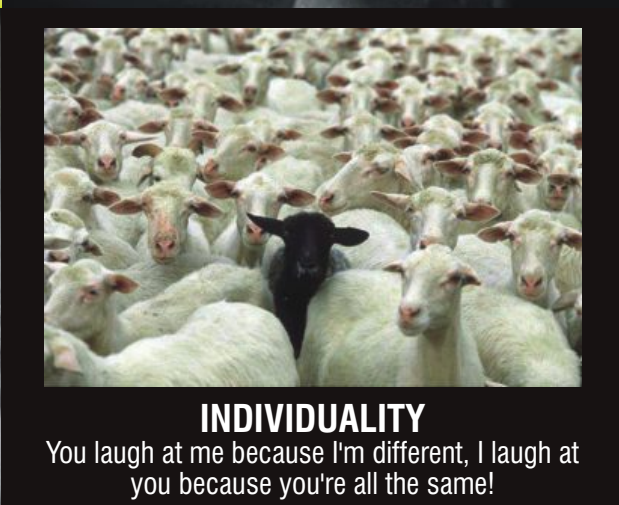
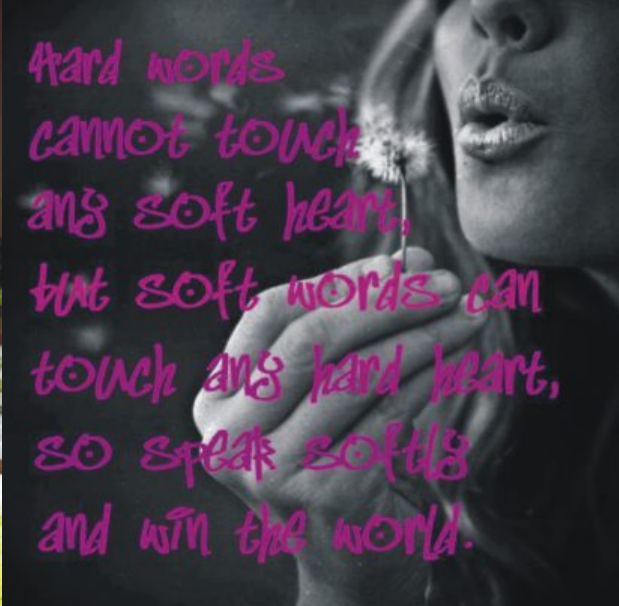


Medifashion



Inspiration Café



| | | |
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Dear Young Doctors,

With pleasure we are welcoming you to the Autumn issue of “**Young Doctors Forum**” Kidney diseases & Urology, the supper specialized & integral part of medicine & surgery always deals with the vulnerable patients. Every young doctor who dreams to be a Kidney specialist or Urologist has to achieve the post graduation degree on Nephrology or Urology. **NIKDU** is such an institute that will help to fulfill your dream. For this in our “**Career Point**” section we have included this institution & we believe it will help to make your post graduation process easy.

As a truly professional we always follow an icon. In our **Professional Icon** section we have drawn the life sketch of the most brilliant physician of Bangladesh, **Prof. Dr. Abdul Mobin Khan**. It will help you to know his biography & make you more enthusiastic to be like him as a professional.

Alzheimer's disease is not very uncommon disease for the people of Bangladeshi. Though it's etiology remain unknown. In our “**Clinical Glimpse**” section we have shown a picture in brief of **Alzheimer's disease**.

“**Medical pearl**” section highlights on the procedure of perfect surgical hand scrubs. This is very common & in your daily practice but we think it will reinforce your confidence.

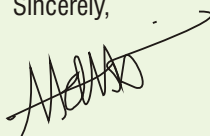
For the first time we have incorporated an exciting & interesting segment “**Medical History**”. In this issue you will come to know about a mostly used equipment of your daily practice **Stethoscope**. As previous you can meet your curiosity with “**Medicine Basket**.”

“**Medi Jokes**”, “**Medi Puzzle**” & “**Medi Fashion**” are the regular interesting items for smile blast, inquisitive gaming & fashion mania.

And, finally welcome to our “**Inspiration Café**” to have some sips of inspiration together, because we believe, life is always in need of inspiration.

Best wishes to all our readers & happy reading....!

Sincerely,



Dr. Md. Murad Hossain
 Manager, Medical Affairs
 Eskayef Bangladesh Limited
 Email: murad@skf.transcombd.com



Editorial Board

- Dr. Mohammad Mujahidul Islam
- Mr. Binay Das
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- Dr. Mohammad Murad Hossain
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National Institute of Kidney Disease & Urology (NIKDU)

NIKDU has been set up in the heart of Dhaka city at Sheer-E-Bangla Nagar to provide modern and scientific management for Kidney & Urological diseases. In our country with a population of about 160 million nearly 20 million people are suffering from various kidney and urological problems. Every year 15-20 thousand patients develop Acute Renal Failure (ARF), 70% of those can be rescued by dialysis therapy and further 18-20 thousand patients are developing End Stage Renal Diseases (ESRD). On the other hand approximately 3 million patients are suffering from various urological diseases. As a result there is huge number of patients and the existing facilities are very inadequate to serve them.



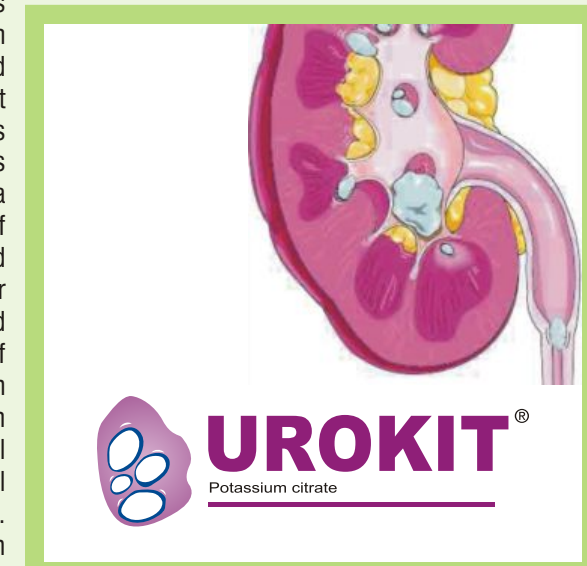
The aim of this Institute is to provide education, research & treatment facilities for nephrology & Urological diseases. As this is the only Institute for Nephrology & Urology in Bangladesh, priority is given on research programs for prevention, early detection and treatment of such diseases. In addition, development of manpower to fight against kidney diseases, higher training and post graduate courses for doctors of home & abroad, training for health care providers like nurses & technicians are also provided.

Within one year of inauguration of this institute, post-graduate course on MD (Nephrology), MS (Urology) have been started since January 2005. In near future the institute is going to start FCPS course in Nephrology, Urology & Paediatric Nephrology. Bangladesh College of Physician & Surgeons

(BCPS) recognized the post-graduate training obtained from this institute on nephrology, urology, pediatric Nephrology, Radiology & Imaging, Biochemistry, Histopathology, Microbiology & Immunology, Hematology and Anesthesiology. The University of Dhaka and Bangladesh Medical and Dental Council also recognized the courses and training of this institute. Also training facilities for junior doctors, nurses technologist & training on dialysis have been extended in this institute for both Government and non-government organizations. This institute is conducting a number of community based research works for early detection and prevention of Kidney diseases in collaboration with different national and international organizations. There is a provision for animal house including veterinary surgeons for research on xeno-transplantations in future.

History:

Although it has knowledge and experience for modern management of kidney diseases but also has scarcity of necessary specialties, hospital beds, equipments and laboratory services. It was the above forces which acted as a movement for



setting up a separate institute for kidney patients. A project concept paper (PCP), prepared by the leading Nephrologists and Urologists, and was placed before the Executive Committee of National Economic Council (ECNEC) in the year 1992. The project was finally passed by ECNEC on 1995 by the Government of People's Republic of Bangladesh and this was certainly a mile stone in the history of Nephrology, Urology and Transplantation in this country. The institute was formally opened on 18th April 2001.

- Project Concept Paper (PCP) placed Before FCNEC : 1992
- Corrected PCP passed in Inter ministerial Meeting : July, 1994
- Final approval of the Project by ECNEC : February, 1995
- Formal Inauguration of the Institute : April 18, 2001
- Formal Inauguration of Hospital activities : December 28, 2003
- Recruitment of all categories of staff completed by : December 30, 2003
- GO issued by Ministry of



Establishment liar Revenue Transfer : June 20, 2005
 • First World Kidney Day Observed : March 09, 2006

Introduction to NIKDU

- Area: 3 acres
- Location: Sher-E-Bangla Naggar, Dhaka-1207, Bangladesh.

Beginning of Different services

- OPD service - July 1, 2001
- Training of Doctors and Paramedics : March.2003
- Indoor Service : November 10, 2003

- Intermittent Peritoneal Dialysis (OPD): January 31, 2004
- Continuous Ambulatory Peritoneal Dialysis (CAPD): May 2, 2004

- Haemodialysis : December 24, 2004
- Uroflowmetry: February 01, 2005
- Per Cutaneous Nephro Lithotomy (PCNL): March 10, 2005
- Urodynamic

- Study: March 31. 2005
- Extra corporeal Shock Wave Lithotripsy (ESWL) : March 16, 2005
- Kidney Transplantation: April 20, 2005
- Direct Immunofluorescence Microscopy: November 01. 2005
- Public address system in Conference room: March 21. 2006
- Total automation of Hospital management & record: March 26. 2006

Number of Staffs and Employees

- Class I - 106
- Class II - 19
- Class III - 184
- Class IV - 137

Total: 446

Hospital Beds:

116 (Present), 400 (Proposed) Bed distributions:
 Nephrology: 36, Urology: 36, Pediatric Nephrology: 8, Pediatric Urology: 8, Post transplant Cubical: 6, General Cabin: 18 & VIP Cabin: 4

Service Provided:

- OPD Service: 8.00 AM to 2.30 PM
- Emergency service: 24 hours
- Average daily outdoor patient: 300/ day
- Indoor Services
- Ambulance Service

Number of Doctors Including Teachers

| | | | |
|-------------------------|----|---------------------------|----|
| Professor | 06 | Assistant Registrar | 28 |
| Associate Professor | 12 | Research Assistant | 02 |
| Deputy Director | 01 | Asst. Research Officer | 01 |
| Senior Research Officer | 01 | Emergency Medical Officer | 04 |
| Assistant Professor | 18 | Medical Officer | 04 |
| Resident Physician | 01 | Transplant Coordinator | 02 |
| Resident Surgeon | 01 | Anesthetist | 06 |
| Registrar | 01 | Lecturer | 04 |
| Number of Nurses | 75 | | |



- Haemodialysis
- Urological Operation
- IPD • CAPD
- All investigations of Nephrology & Urology

- Department of Pediatric Urology
- Department of Transfusion Medicine
- Department of Haematology
- Department of Immunology & Microbiology
- Department of Radiology & Imaging
- Department of Biochemistry
- Department of Anesthesiology

Post graduation course being conducted:

| Name of Course | Govt. Candidate | Non Govt. Candidate | Total |
|---------------------------|-----------------|---------------------|-------|
| MD (Nephrology) | 3 | 3 | 6 |
| MS (Urology) | 3 | 3 | 6 |
| MD (Pediatric Nephrology) | 2 | 1 | 3 |
| Total | 8 | 7 | 15 |

Different department

- Department of Nephrology
- Department of Pediatric Nephrology
- Department of Urology

- Department of Histopathology
- Medical Records & Statistical Department
- Library

Conclusion

Being a national institute, NIKDU has the responsibility to develop nephrology, urology and allied subjects in different parts of the country including development of manpower and also providing state of art treatment facilities for the people of Bangladesh. At present only 116 bed in this hospital is not enough to serve the urology & nephrology patients of the country. In near future hospital will be expanded to 400 bed.

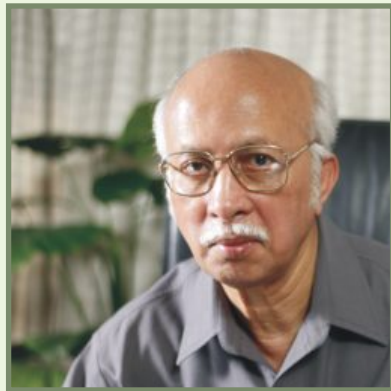
To keep pace with the development of urology all over the world they are planning to strengthen sub specialty services in urology in the field of Andrology, Neuro-urology, Female urology, Reconstructive urology and Uro-oncology.

As a Government institute, it serves a lot of financial benefits to the people of this poor country. NIKDU is now looking upright to quality, standard & increase the quantity of kidney patient services in Bangladesh.

Please find the answers of Medi-puzzle by reflection of mirror
 ৭' বিচিত্রে পুরো প্রশ্নের ২' ২সঙ্গে
 ১' বিজ্ঞান বিজ্ঞান ১' অরবিচ ডেলুমিটিভ ৩' বিসেস চসুচে।
 (Page-15)



Dr. Abdul Mobin Khan



Dr. Abdul Mobin Khan is a prominent & legendary Liver specialist of our country. His career which spans over 40 years has been dedicated to organizing care for hepatic patients and intensive research in the field of viral hepatitis, chronic hepatitis management, Cirrhosis of liver, Peg Interferon Therapy in Chronic Hepatitis. Dr. Khan's work has been widely acknowledged with several awards including "Ibrahim Memorial Oration Gold Medal", "Bangladesh Academy of Science Prof. Emeritus Sultan Ahmed Chowdhury National Science Award Gold Medal" and extreme appreciation by his patients. This time we are very much pleased to have him as our "Professional Icon".

Family History

Dr. Abdul Mobin Khan was born on May 31, 1948 in a religious Muslim family. He is from Comilla district. He is the son of Late Abdul Gafur Khan & Late Asia Khatun. Dr. Mobin Khan passed his SSC from Comilla Cantonment High School & HSC from Comilla Victoria College. Then he got admitted into Dhaka Medical College and passed with distinction marks. In personal life he is blessed with 3

children (Two sons & one daughter). Dr. Khan is a very well behaved, cheerful, friendly and benevolent personality.

Educational Background

| Degree | Institution | Field of Study |
|--------|---|---|
| MBBS | University of Dhaka, Bangladesh | Medicine, Surgery, Gynaecology & Obstetrics |
| FCPS | Bangladesh College of Physicians and Surgeons, Dhaka | Internal Medicine |
| M. Sc. | University of Queensland, Queensland, Australia | Hepatology |
| FRCP | Royal College of Physicians, Edinburgh, UK | Internal Medicine |
| FRCP | Royal College of Physicians & Surgeons of Glasgow, UK | Internal Medicine |
| FACP | American College of Physicians | Internal Medicine |
| FCCP | American College of Chest Physicians | Internal Medicine |
| FCPS | College of Physicians and Surgeons, Pakistan | Internal Medicine |

Academic Ranks & Positions

Dr. Abdul Mobin Khan is the Director of "The Liver Centre", which is situated at Mirza Golam Hafiz Road, House-64, Road-8/A, Dhanmondi, Dhaka; President of Hepatology Society, Dhaka. Recently retired from the post of Professor & Chairman of Department of Hepatology, Bangabandhu Sheikh Mujib Medical University, Dhaka. He was the former President of Bangladesh College of Physicians & Surgeons; Treasurer, Bangabandhu Sheikh Mujib Medical University.

Previous Professional Position & Appointments

House Physician, Department of Medicine, Institute of Postgraduate Medicine & Research, Dhaka 23.12.1972 to 30.06.1975.

Deputed to the course of FCPS in the Institute of Postgraduate Medicine & Research, Dhaka 01.07.1975 to

31.06.1977
Resident Medical Officer, Department of Medicine, Institute of Postgraduate Medicine & Research, Dhaka 27.09.1977 to 24.05.1980

Resident Physician (Assistant Professor of Medicine), Institute of Postgraduate Medicine & Research, Dhaka 25.05.1980 to 16.01.1981

Consultant Physician, Netrokona Subdivisional Modernized Hospital, Mymensingh, Bangladesh 17.01.1981 to 16.03.1981

Consultant Physician, Casualty Medicine Unit, Dhaka Medical College Hospital, Dhaka 17.03.1981 to 10.08.1981

Assistant Professor of Medicine, Institute of Postgraduate Medicine & Research, Dhaka 11.08.1981 to 25.05.1983

Associate Professor of Medicine (Hepatology), Institute of Postgraduate Medicine and Research, Dhaka : 26.05.83 to 10.10.86

On deputation to University of Queensland, Australia : 01.10.84 to 10.10.86

Associate Professor of Medicine (Hepatology), Institute of Postgraduate Medicine and Research, Dhaka : 11.10.86 to 30.04.87

Associate Professor of Medicine, Mymensingh Medical College, Mymensingh : 01.05.87 to 31.01.89

Professor of Hepatology, Institute of Postgraduate Medicine and Research, Dhaka : 01.02.89 to 30.06.2010 & lot more.

Additional Professional Trainings

Participant, Workshop on Hypertension, Sponsored by WHO, 1978.

Participant, Workshop on Ethical Consideration in Research of Human Subjects. Sponsored by Government of Bangladesh and ICDDR,B, Dhaka. December 1981.

Participant, National Course on Research Methodology, Clinical Sciences and Microbiology. Sponsored by ICDDR,B, Dhaka. 1982
Participant, National Course on Training in Cardiovascular Diseases. Sponsored by WHO & Institute of Cardiovascular Diseases, Dhaka. 1982

Participant, National Workshop on Research Methodology. Sponsored by WHO and Bangladesh Medical Research Council. 1983

Participant, National Workshop on Liver Diseases. Sponsored by WHO and Bangladesh Medical Research Council. 1983 & 1984

Participant, Biennial Scientific Meeting, Asian Pacific Association for the Study of the Liver, Bangkok,

Thailand, 1984

Participant, Annual Scientific Meeting, Gastroenterological Society of Australia. 1986

Participant, Biennial Scientific Meeting, Asian Pacific Association for the Study of the Liver, Jakarta, Indonesia. 1990

Participant, International Liver Disease Delegation to China. Sponsored by Citizen Ambassador Program, Spokane, Washington, USA. 1990 & lot more.

Papers Read at different Scientific Meetings

Complications of Cirrhosis of Liver, Bangladesh Medical Association Annual Scientific Meeting. 1978

Management of Hypertension, WHO sponsored Seminar on Hypertension, Dhaka. 1979

Primary Carcinoma of Liver, Scientific Seminar on the occasion of Reunion & Convention of Postgraduates, Dhaka. 1981

Hypertension in Rural Population in Bangladesh. Bangladesh Medical Association Annual Scientific Meeting. 1982

Hypertension in Urban and Rural Population of Bangladesh. 38th Annual Conference of the Association

of Physicians of India, Urisa, India. 1983 picturer

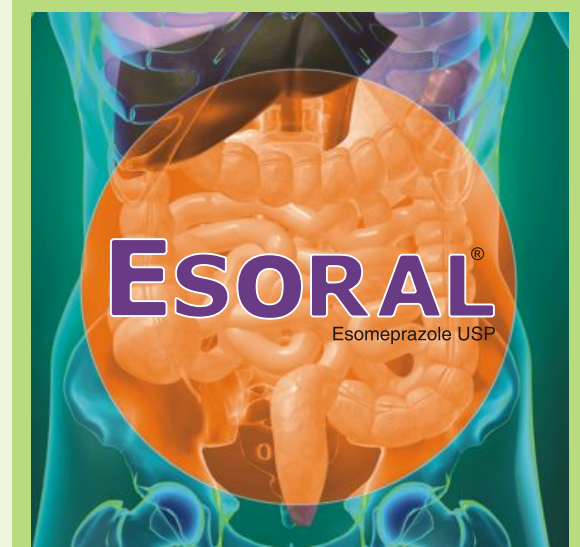
Bronchogenic Carcinoma. Bangladesh Chest & Heart Association Annual Scientific Meeting. 1983

Pattern of Rheumatic Diseases in Hospital Population. Bangladesh Medical Association Annual Scientific Meeting. 1983

Gastrointestinal Reflux. 8th Saudi National Guard Medical Conference, Riyadh, Saudi Arabia. 1983

Management of Chronic Hepatitis, National Workshop on Liver Diseases, Dhaka. 1983

Atypical Presentation of Amoebic Liver Abscess, Biennial Scientific Meeting, Asian Pacific Association for the Study of the Liver, Bangkok, Thailand. 1984 & lot more.



Publications

A. Full papers

1975 Islam N, Khan M. Cirrhosis of Liver in Bangladesh : A preliminary Report. Bangladesh Medical Research Council Bulletin 1975; 1: 39-45.
 1981 Islam N, Khan M. Rheumatic Disease other Than Rheumatic Fever Bangladesh Medical Research Council Bulletin 1981; 7(1): 18-21
 1981 Islam N, Khan M, Ahmed Z. Cirrhosis of Liver Bangladesh Medical Research Council Bulletin 1981; 7(2): 45-51.
 1982 Ahmed Z, Khan M, Islam N. Cervical Spondylosis Asian Medical Journal 1982; 25(4): 271-7.
 1983 Islam N, Khan M, Latif Z. Hypertension in Rural Population in Bangladesh. Bangladesh Medical Research Council Bulletin 1983; 9(2): 11-14.

1983 Islam N, Khan M. Ascites An Aetiological Consideration. Indian Medical Gazette. 1983
 1985 Khan M, Islam N. Complication of Cirrhosis of Liver in some Hospitalized Population. Bangladesh Medical Research Council Bulletin 1985; 11(1): 28-32.
 1985 Khan M, Powell LW. Liver Function Tests : A Frank Evaluation for Physicians. The Physicians of India. 1985; 2(1):52-60.
 1985 Mobin K, Nurul I. Primary carcinoma of liver. Indian Medical Gazette 1985;CXIX(4):122-124.
 1986 Khan M, Hossain M. Diagnosis of Viral B Hepatitis. Bangladesh Journal of Child Health 1989; 13(9/1): 41-50. & lot more.

Former Editor/Member Editorial Board

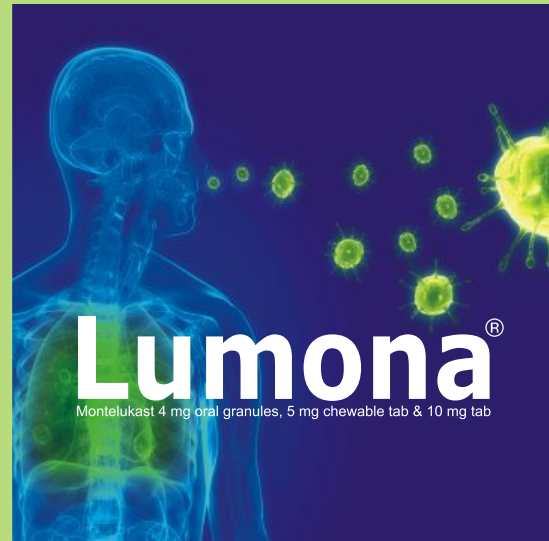
1. Advisor, Editorial Board, Journal of Gastroenterology and Hepatology (Published from Australia)
2. Regional Editor, Hepato-Gastroenterology (Published from Greece)

3. Member, Editorial Board, Bangladesh Medical Research Council Bulletin Investigator of the Following Ongoing Research Projects:

- A) Interferon, Peg Interferon, Lamivudine, Adefovir, Entecavir, Telbivudine and Tenofovir responses in chronic hepatitis B
- B) Peg Interferon with or without ribavirin in chronic Hepatitis C

Professional & Society Membership

1. Past President, Bangladesh College of Physicians & Surgeons
2. Member, International Association for the Study of the Liver
3. Member, American Association for the Study of Liver Diseases (member no. 100678)
4. Member, European Association for the Study of the Liver
5. Past Council Member, Asian Pacific Association for the Study of the Liver
6. Founder President, Association for the Study of the Liver, Dhaka, Bangladesh
7. Founder Member, HEV International Association
8. Life Member, Bangladesh Medical Association
9. Past President, Association of Physicians of Bangladesh
10. Life Member, Association for Advancement of Medical Science, Bangladesh
11. Life Member, Bangladesh Gastroenterology Society.



Alzheimer's Disease (Senile Dementia)

Dementia is a loss of brain function that occurs with certain diseases. Alzheimer's disease (AD) is one form of dementia that gradually gets worse over time. It affects memory, thinking, and behavior.

Causes, incidence, and risk factors

One is more likely to get Alzheimer's disease (AD) if he/she:

- Is older. However, developing AD is not a part of normal aging.
- Have a close blood relative, such as a brother, sister, or parent with AD.
- Have certain genes linked to AD, such as APOE epsilon-4 allele

The following may also increase the risk, although this is not well proven:

- Being female
- Having high blood pressure for a long time
- History of head trauma

There are two types of AD:

- Early onset AD: Symptoms appear before age 60. This type is much less common than late onset. However, it tends to get worse quickly. Early onset disease can run in families. Several genes have been identified.
- Late onset AD: This is the most common type. It occurs in people age 60 and older. It may run in some families, but the role of genes is less clear.

The cause of AD is not clear. Genes and environmental factors seem to play a role. Aluminum, lead, and mercury in the brain are no longer believed to be a cause of AD.

Symptoms

Dementia symptoms include difficulty with many areas of mental function, including:

- Emotional, behavior or personality
- Language
- Memory

- Perception
- Thinking and judgment (cognitive skills)

Dementia usually first appears as forgetfulness.

Mild cognitive impairment (MCI) is the stage between normal forgetfulness due to aging, and the development of AD. People with MCI have mild problems with thinking and memory that do not interfere with everyday activities. They are often aware of the forgetfulness. Not everyone with MCI develops AD.

The early symptoms of AD can include:

- Difficulty performing tasks that take some thought, but used to come easily, such as balancing a checkbook, playing complex games (such as bridge), and learning new information or routines
- Getting lost on familiar routes
- Language problems, such as trouble finding the name of familiar objects
- Losing interest in things previously enjoyed, flat mood
- Misplacing items
- Personality changes and loss of social skills

As the AD becomes worse, symptoms are more obvious and interfere with your ability to take care of yourself. Symptoms can include:

- Change in sleep patterns, often waking up at night
- Delusions, depression, agitation
- Difficulty doing basic tasks, such as preparing meals, choosing proper clothing, and driving
- Difficulty reading or writing
- Forgetting details about current events
- Forgetting events in your own life history, losing awareness of who you are

- Hallucinations, arguments, striking out, and violent behavior
- Poor judgment and loss of ability to recognize danger
- Using the wrong word, mispronouncing words, speaking in confusing sentences
- Withdrawing from social contact

People with severe AD can no longer:

- Understand language
- Recognize family members
- Perform basic activities of daily living, such as eating, dressing, and bathing

Signs and tests

A skilled health care provider can often diagnose AD disease with the following steps:

- Complete physical exam, including neurological exam
- Asking questions about your medical history and symptoms
- A mental status examination

A diagnosis of AD is made when certain symptoms are present, and by making sure other causes of dementia are not present.

Tests may be done to rule out other possible causes of dementia, including:

- Anemia
- Brain tumor
- Chronic infection
- Intoxication from medication
- Severe depression
- Stroke
- Thyroid disease
- Vitamin deficiency

Computed tomography (CT) or magnetic resonance imaging (MRI) of the brain may be done to look for other causes of dementia, such as a brain tumor or stroke.

- In the early stages of dementia, brain image scans may be normal. In later stages, an MRI may show a decrease in the size of different areas of the brain.

■ While the scans do not confirm the diagnosis of AD, they do exclude other causes of dementia (such as stroke and tumor).

However, the only way to know for certain that someone has AD is to examine a sample of their brain tissue after death. The following changes are more common in the brain tissue of people with AD:

Treatment

There is no cure for AD. The goals of treatment are:

- Slow the progression of the disease (although this is difficult to do)
- Manage symptoms, such as behavior problems, confusion, and sleep problems
- Change your home environment so you can better perform daily activities
- Support from family members and other caregivers

DRUG TREATMENT

Medicines are used to help slow down the rate at which symptoms become worse. The benefit from these drugs is usually small. Patient's family may not notice much of a change.

Medicines for AD include:

- Donepezil , rivastigmine and galantamine. Side effects include stomach upset, diarrhea, vomiting, muscle cramps, and fatigue.
- Memantine . Possible side effects include agitation or anxiety.

It may be necessary to stop any medications that make confusion worse. Such medicines may include painkillers, cimetidine, central nervous system depressants, antihistamines, sleeping pills, and others. Never change or stop taking any medicines without the advice of a doctor.

Prevention

- Consume a low-fat diet.
- Eat cold-water fish (Like tuna, salmon, and mackerel) rich in omega-3 fatty acids, at least 2 to 3 times per week.
- Reduce your intake of linoleic acid found in margarine, butter, and dairy products.
- Increase antioxidants like carotenoids, vitamin E, and vitamin C by eating plenty of darkly colored fruits and vegetables.
- Maintain a normal blood pressure.
- Stay mentally and socially active throughout your life.

In addition, early testing of a vaccine against AD is underway.

Surgical Hand Scrubs

Purpose

The purpose of the surgical scrub is to remove or destroy transient microorganisms and inhibit the growth of resident microorganisms.

Preparation

Nail varnish, false nails, rings, watches and bracelets should be removed. Expert opinion proposes that this type of accessory is likely to harbour pathogenic organisms which could contaminate surgically scrubbed hands and arms. A systematic review by Arrowsmith et al (2001) found no randomised controlled trials (RCTs) that compared the wearing of rings versus no rings. They found one small RCT comparing the use of nail polish which measured the number of colony forming units (CFUs) of micro-

organisms following surgical scrub and found there was no significant difference between those wearing and not wearing nail polish.

Expert opinion asserts that hair, mask (if worn) and attire should be comfortable, safe and unlikely to need adjustment after the scrub procedure thus avoiding potential contamination.

Procedure

Nail picks are recommended in UK theatre practice but scrubbing brushes are no longer deemed to be necessary especially for use on skin (AfPP 2007). Until recently brushes were advocated to commence the procedure in US literature (CDC 2002); hence the outdated term of 'scrubbing' which lingers on. The use of nail picks and brushes have been called into question

in a recent randomized controlled trial by Tanner et al (2009) which showed no difference in the amount of colony forming units in the glove juice between those practitioners who used chlorhexidine alone, chlorhexidine plus nail pick and chlorhexidine plus nail brush. The study was relatively small and despite a power calculation failed to demonstrate statistical significance. Therefore it would benefit from replication.

Products

Any surgical antiseptic should have four main properties (CDC 2002):
 1. Antimicrobial activity this should include destruction of a broad spectrum of pathogenic organisms.
 2. Persistent activity the antimicrobial agent should be long lasting especially

Fastest PPI with unique 5 layers of protection

Rabifast[®]
 Rabeprazole Sodium 20 mg Enteric Coated Tablet

Last hope of life

DORIPEN[®]
 Doripenem for Injection INN

Coming soon...

for longer cases.

3. Safety the agent should be safe for the skin and eyes of the person using it, as well as being non-irritating and sensitising. The environment also needs to be considered as the agent may have long term harmful effects.

4. Acceptance this is a more subtle characteristic which may include colour, smell and feel and is required for antiseptic uptake by the surgical team. Acceptance should not be underestimated.

Three types of antiseptic solutions are available:

1. Aqueous scrubs usually contain chlorhexidine gluconate or povidone iodine. Using aqueous solutions require a surgical scrub.

2. Alcohol rubs 3 main types of alcohol ethanol, isopropanol and n-propanol. This involves rubbing the alcohol solution into the hands systematically following removal of visible soiling or a preliminary hand wash.

3. Alcohol rubs containing additional active ingredients these include chlorhexidine gluco-nate, iodophors, biguanides and phenolic compounds such as hexachloro-phene and triclosan.

Process

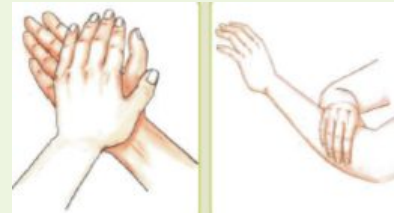
Each step of surgical 'scrubbing' consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000) into eight steps. Sources of evidence drawn on include AfPP's Standards and Recommendations for Safe Perioperative Practice (AfPP 2007), AORN's recommended practices (Paulson 2004), and Ayliffe's six step hand washing technique (Ayliffe et al 2000).

Step 1 (pre-scrub/pre wash)

- ⊙ Wash hands and arms with running water and an antimicrobial solution or plain soap
- ⊙ Remove debris from under nails using a nail pick
- ⊙ Rinse hands and arms
- ⊙ During each of the following steps keep hands above elbows allowing water to drain away
- ⊙ Avoid splashing surgical attire.

Step 2

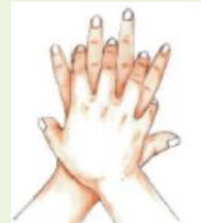
Apply an amount of surgical scrub product recom-mended by the



Manufacturer. Work into hands palm to palm and continue with rotating action down opposing arms working to just below the elbows.

Step 3

Right hand over back of left and vice versa with fingers interlaced.



Step 4

Rub palm to palm, fingers interlaced.



Step 5

Rotational rubbing of right thumb clasped in left hand and vice versa.



Step 6

Rub left palm with clasped fingers of right hand and vice versa. For references please see over



Step 7

Once more rotate down the arm with opposing hand working to just below the elbow. Rinse and repeat steps 2-7 keeping hands above elbows at all times.



Step 8

Rinse hands under running water. Dry thoroughly using one (or one side of a)



sterile paper hand towel for each hand, rotating down hands to elbows before discarding

.Application of alcohol hand rub

- Application of alcohol rub consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000)
- As above, follow steps 2 7
- Allow alcohol to evaporate before donning gloves to avoid the risk of dermatitis.

| Brand | Strength | Indication | Dosage |
|---|--|--|---|
| Levomax[®] (Levofloxacin) | 250 mg Tablet 500 mg Tablet | <ul style="list-style-type: none"> • Acute maxillary sinusitis • Acute bacterial exacerbation of chronic bronchitis • Community-acquired pneumonia • Complicated & uncomplicated urinary tract infections • Acute pyelonephritis • Complicated & uncomplicated skin and soft tissue infections | <ul style="list-style-type: none"> • Acute sinusitis: 250-500 mg daily for 10-14 days. • Acute exacerbation of chronic bronchitis: 250-500 mg daily for 7-10 days. • Community-acquired pneumonia: 500 mg once or twice daily for 7-14 days. • Urinary tract infections: 250 mg daily for 7-10 days. • Acute pyelonephritis: 250 mg daily for 10 days <p>Skin and soft tissue infections: 250 - 500 mg once or twice daily for 7-14 days.</p> |
| Flucoder[®] (Fluconazole) | 50 mg Capsule & 150 mg Capsule | <p>Acute or recurrent vaginal candidiasis</p> <p>Mucosal candidiasis e.g. oropharyngeal, oesophageal, bronchopulmonary, mucocutaneous, denture sore mouth.</p> <p>Tinea pedis, tinea corporis, tinea cruris, tinea versicolor and dermal candida infection</p> <p>Systemic candidiasis including candidaemia, disseminated candidiasis and other forms of candidial infection.</p> <p>Cryptococcosis, cryptococcal meningitis and infections of other sites (pulmonary and cutaneous). For prevention of fungal infections in immuno-compromised patients e.g. neutopanic cancer patients.</p> | <p>Acute and recurrent vaginal candidiasis and candidal balanitis: Orally a single dose 150 mg.</p> <p>Mucosal candidiasis (except vaginal): Orally 50 mg daily (100 mg daily in a single dose in unusually difficult infection) for 7-14 days. Oropharyngeal candidiasis maximum 14 days, in atrophic oral candidiasis with denture for 14 days, in oesophagitis and candiduria for 14-30 days. Tinea pedis, corporis, cruris, pityriasis versicolor and dermal candidiasis: Orally 50 mg daily for 2-4 weeks (upto 6 weeks in tinea pedis) maximum duration of treatment is 6 weeks. Systemic candidiasis and cryptococcal infections (including meningitis): Orally 400 mg initially daily then 200 mg daily and continue treatment according to response. Prevention of fungal infections in immunocompromised patients 50-400 mg daily adjusted according to risk. Prevention of relapse of cryptococcal meningitis, AIDS patients after completion of primary therapy: 100 mg-200 mg orally daily.</p> |
| Etorix[®] (Etoricoxib) | 60 mg Tablet 90 mg Tablet 120 mg tablet | Pain and inflammation in osteoarthritis, in rheumatoid arthritis, and in other chronic musculoskeletal disorders; acute gout; pain of dysmenorrhoea and pain following dental surgery | <p>Adult and adolescent over 16 years:</p> <ul style="list-style-type: none"> • In case of Osteoarthritis, dysmenorrhoea, chronic musculoskeletal disorders, 60 mg once daily. • In case of Rheumatoid arthritis 90 mg once daily. • In case of Pain following dental surgery, acute gout 120 mg once daily. <p>Safety and effectiveness of etoricoxib in paediatric patients have not been established</p> |
| Esoral[®] (Esomeprazole USP) | 50 ml Oral Solution 100 ml Oral Solution 200 ml Oral Solution | Acute & Chronic Constipation Hepatic Encephalopathy | <p>Adults:</p> <p>Initially: 15-30 ml daily for first 2-3 days (45 ml may be given in obstinate cases).</p> <p>Maintenance: 10-15 ml daily or according to the need of the patient.</p> <p>Children:</p> <p>Initially: 10-25 ml daily for first 2-3 days.</p> <p>Maintenance: 5-15 ml daily or according to the need of the patient.</p> <p>Chronic portal systemic encephalopathy</p> <p>Initially 30-50 ml three times daily according to the requirements of the patient for adequate acidification of the colonic contents.</p> |
| Sensit[®] (Flupentixol dihydrochloride and melitracen hydrochloride) | Flupentixol dihydrochloride BP equivalent to flupentixol 0.5 mg and Melitracen hydrochloride INN equivalent to melitracen 10 mg Tablet | <p>Depression (psychogenic depression, depressive neuroses, masked depression, menopausal depressions, dysphoria & depression in alcoholics and drug-addicts).</p> <p>Anxiety and apathy (psychosomatic affections accompanied by anxiety and apathy)</p> | <p>Adult: The usual doses is two tablets daily, morning and noon. In severe case the morning dose may be increased to two tablets.</p> <p>Elderly: In elderly patients the dose is one tablet in the morning.</p> <p>Maintenance treatment: Usually one tablet in the morning. Incases of insomnia or severe restlessness additional treatment with a sedative in the acute phase is recommended.</p> |

The History of Stethoscope



Stethoscopes are often considered as a symbol of the doctor's profession, as doctors are often seen or depicted with

stethoscopes hanging around their necks. A 2012 research demonstrated that among several icons of medical profession, the stethoscope had the highest positive impact on the perceived trustworthiness of the practitioner.

The stethoscope was invented in France in 1816 by René Laennec at the Necker-Enfants Malades Hospital in Paris. It consisted of a wooden tube and was monaural. His device was similar to the common ear trumpet, a historical form of hearing aid; indeed, his invention was almost indistinguishable in structure and function from the trumpet, which was

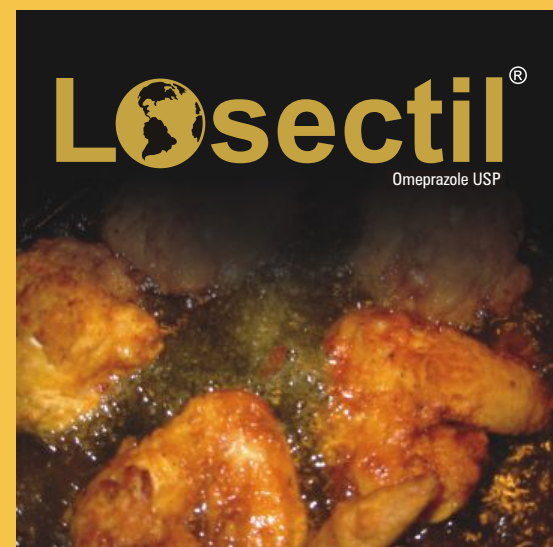
commonly called a "microphone". The first flexible stethoscope of any sort may have been a binaural instrument with articulated joints not very clearly described in 1829. In 1840, Golding Bird described a stethoscope he had been using with a flexible tube. Bird was the first to publish a description of such a stethoscope but he noted in his paper the prior existence of an earlier design (which he thought was of little utility) which he described as the snake ear trumpet. Bird's stethoscope had a single earpiece. In 1851, Irish physician Arthur Leared invented a binaural stethoscope, and in 1852 George Cammann perfected the design of the instrument for commercial production, which has become the standard ever since. Cammann also wrote a major treatise on diagnosis by auscultation, which the refined binaural stethoscope made possible. By 1873, there were descriptions of a differential stethoscope that could connect to slightly different locations to create a slight stereo effect, though this did not become a standard tool in clinical practice.

products division was spun off as part of Agilent Technologies, Inc., where it became Agilent Healthcare. Agilent Healthcare was purchased by Philips which became Philips Medical Systems, before the walnut-boxed, \$300, original Rappaport-Sprague stethoscope was finally abandoned ca. 2004, along with Philips' brand (manufactured by Andromed, of Montreal, Canada) electronic stethoscope model. The Rappaport-Sprague model stethoscope was heavy and short (1824 in (4661 cm)) with an antiquated appearance recognizable by their two large independent latex rubber tubes connecting an exposed-leaf-spring-joined-pair of opposing "f"-shaped chrome-plated brass binaural ear tubes with a dual-head chest piece.

Several other minor refinements were made to stethoscopes, until in the early 1960s Dr. David Littmann, a Harvard Medical School professor, created a new stethoscope that was lighter than previous models and had improved acoustics. In the late 1970s, 3M-Littmann introduced the tunable diaphragm: a very hard (G-10) glass-epoxy resin diaphragm member with an over molded silicone flexible acoustic surround which permitted increased excursion of the diaphragm member in a "z"-axis with respect to the plane of the sound collecting area.

In 1999, Richard Deslauriers patented the first external noise reducing stethoscope, the DRG Puretone. It featured two parallel lumens containing two steel coils which dissipated infiltrating noise as inaudible heat energy. The steel coil "insulation" added .30 lb to each stethoscope. In 2005, DRG's diagnostics division was acquired by TRIMLINE Medical Products.

Rappaport and Sprague designed a new stethoscope in the 1940s, which became the standard by which other stethoscopes are measured, consisting of two sides, one of which is used for the respiratory system, the other for the cardiovascular system. The Rappaport-Sprague was later made by Hewlett-Packard. HP's medical



Doctor's Funeral

A cardiac specialist died and at his funeral the coffin was placed in front of a huge mock up of a heart made up of flowers. When the pastor finished with the sermon and eulogy, and after everyone said their good-byes, the heart opened, the coffin rolled inside and the heart closed. Just then one of the mourners burst into laughter. The guy next to him asked: "Why are you laughing?" "I was thinking about my own funeral" the man replied. "What's so funny about that?" "I'm a gynecologist."

Fourteen Fourteen!

A guy was walking past a big wooden fence at the insane asylum and he hears all the residents inside chanting, "Thirteen! Thirteen! Thirteen! Quite curious about this, he finds a hole in the fence, and looks in. Someone inside pokes him in the eye. Then everyone inside the asylum starts chanting, "Fourteen! Fourteen! Fourteen!"

Getting a Tooth Pulled

A man & his wife entered a dentist's office. The Wife said, "I want a tooth pulled. I don't want gas or Novocain because I'm in a terrible hurry. Just pull the tooth as quickly as possible." You're a brave woman said the dentist. Now, Show me which tooth it is. The wife turns to her husband and says, "Open your mouth and show the dentist which tooth it is, dear."

Testing! Testing!

A man goes to the doctor and complains that his wife can't hear him. "How bad is it?" the doctor asks. "I have no idea," the husband says. "Well, please test her. Stand 20 feet away from her and say something. If she doesn't hear you, get closer and say the same thing. Keep moving closer and closer and repeating



the comment until she does hear you. That way we'll have an idea of her range of hearing loss." So the man goes home and sees his wife in the kitchen chopping up vegetables for dinner. From 20 feet away: "What are we having for dinner?" No answer. From 10 feet: Same thing. From 5 feet: Same thing. Finally, he's standing right behind her: "What's for dinner?" She turns around, looks at him and says: "For the FOURTH time, BEEF CURRY!"

Childhood surgeries

Two little kids lined up for surgery are lying in stretchers outside the operating room.

The first kid leans over and asks, "What are you in here for?"
The second kid says, "I'm in here to get my tonsils out and I'm a little nervous."
The first kid tries to reassure the other and says, "Oh! don't worry. It's very simple. I had that done when I was four. They put you to sleep, and when you wake up they give you lots of Jell-O and ice cream."
The second kid, feeling a little better, then asks, "What are you here for?"

The first kid says, "A circumcision."
The second kid says, "Whoa! I had that done when I was born. I couldn't walk for a year!"

Most terrible constipation

A man went to the doctor and complained that he had the most terrible constipation. The doctor examined him and then gave him a prescription for some tablets to be taken last thing at night.
2 weeks later the patient returned for a check-up and the doctor asked him how his constipation was.
The doctor was rather surprised when the man gloomily answered that the pills worked fine and that he went every morning at 7.30.

"So why the long face?" asked the doctor
"Because I don't get up until 8 o'clock !!
!" replied the patient.

Medi Puzzle



See closely and diagnose the diseases through puzzles. Answers are given in Page-4.