SN. Narasingan is the Current Chairman, Dr. SS. Lakshmanan the Scientific committee chairman and Dr. K. Shanmugam the present Co chair of the Scientific Committee of API Chennai.

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Brucellosis

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Introduction:

Brucellosis is a zoonotic infection caused by the bacteria, genus Brucella. The bacteria are transmitted from animals to humans by ingestion through infected food products, direct contact with an infected animal or inhalation of aerosols.

It's an old disease also known as Mediterranean fever, Malta fever, and undulant fever. Humans are accidental hosts, but it continues to be a major health concern worldwide and is the most common zoonotic infection.

Brucella organisms are small aerobic gram-negative intracellular coccobacilli, localised in the reproductive organs of host animals causing abortions and sterility. They are shed in large numbers in the animal's urine, milk, placental fluid and other fluids. 12 Species have been identified named primarily for the source animal. The following 4 have moderate to significant human pathogenicity

a. Brucella melitensis (from sheep highest pathogenicity)
b. Brucella suis (from pigs, high pathogenicity)
c. Brucella abortus (from cattle, moderate pathogenicity)
d. Brucella canis (from dogs – moderate pathogenicity)

Global burden of human brucellosis > 5,00,000 infections/year worldwide. They have decreased significantly on account of animal vaccination and milk pasteurization.

Interest in brucellosis has been increasing because of increasing international tourism and migration. In addition, potential use of Brucellosis as a biological weapon.

Pathophysiology:

Brucella has the unique ability to invade both phagocytic and non-phagocytic cells and has ways to avoid the immune system, thereby being a systemic disease, that can involve every organ system. It gains entry through breaks in skin, mucous membrane, conjunctiva, respiratory and gastrointestinal tracts.

Ingestion occurs by way of unpasteurized milk, percutaneous needle stick exposure, conjunctiva, and exposure through eye splash and inhalation.

Once in the bloodstream they quickly become intracellular pathogens - within polymorphonuclear cells (PMNs) and macrophages. In addition, they have low virulence, toxicity and pyrogenicity – thus poor inducers of inflammatory cytokines, and do not activate alternative complement systems.

Brucella is transported into the lymphatic system- and in kidneys, spleen, breast, joints – and any organ system – CNS, heart, genitourinary system, pulmonary and skin.

Clinical presentation:

History is most important, occupation, exposure Laboratory workers, those exposed to animals –herders, farmers, dairy workers, veterinarians, abattoir workers, meat workers.

Symptoms:

Fever -80-100% of cases

Intermittent -60% of cases

Undulant -60% of cases

Fever of unknown origin is a common diagnosis.

Constitutional symptoms

Anorexia, Asthenia, fatigue, weakness, weight loss-

Arthralgias: low back pain, spine–joint pain (50-80%)

Neuropsychiatric Symptoms: Headache, depression, fatigue

GI Symptoms - Dyspepsia/ pain abdomen (hepatic abscess)

Genitourinary - orchitis, UTI, glomerulonephritis

Neurologic symptoms - weakness, dizziness, cranial nerve dysfunction

Respiratory- dyspnea

Endocarditis

Physical findings- Hepatosplenomegaly

Right hypochondrial tenderness

Osteoarticular- swelling, tenderness over joints

Systemic- as above

D/D- Collagen vascular disease

Erythema nodosum

FUO

Malignancy

Rickettsial disease

Sacroiliitis

Tuberculosis

Work-up

CBC, ESR, LFT

Culture- blood, bone marrow

Serology- Tube agglutination, IgG titre > 1:80, TAT

ELISA

PCR

Other- Chest Xray, USG Abdomen.

Treatment

Doxycycline 100 mg BD x 6 weeks

Gentamicin

Streptomycin

Rifampin

Trimethoprim- Sulfomethoxazole

Others- Fluroquinolones

WHO Recommendations

1. Doxycycline 100 mg BD + Rifampin 600-900mg OD x 6 weeks
2. Doxycycline 100 mg BD x 6 weeks + Streptomycin 1g/day I.M x 2-3 weeks or gentamicin
3. Ciprofloxacin-based regimen 500 mg BD

Children less than 8 years- Rifampin + TMP-SMX x 6 weeks

Pregnancy- challenging problem- TMP-SMX + Rifampin

Those with sacroiliitis / spondylitis- Doxy + Rifampin + Gentamicin x 2-3 weeks followed by Rifampin + Doxy x 6 weeks

Case Report

A 60-year-old lady with no known co-morbid conditions was admitted to GKNM Hospital in February 2018 with complaints of fever of 1-2 months duration. Fever was high grade, intermittent with chills. Relieved with analgesics. Also complained of significant neck and back pain for 1-month duration. She gave a history of significant weight loss of >10 kg.

No cough, dyspnea, chest pain, bowel or urinary complaints. No history of Jaundice. She was a goatherd by occupation, having around 20 goats.

On Examination

Average built, Afebrile, pallor positive, BP-110/80. No icterus, lymphadenopathy, no

overt joint swelling. Mild neck stiffness, no neurological deficits.

P/A- Liver just palpable, Other systemic examination NAD.

Investigations

CBC- Hb: 11gm, WBC: 6,200/cumm, N69, L26, Platelets: 2.4 lakhs, ESR 36

Smear MP negative (two samples), RBS, LFT, RFT Normal

ECG: sinus rhythm Normal. Blood culture (two samples): no growth.

X-ray of the cervical spine: fused cervical vertebrae. Brucella Agglutination- **1:320 positive**. A diagnosis of brucellosis was made based on the agglutination test report and her occupation. She was treated with Doxycyclin and Rifampicin along with supportives.

She showed a remarkable response, becoming afebrile within a week. She was discharged with tablet Doxycyclin 100 mg BD and Capsule Rifampicin 600 mg OD along with vitamins. She came for review after 1 month and was asymptomatic. She was advised to continue treatment but was lost to follow-up.

The case presented because of not being very common and the need to highlight occupation in the clinical history.

"Medicine is learned by the bedside and not in the classroom."

Sir William Osler.

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Euglycemic Diabetic Ketoacidosis – A Therapeutic Challenge

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Introduction

Euglycemic Diabetic ketoacidosis is a clinical syndrome occurring in both Type 1 & Type 2 DM. Euglycemic DKA is characterized by euglycemia (blood glucose less than 250 mg/dl) with severe metabolic acidosis and ketonemia. The incidence of Euglycemic DKA has increased with the introduction of sodium-glucose transporter 2 inhibitors. It also presents a challenge for physicians due to its various etiologies and the presence of normal glucose levels which often results in a delayed diagnosis. Euglycemic DKA is an uncommon diabetic complication associated with several risk factors such as fasting, surgery, pregnancy and recently the use of SGLT2 inhibitors. Euglycemic DKA can lead to serious complications if not recognized early and treated appropriately with fluids, dextrose and insulin.

Case Summary

A 37-year-old male patient, a case of Type 2 DM came with complaints of abdominal pain and vomiting for 2 days. He was on SGLT2 inhibitors (empaglifozin) for the last one month. The patient with the above-mentioned complaints initially went to a local hospital where he was diagnosed with Euglycemic DKA, He was treated conservatively initially but as it failed to correct the metabolic acidosis, he also underwent 2 sessions of hemodialysis. However, there was no improvement in his general condition, hence he was referred to us for further management. At admission to our hospital patient was conscious and oriented. His pulse was 120/ min and blood pressure was 100/60 mm Hg. He was tachypnoeic at rest with a respiratory rate of 38/ min. His oxygen saturation in room air was 92%. ABG showed uncompensated metabolic acidosis with pH of 7.10 and a bicarbonate value of 5.9mmol/l. His blood glucose was 166 mg/dl, serum ketones were high -127mmol/l. He also had hyponatremia and hypokalemia. The patient was intubated in casualty due to respiratory distress and then shifted to the medical ICU. He was treated with a 5% dextrose infusion, insulin infusion and IV bicarbonate infusion. He developed hypotension with a BP of 90/60 mmHg and hence he was started on inotropes. Subsequent arterial blood gases showed no improvement and even deterioration in pH to 7.05 and bicarbonate of 5.4 mmol/ l. He developed generalized tonic-clonic seizures and his sensorium deteriorated, hence he had to be intubated. He was started on mechanical ventilation and anti-epileptics were also administered. A nephrologist's opinion was taken for refractory acidosis and advised Continuous renal replacement therapy if conservative management fails. We reviewed the literature on the management of Euglycemic DKA changed to high-calorie glucose infusion (10% dextrose) with insulin and continued the aggressive fluid resuscitation. Within six hours of starting 10% dextrose with concomitant insulin infusion, the recalcitrant acidosis improved. The pH corrected to 7.470 and bicarbonate to 27mmol/l. His vitals improved, and he was weaned off inotropes and ventilatory support. Once his general condition improved, he was shifted to the ward.

Serial ABG VALUES BEFORE 10% DEXTROSE

pH	*7.033*	*7.058*	*7.059*
HCO3(mmol/l)	*6.5*	*8.5*	*8.9*
PaCO2 (mmHg)	*25*	*31*	*21.9*
Blood Glucose (mg/dl)	*205*	*200*	*196*

Serial ABG VALUES AFTER 10% DEXTROSE

pH	*7.472*	*7.474*	*7.515*
HCO3(mmol/l)	*27.1*	*35.5*	*31.8*
PaCO2 (mmHg)	*37.6*	*49*	*39.7*
Blood Glucose (mg/dl)	*147*	*148*	*141*

We continued the high-caloric infusion along with insulin infusion for 24 hours. Once the patient resumed oral intake, insulin was continued as a basal-bolus regimen. The patient was discharged in a stable condition.

Discussion

Euglycemic DKA due to SGLT2 inhibitors has 2 important pathophysiological features. Firstly, a significant calorie loss from the increased glycosuria brought by the SGL2 inhibitors leads to lipolysis and the generation of ketone bodies. The second contributory factor is the imbalance between insulin and glucagon levels. There is an increase in glucagon levels in response to the decrease in blood glucose levels due to glycosuria brought about by SGLT 2 inhibitors. The increase in glucagon levels provides a strong drive to promote the production of ketone bodies. There is also a concomitant decrease in insulin levels following a reduction in blood glucose levels. High caloric glucose infusion and tight glycemic control are key factors in the management of the SGLT2 inhibitor-induced euglycemic DKA. Timely intervention prevents the use of dialysis in such patients and protects the patient from its psychosocial impact and financial burden.

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Pregnancy Complicated by Serious Infection

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Introduction

H1N1 Infection in Pregnancy

- Pregnant women and their fetuses are at high risk of infection with the novel H1N1 influenza A virus. Obstetric providers should give appropriate care to such patients to reduce morbidity, mortality, and pregnancy-related complications faced by pregnant women.

Post-C-Section Swine Flu Infection with Respiratory Failure.

- A 27-year lady had a fever, body pain and headache and had to undergo an emergency c-section for obstetrics indication at Pondicherry
- In the postoperative period she developed continuous fever, and toxic, respiratory failure, requiring assisted ventilation
- Due to the unavailability of a ventilator, she was transposed to Chennai with an AMBU bag. we took our ambulance met her on the way connected ventilator and admitted in our hospital.
- She was H1N1 positive and gave her TAMIFLU and IV antibiotics and she was found to have surgical emphysema. She was treated in the ICU and recovered completely.
- She had 2 successful pregnancies after this.

Figure:1 Post LSCS Swine Flu with Respiratory Failure

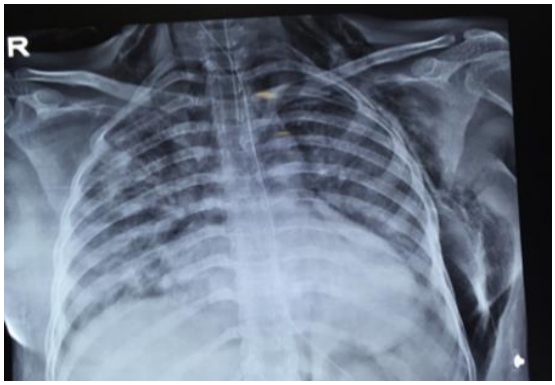

Figure:2 Chest AP Supine (Bed Side)

She was Extubated on Tracheostomy Breathing and Later Tracheostomy Removed with Breathing and Reduction Surgical Emphysema

Figure:3 Extubated on Tracheostomy

Figure:4 Breathing in room air and normal feeding

H1N1 Infection in Pregnancy

- A case of H1N1 infection with a full-term pregnancy and respiratory failure.
- A 30-year-old lady full-term pregnant had 2 weeks fever with headache and body pain.
- She was hypoxia, admitted and ventilated and was found to have an H1N1 infection and TAMIFLU was started. The ARD was very severe and she required prone ventilation.
- She had a stormy period and recovered. She underwent a c-section and delivered a live baby without any evidence of H1N1 infection.

The Full-term Baby Tested Negative For H1N1 Infection.

Figure: 5 Pregnancy with H1N1 on prone ventilation

Figure: 6 At Discharge

Dengue Fever in Pregnancy

- Dengue in pregnancy increases the risk of pre-eclampsia, Dengue Haemorrhagic Fever (DHF), fetal distress, and preterm delivery it increases mortality and maternal morbidity like vertical transmission, intrauterine growth restriction, and stillbirth are possible sequelae of dengue in foetuses.

Pregnancy with Scrub Typhus

- Scrub typhus is a Rickettsial disease uncommon in pregnant women, if present mother and baby are at risk. Since it is uncommon, the treatment schedule has not been properly defined for the safety of the mother and baby.
- Scrub typhus is an unrecognized cause of acute febrile illness in India associated with poor fetal outcomes in pregnant women.
- A meticulous search for an eschar in patients presenting with undifferentiated febrile syndrome can make a diagnosis. Early diagnosis and treatment can prevent fetal loss.

Pregnancy With Dengue Fever with Scrub Typhus – Eschar At Unusual Site

- A 21-year-old pregnant lady was admitted with high fever, arthralgia, and myalgia found to have dengue IgM positive.
- She was given conservative treatment with IV fluids and supportive measures, since she was not improving, she showed an eschar of scrub typhus on the medial aspect of the thigh.
- After getting the results, she was given doxycycline, became afebrile and discharged.

Figure: 7 Eschar of scrub typhus over the medial aspect of the right thigh

Tuberculosis In Pregnancy

- Tuberculosis (TB) in pregnancy causes morbidity for both mother and baby if not diagnosed and properly treated. Obstetrician–gynaecologists should be aware of the complications of the disease. A meticulous history, examination, and lab test will take us a long way in curing this deadly disease. Active TB disease must be ruled out before delivery, with a chest radiograph and other diagnostics as indicated. In pregnancy a woman has active TB diagnosed, it should be treated energetically. Latent treatment should be decided on follow-up monitoring.
- If tuberculosis is not diagnosed in early pregnant women it carries great risk. Babies born to women with untreated Tuberculosis disease may have lower birth weight. Rarely, a baby may be born with TB.

Tuberculous Meningitis in Pregnancy

- Tuberculous meningitis, the most severe form of extrapulmonary tuberculosis, is rarely discussed in pregnancy despite this being a unique period of immune modulation that may predispose women to active disease.
- The true incidence of tuberculous meningitis in pregnancy or the postpartum period is unclear but likely underappreciated. To date, nearly all published cases have occurred in HIV-negative or otherwise immunocompetent women.

Pregnancy With Tubercular Meningitis

- 27 years old lady with pregnancy was evaluated for prolonged fever with altered sensorium, neck stiffness and all features of meningitis
- X-ray chest revealed right upper lobe infiltration and CSF revealed features of tubercular meningitis with low sugar and higher protein with gene Xpert positive for tuberculosis.
- She responded to treatment and both mother and baby were safe.

Figure: 8 X-ray chest shows right upper lobe tuberculosis infiltration

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Case Report

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Emergencies A Series - 8

Dr. Jayaraj

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Status Asthmatics /Acute Severe Asthma

In this era of nebulizers, acute severe asthma is rare, and this condition rarely needs parental broncho dilators. (1) Here we will discuss the history of a patient who had severe breathlessness not able to be managed with a nebulizer. Secondly, we will make a note of parental broncho dilators, parental /oral steroids, oxygen/ heliox, steroid resistance, antibiotics, and soda bicarb. It's a life-threatening emergency that requires rapid aggressive treatment and refers to severe broncho spasms that do not respond to aggressive therapy within 30 to 60 min (2) Acute severe Asthma patients will have the inability to control one sentence in one breath. Mostly the respiratory rate will be more than 25/min and heart rate >110 bpm (4) Features of Life-threatening Asthma are a Silent chest, feeble respiratory effort, exhaustion, bradycardia, hypotension or arrhythmia.

Very severe Life-threatening attack.

Here, the PCO2 will be high > 6Kpa, severely hypoxemic despite treatment with oxygen. A Low or falling arterial pH A note on the pathophysiology of Asthma (2,3) Airway inflammation and bronchoconstriction occurs. Mucus plugs increase airway resistance. There is increased physiologic dead space and hyperinflation of the lung. V/Q mismatching and shunting. Decrease in diastolic filling and cardiac output. Also, there is an increased diaphragmatic and accessory muscle workload. Increased carbon dioxide production and increased oxygen consumption. respiratory acidosis and metabolic acidosis occur. (2, 3)

Management

Oxygen

All patients should receive supplemental oxygen to maintain Spo2 >90%, 95% in pregnancy.

Heliox

It is 10 times costlier than oxygen, its advantage over oxygen is, it prevents turbulence in the airway.

Steroids to be given promptly to all patients.

Corticosteroids

Inj Hydro cortisone100-200 mg IV stat to be given. It is not inferior to Inj methyl prednisolone. A small proportion of patients are resistant to steroid. Those who received medication such as hydroxychloroquine methotrexate azothyoprim because of the reduced glucocorticoid receptor number in these cases. (5)

Parental Broncho dilators

Adrenalin

Dose: 1 in 1000 solution of 0.3 ml to 0.5 ml every 20 min subcutaneously for 3 doses, if no response with the initial dose.

Adrenalin is useful in cardiac arrest. It should be used cautiously in patients older than 40 and those with cardiovascular disease.

Other uses are- In acute Angioneurotic edema, bee stings with hypo tension and acute fall of BP due to drugs.

It is used in serum sickness; we had a case of snake bite treated with antisnake venom had intense pruritus and was not responding to

antihistamines/steroids responded to a single dose of adrenalin. Another patient who received a platelet transfusion caused hypo tension (80/60) mm Hg was normalized with a single dose of adrenalin but not with other drugs. We have treated a case of multiple bee stings with shock.

A case of drug allergy due to IV Inj Ranitidine could be due to preservative phenol. He had hypotension, severe wheezing, and congested eyes and was treated with IV fluids, steroids and adrenalin.

Terbutaline

Its action is similar to adrenalin. Advantage – It is longer acting Dosage- 0.25 to 0.5ml subcutaneous every 20 min. experience showed an asthmatic on second referral was improved with a single dose of terbutaline.

Aminophylline infusion

A loading dose of 500 mg over 20 min, should be avoided if the patient is on oral theophylline. Instead, a maintenance dose of 0.5 mg/kg/Hr IV infusion. Adverse effects: nausea, vomiting, arrhythmia, seizures if exceeding the recommended dose. (1) Cardiac monitoring should be done. If there are signs of arrhythmia infusion of aminophylline dose may be decreased. Intravenous magnesium 2gm over 20 min may be of use Antibiotics Routine use of IV Antibiotics may be useful.

Soda-bicarb

In acute severe asthma, there is metabolic as well as respiratory acidosis. Soda bi-carb infusion is helpful in this situation. Avoid Aspirin /Beta blockers even beta blocker eye drops. Both can provoke Asthma in susceptible individuals.

Case History

A 27- year old female, was brought to the ED around 12:30 AM midnight with severe respiratory distress. Heart sounds were heard, and tachycardia was present. Her heart rate is approximately 130 -140 bpm, chest was silent. Breath sounds are not audible. She has a known asthmatic since childhood. Started on oxygen and she is not in a position to receive nebulizer therapy because of severe respiratory distress. She was started on 100mg IV hydrocortisone. 2 doses of 0.3 ml adrenalin at an interval of 5 min showed only subtle/marginal improvement. A maintenance dose of IV aminophylline was started and IV soda bicarb infusion. Salbutamol nebulizer Q4H ipratropium every 4 hours. The next morning around 7:30 AM, she had partial relief with 50% subjective improvement. Heart rate 120pm. Spo2 93% without oxygen. Squeaky wheeze is present in scattered areas of both lung fields. Infusion of soda bicarb and aminophylline was stopped. Treatment with other drugs was continued. Discharge on the 7th day with clear lungs and advised Montelukast /predmet and sero flow inhaler 25/250.

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Emergencies A Series - 9

Dr. Jayaraj

Associate Professor (former), Dhanalakshmi Srinivasan Medical College & Hospital.

In this series, we will discuss 3 cases of tuberculosis and a note on tuberculosis affecting other systems.

Patient 1

A 40-year-old female weighing 35 Kg cachexic with high-grade fever was admitted. Her chest X-ray showed suspected Pulmonary tuberculosis. She was managed with rifampicin, Isoniazid, ethambutol and pyrazinamide. She was a diabetic, She was on oral hypoglycemic agents. She deteriorated further and developed severe jaundice. Rifampicin /INH and pyrazinamide can cause hepatic injury. These drugs were withdrawn from the regime. She was only on ethambutol and streptomycin along with insulin for her diabetic status. After stopping these drugs, the patient's jaundice improved. and she also improved with ethambutol and streptomycin she gained approximately 10 kgs in 6 months. Her insulin was stopped, and she was only on oral hypoglycemic agents.

Patient -2

A 35-year-old female with prolonged febrile illness was brought to the hospital by her farm owner. She was treated in a private hospital and discharged in a deteriorating condition. On examination, she had neck stiffness. Suggestive of meningitis. Lumbar puncture was done and CSF analysis was not suggestive of pyogenic meningitis. She was treated as a case of tuberculous meningitis with anti-tuberculosis drugs under antibiotic coverage. During illness, she had third cranial nerve palsy. She showed marked improvement with ATT in about 15 days. Her third nerve palsy was recovered, and she was continued on the DOTS regime.

Patient -3

A 45-year-old female with fever and loss of weight about 5 kgs. She had no coughs. She was toxic, her Chest X-ray was normal, ESR done a year before was 20 mm/ hr. Her ESR after 6 months was 50 mm/ hr and her current ESR was 120 mm/hr. Mantoux hyper positive >20mm Hg. Blood PCR for TB was negative. The only positive result was IGM Antibody for TB. She was treated as a case of nonpulmonary tuberculosis. She was started on 4 drugs /2 drugs regime. The fever persisted, even after 10 days with the added ofloxacin. She developed severe gastritis and started vomiting. Endoscopy - antral gastritis. Her Ethambutol was stopped because she complained of problems with vision and streptomycin was added. Then she developed giddiness in the form of swaying and streptomycin was also withdrawn. All anti-tuberculosis drugs were stopped for a week. she was put on pantoprazole and after her gastric problem improved. she was put on INH, Drugs Rifampicin and pyrazinamide for 3 months. Rifampicin and INH continued for 6 months. She had gained approximately 10 kgs Rifampicin, INH and Streptomycin can cause static imbalance. The imbalance caused by streptomycin involves the 8th cranial nerve and the damage is permanent, not in this patient.

Few Rare Cases of Tuberculosis.

A male around 60 years old came with a nonhealing ulcer in the perianal region. A biopsy was done. The report of the biopsy showed a

granulomatous ulcer. The patient was treated with ATT and the ulcer healed.

A 60-year-old male father of ex-servicemen had persistent lower abdominal pain. A colonoscopy was performed, and a biopsy of the colonic mucosa was reported as a granulomatous lesion suggestive of tuberculosis. He was treated with ATT. He was free from abdominal pain after the treatment. An ex-serviceman, a known diabetic presented with chest pain, cough and sputum. Sputum AFB was positive. Chest X-ray showed consolidation type of lesion. He was treated with a course of ATT for 6 months. Even after a full course of therapy, AFB was still positive. According to the sputum sensitivity report he was put on Rifabutin, Amikacin, and Levofloxacin. Advised to continue treatment for 24 months.

Reference

1. A Book on Tuberculosis 2nd edition Editor Surendra K. Sharma

The Journal of the Association of Physicians of Tamil Nadu

(Official Journal of the Association of Physicians of India -Tamil Nadu Chapter)

Free Distribution

Invitation to submit

We invite all the members of the Association of Physicians of India of the Tamil Nadu State Chapter and other academicians involved in scientific and clinical research to contribute their research in the form of original articles/review papers/case reports to this journal. It is a quarterly journal and seeks original, insightful and thought-provoking articles and reviews on all aspects of clinical and academic research.

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Typed manuscript on white bond paper, with margins of at least 2.5 cm. Number pages consecutively, beginning with the title page. The manuscript should be typed in double space and should include consecutively title page, abstract and key words, text, acknowledgements, references, tables and legends.

In the title page, the full names of all authors with their latest qualification, the name of the laboratory or the department/institution and its address should be mentioned clearly. Also indicate address for correspondence and reprints. A running title not exceeding 45 spaces should be provided.

Abstract: It should be concise and should cover all the important aspects of the paper. The abstract format will be those used by Index Medicus/Medicine headings of Index Medicus, should be 150-250 words for all articles, except case reports where it should be around 50 words only.

Key words: A maximum of 5 key words typed well below the summary/abstract, separated by a line typed across the whole page.

Introduction: This should comprise of; (1) purpose of the study/article (2) brief references to pertinent literature only. The introduction should not be an extensive review of the subject.

Patients and methods: This should include the following: (1) Selection of observational or experimental subjects and the controls, (2) Analytical/ therapeutic/surgical methods used. If these are in common use, identify them only by references. If not common, give a brief description, (3) Statistical methods used.

Results: The results should be presented in the text, tables, and illustrations. Do not repeat in the text all the data in the tables and/or illustrations. Emphasize or summarize only

important observations. Do not include discussion of your results and do not refer to observations of other workers in this part of your text; these usually should be included in the Discussion.

Discussion: This should emphasize the new and important aspects of the study and conclusions that follow from them. Do not repeat in detail data given in the results section. Include in the discussion the implications of the findings and their limitations and relate briefly the observations to relevant studies.

Tables: Each table should be typed on a separate sheet and give a number and caption.

Explain in footnotes all nonstandard abbreviations that are used in each Table. Cite each table in the text in consecutive order. If you use data from another published or unpublished source, obtain permission and acknowledge fully. The same data should not normally be presented in both tabular and graphical form.

Photographs should be of good quality and on glossy paper. Illustrations and graphs should be drawn on thick white paper with India ink. They should not be pasted on papers. The numbers should be marked at the back in pencil and the top should be marked by arrow. Legends should be typed on a separate sheet. Each should be brief but sufficiently descriptive to be complete by itself.

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The pattern of References should be as follows.

Article from a Journal: List the first 3 authors with initials. The remaining authors may be given et al., e.g. Glogar D. H., Konar R. A., Muller J., et al; Fluorocarbons reduce myocardial ischaemic damage after coronary occlusion, Science. 1981; 211: 1439-41. (Note Punctuations)

Articles from a Book: Yokoyana K, Suyama T, Naito R Development of Fluosol D. A., And its perspective as a blood substitute. In: Oxygen and life, proceeding of the second Pristley conference. Royal Society of Chemistry, London, 1908; 142-52. (Note punctuations) The whole of the literary matter in The Journal is copyright and should not be reproduced without the written permission of the Editor.

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Authors should retain a copy of manuscript with them. Rejected articles are not returned.

ASSOCIATION OF PHYSICIANS OF INDIA
TAMIL NADU STATE CHAPTER

To
The Secretary
Association of Physicians of India – Tamil Nadu State Chapter
Chennai.

Dear Sir,

Kindly enroll me as a Member of API – Tamil Nadu State Chapter. My details are as follows

Name (Surname)

First Name Middle Name

Father / Husband's Name

Qualifications:

University:

Year of Passing

Tamil Nadu Medical Council Registration No:

API (Central) Life Membership No.

Address:

Please Stick one Stamp Size Photo here

Additional Stamp Size Photo to be attached to Application

City	Pincode	District
Telephone: Office	Clinic	Residence
E-mail		Mobile

I hereby declare the above particulars given by me are correct and agree to abide by the Rules and Regulations of the Association.

Signature
Date

Membership Fee	:	Rs.1000 (Rupees One Thousand only).
Details of Payment	:	Demand Draft to be drawn in favour of "**ASSOCIATION OF PHYSICIANS OF INDIA TAMIL NADU STATE CHAPTER**" payable at Chennai.
For Office Use	:	Application received on. Membership No.
Please Note	:	Members are requested to enclose the xerox copy of the Tamil Nadu Medical Council Registration Certificate and Post Graduation Certificate by a recognized university.
Website	:	www.apitnsc.org
Please send Application to	:	**Dr. V. Palaniyappen - Gen Secretary - API TNSC** Dr. V. Palaniyappen's Diabetes Specialities Center & Sri Sakthi Vinayagar Multispeciality Hospital, No.95, 95A, Near Bus Stand, Karur Main Road, Guziliamparai - 624703. Dindigul (Dt) Tamil Nadu Mob: 9965534483 / 9965534490 / 04551 234422 Email: drpalaniappen@yahoo.com / drpalaniappen1971@gmail.com

Byelaw 2.3.3 which states that 'Persons who have completed MD can be enrolled as Associate Member, if they are not already member of the Central API. The period is for 5 years and within that stipulated time, He / She should get enrolled as Life Member of API Central Body. He / She fails to become a member of Association of Physicians of India Tamil Nadu State Chapter in case He / She fails to become a member of the API Central within 5 years.

The Association of Physicians of India, Turf Estate, No.6 & 7, Off: Dr.E.Moses Road, Opp. Shakti Mills Compound, Near Mahalaxmi Station (west), Mumbai - 400 011. Tel: 022-66663224 / 24912218, Fax:022-2492 0263, Email:api_ho@vsnl.com

For Office use only
R/No.
Date
Membership No.

API Membership Application Form

PHOTOGRAPH

To,
The General Secretary
The Association of Physicians of India
Turf Estate # 6 & 7, Off Dr. E. Moses Road, Opp. Shakti Mills Compound, Nr. Mahalaxmi Station (West), Mumbai 400011
Tel : (022) 6666 3224 / 2491 2218 • Fax : (022) 2492 0263 • e-mail : api_ho@vsnl.com • www.apiindia.org

We hereby propose the admission

(BLOCK LETTERS)

Name (Surname)

First name Middle Name

Qualifications :
(Mention the branch of Medicine in which Postgraduate qualification is obtained)

University :

Year of obtaining first Postgraduate qualification :

Address :

City District

State PIN

Tel. (Office) : Tel. (Resi.) : Fax :

email : Mobile :

as a ☐ LIFE ☐ LIFE ASSOCIATE member of the Association
(Please ✓ appropriate)

MEMBERSHIP FEES : Life Member / Life Associate Member : ₹ 7,500 plus admission fees ₹ 1,000.
Total ₹ **8,500.**

Details of payment : In favour of "Association of Physicians of India" (Cheque* / DD / Cash). Applicant's from outside Mumbai are requested to send Cheque / Demand Draft payable at Mumbai. (*For **outstation cheques** add ₹ **100**)

- I hereby direct The Association of Physicians of India to transfer ₹ 7,500 to the Corpus Fund and the balance of ₹ 1,000 for admission fees.
- I hereby state that the above information given is true and correct.

Note for proposer / seconder : To the best of our knowledge and belief the above particulars are correct, and we consider him/her a fit proper person to be admitted as a member of the Association.

Signature of Proposer

Signature of Seconder

Name

Membership No.

Name

Membership No.

Subject to the approval of the Governing Body in an ordinary or a special meeting, I agree to become a member and if admitted, to abide by the Rules and Regulations of the Association.

Signature of Candidate

Note by Secretary

Xerox copies of registration with Medical Council and Postgraduation Certificate by a recognised university should accompany the application form

N.B. Kindly read carefully the rules and regulations printed overleaf before filling this form.

Rules & Regulations of the Association Regarding Admission of Life Members / Associate Members

LIFE MEMBERS : Life Members are required to posses a post-graduate degree such as MD/DNB, DM, or equivalent in internal medicine from any institution or university recognised by the Medical Council of India and/or approved by the Governing Body of the Association. MD General Medicine / Internal medicine includes specialities such as Cardiology, Gastroenterology, Diabetology, Nephrology, Neurology, Clinical Haematology, Chest & Tuberculosis, Endocrinology, Gerontology, Infectious Diseases, Allergy, Immunology, Rheumatology, Medical Oncology and others approved by the Governing Body notified by the General Body. Life membership shall be open to citizens of India only.

LIFE ASSOCIATE MEMBERS : A person holding a post-graduate degree or diploma recognized by Medical Council of India in any branch of medical science who is not eligible for life membership shall be enrolled as a Life Associate Member. Life Associate Members shall have no voting rights, nor the rights to propose, second any one or contest for any office of the Governing Body. Life Associate Members of the Association are not eligible for any oration, lectureship or any other award of the Association.

Indian College of Physicians

Eligibility Criteria for the Award of Fellowship of Indian College of Physicians

5.2.1.1 Minimum experience of 10 years after Post Graduation.

5.2.1.2 Continuous membership of the Association of Physicians of India for not less than 7 yrs.

5.2.1.3 Should have made a significant contribution to research / teaching / development in the field of medicine.

1.1.1.4 Should have contributed to API by way of scientific or Organizational works.

To make the selection objective, a point system has been followed in assessing the suitability of the applications.

The Criteria used by the Credentials Committee for the award of fellowship are:

1. Qualification
2. Experience in Medical Profession
3. Publications
4. Honours / Awards
5. Research work
6. Contribution to API
7. CME & Conference (API/ICP)
8. Social welfare/ community service

The Fellowship form should be proposed and seconded by Founder Fellow / Fellow of ICP only.

- The Proposer / Seconder should not propose / second more than 3 nominees for award of ICP in a particular year.
- It is responsibility of the Nominee / applicant to get the proposal completed by the proposer and seconder along with the citation.
- API Membership No. of the proposer / seconder should be entered by the proposer / seconder themselves.
- The proposer should satisfy the requirements for proposal as under:-
  - ❖ The Nominee is a life member of API
  - ❖ The Nominee has completed 10 years after post-graduation
- The Nominee should read the Form carefully before filling the columns, to project their achievements appropriately.
- The Nominee should list their achievements in appropriate columns.
- Proof of qualifications, publications, honours, awards, must be submitted as supporting data. The supporting data should be numbered parawise (eg 1., 2., 3. , etc), For more than one supporting documents, the numbering should be in alphabets (eg 1 (a), (b), (c), etc).
- No hand written applications will be accepted.
- One original and seven Xerox copies to be submitted
- Last date for receiving application form is **31st May** of the year.

Dr. Milind Y. Nadkar
Hon. General Secretary

Dr. B. R. Bansode
Jt. Secretary

Format for Submission of Bio - Data of The Nominee for Consideration for Award of Fellowship of Indian College of Physicians.

1.	Name in Full (Surname First) (in Block Letters)			
2.	A. P. I. Membership No. and date of joining			
3.	Date of Birth			
	Address Residence		Address Office	
4.	Tel.:	Fax : Mobile	E-mail:	
5.	Postgraduate degree in Medicine	Year of passing	Institute	University
	Other Professional Qualifications	Year	Speciality / Subjects	University / Institute
a.				
b.				
c.				
d.				
	Certificates Attached			
6.	Experience in Medical Profession after Postgraduation in Medicine			

Name of Hospital / Clinic / Organisation & Location	Number of Beds (if applicable)	Period Served year wise (From-To)

7.	Publications: List below. (If number of publications in Journals exceeds 8, publications which can qualify as research papers may be listed under Research section 9.)

a) Number of Publications in Indexed National / International Journals.	Attach title page / Abstract as Appendix
b) Number of Chapter in Books / monograms	
c) Editorship of National level or State level: Book /Monogram/Update Series	

8.	Honours And Awards (list below with photocopy of proof)
(a) Oration in National / State Association Meeting	

Title of Oration	Organisation	Year

8 (b) Award National / International / or State level		
Title of Award	Organisation	Year

9.	Research work (list below)	
(a) Research sanctioned & funded by Research Agency		Attach Letter of sanction.
(b) Departmental Research. (To qualify, the findings should be published in National/International Journal) Do not include papers already listed under Publications		Attach title page / Abstract

10.	Contribution to API (list below and attach proof)		
Post held in Organisation / Meeting	Name of Organisation / Meeting / CME	National / Zonal / Under API/ICP	Year

11.	Participation in CME or Scientific Sessions of API or ICP as Faculty		
Speaker / Chairperson / Other	Title of Talk / Session	Name of Meeting	Year

12.	Social welfare / Community service. (Include under the headings given below, with documentary evidence) (a) Emergency services during National calamities (Quakes/ Floods/Cyclones, etc) (b) Public education Programme (Radio), TV talk/ writing in news papers . (c) Service in Rural Areas	
Service		Evidence

N.B : No handwritten application will be accepted. * To be typed on separate page
*One original and seven Xerox copies of sets to be submitted
Last date for receiving the application form is 31st May 2011.
Address : Turf Estate, No. 006 & 007, Dr. E. Moses Road, Opp. Shakti Mill Compound, Mahalaxmi (West), Mumbai – 400 011.

Indian College of Physicians

Citation

The Fellows proposing and seconding the nomination for Fellowship of Indian College of Physicians should highlight the professional / scientific achievements of the candidate and the contribution to A. P. I. from personal knowledge in 200 words, in the format given below :

Name _____ Name _____

Membership No._____ Membership No. _____

Signature Proposer _____ Signature Seconder _____

Note:- The Fellowship form should be proposed and seconded by Founder Fellow / Fellow of ICP only. In case there are more than 3 nominations by any proposer/seconder, the first three nominations in order of receipt in API Office and complete in all respects will be considered for award of Fellowship of ICP and the others rejected for consideration.

Available on API and JAPI websites: www. apiindia.org & www.japi.org

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