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INDUS ALIVE

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A Health & Wellness Magazine by INDUS HOSPITALS, Mohali, (Pb.) India

Committed to building better Healthcare

The latest techniques and treatments to ensure an Active, Healthy & Independent Lifestyle

Wishing You A Very

Happy & Healthy

New Year

2024

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Free Medical Checkup Camp organised by Indus Hospitals

Specialities	Doctor Name	Qualifications	OPD Days
Anesthesia & Pain Management	Dr. SPS Bedi	MBBS MD	Mon to Sat
	Dr. Arjun Joshi	MBBS MD	Mon to Sat
	Dr. Devinder Grewal	MBBS MD	Mon to Sat
Cardio Thoracic Vascular Surgery	Dr. Ashwani Bansal	MBBS MS MCh	Mon to Sat
Cardiology & Interventional Cardiology	Dr. Sandeep Parekh	MBBS MD DNB	Mon to Sat
Colorectal Surgery	Dr. Pankaj Garg	MBBS MS	On Call
Critical Care & Emergency Medicine	Dr. Jogesh Aggarwal	MBBS MD	Mon to Sat
ENT Surgery	Dr. Potluri Praneeth	MBBS MS	Mon to Sat
Family Medicine	Dr. Sakshi Grover	MBBS DNB	Mon to Sat
Gastroenterology Surgery	Dr. BS Bhalla	MBBS MS	Mon & Wed
Gastroenterology	Dr. Rajan Mittal	MBBS MD DM	Mon to Sat
General Surgery	Dr. Anil Kr Sharma	MBBS MS	Mon to Sat
Gynaecology & Obstetrics	Dr. Jasmine Kang Rana	MBBS DNB	Mon to Sat
Internal Medicine	Dr. Kanwar Singh Bhinder	MBBS MD	Mon to Sat
Internal Medicine	Dr. Mayank Sharma	MBBS MD	Mon to Sat
Joint Replacement & Sports Medicine	Dr. B. Harna	MBBS, MS, DNB	Mon to Sat
Microbiology & Transfusion Medicine	Dr. Parminder Kaur Gill	MBBS MD	Mon to Sat
Nephrology & Dialysis	Dr. Narinder Sharma	MBBS MD DNB	Mon to Sat
Neurology	Dr. Ruchi Jagota	MBBS MD DM	Mon to Sat
Neurosurgery	Dr. Rajnish Kumar	MBBS MS MCh	Mon to Sat
Nutrition & Dietetics	Dt. Niyati Tejaswini	Msc	Mon to Sat
	Dt. Gauri	MSc.	Mon to Sat
Oncology (Orthopedics)	Dr. Rajat Gupta	MBBS MS DNB	On Call
Oncology (Radiation)	Dr. Vinod Nimbran	MBBS MD	Tue | Thu | Sat
	Dr. Kamalpreet Kaur	MBBS DNB	Mon to Sat
Medical Oncology	Dr. Deepak Singla	MBBS MD DM	Mon to Sat
Oncology (Surgical)	Dr. Ashwan Kallianpuri	MBBS MS MCh	Mon to Sat
	Dr. Ashwani K Sachdeva	MBBS MS MCh	Mon to Sat
Orthopedics & Joint Replacement	Dr. VPS Sandhu	MBBS MS	Mon to Sat
Pathology	Dr. Ankush Nayyar	MBBS MD	Mon to Sat
Pediatrics, Neonatology & Hematology	Dr. Kushagra Taneja	MBBS MD	Mon to Sat
Pediatrics Surgery	Dr. Abhishek Gupta	MBBS MS MCh	Mon to Sat
Pediatrics Neurology	Dr. Mukul Malhotra	MBBS MD DNB	Mon | Wed | Fri
Pediatrics Cardiology	Dr. Amitoz Singh Baidwan	MBBS DNB FNB	Mon to Sat
Plastic & Reconstructive Surgery	Dr. Ritwik Kaushik	MBBS MS MCh	Tue | Thu | Sat
Psychiatry, Behavioral & Drugs Rehabilitation	Dr. Prannay Gulati	MBBS MD	Mon to Sat (1st & 3rd Thu Outside)
	Dr. Vikas Bhateja	PhD(Cognitive Psy.) M.phil (Cl. Psy)	Mon to Sat
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	Dr. Jaspreet Singh	MBBS MD, DNB	Mon to Sat
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Urology	Dr. Prashant Bansal	MBBS MS DNB	Mon to Sat
Vascular Surgery	Dr. Vishal Attri	MBBS MS	Mon to Sat (Every Fri Outside)

From us to you

Throughout the year we generate awareness around specific conditions and diseases that people struggle with daily. Indus Healthcare is committed to bring today's most pressing health issues to the forefont for public awareness.

In this issue of Indus Alive you will find various topics related to health issues, their management and follow-up.

Looking forward for your feedback and suggestions.

feedback@indushospital.in

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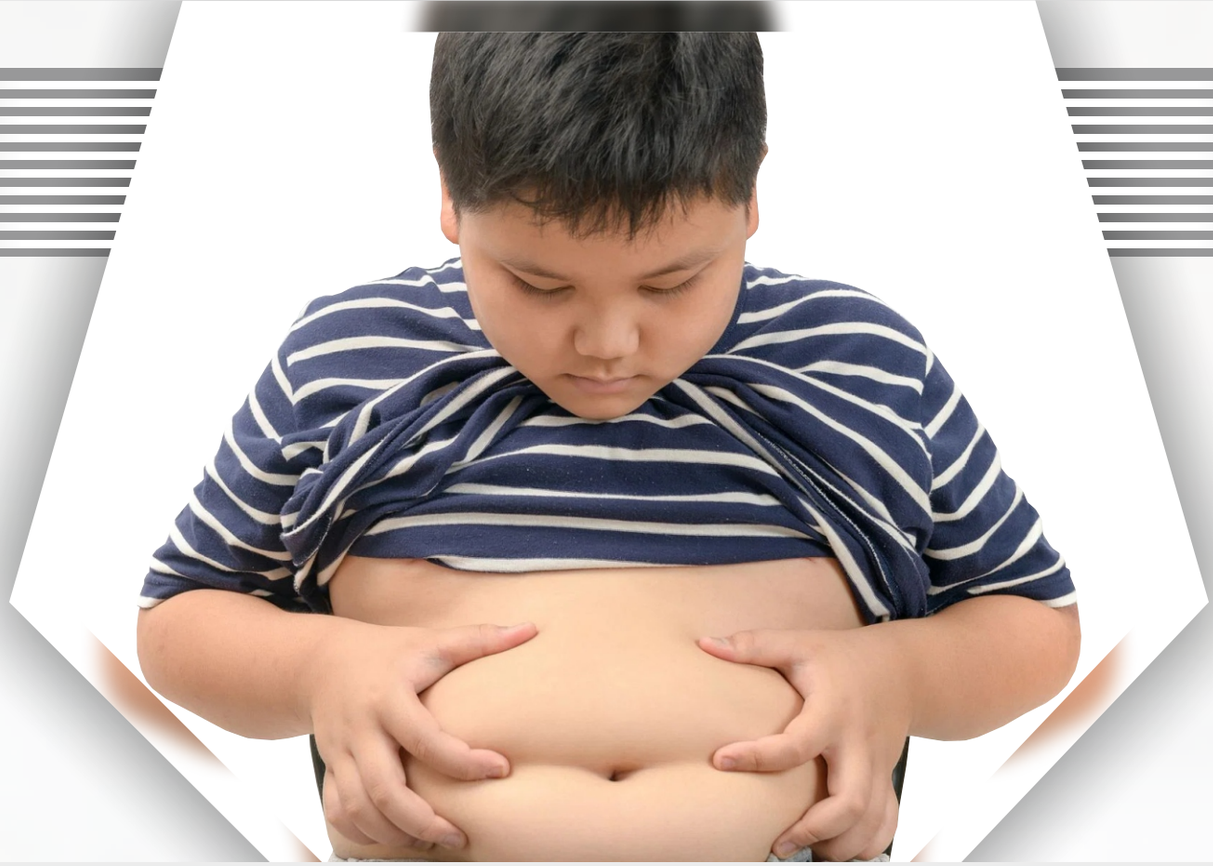

Childhood Obesity

Public Health Challenge

Childhood Obesity is a condition in which a child is significantly overweight for his or her age and height. It is one of the most serious health challenges of this century. This problem is global and is steadily affecting all particularly in urban settings. The prevalence of obesity in children has been increasing at an alarming rate.

The centers for disease control and prevention defined overweight as or above the 95th percentile of Body Mass Index (BMI) for age and obesity as or above 95th centile of BMI.

Overweight and obese children are likely to stay obese into adulthood. The mechanism of obesity development is believed to be a disorder with multiple causes, environmental factors, lifestyle preferences and cultural environment play an important role in rising prevalence of obesity worldwide.

In general, this condition is assumed to be the result of an excess intake in calorie and fat diet with reduced physical activity. There is enough evidence to support that excessive sugar intake by soft drinks, increased portion size and steady decline in physical activity, increased time of viewing television have been playing key roles in the rising rate of obesity.

Childhood obesity can profoundly affect children's health, social and emotional well being and self-esteem, It is also associated with poor academic performance and a lower quality of life. Childhood obesity has been linked to numerous medical conditions. These include but are not limited to fatty liver disease, sleep apnea, diabetes, high bp, high cholesterol, gall bladder stone, glucose intolerance, menstrual irregularities and many orthopaedic problems.

The rising issue of childhood obesity can be slowed. The first step is to detect the problem which can be done by regular growth monitoring at health centre by treating pediatrician. A combined diet and physical activity intervention conducted at the community level with the support of school is more effective in preventing obesity. Moreover, if parents enforce a healthier lifestyle at home, many obesity related problems can be avoided.

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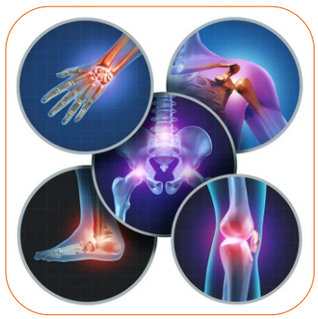
- Frozen Shoulder
- Cervical & Mascular Pain
- Back Pain & Stiffness
- Sciatica
- Prolapsed Intervertebral Disc (PIVD)
- Knee Pain
- Sports Injury



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Rheumatoid Arthritis

What is Rheumatoid Arthritis?

- Rheumatoid Arthritis, or RA, is a chronic systemic inflammatory disease where the immune system causes inflammation in the joints. Since active RA often results in joint and bone destruction and functional disability, it is vital to diagnose and treat this disease early.

Who gets RA?

- Anyone can get RA. On average, every 1 in 100 people have RA. The incidence of RA increases between 25 and 55 years of age, after which it plateaus until the age of 75 and then decreases. But younger people can also develop RA. As compared to men, more women develop RA.

Why does RA happen?

- It is postulated that RA is caused by genetic predisposition, environmental and immunologic factors.
- Allelic variation in the HLA-DRB1 gene, which encodes the MHC II ?-chain molecule, has been linked to RA.
- Multiple studies provide evidence for a link between RA and cigarette smoking, periodontal disease, and the oral microbiome, specifically Porphyromonas gingivalis. Mycoplasma infection, EBV and rubella virus infection have also been implicated in triggering the immune response.
- The genetic predisposition along with environmental factors trigger the synovial T cells causing CD4+ T cell activation in the joint and chronic inflammation leading to focal bone erosions, synovial hyperplasia leading to pannus formation.

What are the symptoms in RA?

- RA starts slowly in most people, developing over weeks. Patients often complain of early morning joint stiffness lasting more than 1 h that eases with physical activity. The earliest involved joints are typically the small joints of the hands and feet. There can also be joint pain, decreased range of motion in the joints, inability to do some activities (Eg turning door knobs, difficulty with keys, etc.), swelling around joints and fatigue.
- Once the disease process of RA is established, the wrists, metacarpophalangeal (MCP), and proximal interphalangeal (PIP) joints stand out as the most frequently involved joints.
- Distal interphalangeal (DIP) joint involvement may occur in RA, but it usually is a manifestation of coexistent osteoarthritis.
- Progressive destruction of the joints and soft tissues may lead to chronic, irreversible deformities. Ulnar deviation results from subluxation of the MCP joints, with subluxation, or partial dislocation, of the proximal phalanx to the volar side of the hand. Hyperextension of the PIP joint with flexion of the DIP joint ("swan-neck deformity"), flexion of the PIP joint with hyperextension of the DIP joint ("boutonnière deformity"), and subluxation of the first MCP joint with hyperextension of the first interphalangeal (IP) joint ("Z-line deformity") also may result from damage to the tendons, joint capsule, and other soft tissues in these small joints.
- Flexor tendon tenosynovitis is a frequent hallmark of RA and leads to decreased range of motion, reduced grip strength, and "trigger" fingers.
- In addition to articular deterioration, constitutional symptoms (eg, fatigue, malaise, morning stiffness, weight loss, and low-grade fever) may be present.

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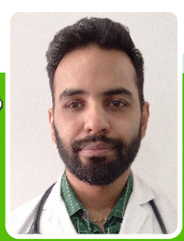

What are the complications of RA?

RA itself is not fatal, but complications of the disease may shorten survival by years in some individuals. Joint disability and pain with daily life are common. Affected joints can become deformed, and the performance of even ordinary tasks may be very difficult or impossible; these factors can severely affect patients' quality of life. In addition, RA is a systemic disease that can affect other parts of the body in addition to joints. These effects include the following:

- Anemia
- Infections - Patients with RA are at greater risk for infections
- GI problems - Patients with RA may experience stomach and intestinal distress
- Osteoporosis - This condition is more common than average in postmenopausal women with RA; the hip is particularly affected; the risk of osteoporosis appears to be higher than average in men with RA who are older than 60 years
- Heart disease - RA can affect blood vessels and increase the risk of coronary ischemic heart disease
- Sjögren syndrome - Keratoconjunctivitis sicca is a common complication of RA; oral sicca and salivary gland enlargement are less common
- Felty syndrome - This condition is characterized by splenomegaly, leukopenia, and recurrent bacterial infections
- Lymphoma and other cancers - RA-associated immune system alterations may play a role; aggressive treatments for RA may help prevent such cancers

How is RA diagnosed?

The 2010 ACR/EULAR classification criteria for RA are designed to identify patients with unexplained inflammatory arthritis in at least 1 peripheral joint and a short duration of symptoms who would benefit from early therapeutic intervention. They represent a paradigm shift from the 1987 ACR criteria, which lacked the sensitivity to detect early RA. The ACR/EULAR classification system is a score-based algorithm for RA that incorporates the following 4 factors:

- Joint involvement - points allocated according to the number of large and small joint involvement
- Serology test results - rheumatoid factor and anti-citrullinated protein antibody
- Acute-phase reactant test results - ESR and CRP
- Patient self-reporting of the duration of signs and symptoms

The maximum number of points possible is 10. A classification of definitive RA requires a score of 6/10 or higher. Patients with a score lower than 6/10 should be reassessed over time.

How is RA treated?

Optimal care of patients with rheumatoid arthritis (RA) consists of an integrated approach that includes both pharmacologic and nonpharmacologic therapies. Many nonpharmacologic treatments are available for this disease, including exercise, diet, massage, counseling, stress reduction, physical therapy, and surgery.

Pharmacologic therapies that are used include nonbiologic and biologic DMARDs and adjunctive agents such as corticosteroids, NSAIDs, and analgesics. Many studies have revealed that early treatment of RA (ie, within months of onset) with DMARDs not only can retard disease progression more efficiently than later treatment but also may induce more remissions. Thus, early DMARD therapy (< 6 months after the onset of symptoms) has become the standard of care. Patients with early forms of arthritis should be evaluated by and, if necessary, referred to physicians who are experienced in the diagnosis and treatment of RA.

RESISTANT HYPERTENSION : AN UPDATE

Introduction

Hypertension is the most common risk factor for cardiovascular events, affecting up to 50% of the global adult population and becoming more prevalent as this population ages. Untreated hypertension leads to the development of left ventilator hypertrophy, incresed intima media thickness, microalbuminuria, coronary heart disease, heart failure (HF) and atrial fibrillation. Resistant hypertension is defined as resistance to treatment, that us, when a therapeutic strategy that includes appropriate lifestyle measures plus a diuretic and two other antihypertensive drugs of different classes at adequate doses (but not necessarily including a mineralocorticoid receptor antagonist) fails to lower systolic and diastolic blood pressure values below 140 and 90 mm Hg, respectively.

Treatment

Before starting any drug treatment, clinicians should exclude pseudoresistant hypertension (which results from nonadherence to medications to from white coat hypertension), causes, and secondary forms of hypertension. The next step should be a combination of lifestyle changes and medical treatment.

Lifestyle Changes

Studies have shown that lifestyle changes (salt restriction, weight loss, physical exercise, moderate alcohol consumption, healthy diet and smoking cessation) are very effective in blood pressure reduction in combination with drug treatment in patients with resistant hypertension (Class l, level A,B). Lifestyle changes in patients with resistant hypertension are associated not only with blood pressure reduction but also with a lower risk cardiovascular events.

Medical Treatment

Physicians should prescribe drug with a long duration of action and high trough-to-peak ratio because not only will this improve the blood pressure control but also the adherence of the patient. Treatment should include two drugs plus a diuretic and, according to the current ESH/European Society of Cardiology (ESC) guidelines, this will be a combination of a renin-antiotensin system (RAS) blocker with a calcium channel blocker and a diuretic, unless there are specific conditions.

The role of the diuretic is crucial. In patients with resistant hypertension, volume overload due to salt and water retention is the most common mechanism leading to increased blood pressure. So, it is important for any antihypertensive treatment to be accompanied by salt restriction. Loop diuretic should only be considered in patients with a glomerular filtration rate (GFR) <30 ml/min, and in all other cases thiazide-type diuretic are recommended. Recently, there has been a lot of debate about which diuretic is the best : Hydrochlorothiazide (HCTZ) chlorthalidone or indapamide? Based on the ESH/ESC guidelines, no recommendation can be made in favor of a particular diuretic agent.

However, if improvement of blood pressure control in highly complaint patients is the therapeutic target, at least two other classes of antihypertensive drugs are available in our armamentarium: beta-blockers (the ones with vasodilatory effect, such as nebivolol and carvedilol, seem preferable) and aldosterone antagonists. According to the ESH/ECS guidelines, the combination of either an angiotensin ll receptor blocker or ACE inhibitor with a beta-blocker is a not a first-line one, probably due to limited efficacy. Things are completely different in patients with clinical organ damage (i.e. coronary artery disease or congestion HF where this particular combination is very effective and should be regarded as a gold standard.

In some patients with resistant hypertensive, plasma aldosterone levels are significantly higher, suggesting a role in blood pressure control resistance. An increasing body of evidence has suggested benefits of mineralocorticoid receptor antagonists, such as spironolactone or eplerenone, in improving blood pressure control in patients with resistant hypertension, regardless of circulating aldosterone levels.

In patients who still have uncontrolled hypertension despite receiving triple drug treatment, including a diuretic at an adequate dose, carotid baroreceptor stimulation or renal denervation can be considered.

Chronic electrical stimulation of carotid sinus nerves via implantable devices has shown significant reduction in both systolic and diastolic blood pressure. One of its main limitation is the surgical procedure, the need for general anesthesia, and the size of the device. Although newly unilateral devices have limited the implantation procedure to one side only, the potential beneficial effect of the method should be balanced, and against the need for periodical control and the replacement of the generator battery or reintervention in case of device failure.

Renal denervation is the bilateral destruction of renal artery by radiofrequency ablation catheters, inserted percutaneously through the femoral (and lately the radial) artery. The sympathetic nervous system innervates the kidney via efferent fibers, and provides regulation of the central nervous system via efferent fibers. Key events after efferent stimulation of the kidneys are the effects of the sympathetic system on renal vascular resistance, reduced renal blood flow, renin release, and sodium reabsorption.

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