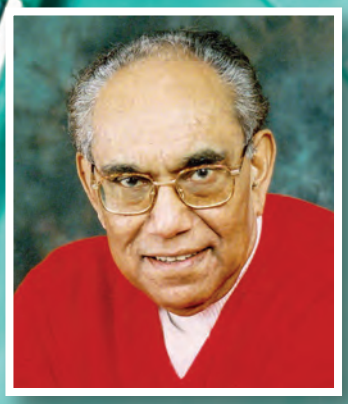
bida Journal



This issue is dedicated to
Dr Madan M Gupta
8.1.1934 – 19.12.2017

Organ Donation
Myths and Facts

Bacterial Vaginosis
Update on management

Anaemia
A review and approach to diagnosis and management

Dr Bawa-Garba's Verdict
BIDA's Response

Acute non-traumatic headache
A 2-year retrospective review

BIDA International Congress
A full report on the Rio event

BIDA 2017 ARM & AGM
Full details of the prestigious weekend

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The Journal of the British International Doctors' Association
Issue No.1, Volume 24. February 2018

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Women more than 55 years and elderly There is a lack of data on the efficacy and safety of dequalinium chloride in women above 55 years of age.
Paediatric population There is a lack of data on the efficacy and safety of dequalinium chloride in children below 18.

Method of administration: For vaginal use
Contraindications: Hypersensitivity to the active substance or to any of the excipients. Ulceration of the vaginal epithelium and the vaginal portion of the cervix.
Young girls who have not yet had their first menstruation, and thus did not reach sexual maturity must not use Fluomizin
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There are no efficacy and safety data available on the re-treatment of patients who did not respond to or relapsed immediately after initial therapy with Fluomizin. Patients should be advised to consult their physician if the symptoms persist at the end of the treatment or in case of recurrence.
Using a higher daily dose or increasing the recommended treatment duration might increase the risk of vaginal ulcerations.
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Interactions: Anionic substances such as soaps, detergents and surfactants can reduce the antimicrobial activity of dequalinium chloride. Thus, concomitant **intravaginal** use of soaps, spermicides or vaginal douches (vaginal washes) is not recommended.
Fluomizin 10 mg vaginal tablets do not impair the functionality of latex condoms. There are no data on the interaction with non-latex condoms and other intravaginal devices such as diaphragms. Thus, concomitant use of non-latex condoms and other intravaginal devices is not recommended.
Pregnancy: Limited data from four clinical studies in 181 pregnant patients did not suggest adverse effects on the pregnancy or on the foetus / neonate.
No reproductive toxicity studies have been conducted in animals because of the expected low systemic exposure to dequalinium chloride after vaginal administration.
Fluomizin should only be used in pregnancy if clearly necessary.
Undesirable effects: Common (≥1/100 to <1/10) vaginal discharge, vulvovaginal pruritus, vulvovaginal burning sensation, vaginal candidiasis Uncommon (≥1/1,000 to <1/100) vaginal haemorrhage, vaginal pain, bacterial vaginitis, fungal skin infection, vulvitis, vulvovaginitis, headache, nausea Unknown Frequency (post-market) ulceration and maceration of vaginal epithelium, uterine bleeding, redness, vaginal dryness, cystitis, allergic reactions with symptoms like urticarial, erythema, exanthema, swelling, rash or pruritus and fever. Please refer to the Summary of Product Characteristics for full information.
MA: PL 39972/0004 **MA Holder:** Kora Corporation Ltd t/a Kora Healthcare, Swords Business Park, Swords Co. Dublin, Ireland
Legal category: POM. **NHS Price:** 6 tablets £6.95
Date of preparation: Feb 2016, FLUUK_021601.

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KORA HEALTHCARE

Date of preparation: May 2016, FLUK_041604

BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

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We would like to begin with paying our highest regards to Dr Madan Mohan Gupta, one of our founder members and the Past President of ODA (now BIDA), who passed away on the 19th of December 2017. He is no longer with us but leaves an indelible impression of love, respect, humbleness and a feeling of warmth. He has touched the lives of many individuals. He will be sadly missed.

It is our assumption that the practice of medicine is orderly and follows a prescribed science. This concept has been challenged by the US physician and health researcher, Atul Gawande. He writes in his book *"Medicine is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line."* Once this practice is combined with an unsafe working environment coupled with the impact of a tougher doctor-patient relationship the complexities increase manifold. This is the reality of the current state of affairs in the NHS of today.

The issues are challenging now as patient demand grows in the UK, there are worrying signs that the retention of doctors is heading in the opposite direction. Added to this a substantial proportion of those working on the frontlines are retiring while our juniors continue to work with stress related problems owing to staffing deficiencies and under-resourcing. Dr Bawa-Garba's case has highlighted the fact that all doctors are at risk in the context of a healthcare system, which is overburdened and is clearly under enormous stress. This case has prompted seniors to challenge the GMC decision. It is a lesson for every doctor to ensure that the environment he or she works in is supportive and safe. BIDA has now released its response, a strong message in support, which has been published in this edition on page 6.

Patients remain central to our profession. We now need to plan for the future and look towards the professional bodies, the BMA, GMC, the Royal Colleges of all specialities, the Medical institutions and the health administrators in the government to get together to establish solutions to these challenges.

This month's edition contains a number of interesting articles. We would like your attention to Dr Sharma's article on "Organ donation". This is an essential read as the last date for public consultation on "presumed consent" is till the 6th of March this year. This raises awareness and presents facts for every individual to decide for oneself. Dr Victor Ameh presents a superb study on presentation of 1624 cases of acute non-traumatic headaches in ED. A normal CT scan does not exclude the diagnosis of sub-arachnoid haemorrhage (SAH). Lumbar puncture is an essential adjunct to pick the suspected cases of SAH. Mr. P K Sarkar highlights that the overall prevalence of "Bacterial Vaginosis" is significant for young women attending GP clinics and GUM clinics. This condition even affects asymptomatic women. Therefore, understanding of this subject is essential. The article on "Anaemia" by Dr. Al-Qurashi gives a systematic approach to the subject. We hope to have a series of articles on this subject.

We all wish our heartiest congratulations to Dr. Prasad Rao, our Past President. He was recognised in the Queen's New Year's Honours with a British Empire Medal for services to healthcare. We are proud of his achievement.

This edition is full of announcements of the upcoming events. Please be prepared. On behalf of the Editorial Committee, we wish you all a prosperous New Year. Be happy and bring happiness to the lives of others. This is what Dr. Madan Gupta taught us.

"Thousands of candles can be lit from a single candle, and the life of the candle will not be shortened. Happiness never decreases by being shared."
Buddha

Ashish Dhawan & Amit Sinha
Joint-Editors, BIDA Journal

Welcome to new BIDA members

Name	Membership No.	Division
Dr J Singh	10531	Manchester
Dr N Bandla	10532	Stoke-on-Trent & Staffs
Dr S Khandelwal	10534	Rochdale & Bury
Dr A Jain	10535	Rochdale & Bury
Dr G Ali Anjum	10536	Rochdale & Bury
Prof M Makin	10537	Rochdale & Bury
Dr S Patel	10533	Rochdale & Bury
Dr S Patel	10539	Rochdale & Bury
Dr S Dontula	10540	Wigan
Dr A Zakaria	10541	Nottingham & North Trent
Dr S Ghoshal	10542	Rochdale & Bury
Dr A Kurup	10543	Stoke-on-Trent & Staffs
Dr M Dhall	10544	Stoke-on-Trent & Staffs
Mr A Sukumoran	10545	Bolton
Dr A Desai	10546	Wolverhampton
Dr S Narasimhamurthy	10547	Stoke-on-Trent & Staffs
Dr S Gubbi	10548	Stoke-on-Trent & Staffs
Dr A Gupta	10549	Rochdale & Bury
Dr P Reddy	10450	Wigan
Dr A K Puttappa	10551	Stoke-on-Trent & Staffs
Dr C George	10552	Stoke-on-Trent & Staffs
Dr Mrs S Gadiyar	10553	Rochdale & Bury
Dr G Bhaskar	10554	Rochdale & Bury
Mr Asheem Naraen	10555	Merseyside & Cheshire
Dr Sangeeta Naraen	10556	Merseyside & Cheshire

BIDA National Chairman's Report

Dr Chandra Kanneganti
National Chairman, BIDA

Dear Colleagues,

I wish all BIDA members a very Happy New Year and may 2018 bring happiness to all of you and to your friends and families.

We now have a new Executive Committee from the AGM in October 2017. The new Executive Committee has already started to work hard in the best interests of our members and the organisation.

We had a very successful ARM in October 2017, hosted by Rochdale and Bury Division, that took place on the 13th, 14th & 15th October at the Last Drop Village Hotel at Bolton. I would like to thank Rochdale and Bury Division for hosting the BIDA ARM event and for the excellent leadership from Dr Vinod Gadiyar, supported by Dr Umesh Prabhu, Dr Ravi Sharma and other divisional officers.

I want to thank Dr Chand Nagpaul, Chairman of the Council of the British Medical Association, who was our chief guest for the event. He spoke on an important topic *"The role of BME Doctors in NHS; How the BMA can help"*. He was our guest of honour for the conference dinner on Saturday night, and impressed our audience with both his eloquent speech and his commitment to support International Doctors.

BIDA's International Congress in Brazil and Argentina went very well in October 2017 and I am thankful to the convenors Dr Ash Dhawan and Dr Sabyasachi Sarkar.

We are looking forward to our next BIDA ARM in 2018 in Cheshire. We are in the process of finalising our International Conference in Jakarta/Bali. We will let members know once we have further details.

BIDA continues to work with all key stakeholders in the NHS, including the GMC, CQC, NHSE , and RCGP. The new BIDA Executive Committee has agreed on a number of initiatives including supporting international GP's coming to the UK as part of GPFV and to assist local acute trusts in recruiting international doctors.

We will let you have an update of all the initiatives on which we are working on your behalf through the newsletters and BIDA Journal.

Dr Chandra Kanneganti
National Chairman, BIDA

BIDA National President's Report

Dr Birendra Sinha
National President, BIDA

Dear Colleagues,

Firstly, I would like to start by wishing you all a happy, healthy and prosperous 2018.

I have been involved with BIDA for a long time and have been National Treasurer for 6 years. I am delighted, thrilled and honoured to be elected the National President of BIDA.

I would like to thank BIDA members for electing me as the National President and look forward to your continued support and I will be working hard for our wonderful organisation.

2017 was another great year for BIDA. We had our national elections and many successful divisional meetings. The BIDA Annual ARM/AGM meeting, which was held at Bolton, was a great weekend attended by many members and was very successfully organised by Rochdale & Bury Division. We discussed several positive resolutions that will take us forward into 2018. I would like to take this opportunity to thank Dr Vinod Gadiyar and his dedicated team for the excellent job they did.

We also had the 12th BIDA International Congress at Rio de Janeiro, Brazil, which was another huge successful event, attended by many members, and which proved highly popular once again. I would like to take this opportunity to thank our Convenor, immediate Past President Dr Sabyasachi Sarker and Co-Convenor Dr Ashish Dhawan, General Secretary, and Dr Sanjay Arya, Chairman of the Scientific Committee, for all their hard work and commitment.

I sincerely thank the immediate Past President Dr Sabyasachi Sarker for doing an outstanding job initially as the National Chairman and then as the National President. Dr Sarker has promised to continue to offer his support and experience to the new EC. I know it will be difficult to step into his shoes, but I will do my very best and look forward to the continued support from the new EC Members and equally from the grass root members who are all so essential to BIDA's success.

The strength of any organisation is in the membership and for BIDA the divisions are our lifeline. I would like to both increase our membership and strengthen our divisions as much as I can.

I would like to thank our Central Office staff Alison and Mandy for their hard work in keeping the office running smoothly. We are still recovering from the loss of Pauline, but have every confidence in the new Central Office team.

Once again, I am very humbled to be elected as the National President by our members and will do my utmost to meet your expectations.

Best wishes,

Dr Birendra Sinha
National President, BIDA

BIDA National Secretary's Report

Dr Ashish Dhawan
National General Secretary, BIDA

Dear members,

As the country enters into the New Year, the NHS once again has made headlines and the same old issues of staffing, funding and long queues were in the limelight. What was different this time compared to previous years was that it has been much worse, and the demand for NHS services has been unprecedented. It seems that this situation has finally managed to generate a national debate with regards to the future direction of the NHS. Politicians and NHS leaders need to act promptly and decisively to secure the future of the NHS.

Since our last edition in September 2017, BIDA has been buzzing with activities on all fronts. We had a very successful ARM/AGM hosted by Rochdale and Bury Division. This year's ARM/AGM saw BIDA thanking and saying goodbye to the old Executive Committee and welcoming the newly elected Executive Committee. In October last year we organised a very successful 12th Annual International Congress at Rio de Janeiro, South America. This edition of BIDA has given a well-deserved plenty of coverage to these two events.

We at BIDA Editorial Board continue to put all our efforts and energy into ensuring that BIDA Journal lives up to the previous standards set, and further excels, both in terms of the quality of its articles and also continuing to highlight issues that are at the heart of NHS in general, and IMG's in particular.

Wishing all our readers a very happy and prosperous New Year ahead.

Best wishes

Dr Ashish Dhawan
National General Secretary, BIDA

BIDA A.R.M. Chairman's Report

Dr Jay Nankani
A.R.M. Chairman, BIDA

Dear friends,

It gives me great pleasure in providing you with an update on last years ARM/AGM which took place at the Last Drop Village Hotel, Bromley Cross, Bolton in October 2017.

To start with, I must say it was one of the most successful ARMs of BIDA, not because I chaired it but due to the perfect organisation of the event, the atmosphere, the ambience and above all the gesture of friendship and fellowship that all the officers and delegates showed throughout the entire weekend.

I cannot thank enough the host division Rochdale & Bury for selecting such a beautiful venue and establishing all the arrangements for the smooth running of our ARM/AGM, which was overseen and fine tuned by Alison and Mandy from Central Office. A special thanks and appreciation must be expressed to Dr Vinod Gadiyar and his team who have been an instrumental and essential conduit in the success of the ARM.

All the delegates were brilliant and their participation and the point of view during the discussion of the motions was exemplary, least to mention about the discipline and courtesy to all fellow delegates, office bearers and central office staff. The discussion and debates over the motions were healthy, precise and productive. I would like to commend all the delegates for making the ARM such an interesting and successful event.

The Saturday evening gala dinner was excellent and was thoroughly enjoyed by all the delegates and guests. The entertainment, both on Friday and Saturday evening was second to none and was enjoyed by all. Speeches by guests were inspiring, informative and encouraging to the organisation of BIDA.

Last but not the least, I would like to mention about the excellent workshops that took place on Saturday afternoon and Sunday morning. My sincere thanks go to Drs Chand Nagpaul, Kiran Patel, Kailash Chand, Nikhil Kaushik, Henrietta Hughes, Umesh Prabhu and Professor Mathew Makin for their excellent presentations and participation.

Dr TK Rastogi, the ARM Vice Chairman has proved to be an excellent support and so have been Drs Chandra Kanneganti, Bachi Sarker, Biru Sinha and Pranab Sarkar and of course all the members of the Agenda Committee.

The next ARM/AGM is going to be hosted by Merseyside & Cheshire Division at the Daresbury Park Hotel, Warrington over the 12th, 13th & 14th October 2018 and we are all looking forward to their excellent hospitality and another successful A.R.M.

Happy New Year to you all.

Kind regards and best wishes

Dr Jay Nankani
A.R.M. Chairman, BIDA

PRESS RELEASE

Dr. Bawa-Garba's Verdict: BIDA's Response

30th January 2018

BIDA (The British International Doctors Association) is deeply concerned about the scapegoating of Dr.Hadiza Bawa-Garba for systemic failure and unsafe workforce in the NHS. We do not believe that striking the doctor from practising will prevent similar unfortunate incidents. We need to support a learning culture in the NHS, not blame. With their ruling, the GMC have contradicted their own statement *"We know that any doctor, no matter how experienced, can make a mistake, particularly when working under pressure. What's important is how you respond".*

In light of recent events, it appears the powers that be are determined to victimise individuals rather than highlight the wider systematic failures.

This is a watershed moment for the medical profession which is going have a lasting effect, like Shipman, in a very negative way of over-regulation and mistrust in the profession. The need of the hour in these difficult times is true learning and not a blame culture, which compromises patient safety. In a preoccupation to avoid error and harm in healthcare we have gone a bit too far and cultivated a culture of fear and blame, instead of a safe space where any health professional could learn from their mistakes, which is having detrimental effect on patient safety. We also believe that studying excellence in healthcare can create new opportunities for learning and improving both resilience and staff morale, and we should concentrate on this aspect of learning. Crucially what's needed is a New Medical act which looks at reforming the regulation of all health professionals and making it more compassionate and fair, enabling a learning culture and thus improving patient safety.

'Change is inevitable, Progress is optional.'

No doctor will now try to go above and beyond the call of duty for patients in a system both underfunded and unsafe, and no doctor will dare to discuss anything of concern with their appraiser.

Today saw the release of this document from The Medical Defence Union (MDU) which states that Doctors convicted of gross negligence manslaughter could face more severe sentences, under plans being considered by the body that sets sentencing guidelines.

A consultation by the Sentencing Council is examining whether to increase sentences for those convicted of manslaughter. The MDU is highlighting its concerns about the consultation as it says doctors are particularly vulnerable to facing a manslaughter investigation.

The high-profile case of Dr Bawa-Garba, convicted of gross negligence manslaughter and struck off the medical register, illustrates this.

Writing in the latest edition of the MDU journal, Dr Michael Devlin, head of professional standards and liaison, said:

"The death of a patient, particularly when unexpected, is a distressing experience for the deceased's relatives and the doctor caring for the patient. Doctors accused of causing a patient's death through gross negligence can be investigated for manslaughter and this casts a long shadow over their professional lives.

'Doctors are given no special exemption in terms of sentencing and may be imprisoned if convicted, usually for a minimum of two years. Worryingly, the proposed new guidelines could lead to longer sentences for doctors."

In its response to the consultation, MDU senior solicitor Ian Barker expressed serious concerns about the impact of more severe sentences for manslaughter. He explained:

"Increasing the severity of a sentence for gross negligence manslaughter will be no greater deterrent in terms of reinforcing doctors' duties to their patients. It may, however, increase any fear or doubt they have when making difficult decisions about patients when they are in a very difficult position yet are trying to act in a patient's best interests.

It seems to us a retrograde step to contemplate increasing the burden on doctors at such times and puts at risk the necessary open environment which enables learning from error and increased patient safety."

BIDA is also deeply concerned that the GMC has suggested that they have pursued the case of Dr.Bawa-Garba to erase her name from the GMC register to install confidence of the public in the medical profession. The GMC should then look at thousands of our elderly patients dying and suffering in the corridors of a number of emergency departments due to underfunding and understaffing of the NHS. The public are already losing confidence in the NHS, and if the GMC really wants to install confidence, then they should have started to look at the multiple systemic failures that are happening in every acute hospital every day, due to underfunding and understaffing of the NHS. Their guidance to walk away from an understaffed work place is against the ethics of the medical profession.

BIDA is concerned about the continuation of the abnormally high representation of BME doctors in GMC referrals which points to an inherent bias and institutional racism . We wonder, if Dr.Bawa-Garba was not from BME , whether the outcome would have been different?

BIDA will fully support Dr.Bawa-Garba when the new legal challenge starts with all our resources. We have continually been on Twitter and raised awareness of the matter amongst colleagues and the wider health community, and provided support to the crowdfunding campaign by spreading the word through all our communication channels. We will meet with the GMC and raise strong objections, and to seek clarification about their role in Dr Bawa-Garba case which has undermined the confidence of the profession in the GMC. It's imperative that the GMC is both held accountable for its actions and that it answers the questions raised by the profession.

Chandra Kanneganti (Dr)
BIDA National Chairman

Anaemia

A Review and an Approach to the Diagnosis

Dr F. Al-Qurashi
Specialty Doctor, Department of Haematology
Wrightington, Wigan & Leigh NHS Foundation Trust

Abstract:

Anaemia is a global health problem affecting both developed and developing countries. It is a common problem frequently encountered in family medicine and investigated by general practitioners.

The aim of this article is to review the pathogenesis of anemia and understand the different factors that play crucial role in erythropoiesis. By the end of this article you should be able to classify anemia according to size (MCV) or proliferation (reticulocyte count) and apply this knowledge in your daily practice. You would know how to manage patients with anemia and decide when to refer them to secondary care

Introduction:

Anaemia, as defined by WHO, is a haemoglobin level of less than 130 g/l in men, less than 120 g/l in non-pregnant women and children older than 5 years old and <110 g/l in pregnant women and younger children. It makes up to at least one third of GP referrals to the haematology service in England.

It is a significant health indicator and associated with poor health outcomes. In patients with chronic renal failure, congestive heart failure and cancer, it is associated with increased mortality and is a marker of poor prognosis [1,2].

Anemia accounted for 65.5 million worldwide Years of Life Lived with Disability (YLD) in 1990 and 68.4million YLD in 2010. Between 1990 and 2010, anemia prevalence decreased from 40.2% to 32.9%, with South Asia accounting for the highest prevalence and iron deficiency anaemia ranking the top 7 causes of anaemia globally [3].

In 2011, the WHO data reported that 22.9% of the population of the European region (12.7 million) are anemic and that 0.3% of them had severe anaemia [4]. Anaemia is a condition rather than a disease. An underlying cause must always be determined. Most anaemia are asymptomatic and detected on routine lab tests.

Pathophysiology of Erythropoiesis:

Haemoglobin (Hb), carried within the Red Blood Cells (RBCs) is the transporter of oxygen (O2) from the lungs to the tissues and carbon dioxide (CO2) from the tissues back to the lung.

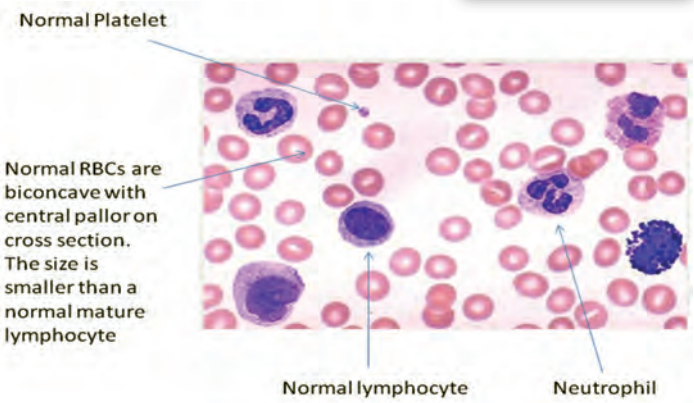
Erythropoiesis is the process which produces red cells (erythrocytes). It is a complex multistep process starting at the level of erythrocyte precursor cells in the bone marrow until it reaches the reticulocytes and finally the mature anucleated erythrocytes in the peripheral blood. This process on the average takes about 7 days from precursor differentiation until the maturation stage. However, in acute severe anemia it may be as short as one or 2 days.[5]

This process is stimulated by the hormone Erythropoietin (EPO) which is secreted by the kidney in response to cellular hypoxia and it stimulates the proliferation and differentiation of red cell precursors. Many other growth factors and cytokines play important role in erythropoiesis. Other general essential factors include thyroxine which accelerates the process, vitamins, cobalt, nickel and zinc.

Maturation factors include vitamin B12, intrinsic factor (IF) and folic acid. Finally there are factors necessary for haemoglobin synthesis (Hb) like iron, copper, vitamin C, healthy bone marrow environment and normal Hb gene type.

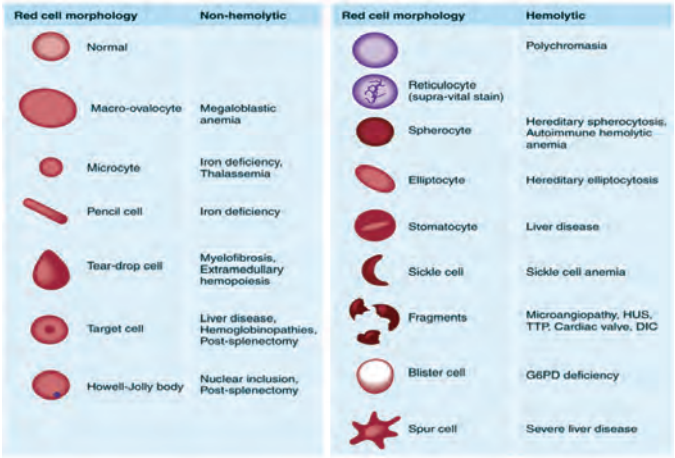
Sites of Erythropoiesis:

During early intrauterine life, production of RBCs takes place in the yolk sac. By the 3rd to the 4th month, it moves to the liver & spleen and after the 7th month, the bone marrow takes over.



The life span of a mature normal red blood cell is 120 days, after that they are removed from circulation by the mononuclear phagocyte system i.e. the liver, spleen & lymph nodes. In chronic diseases the life span is reduced significantly.

Different RPC morphology



Pathogenesis of anaemia:

The basic mechanisms of anaemia can be summarised as:

1. Impaired ability of bone marrow to produce sufficient number of red cells
2. Accelerated destruction (haemolysis) or loss of blood
3. Or a combination of both.[6]

Classification of anaemia:

Anemia can be classified either by the morphology and size (MCV & MCH) or by the underlying cause.

Another classification is according to reticulocyte production; either hypoproliferative (low reticulocytes, also known as reticulocytopenia) or hyperproliferative (high reticulocytes, also referred to as reticulocytosis).[7]

- **Hypoproliferative Anemia:** Where the bone marrow response i.e. the production of reticulocytes is absolutely low or low for the degree of anaemia.8 It is the most common form of anemia encountered in the primary care setting. It occurs when one or more factors are deficient or inappropriately available for utilisation at the DNA and cellular levels. Hypoproliferative anemia could be microcytic, macrocytic or normocytic.

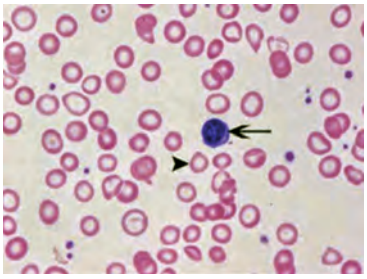
- **Hyperproliferative or Regenerative Anaemia:** occurs as a result of acute blood loss or increased RBC destruction with resultant shortened red cell survival. It could be either congenital or acquired.[7]

It is possible to have both hyper and hypoproliferative anaemia simultaneously.

A. Approach to Hypoproliferative Anaemia:

MCV, which is the Mean Corpuscular (Cell) volume, measures the average size of mature RBCs in peripheral blood. Reticulocytes and immature (nucleated) RBCs are larger and hence have a higher MCV value. A simple approach is to use the MCV as a diagnostic guidance.

Microcytic (hypochromic) anaemia: This is defined as the presence of small red cells with low MCV. The most common cause is iron deficiency. Other causes are anemia of chronic disease, thalassemia, sideroblastic anemia or rarely lead poisoning.

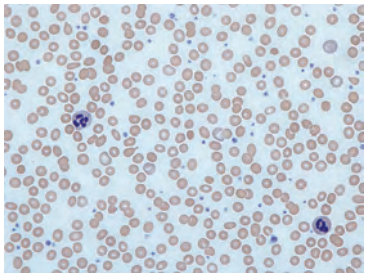


Hypochromic (less colour = low Hb), Microcytic (small size) red blood cells are characteristic of iron deficiencyanaemia, thalassemia and sometimes anaemia of chronic disease. The cells here look very pale and smaller in size.

1. Iron Deficiency Anaemia (IDA): iron deficiency anemia and iron deficiency are global health problems and common medical conditions seen in everyday clinic practice.[9] It continues to be the top ranking cause of anemia worldwide, having a substantial effect on lives of young children and premenopausal women both in the developing and developed countries. IDA results from reduction of the body's iron content due to blood loss, inadequate dietary intake, malabsorption or increased demands.

Most of the iron needed daily for biologic functions (about 25mg) is provided through recycling by macrophages. In normal circumstances only 1-2 mg of dietary iron is absorbed. Maintaining total body iron within normal ranges, both by the limited absorption and recycling is controlled by Hepcidin, a peptide hormone produced mostly by the liver.

Iron deficiency can occur without overt anemia. Several mechanisms influence the actual amount of iron available for utilisation. Iron restricted erythropoiesis indicates that the delivery of iron to the erythroid precursors is impaired. Stores may be normal or even increased because of iron sequestration in cases of chronic inflammation.



Blood picture of Iron deficiency anaemia
(Courtesy: Dr Graham Beards - Own work, CC BY-SA 3.0)

2. Functional Iron Deficiency: is a state of iron poor erythropoiesis in which there is insufficient mobilization of iron from the stores in presence of increased demands.

3. Anaemia of Chronic Inflammation/Anaemia of Chronic Disease (ACD): Besides IDA, ACD is the 2nd most common cause of anemia worldwide. The cytokines and acute phase proteins play important roles in the pathogenesis of anemia of chronic disease. Alteration of iron metabolism via hepcidin and ferritin are largely responsible for the consequent anemia.[10]. Several mechanisms independently contribute to anemia of chronic disease and are likely to down regulate the haemoglobin concentration. These include iron sequestration, inhibition of erythroid progenitors, suppression of erythropoietin production and decreased RBC survival. [2]

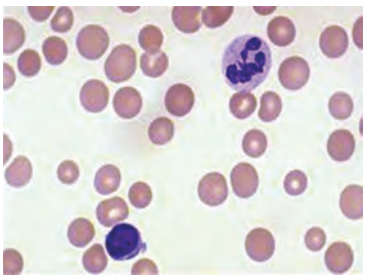
Anemia of chronic disease and iron deficiency anemia usually occu concomitantly. They are both based on disturbances of iron homeostasis. Immune activation drives a diversion of iron fluxes from the erythropoietic site (bone marrow) to the storage sites (mononuclear phagocyte system in the liver & spleen). This results in iron- limited erythropoiesis and anemia.

Macrocytic Anaemia:

Macrocytosis is a relatively common finding in the era of automated blood cell counters with prevalence estimate ranging from 1.7 – 3.6%. Its significance tends to be underestimated since about 60% of patients present without associated anemia unless accompanied by other abnormalities.[14]

Macrocytosis without anemia in the absence of obvious pathology can be seen in newborns, infants and during pregnancy. It could be a normal variant or may suggest genetic predisposition if found in other family members15,16 Macrocytosis with anaemia can be divided into non-megaloblastic and megaloblastic anaemia.

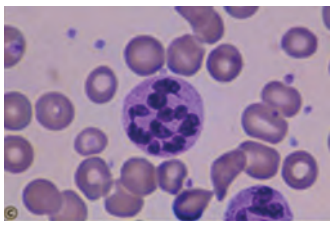
In macrocytic anaemia the cells are larger (High MCV)



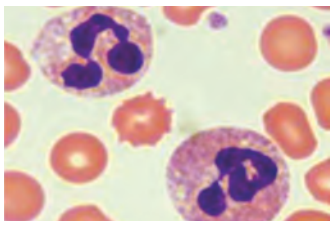
1. Non-megaloblastic anaemia: common causes include alcohol abuse, liver disease, severe hypothyroidism, myelodysplastic syndrome (MDS), chemotherapeutics and reticulocytosis.

2. Megaloblastic anaemia: results from impaired DNA synthesis which is commonly caused by folate or cobalamin (B12) deficiency. Causes include poor dietary intake, malnutrition, chemotherapeutic agents that either impair absorption of B12 and folate or block the enzymes involved in DNA synthesis, autoantibodies against intrinsic factor, gastric diseases or surgical disruption to the stomach, chronic H2 blocker intake, HIV or H.pylori infections.

Hyper segmented neutrophil



Normal neutrophils



Hypersegmented neutrophils have 6 or more nuclear lobes. They are typically seen in megaloblastic anaemia due to vitamin B12 or folic acid deficiency, but may also be present in myelodysplastic syndromes.

Normocytic anaemia:

Includes a broad spectrum of anaemia which could be either hypo or hyper proliferative. There is considerable overlap between aetiologies. Common causes are acute blood loss, renal failure, hypothyroidism, and early stage iron deficiency, anemia of chronic disease, mixed anemias, transfused patients and bone marrow disease/failure.

B. Approach to Hyperproliferative /Regenerative Anaemia:

Acquired causes include acute blood loss or hemolysis. Haemolytic anemias could be immune, non-immune or congenital. Examples of non-immune causes are drugs, infections and microangiopathic haemolytic anemia.

Congenital Haemolytic anaemia is due to defects in one of the following: RBC membrane, RBC metabolism (enzyme defect) and Haemoglobin synthesis. Examples of membrane defects are hereditary spherocytosis, elliptocytosis and stomatocytosis.

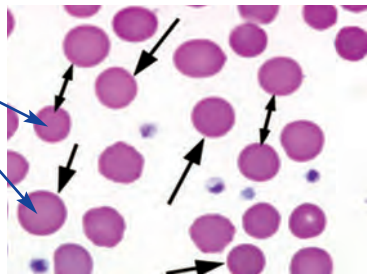
1. Membrane defects:

Hereditary Spherocytosis: the most common membrane defect with incidence of 200–300 per million populations. It is the commonest cause of inherited chronic haemolysis in Northern Europe and North America with a quoted incidence of 1 in 5000 births. [17]

There is usually a family history with inheritance either autosomal dominant or autosomal recessive. The defect caused by mutations in genes relating to membrane proteins Ankyrin and Spectrin. These proteins allow for the erythrocytes to change shape. The abnormal erythrocytes are sphere-shaped rather than the normal biconcave disk shaped. Dysfunctional membrane proteins interfere with the cell's ability to be flexible to travel from the arteries to the smaller capillaries and make the cells highly fragile and prone to rupture. Most affected individuals have mild or only moderate haemolysis

Anaemia

A review and an approach to the diagnosis (continued)



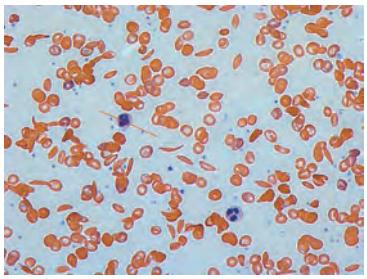
2. Metabolic defects:

G6PD deficiency is the most common red cell enzyme disorder. It is X linked recessive affecting about 400 million people worldwide. It is particularly common in certain parts of Africa, Asia, the Mediterranean and the Middle East. Male are affected more often than female. In 2015 it is believed to have resulted in 33,000 deaths.

The enzyme Glucose 6 Phosphate Dehydrogenase is involved in the pentose phosphate shunt which allows cells to deal with oxidative stresses. Red blood cells that are deficient in G6PD are prone to sudden destruction after exposure to certain drugs, high redox potential, infections, fava beans and metabolic abnormalities.

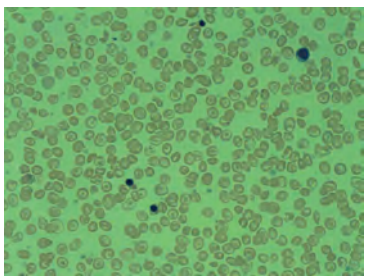
3. Defects in haemoglobin synthesis (hemoglobinopathies):

Sickle Cell Disease/sickle cell Anaemia: is a group of inherited disorders resulting from a single base pair gene mutation at the 6th position of the β globin chain when valine is substituted for glutamic acid. This results in polymerisation of haemoglobin and tendency for red cells to sickle when exposed to hypoxic or acidic stresses.



Blood film showing Sickle cells
(Courtesy: Dr Graham Beards - https://commons.wikimedia.org/w/index.php?curid=18421017)

Thalassemia syndromes: are a heterogeneous group of disorders characterized by abnormal haemoglobin production. The defect can be either in the α or β chains. The inheritance is autosomal recessive with both male and female equally affected. The severity of alpha and beta thalassemia depends on how many of the four genes for alpha globin or two genes for beta globin are missing. As of 2013, thalassemia occurs in about 280 million people, with about 439,000 having severe disease. It is most common among people of Italian, Greek, Middle Eastern, South Asian, and African descent. The defective haemoglobin production results in ineffective erythropoiesis with red cells being destroyed at the site of production, chronic hemolysis, iron overload with significant morbidity and mortality. Thalassemic patients have low hepcidin level and microcytic hypochromic anemia.



Peripheral film of a patient with Thalassemia
(Courtesy: By Prof Osaro Erhabor)

Approach to the diagnosis and management of anemia:

National Institute for Health and Care Excellence (NICE) published several guidelines regarding managing anaemia in certain conditions like anemia in renal failure, megaloblastic anemia, iron deficiency anemia, use of erythropoietin agonists in renal failure and rituximab in haemolytic anemia (see NICE Guidance: Anaemia for details). There are also several pathways which provide a framework for the current best practice in investigation and treatment of anaemia in primary care that had been published by local health Trusts in England.[18, 19]

These pathways are designed to ensure that General Practitioners (GPs) have the appropriate diagnostic and treatment guidance and be clear when to refer patients to secondary care and they are very useful indeed.

Once the pathogenesis of anemia is clear, it would be easy to identify the underlying aetiology and tailor treatment accordingly.

Clinical Evaluation:

Symptoms and signs of anemia:

Many factors influence the clinical presentation of anemia including the acuteness in the drop in hemoglobin, presence of other comorbidities, pregnancy and the age of the patient. Whilst most chronic compensated anemias may go on unnoticed, some subtle symptoms may be the only presenting feature. General symptoms of anaemia include fatigue, pallor, tiredness, reduced exercise tolerance and reduced concentration. Acute, severe or uncompensated anaemia may present as sudden deterioration in general performance or even heart failure.

Some clinical symptoms are specific to certain types of anemias. For instance, iron deficiency anemia patients may present with restless leg syndrome, angular stomatitis, koilonychias, nail fragility, hair fall and or pagophagia (compulsive consumption of ice or iced drinks).

Megaloblastic anemia secondary to B12 deficiency can result in severe neurologic symptoms including sub-acute combined degeneration (SACD) of the dorsal column, cerebellar atrophy, optic neuritis, axonal degeneration of peripheral nerves, dementia and heart failure.

Sickle Cell Disease (SCD) is a syndrome of heterogeneous clinical manifestation with different intensities and age of onset. Most patients with congenital anaemia will present either at birth or during early childhood. History of recurrent vaso-occlusive (painful) crises, previous or regular blood transfusion, positive family history and/or previous hospital admissions should point towards congenital anaemia.

Cancer associated anemia or anemia induced by chemotherapy usually affect more than one line of blood cells i.e. simultaneous reduction in white blood cells and platelets may occur. Proper history is essential. The clinical presentation will depend on the severity and number of cell lineage involvement.

While taking history, special attention should be made towards dietary habits, menstrual and drug history, past history of transfusion, family history, pregnancy, other surgical procedures and whether bleeding was a complication.

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An update on the management of Bacterial Vaginosis

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Introduction

Bacterial Vaginosis (BV) represents one of the most common causes of abnormal vaginal discharge in women of reproductive age. BV is probably twice as common as candidosis. In the UK, the true prevalence of the condition is not clearly known as many women with BV may remain asymptomatic. An overall prevalence of 28-30% has been reported for women aged between 14 and 49 years attending GP clinics and GUM clinics and presenting with vaginal discharge [1]. In asymptomatic women, the reported prevalence of BV is 7 % and 15% in GP clinic and in GM clinic attenders respectively. The condition is frequently associated with a high-risk of recurrence despite currently recommended treatment [2].

What is BV?

BV has been recognised as a polymicrobial clinical condition characterised by replacement of Lactobacilli normally present in vagina with high concentrations of anaerobic bacterial species such as Prevotella species, Mobiluncus species, Gardnerella vaginalis, Mycoplasma hominis and Ureaplasma. Due to the imbalance of the normal vaginal flora with an overgrowth of anaerobic bacteria and a lack of the normal lactobacilli in vagina, there is a state of altered vaginal ecology and absence of host inflammatory response in the vagina. Normal acidity of vaginal pH (normal vaginal pH is between 3.5 and 4.5) is lost with an alkaline shift in vaginal pH to 5 or more. Mucosal inflammation is not a feature of BV, hence the term 'vaginosis' rather than 'vaginitis'.

At present, the precise cause of depletion of vaginal microbial leading to BV is not known. However, Gardnerella vaginalis has been identified as the most potent organism exerting its central role in the pathogenesis of BV [3]. These authors have observed that Gardnerella and a few other BV-associated bacteria have the ability to form a biofilm that adheres to vaginal epithelial cells and induces cytotoxicity (3).

BV is not currently regarded as a sexually transmitted infection, although the prevalence of BV is significantly higher amongst sexually active than non-active women. However, some recent studies support the concept that BV is a STD (4). Whether BV results from acquisition of a single sexually transmitted infection is also not clear. Nevertheless, women with BV are at an increased risk of developing STD (HIV, Neisseria gonorrhoeae, Chlamydia trachomatis, HSV type-2).

Characteristics Features

The commonest presenting symptom is excessive vaginal discharge, sometimes with a characteristic 'fishy' smell in the vaginal discharge. The discharge is classically thin, white to grey in colour, homogeneous in nature coating the walls of the vagina and vestibule (Figure 1). The odour may be related to the presence of non-hydrogen peroxide-producing organisms in vagina as normal hydrogen peroxide producing Lactobacilli sp. inhibit the growth of certain bacterial species, including those present in BV. This malodour is typically worse after unprotected intercourse. Some women may complain of malodour without any discharge. BV is the most common cause of vaginal discharge or malodour in women seeking medical advice. However, the characteristic appearance of the discharge is not specific for BV, but supports the diagnosis. Vast majority of women with BV may remain asymptomatic. BV is not usually associated with soreness, itching or irritation.

Contributing factors in the development of BV

The following factors have been recognised to increase the risk of developing BV;

- Sexual activity
- Multiple male or female sexual partners
- Recent change in partner
- Certain sexual practices – Receptive oral sex
- Vaginal douching, bubble baths
- Copper IUCD - women using copper IUCD are at 2-3 times higher risk (50%) of having had at least one episode of BV infection compared to women using oral contraceptives. (20%).
- Increase in vaginal pH due to menstruation or presence of seminal fluid
- Smoking

Combined oral contraceptive pills, barrier methods of contraception and circumcised partner have been known to reduce the risks.

Complications associated with BV

Bacterial vaginosis (BV) has been implicated with a variety of serious obstetrical and gynaecological complications.

A two to seven fold increase in the risk of adverse pregnancy outcomes in association with BV has been reported. An increased risk of late miscarriage, premature rupture of membranes, premature labour, pre-term birth and low birth weight, postpartum endometritis and puerperal sepsis has been reported [5].

BV has been associated with an increased risk of pelvic inflammatory disease (PID) following termination of pregnancy and post IUD insertion, vaginal cuff infection following hysterectomy, pelvic infection and pelvic abscess. Studies have also shown that BV is associated with an approximately 2-fold increased risk of developing STI including Neisseria gonorrhoeae, Chlamydia trachomatis, HSV-type 2 and HIV. An increased risk of co-infected women transmitting HIV to their male partners has also been noted [6].

Because of the increased frequency of recurrence, with greater than 50% of women suffering recurrence within 12 months of treatment, BV significantly impacts on the quality of life (QoL) [2]. BV also has major psychological sequelae in terms of negatively impacting self-esteem, sexual relationships and quality of life of the women [7].

Diagnosis

The history of malodour is highly suggestive of BV, however is not diagnostic.

BV can be diagnosed by the use of clinical criteria (Amsel's Diagnostic Criteria) which requires 3 of the following 4 features or the Gram stain:

1. homogeneous thin grey-white malodorous discharge that smoothly coats the vaginal walls (Figure 1);
2. pH of vaginal fluid >4.5 (Normal value 3.5 – 4.5)
3. Positive KOH test for amines (Whiff Test): the test involves the addition of a few drops of 10% potassium hydroxide solution to a sample of vaginal discharge, either on a slide or swab. The release of

An update on the management of

Bacterial Vaginosis

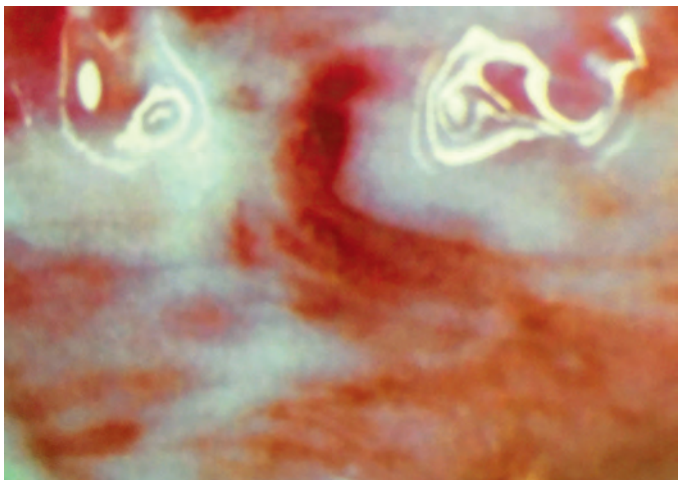


Figure 1. Showing characteristic discharge inside vagina

a short lasting fishy odour represents a positive result and is due to the volatilisation of polyamines, in particular trimethylamine which is thought to be produced by the anaerobic bacteria. The test, which is easy and quick to perform in the clinic, has a sensitivity of 80-90 percent and a specificity of over 90 percent and should form part of the initial assessment of all women with vaginal discharge.

4. Clue cells positive (>20% of the epithelial cells studded with adherent coccobacilli) on microscopy of the wet mount. The diagnosis of BV can be made on a Gram stain appearance of vaginal discharge, when the presence of typical 'clue cells' (exfoliated vaginal epithelial cells are surrounded by anaerobes) and the absence of lactobacilli will be observed. A scoring system providing a 0-10 point scale for evaluating the vaginal flora has been in research works[8].

Culture of G. Vaginalis is not recommended as a diagnostic tool because it is not specific as the presence of Gardnerella vaginalis or anaerobes does not necessarily indicate the presence of BV.

Management

Symptomatic women with BV and also the asymptomatic women with BV who are at greater risk of developing various complications should be considered for treatment.

Pharmaceutical therapy has an important role to play in the treatment of women BV in terms of relief of symptoms and signs of infection. The other potential benefits to treatment include reduction in the risk for acquiring C. trachomatis, N. gonorrhoea, Trichomonas vaginalis and Herpes Simplex Type 2.

Principles of pharmaceutical therapy;

1. Relieving the symptoms and signs of infection
2. Reducing the risk of recurrence
3. Reducing the risks of pregnancy complications
4. Reducing the risk of acquiring STI and other gynaecological complications
5. Improving the quality of life

Currently, oral metronidazole or vaginal clindamycin is recommended as the 'first-line' treatment for BV (15). Although very effective in the management of BV, both drugs have been associated with several disadvantages. A 1-month cure rates of 60-90% for both preparations have been reported. Unfortunately, 15-30% of women have symptomatic recurrence 30-90 days following therapy, and 50-70% within 6-12 months [2]. Additionally, a significant number of 12-24% of women run the risk of developing post treatment candidosis. Increasing resistance against metronidazole and clindamycin has also been reported [9,10].

In recent years, dequalinium chloride (fluomizin), an antimicrobial agent with broad bactericidal and antifungal activity, has been identified as an effective treatment option for BV. The primary mechanism of action of dequalinium chloride (fluomizin), a surface-acting substance, is the disruption of bacterial cell permeability leading to loss of enzyme activity and cell death [11]. The published data on the efficacy and safety has revealed that fluomizin is as effective as one of currently recommended regimens (Clindamycin gel 2%) with a faster recovery of the normal vaginal flora [9,12]. Fluomizin has several distinct advantages over currently recommended therapies in that it's less vulnerable to resistance due to its broad multiple mode of action and has a reduced risk for post treatment vaginal infection. It's is well tolerated with no systemic safety concerns [12]. A recent analysis of data has demonstrated that dequalinium chloride (Fluomozin) is as effective as an antibiotic vaginal cream in the treatment of new and recurrent cases of BV [13]. Another review of currently available data also supports that fluomizin can provide an alternative treatment option for the relief of symptoms and may help to reduce broad-spectrum antibiotic use [14].

Potential role of lactobacilli (present in yogurt as lactobacillus acidophilus) as prophylactic agent against BV and for better long-term results in order to eliminate factors that predispose to recurrent infection has been tried without any convincing beneficial effect. The current BASHH guidelines do not recommend a non-antibiotic treatment for BV [15]. Further research needed to be done to determine the role of probiotics in BV treatment and prevention.

Follow up visits are not recommended if symptoms resolve. However, as persistent or recurrent BV is a common problem, women should be advised to return for evaluation if symptoms recur.

The use of condoms for a few months may be beneficial and has been recommended by some.

Some women with IUD are prone to develop BV, and an alternative form of contraception should be considered if recurrences are troublesome.

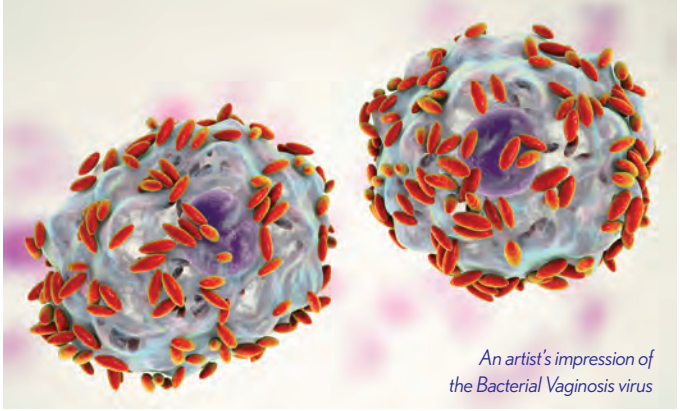
Some recommends that all women with BV should be tested for STDs and HIV as. BV appears to recur with higher frequency in women who have HIV infection. In the management of symptom producing BV, it is immensely important to recognise the need for opportunistic screening for STI in women who may be at a higher risk for STDs in the primary care particularly among sexually active young women. A sexual risk assessment should be considered to determine which women may be at higher risk for having a STDs (age under 21, no condom use, recent change of partner). From a medico-legal point of view, it may become increasing difficult to justify not screening young women with vaginal discharge which may subsequently prove to be due to BV or else. STDs screening should also be considered if symptoms do not improve with empirical treatment for non-sexually transmitted cause of vaginal discharge.

Routine screening and treatment of male partners of women with BV are not recommended as there is no research evidence to indicate that it might improve a woman's response to therapy or the risks of relapse or recurrence.

BV, in particular when recurrent, can cause immense physical and psycho-sexual problems which may require specific interventions. Patient should be clearly explained the nature of her problem and advise her to cooperate and participate in designing a treatment strategy sensitive to her needs and circumstance, as compliance can otherwise lead to frustrations.

Recurrent BV

Currently sufficient evidence based data are not available for optimal management options for women with persistent or recurrent BV. Certain BV associated organisms have been identified which are resistant to



An artist's impression of the Bacterial Vaginosis virus

antimicrobial and might be predictive of risk for subsequent treatment failure.

In women with recurrent BV, a different treatment regimen alternative to currently recommended treatment has been suggested. After the first occurrence, retreatment with the same recommended regimen would be an acceptable approach for persistent or recurrent BV. For women with multiple episodes of BV after completion of a recommended regimen, A short course (eg.3 days) of oral metronidazole or intravaginal clindamycin cream once or twice a month, for a 5-6 months as a prophylactic measure or as suppressive therapy has been shown to reduce the recurrence. New evidence suggests that, in frequently recurrent BV and in resistant cases, repeated use of fluomizin, should be preferable to a repeated course of antibiotics in order to avoid resistance[4].

Asymptomatic women with BV

In view of the potential risk of ascending pelvic infection following hysterectomy, IUD insertion and termination of pregnancy and the increased risk of pregnancy complications, a case could be made for treating asymptomatic pregnant women with BV in these special circumstances.

Pregnant women with BV

As during the pregnancy BV has been known to be associated with various adverse outcomes, in particular preterm birth (PTB), it would not be unreasonable to expect that identification and treatment of affected women would reduce the risk of PTB and its consequences. However, we have no convincing evidence that antibiotic regimen prevents preterm birth (early or late), risk of late miscarriage or adverse outcomes in the neonates in women with BV (symptomatic or asymptomatic).

The Cochrane evidence demonstrated that antibiotic treatment can eradicate BV in pregnancy. The overall risk of preterm birth (PTB) was not significantly reduced. This review provides little evidence that screening and treating all pregnant women with BV will prevent PTB and its consequences. When screening criteria was broadened to include women with abnormal flora there was a 47% reduction of PTB, however, this was based on limited evidence [16]. However, if symptomatic pregnant women with BV should be treated with either of the oral or vaginal regimens recommended for non-pregnant women. Trial has determined the efficacy of metronidazole, orally or vaginally, in the treatment of pregnant women with BV.

In pregnant women, as BV may often carry other organisms as Trichomonas, Candidosis and in such circumstances, dequalinium chloride (Fluomizin) could be a promising alternative therapy. Preliminary report suggests that fluomizin can be safely used during pregnancy and breast feeding women if clinically indicated for the treatment of BV [17]. Although it has been claimed that systemic exposure of breastfeeding women to fluomizin is negligible and no harmful effect on the breast-feeding new born and infant are anticipated, further research is needed to determine the safety of fluomizin in pregnant and lactating women.

Conclusions

The management of BV in particular the prevention of recurrences can be challenging. In the United Kingdom, current recommendation on the therapeutic options in the management of BV, although effective, has its limitations in terms of high recurrence rates and increasing drug resistance.

In recent years, dequalinium (Fluomizin) has emerged as a safe and effective treatment option for BV. Accumulated research data provides the rationale for the use of dequalinium chloride (fluomizin) and confirms that this can play an important role in alleviating symptoms of BV and preventing recurrences.

Therefore, if our ultimate goal is to reduce the burden of BV in women and to improve their quality of life, then the professionals should seriously consider the various treatment options that are currently available. For the first time in recent years, dequalinium chloride (fluomizin) provides the clinicians an unique opportunity to choose another effective therapeutic option alternative to the options currently recommended options for BV.

Key Points:

BV, a common clinical condition, is often underdiagnosed and mis-diagnosed and treated incorrectly or ineffectively.

BV should be considered first when a woman presents with vaginal discharge.

Women with BV are at increased risk of developing a variety of serious gynaecological and obstetric complications.

Recurrence of BV is common.

BV is not a STI - Screening and treatment of male sexual partner of women with BV currently is not recommended.

Dequalinium chloride (Fluomizin), a broad-spectrum, non-antibiotic and anti-infective agent with a very low failure rates, can be an effective alternative to metronidazole and clindamycin for BV treatment.

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Organ Donation – Myths and Facts

Dr Satya Sharma *MBE, DL*
Chair, Promoting Organ Donation

Repeated surveys have shown massive support (more than 90%) for organ donation (OD). The wave of enthusiasm is international. The main reason for organ donation is organ failure requiring replacement.

The organ donation is of two types:

1. **Live** – mainly from friends and family members, sometimes totally altruistic when someone gets motivated to save the life of another human being. It is restricted to some organs only. Everyone needs to go through various aspects with the help of professional support and counselling requiring time and careful consideration. It forms a small part of total OD.
2. The main type is **cadaver** or deceased OD. Although the OD is most frequently for kidneys but many other organs can be transplanted successfully.

Currently 6500 persons are waiting to receive organs and approximately 1600 (25%) are from BME communities due to prevalent illness pattern. 8% of UK population are Asians. This means the need for Asians is 3 times higher. Diabetes is more common and compliance of treatment is poor increasing the chances of kidney failure. The success of OD encourages doctors to put more people on the list. The combined effect is that the waiting list is getting longer. Asians need more organs but the donors are only 1% on the register. This means they need more and give less!! The chances of acceptability for organs are slightly increased if the donors are of the same ethnicity. This results in Asians generally waiting 12 months longer that their "white" friends.

Issues with Asians living in the UK

- 3 times more likely to need organ replacement
- 6500 on the waiting list of which there are 1600 Asians (waiting time for Asians - 1 year longer than the others)
- Asian-to-Asian transplant more likely to be successful.

What are the myths?

There are so many myths and concerns prevailing. Let us explore the myths and look at the facts:

1. Will my care be compromised and the ventilator switched off to get my organs for others if they find out that I am a donor?

This is a common myth and totally inaccurate. The treating doctors are under Hippocratic oath to do the best. The loyalty of doctors is for the patient under their care. If the patient is declared dead (declared brain stem death DBD or declared circulatory death DCD) only then the team of other doctors is alerted for organ removal. This team is independent of the treating doctors to comply with "duty of care".

2. I am too old, what is good in me?

Oldest solid organ donor was 82 and oldest recipient 103. There is no upper age. Children below 16 will need parental consent. If you have a car declared unfit for repair then the seats, doors, gearbox or mirrors may still be good for another vehicle.

Common Myths

- If I am on the register I won't be treated properly
- If they remove my organs my body would be disfigured
- I am too old to receive or donate organs
- I can't be a donor as I have diabetes

3. I have diabetes so I can't be a donor?

Not true. Diabetic patients may have many functioning organs, which may be suitable and useful for others. One must let doctors decide.

4. Will my body be disfigured by removing organs?

The treating doctors would remove organs as if they were operating upon a live patient with minimum discomfort and disfigurement. After removal of the eyes, prosthetic eyes are put in and people viewing the body are unable to tell.

5. My body needs to be buried in full?

Well what happens if a diseased gall bladder, liver or kidney is removed? One may say that part is faulty. Here of course, one has decided to donate by choice. If desired heart, kidney or the liver is to live longer than your age, the only way is let them survive in another person. One kidney donated by a 65-year-old after death is still keeping the recipient alive for 35 years. Isn't that wonderful?

6. Will it hurt?

Certainly, not. There is no pain experienced by a brain dead person.

There are many more myths but rather than burning or burying the organs after death would it not be best to let these be used for benefitting a fellow human being?

What can be donated?

- Organs: Heart, Lungs, Kidneys, Liver, Pancreas, Small and Large Bowel
- Tissues: Cornea, Skin, Heart Valves, Tendons, Ligaments, Bone
- Recently Uterus and Hands transplanted successfully

What do the religions say?

In 1999, a conference of top religious leaders of the world involving Christians, Muslims, Hindus, Sikhs, Buddhists and other religions debated the subject. All agreed that OD is acceptable since the fundamental principle is to help others. There is more on this subject available on NHSBT website **https://www.organdonation.nhs.uk/faq/religion/**

Family matters

You must talk to your family since they can overrule your wishes. 40% white families and 60% BME families do so and many have to live with the guilt of denying others an opportunity to live.

Consent

Consent

- Presumed consent (Opt out)
  Wales: from Dec 2014 (encouraging results)
- Voluntary registration (opt in)
  England, Scotland, N Ireland

In the United Kingdom the registration has been on a voluntary basis and 19 million (32%) are registered as organ donors. This is called "Opting in". After registration you will receive a donor card. If you do not, please ring 0300 123 23 23. Having the card is not absolutely essential.

However, in Wales the law has changed from the 1st of December 2015. Presumed consent was legalised. this means unless people have objected and opted out whilst alive,it will be presumed that they agree.Families will be asked to demonstrate,this is called "Soft opt out". This was accepted in Wales. "Hard opt out" means families are not asked and organs are retrieved after death as in Austria, France and other countries. Initial results have shown a reduction of waiting times in Wales but it may be 2-3 years for firmed up analysed results to influence thinking of rest of the UK. Currently the document is out for public consultation until 6th of March 2018. Organisations and individuals are encouraged to respond.

https://www.gov.uk/government/consultations/introducing-opt-out-consent-for-organ-and-tissue-donation-in-england/consultation-on-introducing-opt-out-consent-for-organ-and-tissue-donation-in-england

https://engage.dh.gov.uk/organdonation/13-2/

Conclusions

Organ donation is a noble act and it helps others after our death. It is a priceless and a selfless gift that will save lives.

If it's OK to receive then it's OK to donate.

Let us live and let live!!

BIDA Annual Representative's Meeting Report

Dr Jay Nankani
ARM Chairman, BIDA

Margaret Barron
BIDA Central Office

The 2017 Annual Representatives Meeting was held at The Last Drop Village Hotel, Bromley Cross, Bolton in October and was hosted by Rochdale and Bury Division.

Welcome by ARM Chairman *Dr J Nankani*

Dr Nankani welcomed delegates and expressed his gratitude to the Rochdale and Bury Division for the organisation. We had the honour of having **Dr Chaand Nagpaul**, *Chairman of the BMA Council*, **Mrs Henrietta Hughes**, *Chairperson of the National Guardian of the NHS*, **Dr Kailash Chand OBE**, *Honorary Vice-President - BMA*, **Prof Matt Makin**, *Medical Director, Pennine Acute Hospital NHS Trust*, **Mr Nikhil Kaushik**, *Consultant Ophthalmologist* and **Dr Kiran Patel**, *Chair and Clinical Lead of the CCG Bury*.

Overview of BIDA by National Chairman

BIDA National Chairman, **Dr Chandra Kanneganti** thanked Rochdale and Bury Division for an excellent Educational Meeting on Friday evening. He informed delegates that the last 12 months had not been easy for the organisation and our main aim remains the same, to build up and strengthen membership.

BIDA continue to be stakeholders in decision making with BMA and GMC and makes its views known. We challenge the GMC regularly on international doctors issues. **Dr Chand Nagpaul** has been appointed Chairman of BMA and as a BIDA member his appointment is an achievement for all of us and we should explore how we can work with BMA. One of BIDA's main contributions this year has been a booklet informing international doctors what to expect when they come to the UK. 2,000 doctors are forecasted to come to the UK over the next 2 years. We have put in a bid to NHS England for International GP recruitment and to support these doctors. For that purpose, we are launching a Mentoring and Support line lead by our GP Forum Chairwoman, **Dr. P Shukla**. Dr. Kanneganti asked for volunteers to put their names forward for this venture.

We have drafted a letter to go to the Acute Trusts regarding the MTI scheme offering our support to junior doctors. We are also offering junior doctors free membership of BIDA for a year.

BIDA meets with the Royal College of General Practitioners every 3 months. The College continues to support BIDA by giving us a seat on the Council.

BIDA held its national elections earlier this year and he welcomed the newer members of the next National Executive Committee who will hopefully bring fresh ideas to the association.

Last year was also a very difficult time for the Central Office and sadly our Office Manager, **Pauline Gahan**, passed away. We now have a new member of staff and **Alison Sherratt** has been promoted to Manager.

In response to Dr Kanneganti's question the following suggestions were made on how to improve membership: -

1. Adopting a personal approach to new doctors and inviting them along to divisional meetings

2. Finding the right person within a division who is prepared to take an active role

3. Perhaps holding separate social events for retired doctors 2 or times a year

4. Rewarding and acknowledging those members who are pro-active within the Association.

Dr Kanneganti said that over the last year BIDA has continued to be a strong Association and asked how we can improve. We are relying more than ever on social media and have set up

Above: The 2017 recipients of the prestigious Fellowship of BIDA, Dr Satya Sharma, Dr Sunil Sapre and Dr Chandra Kanneganti (left to right) are pictured following their felicitation.

a Facebook account. He urged members to add their names. We also have a Twitter account.

He thanked Rochdale Division for making this weekend successful. Rochdale Division has shown that divisions can be strong in a very short space of time by meeting and supporting each other.

Motions discussed

We discussed 14 motions, of which 9 were passed unanimously, 1 by a majority, 2 were referred to the NEC and 2 were lost.

The first motion to be debated called on BIDA to support the principles of BREXIT as a nation wishing to end its dependence on a migrant workforce. The general feeling was that the NHS has heavily dependent on a highly skilled migrant work force over the years and will continue to do so. It is wishful thinking to expect every country to have their own work force. Delegates agreed to refer this motion to the National Executive Committee.

A motion urging British Medical Schools to lay emphasis on traditional medical education was put forward by North Wales Division. Some delegates felt that students are not being taught basic skills and are relying more on on-line teaching. Other delegates disagreed and felt we should move forward and embrace changes. This motion lost.

A motion asking for BIDA to take the lead in educating the British public to lower its expectations of the NHS also lost. Scottish Division felt it was time for open public debate about the limited resources and what areas of health care NHS should fund. Some doctors felt uncomfortable with the wording of the motion i.e. "lowering expectations". **Dr Matt Makin** said doctors should take responsibility for over diagnosis and over treatment and have conversations with patients where there are benefits and consequences. Before asking patients to lower their expectations we should put our own house in order.

A similar motion calling on the Government to hold an honest public debate on the limited resources of the NHS was taken with the previous motion but was passed unanimously.

Delegates debated CQC visits asking for them to be simple and fit for purpose and less time consuming, which would be better utilised on patient care. Practitioners and staff find the process extremely stressful. CQC has spent £16 million on this, which would be better spent to benefit patients. BIDA has been invited to a CQC workshop, which supports the 40-point Annual Report. We will oppose this as a complete waste of resources. Delegates voted in favour of this motion.

Delegates discussed foreign medical graduates taking part in NHS Medical Training Initiative and believe they should have more clarification regarding the job contract, employment security and visa arrangements. Dr Sinha informed the meeting that 2000 doctors are expected to be recruited to the UK because of the NHS crisis but they will only be allowed to stay for 24 months and then have to go back. We believe in equality and justice not exploitation. We believe they should have good contracts and salaries and visas should be for at least 5 years to secure those doctors' futures. Stakeholders need to sit down with the Government and discuss these issues. Delegates voted unanimously in favour of more clarification regarding job contract, employment security and visa arrangements for foreign medical graduates.

Guest Lectures and Workshops

It was an honour to have **Dr Chaand Nagpaul**, Chairman of the Council of the British Medical Association as the Chief guest. His inspiring talk on the *"The role of BME doctors"* will go a long way to build bridges, particularly when he at the helm would steer the BMA for the utmost support for these doctors.

Dr Henrietta Hughes is the Chairperson of the National Guardian for the NHS. Her office is unique as it aims to provide leadership; training and advice for Freedom to Speak Up Guardians based in all NHS Trusts. It provides challenge, learning and support to the healthcare system as a whole by reviewing Trusts' speaking up culture and the handling of concerns where they have not followed good practice. Dr Hughes' role was a key recommendation from Sir Robert Francis'

BIDA Annual Representative's Meeting Report

Freedom to Speak Up Review in response to the Mid-Staffordshire scandal. There are "Guardians" now in every NHS Trust of the country. This is expected to promote an open culture in the NHS.

Dr Kailash Chand (left), Honorary Vice President of the BMA and **Mr Nikhil Kaushik** (below left), Consultant Ophthalmic Surgeon from Wrexham Maelor Hospital conveyed to the delegates the most interesting and forthright discussion about the concerns of the NHS; the "Good, the Ugly and the Bad" aspects of state of affairs of the NHS. Their entertaining talks delivered a series of measures as well to take the NHS forward in a positive direction.

Address by BIDA's National President

Dr Sarker expressed his delight at seeing so many members in attendance. He thanked Bury and Rochdale Division for hosting such an excellent ARM. As outgoing President, he has felt it a privilege to serve as President for the last 3 years and looks forward to handing over to the new President, **Dr B K Sinha**. He thanked **Dr J Nankani** and **Dr T K Rastogi**, ARM Chairman and Vice Chairman, for all their hard work. All delegates gave a standing ovation to Dr S Sarker who has been a rock to the Association over the last 9 years.

Special Achievement Award

Dr Sarker gave a very special award to **Dr Surendra Kumar** (right). Over the years Dr Kumar has made significant contributions to the establishment and functioning of BIDA.

Fellowship Awards

Dr Sarker presented Fellowship of the Association to the following members: -

Dr Sunil Sapre	*Merseyside and Cheshire Division*
Dr Chandra Kanneganti	*Stoke-on-Trent Division*
Dr Satya Sharma	*Wolverhampton Division*

Dr Sunil Sapre has been an active BIDA member of the local division for several years. Besides being a *"Forensic Medical Examiner"* to Merseyside Police, he has also held the post of *"Clinical Director and Governing Body GP Member"* of South Sefton CCG. Since 2002, he has raised funds for a number of charitable institutions by completing mountain expeditions throughout the world, including the Himalayan range, Mount Kilimanjaro in Africa and Mount Aconcagua in South America.

Dr Chandra Kanneganti, our current Chairman is passionate about his responsibilities towards BIDA and his general practice in providing a strategic leadership. He has held numerous lead posts including being the *Clinical Director of the CCG*, during which period he made several positive plans. He is a GP tutor and trainer and has worked with the RCGP in developing PG medical training. He is *Chair of the North Staffordshire GP Federation* and a lead in developing Multi Speciality modules of care. He is a real champion for the NHS services.

Dr Satya Sharma was awarded the MBE in 2011 for his services to healthcare at Wolverhampton. He received the Fellowship of the BMA in 2013 and Global India Excellence award in 2014. He is the Founder Chairman of *"Promote Organ Donation"* UK. He is credited with several charitable activities in Nepal as well as many national and international services.

Sports Awards

Dr R Hegde, BIDA Sports Co-ordinator, informed delegates that for the past 15 years 8 or 9 Divisions have participated in the President's Cricket Cup and he would like to see more Divisions taking part. He thanked **Dr S Sarker** for his support and advice over the last 3 years, the Chairman, **Dr Kanneganti**, the Sports Committee and Central Office. This year's final took place between Wigan and North-East Divisions and was won by Wigan for the second year running. Dr S Sarker presented the President's Cricket Cup to Wigan's captain **Dr R Badge**.

7 Divisions took part in the Badminton and Table Tennis tournaments. He thanked **Dr Sunil Sapre** for organising the events. Dr Sapre asked if it would be possible to have a Sports section in the Journal to promote forthcoming events. We could also promote this through social media.

Vote of Thanks

Dr V Gadiyar thanked everyone for all the support that both he and Rochdale Division have received in organising this year's ARM.

Congratulations!

Award for Dr Prasad Rao

It is with great pride that we wish to share this news with you. **Dr. Prasad Rao**, our previous BIDA National Chairman has been awarded the British Empire Medal in this New Year's honours list. Dr. Rao has been such an inspirational leader and a staunch patient advocate, whilst being selfless, modest and giving. He has been a major influence in health care delivery in Stoke-on-Trent; his motive and drive always being to improve the services to the patients.

Dr Rao has lived and worked in North Staffordshire for more than 30 years, working as a GP in Dresden. Dr Rao has personally taken on a number of challenging roles at local, regional and national levels such as setting-up the North Staffordshire Doctors Out of Hours Co-operative in 1994, which provided care to over 500,000 people.

He was instrumental in the successful creation of Stoke on Trent Clinical Commissioning Group as the former Chair. His strong vision and belief in high quality primary care services ensured he commanded respect from the GPs in North Staffordshire leading to improved care for patients.

At a national level he was Chairman of the British International Doctors Association (2005-2009) actively promoting the valuable contribution that overseas doctors have made in the NHS. During his 3 years as Chairman of BIDA he made tremendous contributions to BIDA for many years. He has also donated for the BIDA central office library.

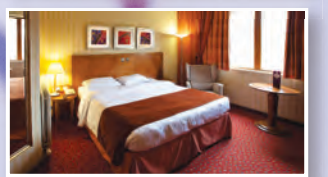
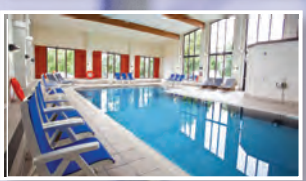
Dr Rao came to this country when it needed General Practitioners. He has served his patients with acumen and advocacy, both face to face in the consulting room and at countless levels within the local and national health economy. He has actually made a difference to the overall primary care health delivery to the population of Stoke-on-Trent and North Staffordshire, which on occasion in the past has been cited as the sickest county in England. He has often had to work in adversity or negotiate time and again with an NHS system that has the inertia of a super-tanker. He has had the patience, determination and a vision of what is right and the stamina to slowly but steadily influence change for good.

Professor Ruth Chambers OBE, Chair for Stoke on Trent CCG, said: ***"Prasad has worked hard for over three decades to improve care for his patients and the people of North Staffordshire. He is an exceptional leader whose determination, vision and respect amongst clinicians were instrumental in building the foundations for our local healthcare system."***

Dr Rao never seeks adulation and doesn't do all that he does for personal gain, but to ensure as GPs we develop and come together to do and be the best we can on behalf of all our patients. We wholeheartedly admire him who absolutely deserves this national honours award.

BIDA 2018 ARM & AGM Announcement



BIDA AGM 2018

Notice is hereby given *that the* **43rd Annual General Meeting** *of the* **British International Doctors' Association** *will be held on* **Sunday 14th October 2018** *at the* **The Daresbury Park Hotel,** Warrington, Cheshire WA4 4BB

Hosted by BIDA's Merseyside and Cheshire Division.

(All fully paid members are cordially invited to attend, but please note that prior notification to Central Office is required).

A 2-year Retrospective Review of Adult Patients presenting to the Acute non-traumatic

ABSTRACT

Background:

Acute non-traumatic headache is a very challenging presentation to clinicians the world over. Most of these patients end up either being over investigated or under investigated leading to clinical errors or unnecessary investigation and hospital admission.

Result:

A total of 1624 patients were evaluated. The mean age of patients presenting with acute lone non-traumatic headache was 43 years with an age range from 19-97 years. The majority of patient were discharged (75%). 349 (21%) patients underwent a CT head scan. 15% of those who had a CT scan had an abnormality. Our results also showed that 0.8% of all the patients presenting with non-traumatic headaches were diagnosed with SAH.

There was a slight female preponderance 941 (58%). Females were also over represented in patients diagnosed with SAH, migraine and non-specific headaches.

Conclusion:

The majority of patients presenting to the Emergency Department with acute non-traumatic headache do not require admission or any kind of imaging.

Less than 1% of these patients were diagnosed with SAH.

There is a female preponderance in those diagnosed with SAH, migraine and non-specific headaches. The average age of all patients was 43 years. It was 50 years for those with a positive finding on CT scan.

Key Words:

Acute headache, subarachnoid haemorrhage, lumbar puncture, Emergency Department.

INTRODUCTION

Headache is a common primary complaint of patients presenting to the Emergency Department (ED). According to figures in the United States, this represents about 2% of all ED visits[1].

The underlying pathophysiological mechanism of many types of headaches is still poorly understood and the terminology is rapidly evolving. The international classification of headache disorders (ICHD-2) provides an exhaustive and categorised list of more than 200 disease entities; each with specific and detailed diagnostic criteria. [2]

Of all the causes of headaches, subarachnoid haemorrhage (SAH) presents the greatest concern for Emergency Physicians because it commonly presents as an isolated headache in the absence of other findings. It is also highly lethal if left undiagnosed. Although some patients who describe their headache as the "worst ever headache of their lives" are eventually found to have SAH, most of them actually do not. [3,4]

The primary focus of obtaining a neuroimaging study in the Emergency Department is to identify a treatable lesion; such as tumours, SAH, vascular malformations, aneurysms, intracranial haemorrhages (such as subdural and extradural), cerebral venous sinus thrombosis, intracranial infections, stroke, hydrocephalus etc.

Acute nontraumatic headache is a very challenging presentation to a lot of clinicians the world over. Most of these patients end up either being over investigated or under investigated leading to clinical errors and or un-necessary investigation and hospital admission.

AIM

The objective of this study is to explore the characteristics of adult patients presenting to the Emergency Department of a large District Hospital with non-traumatic lone headache over a 2 –year period.

Our Emergency Department is situated in the Greater Manchester region of the United Kingdom. It sees approximately 90,000 new patients of which approximately 24% are children. It covers a catchment area of approximately 330,000. It is a trauma unit providing a 24-hour service.

METHOD

Study Design

This is a retrospective study of the characteristics of adult patients presenting to the Emergency Department with acute non-traumatic headache. The data was analysed retrospectively and covered the period November 2012 to November 2014.

Study Population

We included patients who were aged ≥ 16 years who presented to the ED with their main complaint being an acute non-traumatic headache. "Non-traumatic" was defined as the absence of falls or a direct trauma to the head within the preceding 14 days to presentation.

We excluded patients with a history of significant trauma as a part of their presentation. We also excluded pregnant women, patients with a previous diagnosis of intracranial aneurysms or SAH, previous diagnosis of intra-cranial neoplasms or Surgery.

Data Collection

Patents that have been coded with the term "headache" were identified from the Hospital IT data collection system. Eligible patients were identified from this cohort base and also manually from the case notes; according to the inclusion and exclusion criteria.

Emergency physicians reviewed the records of all the ED visits to identify eligible patients. For these patients, we recorded information on age, sex, admission rate, whether or not a CT head scan was undertaken, diagnosis on CT, and the final diagnosis following CT and lumbar puncture.

Outcome Measures

The main outcome measure was to estimate the number of patients that attended during the study period, the number of patients undergoing CT brain scan, the diagnosis on CT and a subgroup of patients diagnosed with SAH following CT and lumbar puncture.

The age and sex distribution was also determined from this cohort. We examined the rate of admission, discharge and transfers from the Emergency Department.

The CT scans were reported by Consultant Radiologists (either neuro-radiologists or general radiologists who routinely interpret CT scans of the brain)

Lumbar punctures were done in line with our local practice protocols; with the laboratory technicians inspecting CSF for the presence of red blood cells (RBC) or xanthochromia.

Subarachnoid haemorrhage was defined as subarachnoid blood on un-enhanced CT scan of the head, xanthochromia in the CSF or Red Blood Cell (RBC) count >5X106/L in the final CSF sample.

Data Analysis

Continuous data was expressed as mean and standard deviation. Categorical data was expressed as frequency and percentage.

Emergency Department with Headache

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Statistical analysis was undertaken by Microsoft Excel.

The study was approved by the Research and Development committee of our institution.

RESULTS

A total of 1624 patients were evaluated. The mean age of patients presenting with acute lone non-traumatic headache was 43 years with an age range from 19-97 years. There was a slight female majority 941 (58%). 425 patients were admitted (26%) for further investigation and treatment.

21 patients (2%) were transferred from the Emergency Department. They were transferred to the regional Neurological and Neurosurgical Centre for further Specialist care. These patients all have abnormal CT scan with findings such as SAH, cerebral infarcts, intracranial haematomas, filling defects requiring further evaluation.

349 (21%) underwent a CT head scan; of these 256 (73%) were discharged; all of them had a normal CT scan. Our results also revealed that only 54 (3%) patients had any kind of abnormality on the scan such as a mass lesion, SAH, intracranial bleed and cerebral infarct. (Table 1,2)

93 patients with a normal CT head scan were admitted for further evaluation and treatment. 19 of these patients were admitted for SAH and therefore had a lumbar puncture. The LP was positive in three patients; two for xanthochromia and one showed evidence of bacterial meningitis. 16 patients had a normal PL and were diagnosed with non-specific headache. (figure 2).

With regards to the final diagnosis, it has been noted that non-specific headache, migraine and viral illness account for two thirds (67%) of the final diagnosis. There is a female preponderance in those presenting with migraine and non-specific headaches (78% and 81% respectively). There was no diagnosis recorded in 6 cases.

Of the 1624 patients presenting over the 2-year period, 13 patients (0.8%) were eventually diagnosed with SAH; 11 patients were diagnosed following an initial CT scan whilst a further 2 patients were diagnosed with SAH following a lumbar puncture. There were more females diagnosed with SAH in this cohort (10 females versus 3 males). (Tables 3, 4; Figure 1)

Table 1. Characteristics of 1624 patients presenting to the ED with acute lone headache.

Characteristics	Value
Age range	19-97
Mean age	43 (SD=18)
Female	941 (58%)
Admitted	425 (26%)
Discharged	1125 (72%)
Transfer to another health facility	24 (2%)

Table 2. Findings on initial CT brain scan.

Diagnosis	No. of Patients
Normal	295 (84%)
Subarachnoid haemorrhage	11 (3.2%)
Cerebral infarct	16 (5%)
Mass lesion	9 (2.6%)
Internal carotid aneurysm	2 (0.6%)
Intracranial bleed	10 (2.8%)
Others	6 (1.7%)

Table 3. Diagnosis following initial CT brain scan

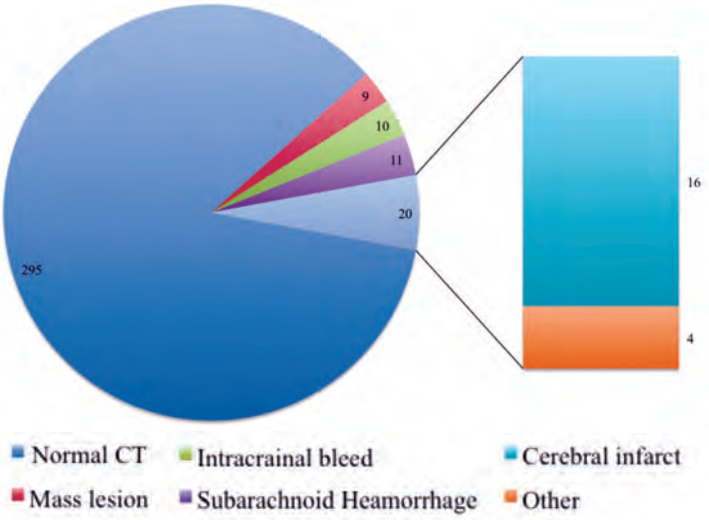
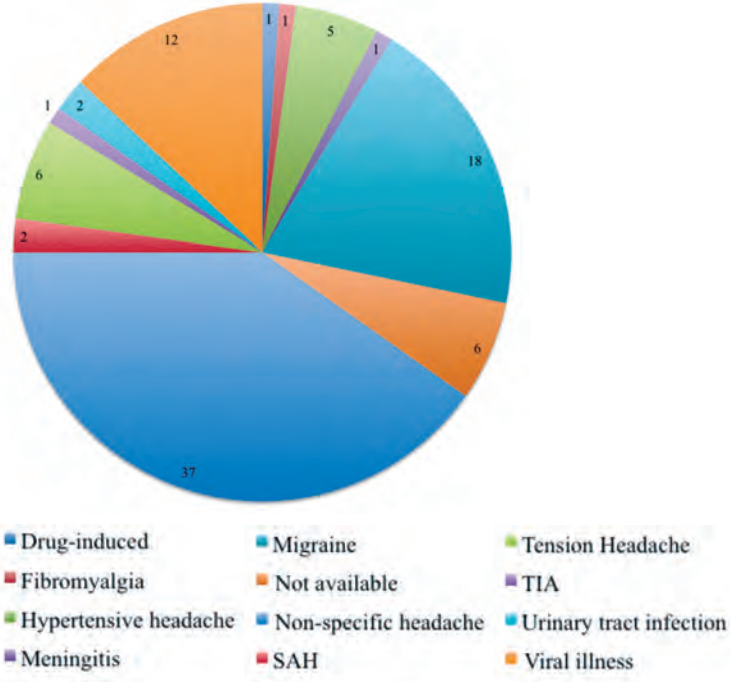


Table 4. Mean age of patients undergoing CT brain scan

Diagnosis on CT Scan	N	Mean age (Yrs)
Normal	295	43
SAH	11	42
Cerebral infarct	16	53
Mass lesion	9	40
Intracranial bleed	10	47

Table 5. Final diagnosis in patients admitted following a normal CT brain scan (n = 93)



Acute non-traumatic Headache (continued)

Table 6. Sex distribution in those admitted with a normal CT brain scan (n = 93)

Diagnosis	N	Female	Male
Non-specific headache	37	30	7
Migraine	18	14	4
Viral illness	12	5	7
Tension headache	6	4	2
Hypertensive headache	5	2	3
Subarachnoid haemorrhage (SAH)	2	2	0
Urinary Tract Infection	2	1	1
Fibromyalgia	1	0	1
Meningitis	1	1	0
Transient ischaemic attack (TIA)	1	1	0
Drug-induced headache	1	1	0
Diagnosis not available	6	3	3

DISCUSSION

Various studies have used different have used different criteria to decide when to undertake imaging of patients presenting with acute headaches. Ramirez et al and Duarte et al. used age cut-offs in the range 50-60 years to decide when to undertake imaging [5,6]. A multivariate analysis of the results from the 1991-2001 survey of the National Hospital Ambulatory Care services for headaches on all available historical factors showed that patients over the age of 50 years were more likely to have a CT scan. They were also more likely to have pathology on their CT scans. Our study showed however that the mean age of patients undergoing a CT scan was 45 years. It was 45.5 years for patients with an abnormality on their scans.

Although we found a female preponderance in our study, some other studies have attempted to identify risk factors and features for the diagnosis of SAH. In a review of 500 patients with SAH, Schievink et al found that risk factors included women over the age of 50 years and men under the age of 50 years. The average age of women diagnosed with SAH in our series is 52 years and 49 years for men. [7]

Several studies have attempted to assess the value of CT scanning and LP in the evaluation of patients with suspected SAH. Some studies have found that the rate of SAH diagnosed by LP after a normal CT scan was 2.5% to 3.5% [8]. In our cohort we found a rate of approximately 10%.

Advanced imaging techniques are available that may facilitate a more accurate diagnosis of SAH. Boesinger and Shiber undertook a retrospective chart review of ED patients presenting with headaches during a one-year period who had both a lumbar puncture and CT scan. Of the 177 patients evaluated, none with a negative CT had SAH giving a sensitivity of 100% [9]. However, a review of 149 patients by Byyny et al found a sensitivity of 93% for CT scan.

The bulk of the evidence currently suggests that a lumbar puncture must still be performed after a negative CT scan in patients with suspected SAH.[10]

Despite advanced imaging techniques, the evaluation of patients with severe headaches continues to be challenging. No single imaging modality is 100% sensitive in detecting SAH and other significant intracranial lesions causing headaches.

Another question that needs to be addressed is whether there is a need for further imaging in patients with a sudden onset severe headache who have had both a negative CT and negative LP. The current teaching is that if both tests are negative then subarachnoid haemorrhage is excluded [11]. Cerebral angiography has been used to evaluate these patients but there is no convincing evidence that it is of benefit in this group of patients. Some centres have used multimodal CT and MRI scanning to evaluate these patients but neither CT nor MRI scan reliable excludes SAH.

The largest study addressing this issue is by Perry et al. in a review of 592 patients with acute severe headache presenting to the ED. These patients had both CT and LP with 61 (10%) diagnosed with SAH. They then followed up the patients with a negative CT and LP for 6 to 36 months and none of them was subsequently found to have SAH. [12]

More recently, Perry et al in their prospective cohort study were able to derive 3 decision rules for the diagnosis of SAH. The rules are based on the clinical characteristics of 1999 patients. They derived the rules from high-risk characteristics such as the age of the patients, mode of arrival to the ED, complaint of neck pain or stiffness, vomiting, onset with exertion and blood pressure. Each of the three models suggested that only patients with any of the high-risk characteristics need to be investigated. They found that all three rules have a retrospective sensitivity 100%. The specificity of the models ranged from 28.4% to 38.8%, with a corresponding investigation rate ranging from 63.7% to 73.5%. [13]

CONCLUSION

Majority of patients presenting to the Emergency Department with acute non-traumatic headache have benign underlying aetiology and do not require admission or any kind of imaging.

Less than 1% of these patients were diagnosed with SAH. This study further buttresses the point that CT scan alone is insufficient to make a diagnosis of SAH; lumbar puncture is usually required to exclude SAH following a normal CT in patients suspected of having SAH.

There is a female preponderance in those diagnosed with SAH, migraine and non-specific headaches. The average age of those with a positive finding on CT scan is less than 50 years.

As this is a retrospective cohort study, we were limited by incomplete data collection and recording. For example, some patients did not have a definite diagnosis despite a rigorous search of both their electronic and paper records. Furthermore, it would have been interesting to follow up some of the patients who were discharged from ED without any imaging and without any clear diagnosis. Presumably some of these patients may well have unidentified significant intracranial pathologies. Furthermore, we had no record of the re-attenders who subsequently had imaging of some sort and/or were admitted.

The generalizability of the results is also a limitation. Although the cohort size is relatively large, it is limited to a single centre covering a catchment area with its own unique demographic characteristics.

There limitations will be best overcome by a large prospective, multi-centre study to further build on the findings of this study.

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Letter to the Editors

National Guardian
Freedom to Speak Up

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16 October 2017

Dr Chandra Kanneganti BIDA National Chairman and
Dr J Nankani BIDA ARM Chairman

Dear Dr Kanneganti and Dr Nankani

Thank you both so much for making me so welcome at the BIDA ARM and AGM this weekend. From the generous hospitality and kind words from your leaders and members I felt very much included in the meeting and the evening's events. Thank you also for the very kind gift which is very much appreciated. I found the questions and the debate in the afternoon very interesting and we are working hard to ensure that Freedom to Speak Up is inclusive for all staff in the NHS. I hope that we will be able to continue to work closely to achieve the common enterprise of all staff being valued, listened to and to be able to deliver great care.

Please can you also send my thanks to Alison for making all the arrangements so straightforward and helpful.

Kind regards

Henrietta

Dr Henrietta Hughes
National Guardian for the NHS
National Guardian's Office
151 Buckingham Palace Road | London | SW1W 9SZ

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National Guardian
Freedom to Speak Up

The 2018 ACCEA Awards

Please be aware that the 2018 Clinical Excellence Awards round will open on Tuesday 13 February and will close at 5:00pm on Thursday 12 April.

ACCEA will accept applications for new national awards and from those due to renew their award in 2018.

Consultants will need to put in a renewal application if:

- they received their current award in the 2014 round
- their award was last renewed in 2013 (awarded in 2009, 2004, 1999)

In some cases, consultants will be renewing out of the usual cycle. Awards are reviewed earlier if there is a change in job or a significant change in job plan.

Updated guidance for applicants, nominators, employers and assessors will be published on the ACCEA website before the round opens.

www.gov.uk/accea

Please cascade this information to your members and ensure that your own internal processes allow applicants sufficient time to complete and submit their applications to ACCEA.

SAVE THE DATE! – The Biennial BIDA Oncology Symposium

The Christie Hospital Education Centre - Saturday 9th June 2018

Highlights will include:

1. *An update on Greater Manchester Cancer Service*
2. *Updates on common cancers.*
3. *Multidisciplinary meeting jointly with the primary care and secondary care teams.*
4. *Trainee forum with the opportunity to present and display posters and the chance to win prizes.*

And so much more...

Registration & trainee abstract submission will be through The Doctors Academy.

If anyone has suggestions on topics to be covered, or cases to be discussed at MDT, please contact **Mr C R Selvasekar** directly via e-mail at **crselvasekar@gmail.com**.

We would kindly ask any **Sponsors** who may wish to be associated with this prestigious event to contact the organisers directly via e-mail at **crselvasekar@gmail.com**.

The organising team:
Professor S Senapati; Dr Vinod Gadiyar; Dr Gajanan; Mr CR Selvasekar.

12th BIDA International Congress

24th - 25th October 2017, Rio de Janeiro

Dr Sanjay Arya
Chairman,Scientific Congress,
12th BIDA International Congress

BIDA International Congress is an important event in the diary of our organisation and has always been oversubscribed. The 12th BIDA International Congress was held at Rio-De-Janeiro on the 24th and 25th October 2017. As in previous times, the congress was very popular amongst our members and was attended by over 100 delegates.

A high quality scientific programme was arranged covering major topics of health care. I would like to personally thank all the twenty one speakers and the ten chairpersons for their contribution. The Scientific Congress provided the delegates with a forum to learn from each other, exchange ideas and discuss the challenges we face in the field of medicine and in the NHS. I sincerely hope that colleagues found the congress as mentally stimulating and socially satisfying as in previous years.

I would like to particularly thank Bachi Sarkar, who planned this event, Biru Sinha who skilfully supported the programme and Ashish Dhawan, who helped me put up an exciting and educational Scientific Congress agenda. The Congress would not have been a success without the close involvement of BIDA Central Office Manager Alison and Mandy. I would also like thank Kevin who was at the scientific meeting, along with Alison to assist us in the proceedings of the Congress. My special thanks to Srinivas Patnaik and Aruna Shah from Arburton Travels for coming up with personalised tour plans. Their effort in making the whole trip a big success must be appreciated.

Dr Sanjay Arya

Chairman, Scientific Congress,
12th BIDA International Congress

Abstract Presentations

Dr Sayeed Ahmed

Consultant Anaesthetist & Intensivist, Wrightington, Wigan and Leigh NHS Foundation Trust; FICE (Focussed Intensive Care Echo Mentor) for Intensive Care Society Lead for Intensive Care Echo Services and Echo Simulation Training

The role of Echocardiography in critically ill patients:

Echocardiography is one of the most powerful diagnostic tools in Cardiology. In the United States it accounts for a significant spending of the Medicare Budget. In the UK 336 institutes have echocardiographic facilities and each institute performs an average of 3500 echocardiograms per year. (1176000/year). Echocardiography, once the remit of Cardiology is being used increasingly used in other areas such as Cardiothoracic theatres, Emergency departments and on Intensive Care Units. In the acute and intensive care setting, Echocardiography is used mainly to assess the ventricles, aorta and the pericardium. This talk introduced the delegates to the indications for Echocardiography, the different techniques available i.e. surface (Transthoracic) vs. Transoesophageal Echocardiography, its advantages, disadvantages and contraindications. Some interesting emergency cases were discussed.

Dr Ashish Dhawan

Consultant Cardiologist and Electrophysiologist, Wrightington, Wigan & Leigh NHS Foundation Trust

Conundrum in the management of Cardiac Arrhythmia:

Heart arrhythmia, also known as cardiac dysrhythmia or irregular heartbeat, is a group of conditions in which the heartbeat is irregular, too fast, or too slow. Arrhythmias or heart rhythm problems are experienced by more than 2 million people a year in this country. Its impact on patients can range from almost being asymptomatic and leading a normal life to severely debilitating symptoms. It can also impact fitness to drive and travel. However, with the advancements of cardiac electrophysiology diagnostics and interventions most of these people can be cured and can live normal lives.

Mr Brajesh K Jha

Associate Urologist / SAS Tutor, Whiston Hospital

Everything you wanted to know about Erectile dysfunction:

Erectile dysfunction is defined as the inability to achieve and maintain a penile erection adequate for satisfactory sexual intercourse. Data from the Massachusetts Male Aging Study (MMAS), a community based, random sample prospective observational survey of non-institutionalised men aged 40-70 years found that 52% of men reported erectile dysfunction. It is a common cross cultural condition in developing and industrialised countries, but its true incidence is probably under-estimated owing to embarrassment about seeking help. Increasing public awareness and the universal availability of effective oral drugs has resulted in more men seeking treatment for the problem and an increase in the number of primary care consultations and referrals to secondary care.

Dr Sudheera Reddy

Consultant Anaesthetist, Lancashire Teaching Hospitals NHS Trust

How fit are you? – Cardio Pulmonary Exercise Test (CPET):

Cardiopulmonary exercise testing (CPET) is a non-invasive functional assessment of cardiopulmonary reserve. It has clinical applications in diagnosis, assessment of adequacy of treatment and pre-operative risk stratification of patients. It has also been used in the assessment of elite athletes and for the diagnosis of dyspnoea. CPET is becoming routine in the preoperative assessment of patients undergoing major surgical procedures and the results can help to assess an individual's risk of perioperative morbidity and mortality and plan their care including critical care bed allocation. CPET systems use the analysis of gas exchange at rest, during exercise and recovery, in combination with physiological variables such as heart rate, blood pressure and ECG monitoring, to provide a comprehensive assessment of exercise tolerance.

Dr Sanjay Arya

Consultant Cardiologist & Medical Director, Wrightington, Wigan & Leigh NHS Foundation Trust.

Challenges in the Management of Heart Failure

Heart Failure (HF) is the final pathway for all cardiac diseases. Many believe that HF is the malignant manifestation of coronary heart disease. Patients with HF have worse quality of life compared to arthritis, chronic lung disease and angina. 5% of all deaths in the UK are due to HF with 40% of patients with HF dying within a year. Survival rates for patients with HF are as bad as cancer of colon and worse than cancer of breast, uterus, cervical, bladder and prostate. HF accounts for 5% of all medical admissions with nearly 40% patients getting readmitted within 6 months. The average length of stay is nearly 14 days with over 1 million inpatient bed days due to HF.

Nidhi Srivastava

St Helens & Knowsley Teaching Hospitals

The changing face of Gynaecological Cancers: Are we ready?

Gynaecological cancers comprise different types. In the UK, over 21,000 women every year are given a diagnosis of a gynaecological cancer. This equates to 58 women being diagnosed daily. Of those diagnosed, sadly 21 women will die every day. In the UK, ovarian cancer is the most common gynaecological cancer, and the fourth most common cancer among women, accounting for around 5% of all cancers in women. Endometrial cancer is the fifth most common cancer, accounting for around 5% of all cancers in women. Worldwide, cervical cancer is the second most common cancer among women. About 83% of the cases occur in developing countries, where cervical cancer accounts for 15% of all cancers in women. However, in the developed world it accounts for only 3.6% of all cancers in women.

Anita Sanghi

Consultant Obstetrician & Gynaecologist, Divisional Director Women's' & Children's'; Caldicott Guardian, Barts Health, Royal London Hospital, London

Update on Contraception:

Contraception or Birth control is a method or device used to prevent pregnancy. Birth control has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century. Planning, making available, and using birth control is called family planning. Globally, as of 2009, approximately 60% of those who are married and able to have children use birth control. The most common method in the developed world is condoms and oral contraceptives, while in Africa it is oral contraceptives and in Latin America and Asia it is sterilisation. In the developing world overall, 35% of birth control is via female sterilisation, 30% is via IUDs, 12% is via oral contraceptives, 11% is via condoms, and 4% is via male sterilisation.

Dr Rajesh Kumar

Associate Specialist in Anaesthetics & Pain Management; Chair, BMA Staff Associate Specialists and Specialty Doctors (SAS) Conference; Member, BMA National SAS Committee; Hon. Secretary, North West SAS Committee

BMA and International Medical Graduates:

The British Medical Association (BMA) is the largest trade union for doctors in the UK. Membership is regarded as an extremely important insurance against any employment related problems. They not only negotiate contracts but also provide various services including medical ethics advice and support, fighting against bullying and harassment, and ensuring you are treated fairly without any discrimination by your employers. For International doctors working in UK, these are vitally important issues. In my career as a BMA executive, I have seen numerous malpractices by employers against International doctors. It is the BMA who has been able to fight for them. However, what makes the BMA? It is all of us. BMA's strength depends upon doctors standing and working together and representing our profession. International doctors like us must join and be active within the BMA to highlight the issues that matter most to us.

Dr Sanjeev Srivastava

Consultant Acute Medicine, East Cheshire NHS Trust, Macclesfield

Hyponatraemia: a pinch of salt.

Hyponatraemia is defined as low serum sodium levels (<135mmol/l). This is the most common of the electrolyte disorders, and affects about 15-30% of hospitalised patients in the UK. It also affects around 7% of patients attending ambulatory clinics. Hospital acquired hyponatraemia is common, and these patients have an increased risk of hospital death. The economic cost of hyponatraemia is estimated to be $2.6 billion per year in the US. There are three stages of hyponatraemia: mild, moderate and severe (<120mmol/L). Depending on the stage, symptoms can range from being asymptomatic to having headache, nausea, coma and eventually death. Causes of hyponatraemia are typically classified by the patient body fluid status, into hypovolaemic, euvolaemic, hypervolaemic.

Dr Birendra Jha

Associate Specialist, Care of the Elderly, Upton Hospital, Slough

Frailty Syndrome – diagnosis and management:

There have always been frail people but only in recent years the term "Frailty" has become a medical diagnosis. Although linked with ageing, disability and co-morbidity many consider frailty as a distinct clinical entity. This is a worldwide problem. There are about 500 million people over 65 in the world. This population will be around 2 billion by 2050. Frailty increases with advancing age and is more common in older women than men and among lower socioeconomic group. Frail older adults are more likely to have adverse health outcomes and falls. Most common organs affected in frailty are the brain endocrine system and the skeletal muscles. Comprehensive geriatric assessment is most important in the management of frailty. Frail people are more prone to post operative morbidly and mortality. Assessment of older people before elective surgery can predict the patient's recovery. Patients with frailty spend 50 percent more time in hospital and are three times more likely to be discharged to a nursing home facility.

Dr Saylem Jayagopal

Consultant in Gastroenterology, Bronx, New York. Ex-Consultant and Asst Professor in Albert Einstein College of Medicine, New York

The management of difficult airways:

There is a noted increase in rates of obesity around the world, both in developing and developed countries. In the United States, 1 in 3 are obese, resulting in airway access to be a challenge to health care providers, especially the anaesthetic teams. The presentation gave an overall view of identifying potential difficult airways and management in all patients scheduled for surgical procedures. The presentation introduced one of the tools, which can be a lifesaver.

Abstract Presentations

Amit Sinha

Consultant Orthopaedic Surgeon Glan Clwyd Hospital, Rhyl, North Wales

The mysteries of understanding shoulder pain:

The shoulder joint differs from all other joints in several aspects. This multidimensional structure encompasses in reality 4 differing joint complexes. This combination of multiple bones and their joints accompanied by complex muscles is unique only to this mysterious joint. The joint exhibits a range of movement, which cannot be mimicked by any other joint in the body. The main function of the shoulder joint is to place the hand in any position required by the individual. There is tremendous demand on the shoulder joint in everyone's daily activities, particularly if the dominant one is afflicted by either injury or degenerative changes, both of which are quite common in clinical practice. Shoulder pain can arise from a multitude of causes. The talk provided an insight into the all the common as well as some uncommon aetiologies, which would give rise to pain.

Aprajay Golash

Consultant Neurosurgeon and Clinical Director, Lancashire Teaching Hospitals NHS Trust

Red flags in low back pain:

Low back pain is a very common problem and in general it is a self limiting condition without any serious underlying pathology. This may lead to a rather "casual" approach in its management and may lead to a missed serious underlying condition or delayed diagnosis which may have serious consequences. On the other hand more than 80% of MRI scans only show age related changes so the pickup rate for serious pathology is very low. To help with clinical management and early diagnosis of any serious underlying pathology the "red flags" were introduced in 1994 in the Clinical Standards Advisory Committee report. They comprise a number of symptoms and signs which have been associated with increased risk of underlying serious conditions. Sensitivity and specificity of these red flags may depend on correct interpretation of symptoms and signs but real evidence is lacking.

Dharmendra Mittal

Associate Specialist, Lancashire Teaching Hospitals NHS Trust

Why is your foot painful?

The foot is a complex anatomical structure that may be affected by disease within the body or the foot itself. The arches of foot are the primary structures that control the amount of ground force transmitted into the body. Injury, overuse or conditions causing inflammation involving any of the bones, ligaments or tendons in the foot can cause foot pain. Arthritis is a common cause of foot pain. Injury to the nerves of the feet may result in intense burning pain, numbness or tingling (peripheral neuropathy). The foot is divided in 3 main areas - forefoot, midfoot and the hindfoot. Treatment of foot pain will depend on the cause of the pain and may involve medication, strengthening, stretching, and possibly the use of physical therapy. Frequently, it is the inappropriate foot wear which is the cause of the painful foot.

Dr Pradeep Sanghi MD, FRCP, FRCPI, AGAF

Consultant Gastroenterologist

Gastroenterology snippets - an update:

Helicobacter infection leads to gastritis, ulcer and increased risk of gastric cancer. Standard triple therapy to eradicate Helicobacter is no longer adequate due to antibiotic resistance. Recent updated guidelines advise two week regimen, quadruple therapy and Bismuth based protocols to achieve reasonable success rate. Proton pump inhibitors (PPIs) have been in use for >25 years and are widely prescribed. Indications include ulcer healing, gastro-oesophageal reflux disease and gastro-protection to reduce risk of GI bleeding. Many patients on PPIs do not have a clear indication. It is possible to de-prescribe PPIs in many patients when appropriate. Screening for colon cancer/ polyps has clearly been shown to reduce deaths from colon cancer. Colonoscopy is the best option but some patients prefer non invasive tests. These include stool based tests, CT colonography and flexible sigmoidoscopy. There is limited role of capsule colonoscopy.

Dr Micky Malhotra

Consultant and Clinical Director, Care of the Elderly,
Wrightington, Wigan & Leigh NHS Foundation Trust

Atrial Fibrillation and Stroke:

AF is the most common sustained cardiac arrhythmia. The most obvious symptom is palpitations. The prevalence in general population is about 1-2 % (> 6 million Europeans suffer from AF, including an estimated 1 million in the UK). Men carry a 1.4 times greater risk than women. Incidence is projected to grow significantly. 20% of all strokes are due to AF and these strokes are associated with increased disability and increased risk of death compared to non-AF strokes. Estimated annual cost to NHS is £2.8 billion. Of the 152,000 strokes in the UK annually, 20% (30,400) are due to AF. Around 6500 strokes may occur annually in the UK as a result of lack of appropriate treatment. CHADS2-VASc score is used to assess the stroke risk and guide use of anticoagulant treatment. The HAS-BLED score assesses bleeding risk in NVAF. The aims of treatment in NVAF are to prevent complications particularly stroke and to alleviate symptoms.

Dr Nadim Fazlani

GP, Liverpool, Mental Health Lead, Liverpool CCG

Approach to a patient with dizziness:

It is important to have a pragmatic approach on how to deal with patients who present with dizziness. It is the third most common complaint in primary care after pain and fatigue, with a prevalence of 30% in patients aged over 65y. History is critical and should focus on the nature of the symptoms, duration, and any triggering or alleviating factors. A thorough neurological and cardiovascular examination should be performed in all patients. It is essential to distinguish dizziness from vertigo, which is a subtype of dizziness defined as an illusion of movement caused by asymmetric input to the vestibular system. This dichotomy is helpful because true vertigo is often due to inner-ear disease, whereas dizziness may be due to central nervous system (CNS), cardiovascular, or systemic diseases. Acute dizziness and vertigo is usually managed with vestibular suppressants, antiviral medication and antiemetic medications. Steroids are useful in selected patients.

Dr Satya Sharma

Chair, Promoting Organ Donation (POD), UK; Deputy Lieutenant, West Midlands.

Organ Donation – Myths and the truth:

Repeated surveys in UK have shown over 90% public support for organ donation, yet only 38% are registered on the donor register. The situation for Black and Minority ethnic communities (BME) is much worse. The need is 3 times higher and yet less than 1% are registered for voluntary organ donation. The consequence is that BME patients on average wait 12 months longer than the rest of the community. 6500 are on the waiting list to receive organs and the list is getting longer each year due to many more being put on the waiting list and the success of the programme. Experience shows different attitudes and many prevailing myths within the BME.

Dr Pamadeth Shobha MBBS MRCPsych

Consultant Psychiatrist, Kent Institute of Medicine and Surgery (KIMS), UK

Physical health monitoring in mental health:

Mental health has come a long way from being a social exclusion institution to the era of a recovery focused social inclusion speciality. The present mental health strategy "No health without mental health and making mental health everybody's business" promotes mental health. Despite this, stigma and discrimination remains attached to mental ill health due to negative stereotypes and prejudicial attributes. There has been increasing emphasis on provision of general physical health advice to people with severe mental illness (SMI) spectrum. Historical evidence has shown morbidity and mortality rate much higher in people with SMI than general population. People with severe mental illness (schizophrenia, depression and bipolar disorders) are two to three times more likely to die from heart and respiratory disease. This is because people with mental health conditions are less likely to receive the physical health care they need.

Dr Dhuni Soren

GP, Liverpool

Indigenous medicine and food:

Indigenous medicine or traditional medicine (also known folk medicine) comprises medical aspects of traditional knowledge that developed over generations within various societies before the era of modern medicine. The World Health Organization (WHO) defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness". In some Asian and African countries, up to 80% of the population relies on traditional medicine for their primary health care needs. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Iranian (Persian), Islamic medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture and traditional African medicine.

Dr Alka Trivedi

GP Leigh and Wigan, National Vice-President; BIDA.
Patron and President, Wigan Division, BIDA.

Healthy Mind – Healthy Body:

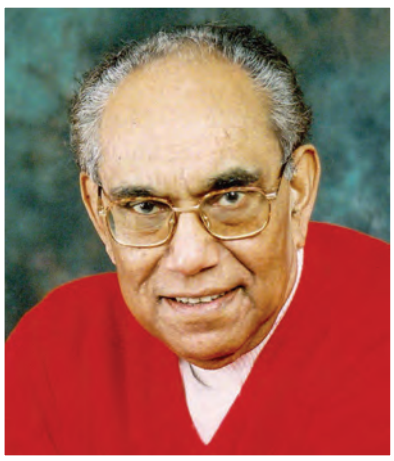
Laughter yoga (Hasya yoga) is a practice involving prolonged voluntary laughter. It is based on the belief that voluntary laughter provides the same physiological and psychological benefits as spontaneous laughter. Laughter yoga is done in groups when forced laughter soon turns into a real and contagious laughter. There is scientific evidence that laughter stimulates production of serotonin, dopamine and endorphin which are happy hormones. Scientific studies have indicated that laughter yoga may potentially have beneficial effects including lowering blood pressure, bringing more oxygen to the body and brain by incorporating yogic breathing which results in deep diaphragmatic breathing. Mental stress is released. It makes one feel young and look young and boosts relationship. Meditation is the practice of turning your attention to a single point of reference. It can involve focusing on breathing, on bodily sensation or on a word or phrase known as Mantra. In other words meditation means turning your attention away from distracting thoughts and focusing on the present moment.

OBITUARY

Dr Madan Mohan Gupta

MBBS, DTD, DCH, DIH, MRCGP, FIAMS, FODA, JP

8th January 1934 – 19th December 2017



Dr Madan Mohan Gupta of Oldham sadly passed away on the evening of 19th December 2017 following a short illness.

Dr Madan Mohan Gupta was born in Arrah, Bihar. His early education was all in Bihar. He graduated from the Prince of Wales Medical College in Patna in 1957. Following graduation he was posted as Chief Malaria Officer in Arrah.

He travelled to the United Kingdom in 1964, and after initially pursuing a career in paediatrics, he opted to become a general practitioner. In 1972 he settled in Oldham, Lancashire and excelled as a general practitioner (GP) there. He maintained a special interest in paediatrics and child health. He was much respected by patients and colleagues. He achieved numerous postgraduate qualifications. He was one of the first Asian GPs to pass the Membership of the Royal College of General Practitioners (MRCGP) exam, and to become a GP trainer. He successfully grew his practice from a single handed practice to a group training practice.

He continued to keep strong links with India and spoke at symposia and conferences on general practice and community medicine there. For his continuing work in India he was made a Fellow of the Indian Association of Medical Specialists.

He was also politically active. He was a founder member, past President and Fellow of the Overseas Doctors' Association (ODA) (now the British International Doctors' Association - BIDA). Through his work with the ODA/BIDA, he successfully campaigned to bring about very much needed changes which have ensured that international doctors in the UK are treated fairly.

He was also a founder member, past president, and patron of the Bihar Jharkhand Medical Association (UK).

He worked tirelessly for charities, and the community. He was a Rotary Club member and a retired Justice of the Peace (JP).

He had strong connections with the Indian Association of Oldham, and was a past president and trustee. He was integral in the association securing a purpose built mandir in Oldham.

He maintained strong connections with Bihar and made regular visits to friends and family there. He also contributed to charitable activities in the State.

Socially he was very active. He was always well connected with family and friends all over the world. Even prior to the advent of social media he made a conscious effort to keep in touch with others, whether that be in person, by telephone, by letter, or by telegram.

He leaves behind his wife Prem Shila (also originally from Arrah), 3 children and their spouses and 5 grandchildren.

He was a successful, but humble, and an unassuming man. He went out of his way to help others and has touched many lives. He is very much loved and respected by his family and many generations of doctors, patients and friends. He did not seek fame or recognition; he was simply a lovely human being. He will be sorely missed.

Rajat Gupta

Divisional News

North East Division Meeting

The meeting was held at Le Raaj Restaurant at Sedgfield on Sunday 3rd December 2017, and was attended by several members. BIDA's national tournaments for Badminton and Table Tennis were held in Liverpool on 21st May 2017, and the North East BIDA team were winners both in doubles in badminton as well as in table tennis. At the North East Division meeting, the winning pairs were honoured with their trophies.

Badminton doubles winners:
Chakra Pani Kalluri & Rahim Khan

Table Tennis Doubles winners:
Prathish Thakkar & Aninda Saha

Pictured, l to r – Ambu Patel, Aninda Saha, Chakra Pani Kalluri, Y KS Viswanath, Rahim Khan, Prathish Thakkar, and Sarup Tayal.

13th BIDA INTERNATIONAL CONGRESS JAKARTA & BALI, INDONESIA

(22nd to 23rd October 2018)

BRITISH INTERNATIONAL DOCTORS' ASSOCIATION
OAN: 970289

ODA HOUSE, 316A BUXTON ROAD,
GREAT MOOR, STOCKPORT SK2 7DD

TEL: 0161 456 7828

Mandarin Oriental Hotel, Jakarta

Laguna Resort and Spa, Bali

FULL PACKAGE

(Congress and Touring)

Price: **£ 2435.00** per person
(Twin or Double share)

£ 2945.00 per single person

£ 1935.00 per child
(in parent's room)

£2305.00 per person
(Adult, 12 years or over with extra, based upon triple-sharing)

Price includes:

- Fully ATOL protected Holiday.
- Return International flights on scheduled airlines with departures from Manchester and London Heathrow.
- One-way Domestic flight on scheduled airlines with departures from Jakarta to Denpasar (Bali).
- Return transfers: airport – hotel – airport.
- Cultural Welcome to Indonesia at Jakarta Airport.
- Welcome Dinner and enjoy the Cultural Event.
- 3 nights' accommodation at the Mandarin Oriental (5 Star) Hotel in Jakarta.
- 2 full days Conference package at the hotel.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day one of conference.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day two of conference.
- 1 Gala Dinner with Local Beer, Soft Drinks & Juice.
- 6 nights accommodation at the Laguna Resort and Spa in Bali.
- 1 Dinner including local performance with instruments and DJ music.
- Internal flights Jakarta to Denpasar in economy class.
- Tour of Uluwatu Temple, Pandawa Beach, Kecak and Fire Dance Performance.
- Dinner included at Jimabaran Bay.
- Full day Tour, Heartland of Bali, with Lunch at Batur Lakes.
- Full day Traditional Village Sightseeing.
- Full day Ubud Town & Tanah Lot Temple and lunch at local restaurant.
- Exclusive Cruise to Lembongan island with snorkelling equipment, Village tour, Unlimited Banana Boat, Semi- Submersible coral viewer, BBQ lunch, snack on the way back, 3 glasses of beverages (1 Soft Drink, 1 Beer, 1 House wine) private cruise and private beach club on the island.

CONFERENCE PACKAGE

Price: **£ 1799.00** per person
(Adult, Twin or Double share)

£ 2199.00 per single room

£ 1435.00 per child
(2-11 years Sharing with 2 full paying Adults)

£1805.00 per person
(Adult, 12 years or over with extra, based upon triple-sharing)

Price includes:

- Fully ATOL protected Holiday.
- Return International flights on a schedule airlines with departures from Manchester and London Heathrow.
- Return transfers: airport – hotel – airport.
- Cultural Welcome to Indonesia at Jakarta Airport.
- Welcome Dinner and enjoy the Cultural Event.
- 3 nights' accommodation at the Mandarin Oriental (5 Star) Hotel in Jakarta.
- 2 full days Conference package at the hotel.
- Conference Venue available from 08.00 – 17.00 (2 Full days).
- Morning and afternoon coffee break with refreshment.
- Buffet lunch at function room.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day one of conference.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day two of conference.
- 1 Gala Dinner with Local Beer, Soft Drinks & Juice.

OTHER INFORMATION

- **Currency:** Indonesian Rupiah £1 = 18343 (Approx).
- **Weather:** Sunny 30 Degrees in Jakarta and around 27 Degrees in Bali.
- **Packages are exclusive to BIDA members.**
- **Non-BIDA members** are welcome to join at a supplement of **£100.00** per person.
- **For bookings and enquiries,** please contact **BIDA Central Office,** or call **Bolton Travel** on the phone numbers detailed below.
- **LIMITED AVAILABILITY!**
  Closing Date for bookings:
  As soon as all places are filled (first come, first served basis) **or 15th March 2018** (whichever is earlier).

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3853 ATOL PROTECTED

13th BIDA INTERNATIONAL CONGRESS – JAKARTA & BALI, INDONESIA

BOOKING FORM

This document is a receipt issued for your financial protection. It is not a 'confirmation invoice'.
The invoice will be sent to you as soon as it is received by Bolton Travel Ltd, in association with Brightsun Travel, with whom you have a contract.
Full details of your booking will be shown on your 'confirmation invoice' and your booking is subject to the terms and conditions of Brightsun Travel.

Travel Details

Booking Reference:	Date of Departure / Date of Return	Tick box as appropriate:
BIDA / JAKARTA / OCTOBER 2018	**20 October 2018 / 30 October 2018**	**CONGRESS PACKAGE ONLY** ☐
		FULL PACKAGE ☐

Passenger Details:

Title: Dr / Prof / Mr / Mrs / Ms (Delete as appropriate)

First Name: .....

Surname: .....

Address: .....

Postcode: .....

Telephone: .....

E-mail: .....

BIDA Member: **YES / NO** (Delete as appropriate)

BIDA Membership No.: .....

Preferred Regional Airport: †

LHR / MAN / Other (Delete as appropriate)

† Suitable alternate airports may be suggested if feasible flight connections and fares not possible.

Traveller Details

Title	First Name	Surname	Date of Birth	Nationality	Passport No.	Meal Pref*

NB. Please ensure that the above details are as per passport. (All Passports must be valid for at least 6 months prior to departure)
*Meal Preferences - please indicate if Vegetarian (**VEGIN**) / Vegan (**VG**) options are required

Travel Insurance Details

It is Mandatory that each passenger is adequately insured at the time of travel. (Please tick as appropriate)

☐ I/We wish to purchase comprehensive insurance through you. £49 onwards Single Travel £99 onwards Annual Multi Travel (All delegates will be required to vet their conditions with our referred Insurance provider(s). And delegates with pre-medical conditions or over 65 years may not be covered under our insurance and must purchase their own insurance policy.)

☐ I/We will arrange my/our own Insurance.

Payment Schedule

At the time of booking, a non-refundable deposit of £ 750.00 per passenger (Adult or Child) will be payable by 10th March 2018.
Cheques Payable to: '**British International Doctors Association**'
Bank details for direct transfer (**Lloyds Bank**): Account name: **BIDA** Sort Code: **30-65-62** Account number: **25036268**
Second instalment of £ 900.00 per passenger is due by 10th April 2018. (Payable directly to **Brightsun Travel**)
Full and final payment of remaining money is due no later than 15th July 2018. (Payable directly to **Brightsun Travel**)

Places will be allocated on a first come first served basis, as places are strictly limited.
Closing date for bookings: As soon as all places are filled or 10th March 2018 (whichever is earlier).

Declaration

I agree on behalf of all persons on the booking form, which I have submitted, to accept the unaltered Booking Conditions and the Insurance Conditions and warrant that I have the authority of all persons named to make the booking subject to these conditions. I am over 18 years of age. I also agree that, where applicable, I authorise Bolton Travel Ltd in association with Brightsun Travel to make this booking on my behalf.

Signature: ..... Date: .....

bolton travel Your Travel Planner in association with Brightsun TRAVEL

All Booking Forms, along with the deposit, should be sent to:
BIDA
'ODA House'
316A Buxton Road,
Great Moor,
Stockport SK2 7DD

TOGETHER, WE ARE STRONGER

BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

The British International Doctors Association (BIDA) is a professional doctors' association. Its sole objective is promoting ***Equality*** and ***Fairness*** for all doctors and dentists working throughout the UK.

BIDA's mission is to achieve equal treatment of all doctors and dentists based on their competence and merit, irrespective of their race, gender, sexual orientation, religion, country of origin or school of graduation.

If you believe in this mission and would like to be part of this endeavour, join us!

- You will make professional contacts, gaining the opportunity to network with people who can impact your profession, and giving you access to new opportunities, friends and information.
- In addition to being part of a group of like-minded professionals, and having the recognition of your peers, specific member benefits include:
  - Attending BIDA-organised international, national and regional conferences, seminars, meetings and many other educational and social activities
  - Constant access to pastoral support
  - Nominations for excellence awards
  - BIDA Journal, our Scientific journal, complete with news, interviews and much more.

If you are interested in joining BIDA, or would simply like to know more about us, please either write to **BIDA, ODA House, 316A Buxton Road, Great Moor, Stockport, SK2 7DD** or e-mail us at **bida@btconnect.com**, or contact us through our website at the address below.

We look forward to hearing from you!

www.bidaonline.co.uk