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COMMONWEALTHMEDICALJOURNAL
CMJ EDITORIAL

WarmNewYearGreetings2025

Happy to introduce the First issue of our Commonwealth Medical Journal, January 2025. It will be a Bimonthly Digital Journal. This will bring Health News throughout the 46 Commonwealth countries through our team of CMA. We can exchange risks& benefit in Health-care too.

CMA was formed on November 21 -24, 1962 at Colombo, Srilankawith Dr. ADPA wijegoonewardene, the Founder President. This was supported by Commowealth Secretariat & Foundation.

CMA was formed to support the Health of Commonwealth countries as most of them, were in the stage of Development. CMA was influencing Governments through National Medical Association to the Health Ministers of their contries. CMA takes active participation in the Commonwealth Health Ministers Meeting (CHMM) every year in Genera, in the last week of May.

Later Commonwealth Health Professions Alliance (CHPA) was formed with CMA, CNMF,CPA,COMHAD,CADGAN,COSWI with CMA President Dr. Arulrhaj, as Founder Chairman.This CHPA is to involve total Health workforce to create a Healthy Commonwealth & also assist to solve the issues in Healthcare in their respective Countries.

Our President of CMA, Prof.Dr.J.A.Jayalal is very keen to make CMA Vibrant by improving the Healthcare in all the Commonwealth Nations & the Key is CMJ. CMJ help us to disperse& share Health information in all countries. In addition there are clinical challenges we meet in our practice, Clinical album with picturised visualization of clinical scenerios, Policy Articles and Medical Articles will definitely upscale our Clinical & theoretical knowledge & elevate the level of Healthcare in Commonwealth Countries.

Kindly share your clinical thoughts in CMJ&support.

Kindly share CMJ to your regional NMAs & leaders so that we will create a vibrant Healthy Commonwealth.

BestWishes

Prof.Dr.S.Arulrhaj.,MD.,PhD,DSc,FRCP(G),(L)MBA
PastCommonwealthPresidentCMA,UK
Editor, CMJ

FROM THE PRESIDENT'S DESK
COMMONWEALTH MEDICAL ASSOCIATION

To
All national medical associations.
Commonwealth Nations

Subject: Strengthening Partnerships for Resilient Common

Health: Utilizing Our Commonwealth

Dear colleagues,

Warm greetings from the Commonwealth Medical Association. It is an honor and privilege to meet with distinguished leaders and members of our National Medical Associations throughout the Commonwealth. Please accept my sincerest thanks for your tireless efforts and invaluable contributions to improving healthcare systems and millions of lives. I join the Commonwealth Secretariat in wishing everyone a prosperous and healthy New Year.

The theme for the Commonwealth is "One Resilient Common Future: Transforming Our Common Wealth." It highlights the identification and development of each country's strengths by leveraging the Commonwealth's unique network and resources for mutual benefit, fostering a connected and digital Commonwealth. Resilient CommonHealth calls us to join forces in our shared mission of creating a future that ensures affordable, accessible, and equitable healthcare for all. I urge you to include this topic in your national policies and programs, knowing that resilience is key to attaining long-term and significant healthcare outcomes. By stressing collaboration and innovation, we can address our communities' unique health concerns. Together, we can build a framework that empowers people and improves the overall well-being of communities across the Commonwealth.

Climate Change & Health:

Climate change has far-reaching health consequences, with disadvantaged groups across the Commonwealth bearing the brunt of the repercussions. Let us step up our efforts to advocate for climate change mitigation policies that prioritize public health, address environmental determinants of health, and create climate-resilient healthcare systems. We can effectively allocate resources to those in most need by encouraging collaboration among government agencies, healthcare providers, and community organizations. Furthermore, combining education and awareness initiatives will provide individuals with the knowledge they need to adapt to and combat the health risks caused by climate change.

Tuberculosis eradication:

The Commonwealth states account for two-thirds of the worldwide tuberculosis burden. This necessitates a concentrated and comprehensive approach to TB ontrol, including early detection, effective treatment, community participation, and cross-border collaboration. Together, we can work toward the lofty goal of eradicating tuberculosis from our countries. The Commonwealth Medical Association, in partnership with the UN Assembly's Stop TB Partnership Program, promotes high-burden countries to work with commercial and public health practitioners on the urgent goal of eradicating tuberculosis. This mission demands not just focused resources but also a shared commitment from all stakeholders. We can improve our response to tuberculosis by supporting research innovation and sharing best practices, resulting in a healthier future for all Commonwealth inhabitants.

FROM THE PRESIDENT'S DESK
COMMONWEALTH MEDICAL ASSOCIATION

Youth Empowerment:

Our youthful medicos and doctors are the healthcare industry's future leaders. I encourage all organizations to actively promote youth exchange programs that facilitate cross-country learning, leadership development, and collaborative creativity. Let us invest in empowering young healthcare professionals to build a more vibrant and inclusive medical workforce in the future.

Joining this participatory democracy:

The Commonwealth Medical Association invites all member countries to actively participate and share their ideas, needs, and opportunities—building a strong relationship amongst healthcare professionals across national borders. I strongly encourage you to renew your membership and build togetherness.

Commonwealth Individual Associate Membership:

I invite all medical professionals to join as individual associate members, strengthening our collective voice and broadening the scope of the CMA. This will create a unique platform for international information exchange, cooperation, and the sharing of best practices. Finally, I am requesting your support for the newly formed CMA team. We shall work together to maintain the Commonwealth's objectives, confront pressing health concerns, and support new solutions for the greater good. Let us stand together, dedicated to achieving the vision of a healthier, more equal, and sustainable future for all Commonwealth countries. I look forward to your active participation, guidance, and collaboration on our mission of health for all.

With heartfelt regards and best wishes.
Professor Dr. J.A. Jayalal
President, Commonwealth Medical Association

JOURNAL REPORT FROM THE SECRETARY,
COMMONWEALTH MEDICAL ASSOCIATION (CMA)

Title: Stepping Into Office and Building Momentum

Introduction: A New Chapter Begins

November marked the beginning of an exciting journey as I assumed the role of Secretary of the Commonwealth Medical Association (CMA). With this honour came the responsibility to reinvigorate the association's mission and set a dynamic pace for the future. These initial months have been filled with opportunities to engage, collaborate, and lay the groundwork for transformative initiatives. This journal captures the essence of these engagements and offers a glimpse into our vision for 2025.

1. First Engagements: Driving Change, One Initiative at a Time

The Commonwealth Medical Association (CMA) hosted a series of impactful Lancet Countdown launch events to emphasize the importance of climate-smart healthcare delivery models. These events highlighted the critical role healthcare workers play in addressing climate challenges while fostering regional collaboration and inspiring actionable change across the Commonwealth.

The journey began in Nairobi, Kenya, on December 6, 2024, the vibrant citybecame a melting pot of ideas as CMA partnered with Kenya Medical Association and the Lancet Countdown Commission on Health and Climate. Stakeholders, from policymakers, universities, media houses and grassroots advocates, converged to discuss strategies for adapting health systems to the realities of climate change.

Building on the momentum, the second event was held in Kuala Lumpur, Malaysia, on December 17, 2024, followed by a final gathering in Chennai, India, on January 5, 2024. Each city became a hub of dialogue and collaboration, uniting healthcare professionals, policymakers, and community advocates to tackle the intersection of health and climate change. These events underscored the urgent need for healthcare professionals to take an active role in climate resilience, equipping participants with actionable knowledge to address climate-related health challenges.

The partnerships forged during this initiative have solidified CMA's position as a leader in climate -smart healthcare. The events not only inspired participants but also catalyzed long-term collaboration to build climate-resilient healthcare systems across the Common wealth.

In another impactful collaboration, CMA joined forces with the StopTB Partnership to amplify efforts to end tuberculosis. This engagement highlighted the association's commitment to advocacy, capacity building, and policy influence. From raising awareness about the devastating impact of TB to equipping healthcare professionals with effective tools, every aspect of this collaboration reinforced CMA's resolve to eliminate the disease.

Simultaneously, CMA took on the formidable challenge of antimicrobial resistance. Recognizing its global threat, the association prioritized antibiotic stewardship in its agenda. Through dynamic continuing medical education (CME) events, healthcare professionals were empowered to use antibiotics responsibly. Community engagement efforts emphasized the dangers of misuse and the importance of adhering to prescribed treatments. Policy frameworks were also supported to ensure long-term success in combating this challenge.

Understanding that healthcare must address the diverse needs of its recipients, CMA placed a gendered lens at the forefront of its initiatives. This approach sought to bridge gaps in health equity

by advocating for services tailored to the unique needs of all genders. Training programs empowered healthcare workers to provide gender- sensitive care, while collaborations with like-minded organizations paved the way for more inclusive healthcare practices.

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2. Vision for 2025: Building Bridges, Transforming Lives

As CMA looks to the future, the vision for 2025 is both ambitious and inspiring. The association is dedicated to organizing CME events that will not only educate but also foster dialogue and innovation. Topics such as climate resilience, mental health, and primary healthcare will take center stage, with workshops and interactive sessions ensuring practical value. These events aim to strengthen bonds among medical associations across the Commonwealth, creating a unified front to tackle global health challenges.

Membership remains at the heart of CMA's strategy. Plans are underway to launch campaigns that will inspire professionals to join the association, with a focus on young and underrepresented groups. Membership benefits, including access to resources, training, and networking opportunities, will be expanded. Regional chapters will be established to provide localized engagement and address region specific challenges, ensuring that CMA's impact is felt on every level.

Collaborations with global and regional organizations will be key to driving CMA's agenda forward. From addressing health crises like TB and antimicrobial resistance to advocating for equitable health policies, partnerships will amplify the association's efforts. CMA is also committed to fostering innovation in healthcare delivery, working with academic and research institutions to advance evidence-based practices.

Advocacy will remain a cornerstone of CMA's work. Clima te action and responsible antibiotic use will be at the forefront of public campaigns, resonating with both communities and policymakers. These efforts will not only champion health equity but also ensure that CMA

3. Reflections and Gratitude

Reflecting on these initial months, I am filled with pride and gratitude for the opportunities to make a difference. Collaborations with the Lancet Countdown, StopTB Partnership, and KMA have reinforced CMA's ro le as a leader in addressing global health challenges. The Lancet Countdown launch events in Kenya, Malaysia, and India have further solidified our commitment to climate-smart healthcare, creating momentum for collective action across the Commonwealth. These partnerships have laid the foundation for impactful initiatives, and the journey ahead is filled with promise. Together, we will turn aspirations into achievements and create a healthier, more equitable future for all.

Closing Note

The Commonwealth Medical Association stands united in its mission to advance healthcare practices and address emerging challenges. I invite all members to join hands as we continue this transformative journey.

Dr. Joy Mugambi,
Secretary General,
Commonwealth Medical Association.

CMA BIENNIAL CONFERENCE AND CMA PRESIDENT INSTALLATION 9 & 10TH NOVEMBER 2024, CHENNAI, INDIA

Installation Ceremony of Prof. Dr. J. A. Jayalal as President of Commonwealth Medical Association held on 9th to 10th November 2024 at Hotel Green Park Chennai

REPORT OF THE VISIT OF CMA PRESIDENT PROF. DR. J. A. JAYALAL TO THE NORTHERN

PROVINCE SRI LANKA FROM 11TH NOVEMBER TO 13TH NOVEMBER 2024

- Dr. Sumathi UK

On the invitation of theNorthern Province Development council of Sri Lanka, represented by Dr. Sumathi Luxman UK and Mr. Premendra RajahI visited Jaffna, Vavuniyaand Mullaitivuon the dates 11th to 13th November 2024, representing CMA.On 11th November evening 5 pm we met with the Northern Province Governor Hon'ble Mr. Nagalingam Vethanayahan in his office, along with their Province Director of Health ServiceDr. Saman Pathirana and team and had discussion for two hours.

On 12th Nov evening visited Vavuniya university which is almost 3 hours'drive fromJaffna and had meetings with the Vice chancellor of University of Vavuniya Prof. Dr. Arulampalam Atputharajah and team Ex Vice Chancellor Prof Dr Thampoe Mangaleswaran, Dr K Senthurpathirajah Deputy Director of District General Hospital Vavuniya, Prof Dr Y Nanthagopan Dean and Professor Faculty of Business Studies, Dr Bhavanandhan Deputy Director of Health Services Jaffna & Director Manipay Co Operative Hospital, Dr Surenthiran Consultant Psychiatrist, Prof Er S SivakumarVavuniya, Dr Peranandha Rajah Visiting Physician, Vavuniya Hospital, staff at Vavuniya University and Hospital, present.

After the meeting, the University visited the Vavuniya 560 bedded hospital and interacted with the staff. 200 deliveries per month handled by 2 qualified Gynecologists.

Visit to Vavuniya District General Hospital with the Vice Chancellor of University of Vavuniya Prof Dr ArulampalamAtputharajah, Dr K Senthurpathirajah Deputy Director District General Hospital Vavuniya and hospital staff

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In the night we had dinner meeting with the doctor sofJaffna including Dr. Bhavananda Rajah, who was contesting for the Parliament election and has subsequently won the election and become the Member of Parliament. On the morning of 12th Nov visited the University of Jaffna and to the Clinical Training and Research Institute, Faculty of Medicine. Meeting held with the Vice Chancellor Prof Dr S Satkunarajah and Prof. Dr. R.Surenthira kumaran Dean of Medical Faculty, and with some of the faculty staff at the University and at the new Training and Research Institute which was Inaugurated-by the former Presiden tof Sri Lankain May, astateofart 10 storied building with lot of infrastructure, but not in operation due to lack of staff

Meeting with Deputy Regional Director of Health Services Dr S Mathurahan and Dr Gajan Superintendent @ Manakullam Tertiary Rehabilitation Centre with ICU and HDU units, Mullaitivu. In this high-endtertiary Care Rehab Centre fully Equipped and voted Best in South Asia builtin collaboration by Netherlands Govt. with the SriLankan Govt, the Rehabunits and equipment not usable including 2 fully equipped ICU beds and 8 HDU beds and part of the General wards due to lack of trained staff

On 13th Nov had a meeting with th eConsulate General of India, Hon'ble Mr. Sai Murali IFSand the Deputy High Commissioner Mr. Nagarajan at the Consulate General Office, Jaffna and discussed with them the modality and help the Indian embassy can offer to the needs of the hospitals and the training center.

We observe,

- ►The health indicators of SriLanka's Northern Province are much better ; 98 percent of deliveries are in government hospitals.
- ► The infrastructure facilities of the hospitals are appropriate.
- ► Both Jaffna and Vavuniya are experiencing an acute shortage of qualified specialist doctors in departments uchassurgery, ophthalmology, oncology, andmanyothers.
- ► The Northern Province has only one medical college, covering five districts.Vavuniya has the potential to establish a medical faculty but lacks the necessary academic infrastructure.
- ► The low cadre hospitals tafflacks basic trainingin lifes kills, infection control, and basic nursing skills, necessitating intensive, short-term onsite training.
- ► The Manakulam rehabilitation center has state-of-the-artequipment but no qualified staff to run it. Despite the presence of qualified personnel, the ban on appointments prevents their use.
- ► Only PGI Medical Science Colombo provides postgraduatesfor all of SriLanka. Which is much below the need. Annual MBBS seats are around 2250, while the PG seat sareonly 350.

Were commend and offer our support in

- ► We will be organizing structured soft skills and basic medical skill training for the staff, providing them with onsite, short-term, comprehensive training. CMA will facilitatethis.
- ► Weare offering ther equired assistancein selecting five skilled employees from the local workforce for the rehabilitation unit, and we will also be providing them with basic financial assistance.
- ► CMA will write to the SriLanka Medical Council to discuss the possibility of establishinga PGI Munitinother medical facultiesasanextension,with the goal of developing new PG departments.
- ► We plan to organizea free, structured training program for the faculty on advanced skills in the chosen hospitals in India.
- ►Select candidates can receive free long-term training in laboratory skills, pharmacology, occupational therapy, and physiotherapy at accredited centers in India.

Establish a short-term geriatric care training course at Jaffna University with voluntary faculty support.

UNRELENTING COUGH A CLINICAL CHALLENGE

History

A 69 years old male patient presented with complaints dry cough for past 3 months visited multiple doctors and took several course of antibiotics, but there was no relief.cough wasnot associated with Hemoptysis, Sputum, Fever, Weight loss, BreathlessnessNo H/O, Orthopnea,PND, Swelling of legs. Patient is a known case of Diabetes Mellitus, Hypertension for Past 10 years and Hypothyroidism for 3 years , on regular treatment.

Not a smoker or alcoholic,Consumes mixed diet

Examination

Well built and well nourished

No Pallor, Icterus, Cyanosis, Clubbing, Edema, Lymphadenopathy Vitals: Normal

Systemic examination n–ormal

Examination Of Paranasal Sinus and Nasal Cavity -Right Maxillary sinus tenderness Present.Other sinuses were normal

Nasal Cavity D–eviated Nasal Septum to left

Investigations

Hb- 11.2 g/dl

TC- 10000 cells/cu.mm DC- 80 %/14 %/6 % ESR -15/35

Blood Sugar- 143 mg/dl HbA1C- 6.3%

Urea- 28 mg/dl

Creatinine- 0.9 mg/dl

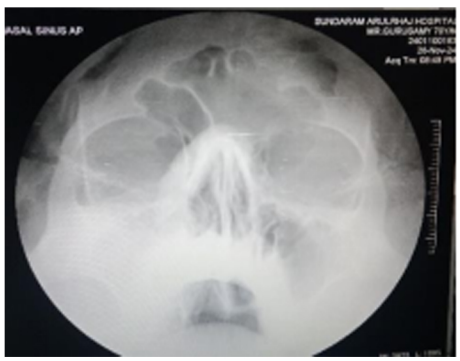
Urine Routine N–ormal

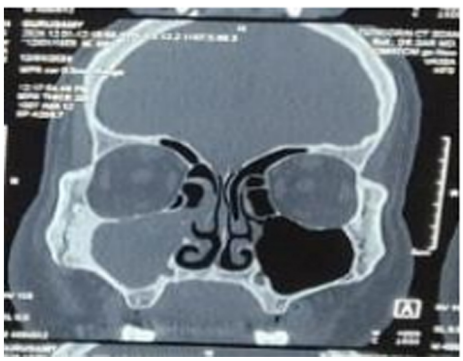
CXR- Normal

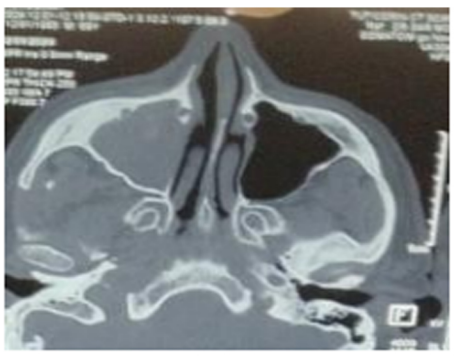
CT Chest N–ormal

Echo- EF 56% ,LVDD

Pre OP Xray -Right Maxillary Opacity







CT PNS - Soft tissue attenuation in Right Maxillary sinus with obliteration of Osteomeatal Complex.Mucus retention cyst in Right maxillary sinus.Mucosal thickening in Frontal and Sphenoid sinus

Course in the hospital

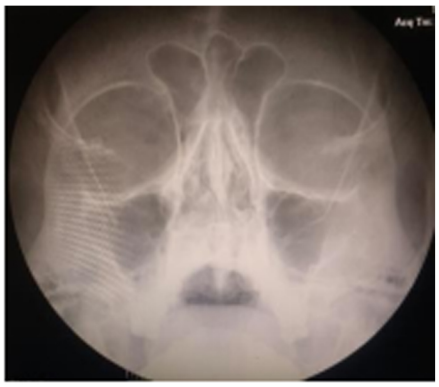
In view of this ENT opinion was taken and Functional Endoscopic

Sinus Surgery was done

Pus collected from Right maxillary sinus and sent for culture and sensitivity

Fungal ball removed and sent for culture and sensitivity and it showed Aspergillus and Staph Aureus. Treated with IV antibiotics (ceftriaxone + sulbactam) and antifungal (Fluconazole). patient improved and went home symptom free.

Fungal Ball



Post OP Xray

Final Diagnosis

SBS- Chronic Right Maxillary Sinusitis F–ungal with secondary bacterial Infection

Diabetes Mellitus /Hypertension /Hypothyroidism

TAKE HOME MESSAGE

C/C Cough with normal lungs focus on sinusitis

In DM fungal infections are common

Reference

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TYPE 2 DM REVERSAL REVIEW ARTICLE AN OBSERVATIONAL STUDY

Dr S Arulrhaj , Dr Aarathy Kannan, Dr Nikhil , Dr Muhammed Basil , Dr Dhinesh Kumar

ABSTRACT

Over the past 50 years, many countries around the world have faced an unchecked pandemic of obesity and type 2 diabetes (T2DM). The conventional view has been that T2DM is irreversible and progressive. However, in 2016, the World Health Organization (WHO) global report on diabetes added for the first time a section on diabetes reversal and acknowledged that it could be achieved through a number of therapeutic approaches. Many studies indicate that diabetes reversal, and possibly even long-term remission, is achievable, belying the conventional view. Diabetes reversal through diet is not articulated or discussed as a first-line target (or even goal) of treatment by any internationally recognized guidelines, which are mostly silent on the topic beyond encouraging lifestyle interventions in general

This research paper examines all the sustainable, practical, and scalable approaches to T2DM reversal, highlighting the evidence base, and serves as an interim update for practitioners looking to fill the practical knowledge gap on this topic in conventional diabetes guidelines

INTRODUCTION

According to the International Diabetes Federation 2023, there are around 70 million people with diabetes mellitus in India.

The highest prevalence of diabetes was found in south India (9.39%), followed by eastern (6.81%) and western Indian (6.58%). Northern India had the lowest prevalence of diabetes

Diabetes management continues to evolve. The last few decades have shown a paradigm shift in our understanding of prevention and remission of Type 2 Diabetes1, Recent studies have shown that it is possible for some people with T2DM to reverse it.

T2DM is an ongoing process, initially requiring life style modifications & OHA'S & in some cases insulin too.

ADA call this as "Remission of Diabetes".

WHO global report on Diabetes says that diabetes remission can be achieved through weight loss and calorie restriction

Although the terms "reversal" and "remission" are used interchangeably, recent consensus supports the use of "remission" in the context of T2DM. Furthermore, a distinction could be made between mere reversal (return to normoglycaemia) and true remission (normoglycaemia maintained for at least 3 months in the absence of glucose-lowering drugs)

AIMS AND OBJECTIVES:

To assess the relation between weight reduction and reversal of T2DM.

To relate HbA1c levels and weight control.

MATERIALS AND METHODS:

Name Of the Study: Observational

Sample size : 175

Place of Study : Dept.Of Medicine, SAH, Tuticorin

Duration Of Study: Jan 2022 to Jan 2024

SELECTION CRITERIA

INCLUSION CRITERIA

All diagnosed patients with type 2 DM in the age group of 25 to 65 yrs

EXCLUSION CRITERIA

Patients with gestational diabetes mellitus. Patients with Type 1 DM

All patients with diabetic complications (CVA/CAD/PVD etc)

ADVISE GIVEN TO PATIENTS

Nutrition :
low carbohydrate diet has been advised to the patients in the study to maintain calorie intake between 800-1000 kcal per day. Nutrition counselling given and sustainability of the proposed diet checked in each visit.

Exercise:
daily morning walk of approx.2km, making habit to increase physical activity like bicycle use , taking stairs in spite of lift or elevator .

Drugs:
use of SGLT2 and GLP agonists to decrease blood glucose levels ,so as to make glucose less available for the fatty acid synthesis.

AGE(Years)	No. of Patients
25-35 years	18
36--45 years	68
46- 55 years	79
56-65 years	10
	Total = 175

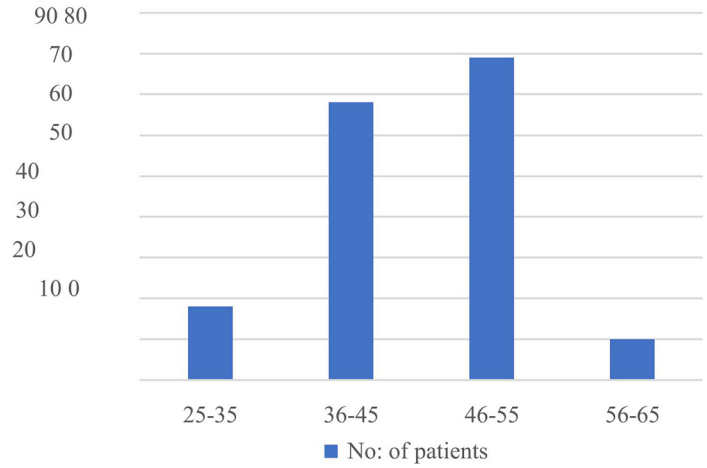


Table 1 : Age Wise Distribution

In our study population, major group fell in to 46-55 years of age.

	Total (N=175)
MALE	80
FEMALE	95

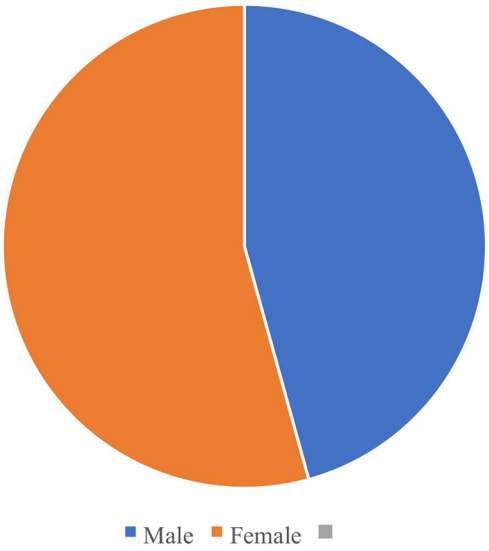


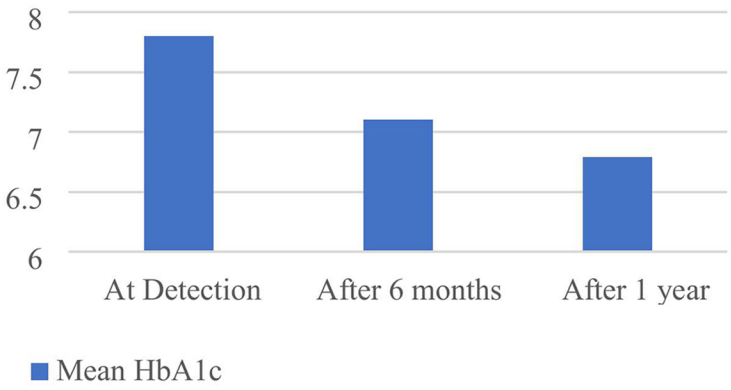
Table 2 : Sex Wise Distribution

In our study females were more than males.

- Mean Years of Diabetes = 6 years

Mean HbA1c

	Mean HbA1c
At Detection	7.8
After 6 months	7.1
After 12 months	6.79



- Mean HbA1c at the time of detection = 7.8
- Mean HbA1c after 12 months = 6.79

Table 3 : Mean HbA 1c

Mean Weight

	Mean weight (in kgs)
At Detection	71.82
After 6 months	66.34
After 12 months	62.29

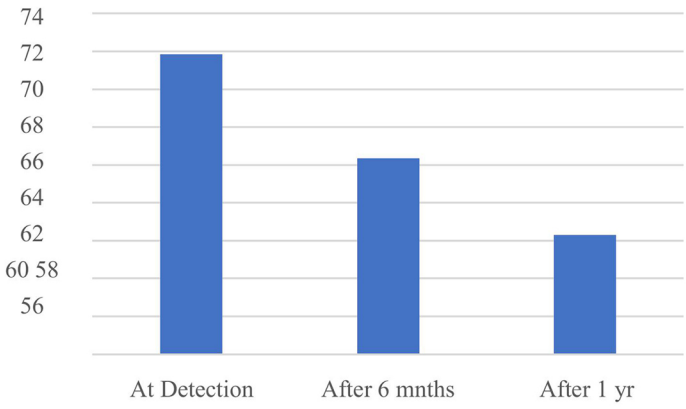
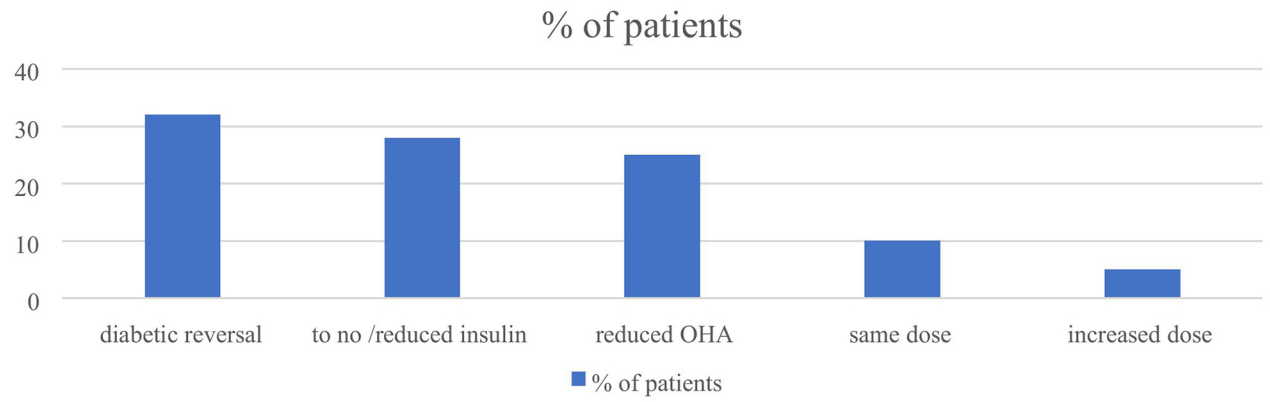


Table 4 : Mean Weight

- **Mean weight at detection = 71.82 kgs**
- **Mean weight after 12 months = 62.29 kgs**

OUT COME



- People with Diabetes Reversal = 32 %
- People from insulin to no insulin/dose reduced = 28 %
- People with OHA dose reduced = 25%
- People continuing same dose = 10 %
- People with increase in OHA/ Insulin dose = 5%

RESULTS

- It was concluded that for diabetes remission Dietary interventions are mainstay.
- A simple weight reduction in obese/ overweight diabetics can still induce larger benefits even if remission is not achieved
- However we require a randomised clinical trial to prove that reduction in the carbs and increase in protein and healthy fats can induce Remission.

- **Discussion**

DEFINING REMISSION- ADA [3]

» REMISSION : Term “remission” is to be preferred to “reversal,” . Defined as; Return of HbA1c to <6.5% and/or fasting plasma glucose to <126 mg/dL.It persists for at least 3 months in the absence of glucose-lowering pharmacotherapy

» PARTIAL REMISSIONAchieve HbA1c <6.5% and/or fasting glucose 100–125 mg/dL and is off all diabetes medication for more than 1 year.

» COMPLETE REMISSIONAchieves HbA1c <5.6% and/or fasting glucose <100 mg/dL and is off all diabetes medication for more than 1 year.

» PROLONGED REMISSIONAchieves an HbA1c <5.6% and/or fasting glucose <100 mg/dL and is off all diabetes medication for 5 years and more

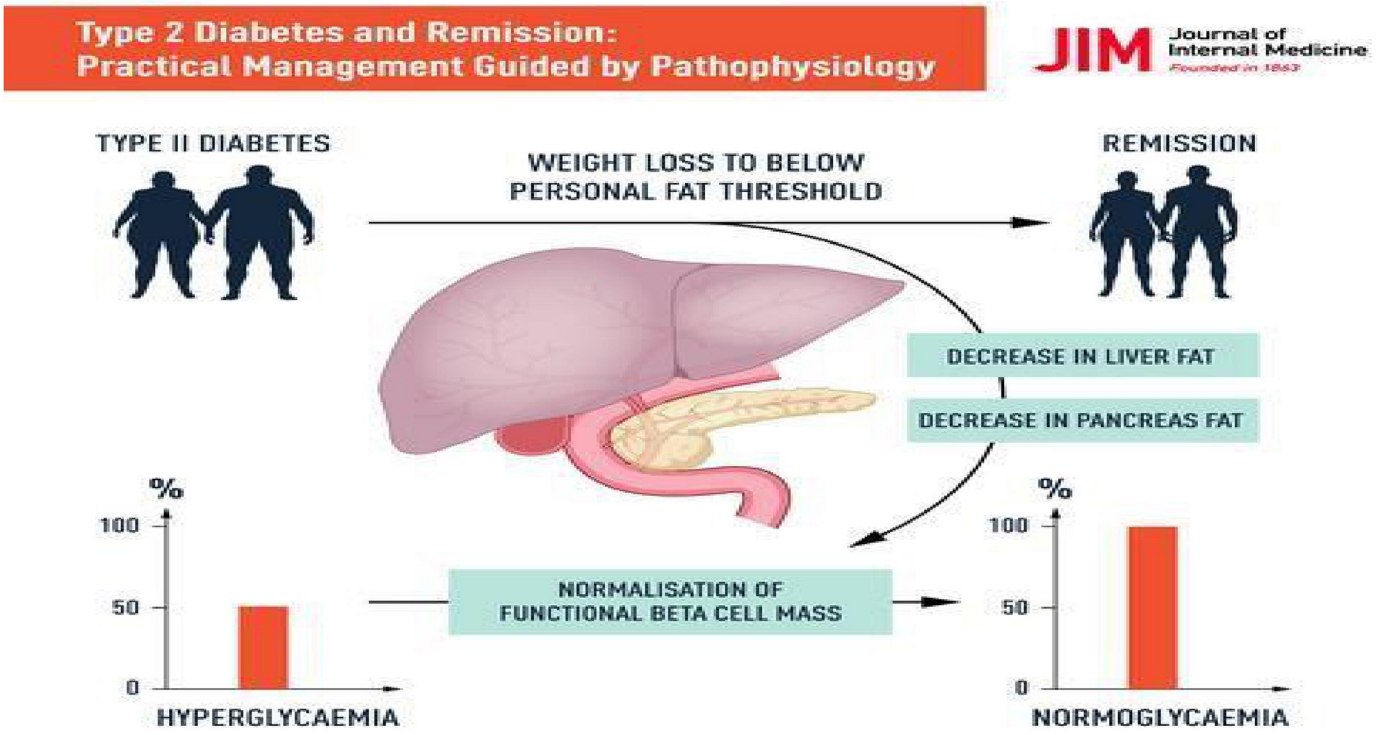


Fig 1 : Mechanisms of Remission of T2Dm with LCD[4]

WHAT ARE THE DIETARY RECOMMENDATIONS FOR REMISSION IN T2DM[5]

Standards of Care in Diabetes—2023

Low calorie diet –(LCDs) (1000–1500 kcal/day) or

Very low-calorie diets (VLCDs <800kcal/d)

- Comprise 50–60% CHO, essential fatty acids and high-BV proteins such (1.2–1.5 gm/kg BW) to preserve loss of LBM

Low carbohydrate diet (LCBD) help lowering insulin secretion thereby reducing fat storage, facilitating weight loss, and improving cardio-metabolic function

- LCBD—<26% of en from CHO or less than 130 gm CHO/ day

Very low carbohydrate diet (VLCBD)—

<10%en from CHO or 20–50 gm CHO/ day.

WHO IS THE RIGHT CANDIDATE FOR SUCH DIETARY INTERVENTIONS?[6]

The ABCDEF formula can help us identify individuals with T2DM most likely to achieve remission;

A: A1c or HbA1c those who do not have markedly elevated A1c are more likely to achieve remission.

B: Body weight greater the body weight, greater the chances of achieving remission (15 kg or more weight loss is required to achieve T2DM remission).

C: C-peptide higher chances for remission are seen with better levels of Cpeptide

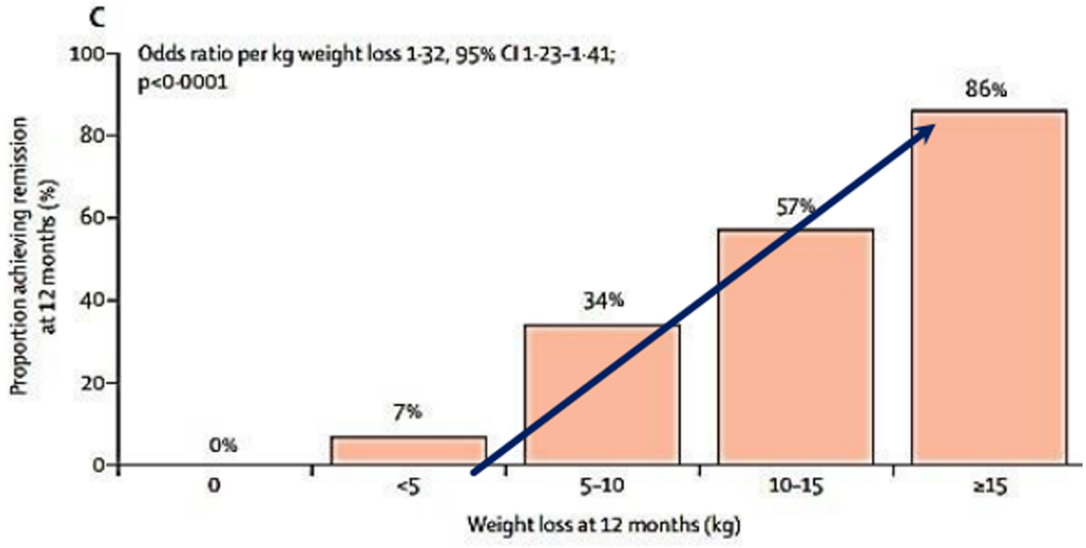
D: Diabetes duration greater the chance of remission with shorter duration of diabetes (<6y)

E: Enthusiasm high motivation levels are needed for remission.

F: Frequent follow-ups individuals should be willing to follow-up frequently with the health care team

THE DIABETES REMISSION CLINICAL TRIAL (DIRECT), 2018 & 2021[7]

298 obese patients with T2DM were initiated on complete meal replacement providing 825 - 853 kcal/-day for 3 - 5months, f/b stepwise food reintroduction (2 - 8–wks), and structured supportof long-term maintenance of weight loss

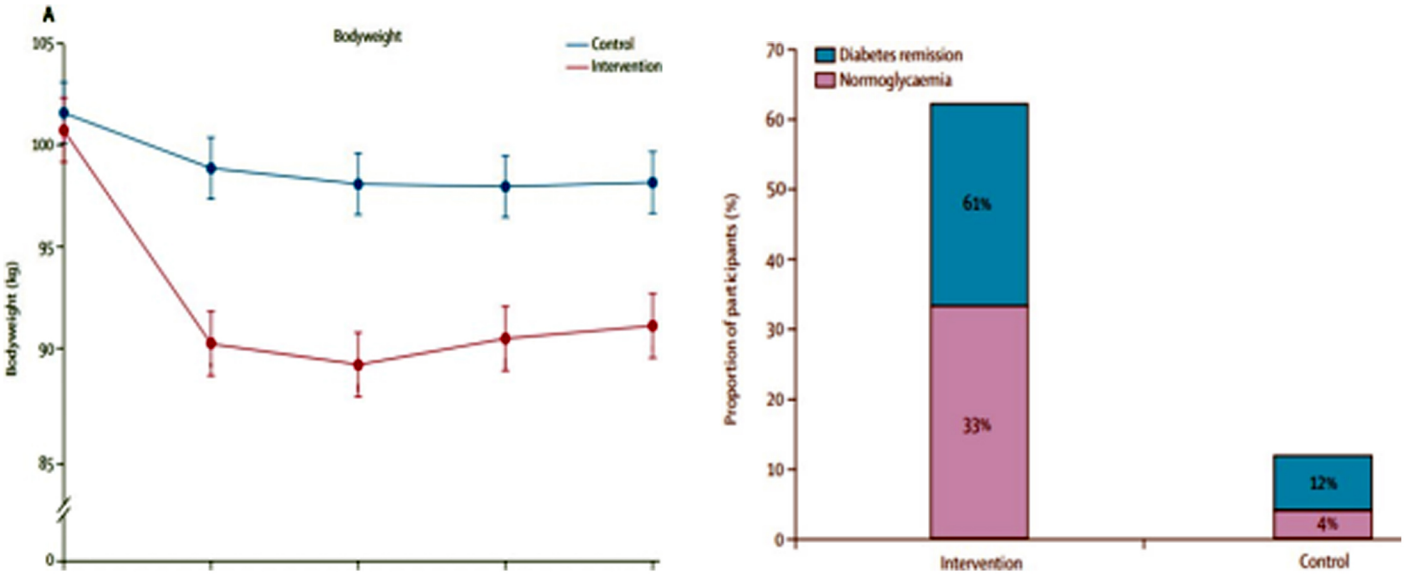


Conclusion

At 12 months, ~50% achieved remission to a non-diabetic state and off antidiabetic drugs.

Weight loss was the strongest predictor of remission at 12 months and 24 months.

EVIDENCE OF DIETARY INTERVENTIONSIN DIABETES REMISSION -DIADEM-1, 2020[8]



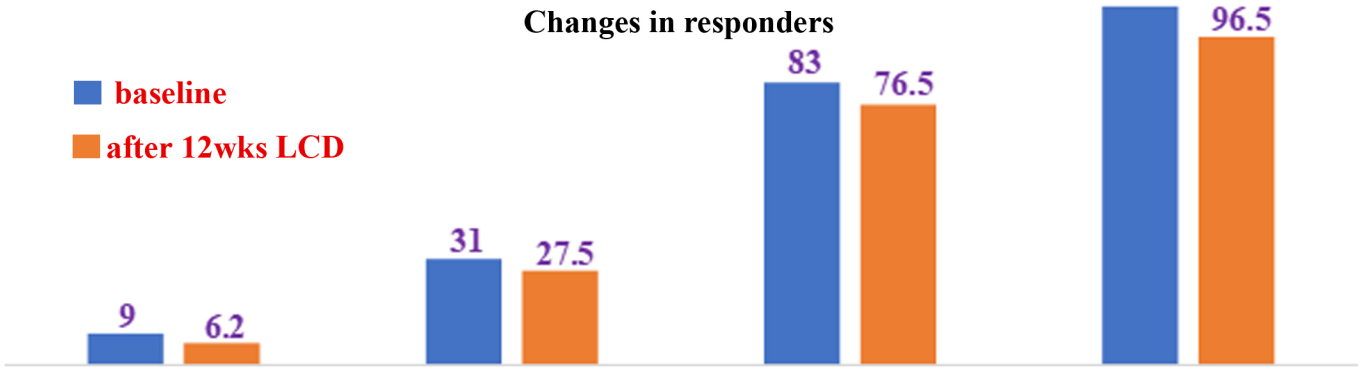
T2DM, BMI of 27·0 kg/m2
12-wk total diet replacement phase, VLCD
(800 - 820 kcal/day) f/b a 12-wk structured food reintroduction phase

Conclusion

The intensive lifestyle intervention led to significant weight loss at 12 months, and was associated with diabetes remission in over 60% of participants and normoglycaemia in over 30% of participants

BHATT ET AL (2017), PUNE, INDIA

- **12 obese participants with T2DM**
- **12-week low-calorie diet 1000 kcal/day**



Conclusion

If long-term follow-up proves sustained benefits, such dietary restriction may be an alternative to more drastic options for reversal of type 2 diabetes

Conclusion

In the unprecedented epidemic of diabetes, current standard of care may be suit able for some, but others would surely choose reversal if they understood there was a choice.

Many risk factors for prediabetes/ metabolic syndrome are modifiable by changes in lifestyle.

Diet, physical exercise and weight reduction(min 10kg loss) are key for diabetic reversal.

This choice can only be offered if providers are not only aware that reversal is possible but have the education needed to review these options in a patient- centric discussion.

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2. **Reversal and Remission of T2DM A–n Update for Practitioners LinaShibib,[1]Mo Al-Qaisi,[1]Ahmed**

3. **Salis S, Anjana RM, Unnikrishnan R, et al. Remission of Type 2 Diabetes: How, When, and for Whom? J Assoc Physicians India 2022;70(8):74 - 82**

4. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7673778/ Journal of Internal Medicine, 2021, 289; 754 - 770**

5. **Taylor R. Diabetologia. 2008; 51: 1781-1789Taylor R, Al-Mrabeh A, et al. Lancet. 2019; 7(9): 726-736**

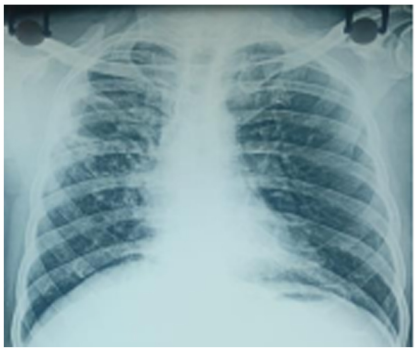
6. **Salis S, et al. J Assoc Physicians India 2022;70(8):74 8–2**

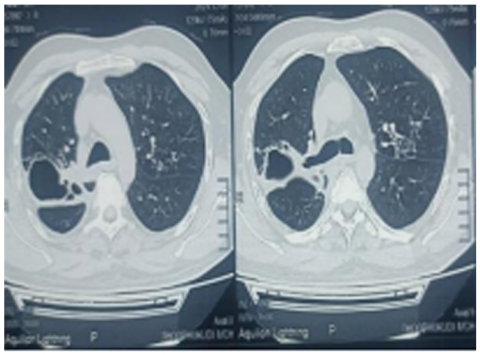
7. **Lancet Diabetes Endocrinol 2020; 8: 477 4–89**

*Dr S Arulrhaj,**Dr Aarathy Kannan,***Dr Muhammed Basil,Dr Dhinesh Kumar, Dr Nikhil

CHEST X RAY

A 35 years old male ,came to emergency with complaints of hemoptysis, kco tb copletedatt 6mnago and an x ray chest was taken as shown here. O/e-: bp-130/70, pr-114/min , spo2-85% on Room air rbs- 134 mg/dl





Q. What is the finding in the xray?

Cavitatory lesion in the right upper lobe of lung.

Q. What are the causes of cavity formation in lungs ?

Infections(e.g. Tb), cancer, auto-immune conditions(wegners, sarcoid), trauma.

Q. Whatis the pathophysiology of cavity formation ?

A cavity is usually produced by the expulsion or drainage of a necrotic part of the lesion via the bronchial tree

Q.what are the differentialdiagnosis of lungcavity on x ray ?

Tuberculosis, fungal infection ,malignancy ,lung cysts, emphysema, bullae, and cystic bronchiectasis. Lung cysts are the most common mimics of lung cavities

Q.what are the complications of lung cavity?

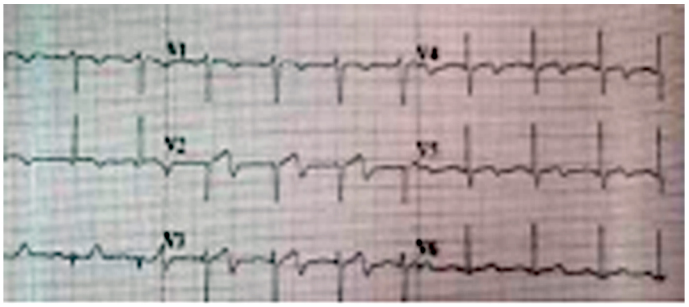
Pneumothorax, secondary infections, hemoptysis,fungal ball

Summary:35 yrs old male presented with breathlessness, patient treated with antibiotics, bronchodilators, vitamin k

ECG

A 55 years old male came to emergency with complaints of chest pain since morning which got subsided on its own after few hours . BP- 130/70, PR -84/MIN ,SPO2-96% IN RA, Trop I- 123 pg/ml

Q: what is the finding in this ECG ?



Biphasic or deeply inverted T waves in leads V2 and V3 suggestive of wellen syndrome.

Q:What is the pathophysiology of this syndrome ?

Temporary Proximal LAD obstruction causes ischemia leading to up and down of T waves

Q:what is the cause ?

Rupture of an atherosclerotic plaque leading to LAD occlusion, with subsequent clot lysis or other disruption of the occlusion before complete myocardial infarction has taken place.

Q:what are the differential diagnosis of anterior leads T wave inversion?

left ventricular hypertrophy , RBBB, HOCM, and pulmonary

Q.Differential diagnosis of biphasic t wave ?

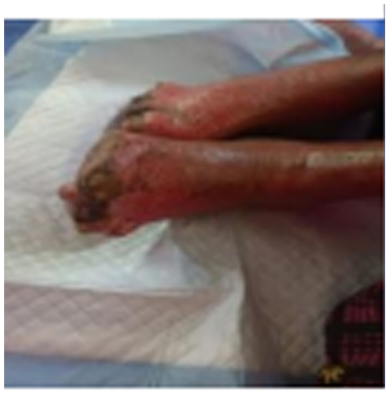
Wellen syndrome, hypokalemia

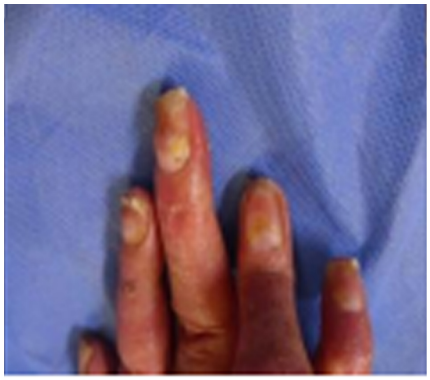
Summary:A 55 years old male came to emergency with complaints of chest pain since morning which got subsided on its own after few hours . Patient was evaluated and diagnosed as wallen syndrome

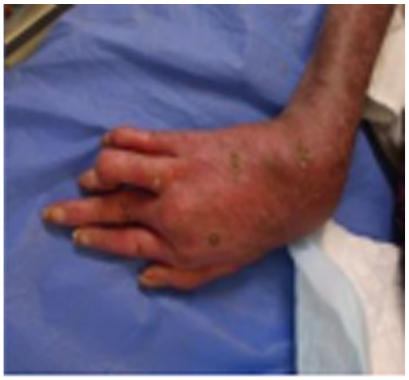
CLINICAL PICTURE

68 yrs old male presented with c/o tiredness, multiple joint pain, and deformities, generalized itching

o/e vitals stable







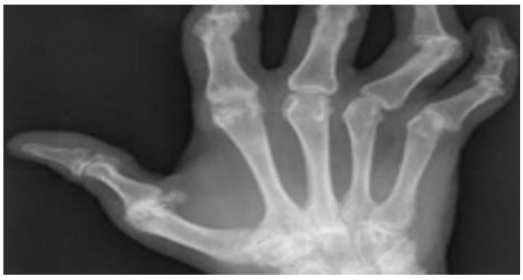
What is the clinical diagnosis?

Psoriatic arthritis with extensive skin involvement, nail changes and arthritis mutilans

What are the types of psoriasis?

plaque-type, inverse , Guttate psoriasis (eruptive psoriasis), pustular psoriasis

What are the extracutaneous manifestations psoriasis?



Fingernail involvement(punctate pitting, onycholysis, nail thickening, or subungual hyperkeratosis), 30% of patients with psoriasis have psoriatic arthritis (symmetric PsA, asymmetric PsA, distal PsA, spondylitis, and arthritis mutilans.)

CT ABDOMEN

A 63 years old Male known case of DCLD with Portal Hypertension (Post splenectomy / post PCI on antiplatelets/DM presented with complaints of abdominal distension and pain for past 3 days

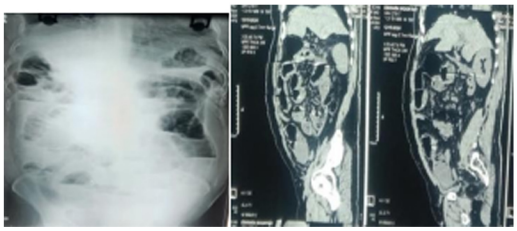
O/E BP- 120/70, PR-73, CVS- S1,S2 , RS-NVBS,

PA- Distended, Diffuse tenderness, No free fluid

How will you evaluate this patient?

CBC , electrolytes, Urea, Creatinine, X- Ray Abdomen, CT Abdomen

What does this X Ray and CT shows?



X-Ray:Multiple air fluid levels suggestive of Intestinal Obstruction

CT :Dilated small bowel loops, post splenectomy, CLD

Final Diagnosis?

Subacute Intestinal Obstruction- Paralytic ileus

What are the causes?

Adhesions, Hernia, Volvulus, Tumor, Foreign body

How will you manage?

NPO, RT Aspiration, Prokinetics, Antibiotics, Adhesiolysis if not resolving

CT PULMONARY ANGIO

45 year old obese female came with exertional breathlessness since 1 week

O/E Pt conscious oriented BP-110/70 , PR-121/min,Tachypniec

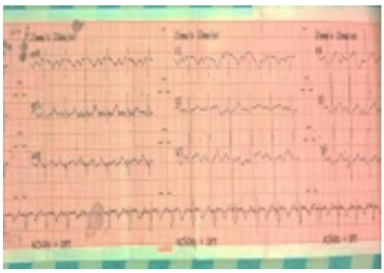
+,CVS-s1s2+,RS-nvbs+,

P/A - soft, No calf swelling, tenderness.

What is the clinical diagnosis?

Pulmonary Thromboembolism.

What does this ECG show?

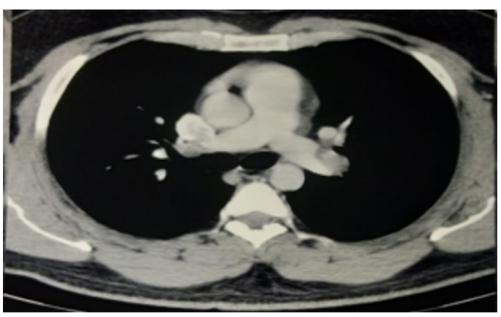


S1Q3T3 with sinus tachycardia. Classical finding in Pulmonary thromboembolism.

How to proceed?

Blood parameters-normal, Echo-EF-63%,Good RV function ,Mildly dilated RA and RV, Moderate pulmonary HTN, No RWMA ,Venous doppler Both LL-no DVT,CECT chest/CT Pulmonary angiogram.

What does this CECT Chest show?



Dilated pulmonary artery (Trunk,Rt,Lt branch)-S/O Pulmonary HTN, Thrombus seen in Both Rt and Lt pulmonary artery - S/O acute pulmonary thomboembolism.

What is the final diagnosis?

Acute Pulmonary thromboembolism

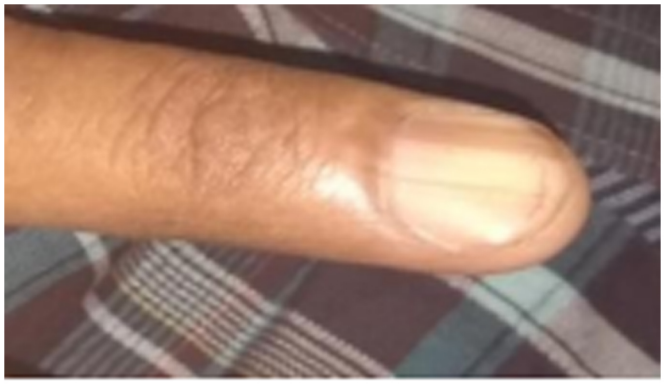
How to manage ?

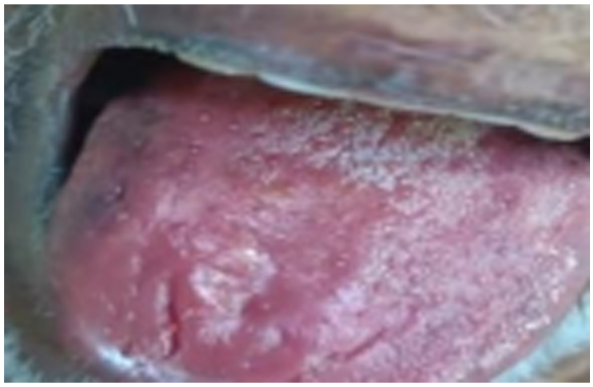
Mechanical thrombectomy can be done in unstable Patient. LMWH, NOAC,

OGD SCOPY

58 yrs aged Female pt presented to ER with c/o dysphagia for last 3 months , which was slowly progressive, only to solids general examination -flat spoon shaped nails, tongue inflamed and swollen, vitals -BP- 120/70, PR-107/MIN , SPO2-94%ON RA S/E;

CNS - alert ,cvs-s1s2+ ,RS-NVBS ,PA-soft

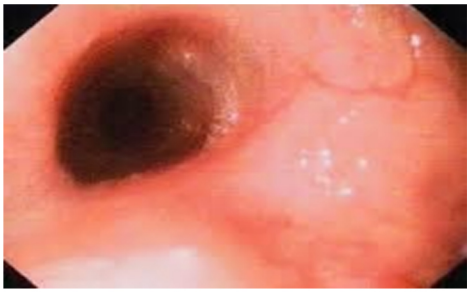




What is the diagnosis?

Iron deficiency anemia

What does the UGI scopy shows?



Post cricoid web

What is Peterson Brown Kelly syndrome?

A disorder marked by anemia caused by iron deficiency, and a triad of glossitis, koilonychia, post cricoid web. Also called Plummer- Vinson syndrome and sideropenic dysphagia

How to manage?

Iron supplementation and mechanical dilation.

LIVER BIOPSY

49 YRS old female presented with C/O tirednes rt hypochondrial pain and yellowish discoloration of eyes for last 2 wks, pt had similar complaints 15 yrs ago and was diagnosed as AIH(ANA+, ASMA+)-But no treatment was taken.

o/e jaundice +, vitals stable

What is the clinical diagnosis?

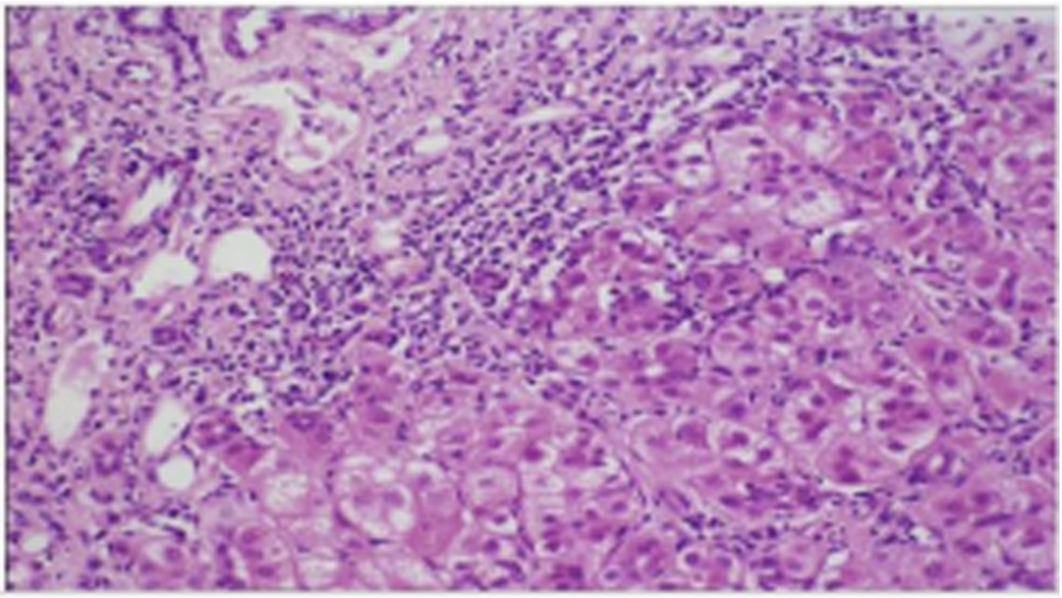
Acute hepatitis (metabolic/viral/druginduced/Wilsonian)

How to evaluate?

TC- 8400, DC-73/22.9/3/3.8, esr-8/18,plt- 1.62, urea-28, creat- 0.9, pt-18/13, INR- 1.43
LFT- s.bili- 14.5/11.2/3.3, sgot/pt-220/350, ALP-145, protein- 6/3.6/2.4
ANA-neg, ASMA- neg, Hep panel - neg, Anti LKM Ab- positive, total IgG- Normal,

What does the liver biopsy shows?

Interface hepatitis and lymhoplasmacytic infiltration suggestive of AIH



IMPRESSION:
Liver biopsy:
Features are in favour of Autoimmune hepatitis.

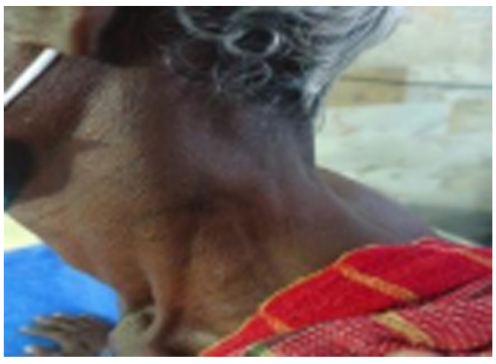
How managed?

Steriods(prednisolone) and immunomodulators(azathioprine)

Summary - 49 YRS old female presented with c/o tiredness rt hypochondrial pain and yellowish discoloration of eyes for last 2 wks,On evaluation diagnosed as AIH, pt started on steroids and immunomodulators and patient improved symptomatically.

CLINICAL PICTURE

57 Yrs old Female presented with occasional cough and swelling over the left side of neck for past 1 month O/E:GE-Swelling measuring 2x2cm over the left side of neck,

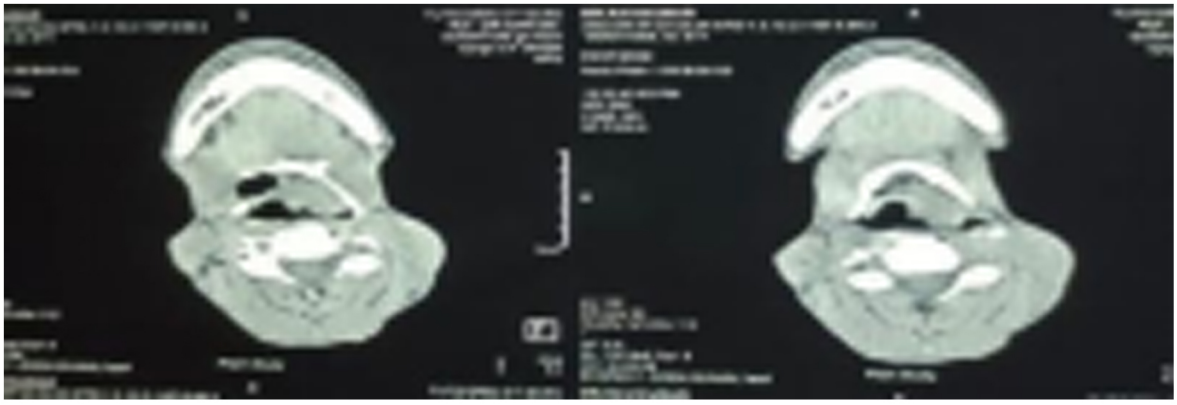


mobile, tender
S/E;CNS alert ,cvs-s1s2+ ,RS-NVBS ,PA-soft. Upper GI scopy was done which shows a growth in the epiglottis
BP-130/70, PR- 76/ MIN , SPO2-96%ON RA

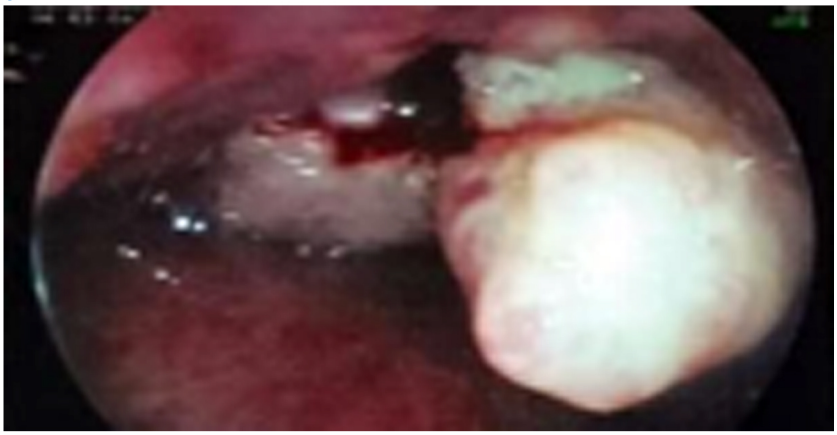
what is the clinical diagnosis?
Extrapulmonary TB- nodal TB, ?
METS, LYMPHADENOPATHY

How to evaluate?
CT NECK , UPPER GI SCOPY , ROUTINE LAB TEST, FNAC/BIOPSY, AFB +

What does this CT neck show?



What does UGIscopy show?



What does the histopathology of biopsy specimen shows?
Central keratinization surrounded by abnormal squamous cells- suggestive of scc

What is the final diagnosis?
SQAMOUS CELL CARCINOMA

SUMMARY :

A 57 Yrs old male presented with occasional cough and swelling over the left side of neck for past 1 month, UPPER GI SCOPY WHICH SHOWS GROWTH IN EPIGLOTTIS AND BIOPSY DONE AND DIAGNOSED AS SQUAMOUS CELL CARCINOMA WITH METASTASIS AND AFB POSTIVE TB , CHEMOTHERAPY AND ATT STARTED , PATIENT STILL IN FOLLOW UP.

HER EXCELLENCY WINNIE ANNA KIAP CBE APPOINTED CHAIR OF THE COMMONWEALTH FOUNDATION, LONDON, UK

Her Excellency Winnie Kiap brings extensive leadership and governance experience to the role.

POSTED ON 08/01/2025

BY LEO KISS

Following approval by Commonwealth Heads of Government last week, Her Excellency Winnie Anna Kiap CBE has been announced as the new Chair of the Commonwealth Foundation, the Commonwealth's agency for civil society.

The Chair of the Foundation is a distinguished private citizen of a Commonwealth country appointed by Heads of Government. As Chair, Her Excellency Winnie Kiap will lead Board meetings that govern the Foundation and support its future direction. She succeeds Dato' Sudha Devi K.R. Vasudevan, who has served with distinction since 2020.

The Commonwealth Foundation is one of the Commonwealth's three inter governmental agencies with a mandate to support Commonwealth civil society and, through that work, to advance the interests of the Commonwealth's 2.7 billion citizens.

The Foundation delivers an annual grants programme that supports civil society to engage with governments to advance participatory governance, democracy, and human rights. It also administers a creative programme showcasing Commonwealth culture from writing to filmmaking including the renowned Commonwealth Short Story Prize. Through a range of 58initiatives, such as the Commonwealth People's Forum and the Critical Conversations online event series, the Foundation amplifies the voices of the People of the Commonwealth, enabling them to shape the policies and decisions that impact their lives.

Her Excellency Winnie Kiap brings extensive leadership and governance experience to the role. She served as Papua New Guinea's High Commissioner to the United Kingdom from 2011 to 2022, where she also represented Papua New Guinea at the International Maritime Organization and Chaired the Commonwealth Secretariat Board of

Governors. Before her appointment as High Commissioner, she was Papua New Guinea's longest -serving and first woman Cabinet Secretary and worked in consultancy roles for Non-Governmental Organisations promoting gender-inclusion.

Prime Minister of Papua New Guinea, James Marape, had this to say of the appointment:

The appointment of Her Excellency Winnie Kiap as Chair of the Commonwealth Foundation Board is a historic achievement. It recognises the professional capabilities of one of our most senior diplomats and elevates the presence of the Pacific in global leadership roles. This is a proud moment for Papua New Guinea and a landmark achievement for career wom

Director-General of the Commonwealth Foundation, Dr Anne T. Gallagher AO, said:

I am delighted to welcome Her Exce llency Winnie Kiap to the Commonwealth Foundation. Her appointment comes at a critical time as we work to deepen the engagement of civil society with governments across the Commonwealth. Her Excellency's wealth of experience and her distinguished career in diplomacy and governance will provide invaluable leadership to the Foundation as we navigate the challenges and opportunities ahead.'The outgoing Chair of the Board of Governors, Ambassador Dato' Sudha Devi K.R. Vasudevan, who has now completed her second and final term, said of the appointment:

'I extend my warmest congratulations to Her Excellency Winnie Kiap on her appointment as the new Chair of the Commonwealth Foundation. Her exemplary leadership and dedication to the Commonwealth will undoubtedly guide the Foundation to even greater achievements in the coming years.'

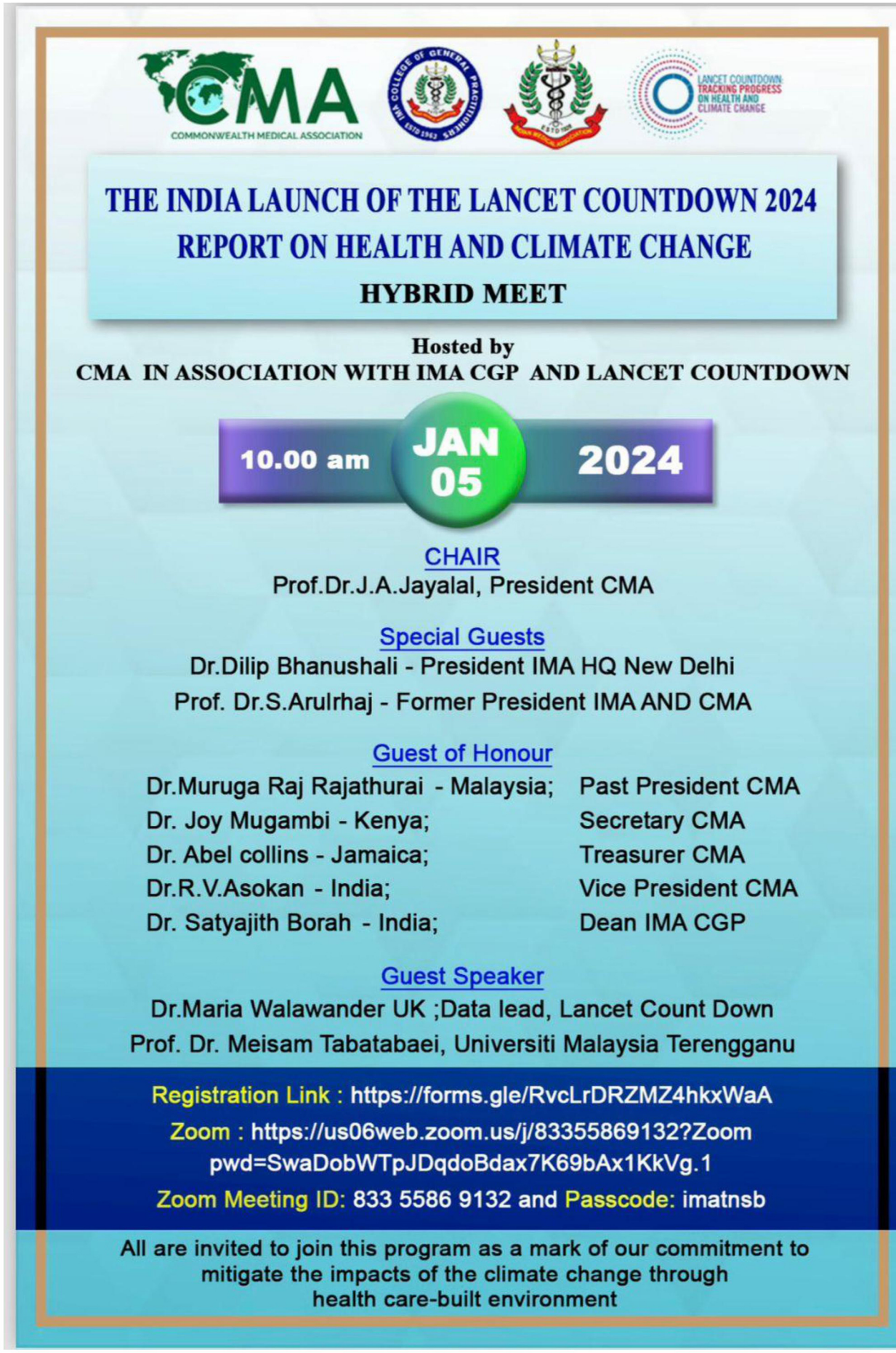
The Foundation welcomes Her Excellency Winnie Kiap's historic appointment as Chair of our Board. Her extensive diplomatic and governance expertise will be instrumental as we continue to champion the voices of the People of the Commonwealth in 2025 and beyond.

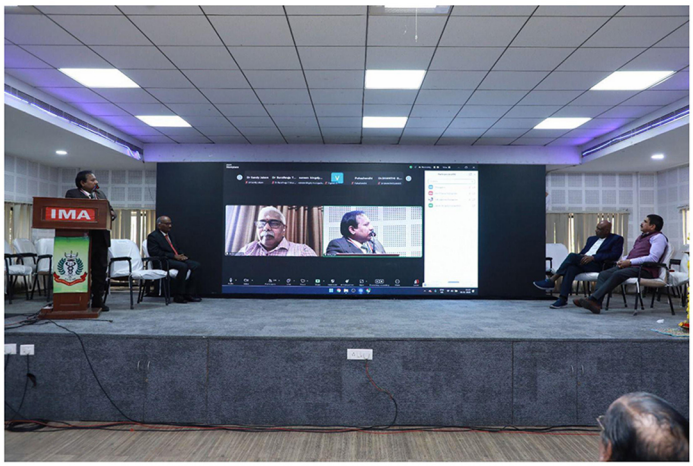
For more information

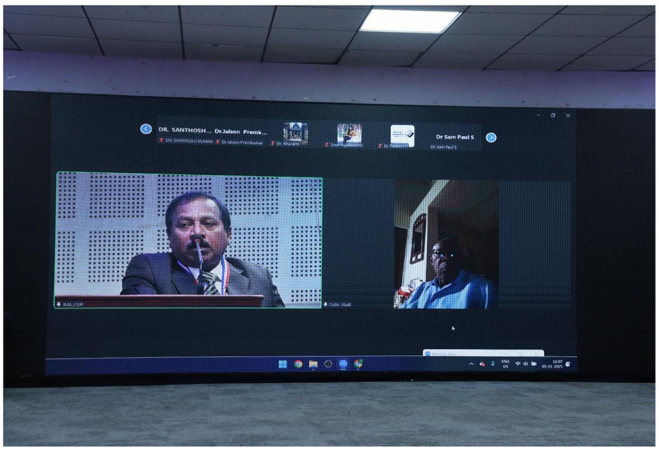
For further details about the Commonwealth Foundation, additional comments, or photo requests, please contact Leo Kiss, Knowledge, Learning and Communications Manager, at l.kiss@commonwealth.int.

Notes

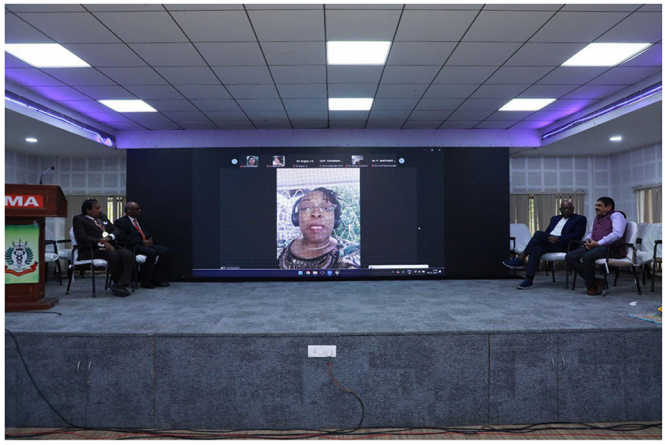
Annual priorities of the Commonwealth Foundation are determined by a Board of Governors, comprising representatives of Commonwealth governments and High Commissioners based in London, civil society representatives, and the Commonwealth Secretary-General. The Chair of the Foundation is a distinguished private citizen of a Commonwealth country appointed by Heads of Government.


CMA
COMMONWEALTH MEDICAL ASSOCIATION
LANCET COUNTDOWN
TRACKING PROGRESS
ON HEALTH AND
CLIMATE CHANGE
THE INDIA LAUNCH OF THE LANCET COUNTDOWN 2024
REPORT ON HEALTH AND CLIMATE CHANGE
HYBRID MEET
Hosted by
CMA IN ASSOCIATION WITH IMA CGP AND LANCET COUNTDOWN
10.00 am
JAN 05
2024
CHAIR
Prof.Dr.J.A.Jayalal, President CMA
Special Guests
Dr.Dilip Bhanushali - President IMA HQ New Delhi
Prof. Dr.S.Arulrhaj - Former President IMA AND CMA
Guest of Honour
Dr.Muruga Raj Rajathurai - Malaysia; Past President CMA
Dr. Joy Mugambi - Kenya; Secretary CMA
Dr. Abel collins - Jamaica; Treasurer CMA
Dr.R.V.Asokan - India; Vice President CMA
Dr. Satyajith Borah - India; Dean IMA CGP
Guest Speaker
Dr.Maria Walawander UK ;Data lead, Lancet Count Down
Prof. Dr. Meisam Tabatabaei, Universiti Malaysia Terengganu
Registration Link : https://forms.gle/RvcLrDRZMZ4hkxWaA
Zoom : https://us06web.zoom.us/j/83355869132?Zoom
pwd=SwaDobWTpJDqdoBdax7K69bAx1KkVg.1
Zoom Meeting ID: 833 5586 9132 and Passcode: imatnsb
All are invited to join this program as a mark of our commitment to
mitigate the impacts of the climate change through
health care-built environment

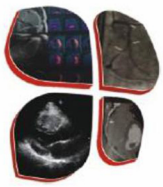



DR. SANTHOSH... Dr.Jaison Prem...
Dr Sam Paul S


Vulnerability of Indian agriculture to climate change




Today
Climate change as health issue
Impacts of climate change
Health co-benefits of climate change mitigation
The role of health professionals



WCCICC 2025 • MUMBAI

4TH WORLD CONGRESS ON CARDIAC IMAGING & CLINICAL CARDIOLOGY

10TH - 12TH OCTOBER 2025

HOTEL LALIT RESIDENCY, SAHAR AIRPORT ROAD, MUMBAI

REGISTER

KEY HIGHLIGHTS

1. INTERNATIONAL AND NATIONAL GUEST SPEAKERS ON VARIOUS HOT TOPICS
   - CLINICAL CARDIOLOGY
   - CARDIAC IMAGING
   - 2D ECHO
   - NUCLEAR, PET, MRI, CF
   - CARDIO DIABETOLOGY
   - PREVENTIVE CARDIOLOGY
   - INTERVENTIONAL CARDIOLOGY
   - CARDIAC SURGERY AND CARDIAC TRANSPLANTATION
2. PLENARY SESSIONS
3. SCINTILLATING HEART FAILURE SYMPOSIA OF HFpEF & HFrEF
4. USEFUL LEARNING POINTS FROM VARIOUS SYMPOSIA
5. USEFUL PANEL DISCUSSION ON HOT TOPICS
6. HOT DEBATES
7. CONTROVERSIES
8. FREE PAPER AWARD SESSION BY YOUNG PRESENTERS
9. CERTIFICATE COURSE IN CARDIAC IMAGING AND CLINICAL CARDIOLOGY APPROVED BY MMC
10. CHALLENGING CASE PRESENTATION
11. STATE OF THE ART CARDIAC IMAGING QUIZ BY OUR EMINENT INTERNATIONAL SPEAKER DR VIDHU ANAND, MAYO CLINIC, USA
12. CONGRESS CREDIT POINTS
13. CARDIAC LIPIDOLOGY
14. HYPERTENSIVE HEART DISEASE
15. HIGH RISK CORONARY ANGIOPLASTY
16. HEART FAILURE OF HF PEF AND HFREF
17. ACUTE CORONARY SYNDROME (ACS)
18. CHRONIC CORONARY SYNDROME (CCS)
19. TAVR
20. SAVR
21. CARDIAC TRANSPLANT SURGERY
22. TO HAVE 4TH TEXT BOOK ON CARDIAC IMAGING UPDATE 2025 AND MANY MORE ACTIVITIES
23. CERTIFICATION COURSE & PG TRACK SESSION

Dr A B Mehta — President
Dr G N Mahapatra — Executive President
Dr P C Manoria — Chair Scientific Committee
Dr Prafulla Kerkar — Vice-President
Dr C K Ponde — Secretary General

mahpatrag@rediffmail.com / mahpatrag@gmail.com / wccicc.mumbai2025@gmail.com

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REGISTER NOW

KOCHI DECLARATION 2024:
INTERNATIONAL LEADERSHIP SUMMIT OF MEDICAL ASSOCIATIONS

First-ever International leadership summit of medical associations on achieving UN High-Level Meeting targets to end TB concludes with the Kochi Declaration.

KOCHI, India, 3 June 2024 - The Private Sector Provider (PSP) constituency of Stop TB Partnership in collaboration with the Commonwealth Medical Association (CMA) and the Indian Medical Association (IMA) convened the first-ever 'International leadership summit of medical associations on achieving UN High-Level Meeting targets to end TB', on 1-2 June 2024 in Kochi, India.

The participants in the meeting were the leadership of the Commonwealth Medical Association and professional medical associations from 12 countries that account for about 60% of the global TB burden and include a significant proportion of people seeking care in the private sector.

Ending TB needs the engagement of public and private sector providers and support from the medical associations in countries and, often, we forget the respect, professionalism and convening power they bring in this effort.

The meeting ended with the "Kochi Declaration 2024" signed by all participating medical associations which encapsulates the commitments made by the associations.

Discussions in the meeting focused on the role and contribution of professional medical associations in achieving the targets and commitments of the 2023 United Nations High-Level Meeting on Tuberculosis. Meeting participants shared best practices in leadership, policy advocacy and private-sector TB care, and discussed challenges and opportunities. Participants visited an innovative local private health care sector-led TB response called "STEPS" and appreciated how the private health care sector is leading in providing high-quality diagnosis and treatment services in a highly efficient and client-friendly manner.

The Commonwealth Medical Association Secretary Prof.Dr.J.A.Jayalal ,termed this as a pathbreaking step and stated CMA , has taken the StopTB project as the priority agenda of the Commonwealth Medical Association and ensure this will lead to the coordination among the high burden countries National medical assoction to mutually healp each other to make an positive impact .

Dr. RV Asokan, President of the IMA and Alternate Board Member of Stop TB Partnership representing the PSP constituency while expressing his happiness over the role played by the IMA in convening and hosting the meeting in a IMA owned facility in Kochi said, “The meeting highlighted how one profession with one voice across several countries can end TB globally”.

Dr. Suvanand Sahu, Deputy Executive Director of Stop TB Partnership said, “We need leaders among different stakeholder groups to eliminate TB. It was amazing to see the leadership of professional medical associations as they discussed TB and issued the Kochi Declaration.”

Dr. Erlina Burhan, Board member of Stop TB Partnership representing the PSP constituency said, “This was a landmark meeting which has added a network of committed leaders of the medical profession and private sector health care to the global fight against TB and has expanded our PSP constituency.”

KOCHI DECLARATION 2024

United to End Tuberculosis (TB): Declaration from Private Sector Provider Constituency of Stop TB Partnership and Leaders of Commonwealth Medical Association, National and other Medical Associations of

Bangladesh	Ghana India	Indonesia	Jamaica	Kenya
Nigeria	Philippines	Tanzania(UR)	Uganda	Zambia

We, members of the Private Sector Provider Constituency of the Stop TB Partnership and Leaders of Medical Associations assembled at Kochi, Kerala, India for the 'Leadership Summit for Achieving UNHLM TB targets' on 1-2 June 2024, with a dedicated focus for the first time on the global TB epidemic, reaffirm our commitment to end TB globally by 2030 in line with the Sustainable Development Goals target and commit to support all efforts by governments and other stakeholders to achieve the UNHLM 2023 targets on TB.

We pledge to provide leadership and to work together to urgently accelerate our national and global collective actions, investments and innovations to fight TB, this airborne preventable and treatable disease, affirming that this disease, including its drug-resistant forms, is a public health challenge and the leading infectious disease cause of death, a common form of antimicrobial resistance globally as well as the leading cause of death of people living with HIV. We underline that poverty, gender inequality, vulnerability, discrimination, and marginalization, exacerbate the risks of acquiring TB and its devastating impacts - including stigma and discrimination - require a comprehensive response, including addressing the social and economic determinants and the protection and fulfilment of the human rights and dignity of all people, towards achieving Universal Health Coverage.

Therefore, we:

1. Reaffirm our commitment to the 2030 Agenda for Sustainable Development, including the resolve to end TB by 2030,

2. Recognize that while the World Health Organization declared TB a global emergency 30 years ago, it is still an emergency and the top cause of death due to a single infectious disease worldwide, furthermore recognize that the problem is exacerbated by the rise of multi-drug-resistant TB and co- morbidities such as HIV, malnutrition and diabetes, that one quarter of the world's people are infected with the mycobacterium TB and that millions of people ill with TB are missing out on diagnosis and treatment;

3. Acknowledge that multidrug-resistant TB is a key component of the global challenge of antimicrobial resistance and express grave concern that that there is a profound gap in access to quality diagnosis, treatment and care for those affected, a low treatment success-rate for those who are treated, and therefore ask for a strong public health response, including strong partnership with private health care systems, and additional investment in research, development and innovation;

4. Recognize that in recent years there has been progress in research and development of new and more accurate diagnostics, new medicines that have shortened and simplified treatment regimen and digital technology including A.I, all of which have great potential of substantially improving diagnosis, care and prevention of TB;

5. Recognize the role played by the Stop TB Partnership, that is spearheading the advocacy and political commitment for TB globally and nationally, including through Private Sector Provider Constituency of the Governing board;

6. Appreciate the innovative private sector provider led engagement through 'Systems for TB Elimination by Private Sector (STEPS)' a private -private partnership owned and operated by private hospitals.

7. Highlight that 60-80% of people with symptoms of TB go first to a private health care provider in most high TB burden countries, yet:

> The government funding for TB response in these countries often excludes or inadequately funds the private health care system involved in diagnosing and treating TB, leaving the financial burden on TB affected people.

> The private health care providers have sub-optimal or no access to essential new tools in diagnosis, treatment and prevention of TB, including rapid molecular tests, A.I -enabled X- rays and new TB drugs.

8. All national and other professional associations commit to

> Promote the provision of preventive services, diagnosis and treatment and supportive care for people with TB with special focus to those seeking care with private sector health providers with the aim of supporting countries to achieve their share of the global UNHLM TBtargets;

> Provide leadership and foster collaboration between government led TBprogrammes and private sector providers to end TB by 2030, through advocacy, policy development support, capacity building and monitoring,

> Engage with ministry of health/national TB programs and national health product regulatory authorities to ensure that the new diagnostics and new drugs are promptly available and accessible to the private health care providers;

> Advocate for increasing awareness among heads of States/Governments, political leaders, parliamentarians, local governments, academia, private health care sector and other stakeholders, promoting the need for greater attention and resources to the country TB responses and development of comprehensive national TB strategic plans to end toTB;

> Engage with Governments to ensure that country TB responses are prioritized and sufficient resources are allocated for people with TB seeking care in the private health care system from domestic as well as external funding sources, and TB is included within essential package of social health insurance schemes;

> Network with other medical professional associations and hospital associations to improve TB care, including through private-private partnership like 'STEPS'.

> Promote TB prevention, diagnosis, treatment and care in the context of child health and survival as TB is a significant cause of preventable childhood illness and death;

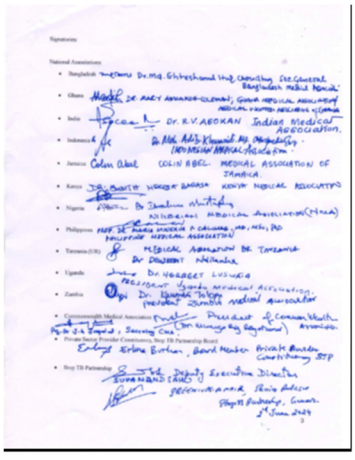
> Advocate for inclusion of TB management as a core competency in undergraduate medical education curriculum.

> Identify and institute a core team of leaders within the professional association and mentor them in leadership towards TB elimination;

> Build capacity of the members who are engaged in TB management as well as those who could potentially contribute and train/update their knowledge, and constantly engage with them.

9. The Commonwealth Medical Association commits to global advocacy for ending TB and coordinating with national and international professional bodies for actions on TB.

10. Stop TB Partnership Private Sector Provider Constituency and the Secretariate commit to providingnecessary technical andfacilitatory support, working with Commonwealth Medical Association, National and other medical associations.



COMMONWEALTH DECLARATION ON ANTIMICROBIAL RESISTANCE

27TH BIENNIAL CONFERENCE OF COMMONWEALTH MEDICAL ASSOCIATION

CHENNAI

NOVEMBER 2024

Commonwealth Declaration on Antimicrobial Resistance

Preamble

1. We, the representatives of National Medical Associations across the Commonwealth, assembled in Chennai, India, during the 27th Biennial Conference of the Commonwealth Medical Association, recognize the critical and escalating threat posed by Antimicrobial Resistance (AMR) to public health and global development.

2. This Commonwealth Declaration on Antimicrobial Resistance reaffirms our unified commitment to combat AMR through coordinated, multisectoral efforts grounded in the principles of One Health and guided by the Sustainable Development Goals.

3. With this Declaration, we call upon Governments, Healthcare providers, and International agencies across the Commonwealth to join forces in combating AMR through sustainable policies, integrated stewardship, and enhanced infection prevention measures that will safeguard the health of current and future generations.

Recognition of AMR Challenges

4. We recognize that antimicrobial resistance (AMR) has escalated into a critical global health threat, undermining the effectiveness of life-saving treatments and driving rising rates of morbidity and mortality worldwide. Designated as a "silent pandemic" by the World Health Organization (WHO), AMR urgently calls for united international action (1).

5. We reaffirm that AMR significantly impacts global mortality and morbidity, with an estimated 4.95 million deaths associated with drug-resistant infections in 2019 alone, 1.27 million of which were directly caused by AMR (2). The persistent rise of AMR results in prolonged illnesses, increased patient risk, and heightened death rates, highlighting its severe human cost.

References:
(1) Global antimicrobial resistance forum launched to help tackle common threat to planetary health [Internet]. [cited 2024 Jul 29]. Available from: https://www.who.int/news-room/articles-detail/global-antimicrobial-resistance-forum-launched-to-help-tackle-common-threat-to-planetary-health

(2) Murray CJL, Ikuta KS, Sharara F, Swetschinski L, Aguilar GR, Gray A, et al. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. The Lancet. 2022 Feb 12;399(10325):629–55.

6. We note that AMR imposes extensive economic burdens, impacting national economies and healthcare systems across income levels. The World Bank projects AMR could lead to an additional US$ 1 trillion in healthcare expenses by 2050, with annual GDP losses ranging from US$ 1 to 3.4 trillion by 2030 due to lost productivity, higher medical costs, and extended hospitalizations (3).

7. We acknowledge that AMR challenges the progress of modern medicine, compromising essential treatments, such as surgical procedures and infection management. This rollback of medical advancements not only risks current health outcomes but also threatens future innovations and resilience in healthcare.

8. We recognize that AMR's impact spans across human and animal health, agriculture, and the environment, necessitating a robust One Health approach. AMR disproportionately affects vulnerable populations, such as children, the elderly, and immunocompromised individuals, underscores AMR as a critical issue of health equity and social justice.

9. We emphasize that addressing AMR requires extensive collaboration across local, national, and global levels, engaging both public and private sectors to strengthen policy, enhance surveillance, and support antimicrobial stewardship. Collaborative efforts are crucial to creating resilient health systems equipped to manage AMR effectively.

10. We note with concern that AMR mitigation efforts face significant barriers, including limited access to diagnostics, inadequate research funding, and low levels of public and professional awareness. These challenges call for innovative and scalable solutions that are adaptable across diverse regions to effectively reduce AMR's impact on health and society.

Commitments

11. We commit to prioritizing AMR awareness by embedding discussions and education around antimicrobial stewardship in national and state medical conferences and educational initiatives.

12. We are dedicated to advancing the "One Health approach" by fostering cross-sector collaborations with human health, animal health, and environmental sectors to comprehensively address AMR challenges.

References:
(3) Antimicrobial resistance [Internet]. [cited 2024 Aug 23]. Available from: https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance

13. We pledge to implement robust infection prevention and control (IPC) measures in healthcare facilities to reduce the transmission of drug resistance microbes and limit the necessity for antimicrobial use.

14. We commit to advocating for responsible antimicrobial prescribing practices among all healthcare professionals to curb unnecessary and inappropriate use.

15. We commit to supporting Global and National AMR surveillance systems to monitor antimicrobial resistance patterns and inform policies based on real-time data and emerging trends.

16. We are committed to enhancing antimicrobial stewardship (AMS) education through the inclusion of structured AMS modules in medical training curricula and continuous professional development programs.

17. We pledge to work toward the development and dissemination of evidence-based treatment guidelines for infections across healthcare settings, ensuring the prudent use of antimicrobials.

18. We commit to encouraging community-level AMR awareness campaigns to educate the public on the responsible use of antimicrobials and the importance of IPC in preventing infections.

19. We commit to collaborating with international and local regulatory bodies to strengthen and enforce guidelines restricting over-the-counter antimicrobial sales.

20. We commit to fostering research and innovation in developing new antimicrobials, diagnostics, vaccines, and AMR mitigation strategies, aligned with the specific needs of Commonwealth Nations.

21. We are committed to improving access to quality, affordable diagnostics, and antimicrobial therapies to ensure equitable healthcare and address AMR challenges comprehensively.

22. We commit to advocate for dedicated funding within national health budgets specifically allocated for AMR initiatives in alignment with National Action Plans to support implementation, surveillance, and public health interventions.

23. We pledge to engage with and support policy advocacy for AMR containment at local, national, and international levels, ensuring AMR is a priority in health policy agendas.

24. We are committed to enhancing WASH (Water, Sanitation, and Hygiene) standards in healthcare facilities and communities to minimize the spread of AMR through contaminated environments.

25. We pledge to identify AMR coordinators within each National Medical Association to guide and monitor AMR initiatives, ensuring that the Commonwealth countries progress in unity against AMR.

26. We commit to actively involving youth in the fight against antimicrobial resistance (AMR), recognizing that today's young professionals will be tomorrow's leaders in public health.

27. We are committed to facilitating the enhancement of laboratory infrastructure and diagnostic capabilities across Commonwealth countries, supporting timely and reliable AMR detection and surveillance.

28. We commit to implementing and promoting evidence-based infection prevention protocols to reduce surgical site infections, ensuring safer surgical practices, and minimizing the need for postoperative antimicrobial use across Commonwealth healthcare facilities.

29. We commit to adopting and promoting the WHO AWaRe (Access, Watch, and Reserve) classification of antibiotics to guide responsible antibiotic use, prioritize the use of Access group drugs (at least 60% of total antibiotic consumption), and minimize the overuse of Watch and Reserve antibiotics, thereby enhancing antimicrobial stewardship across Commonwealth countries.

Call to Action

30. Appoint one AMR coordinator from each National Medical Association within 30 days to liaise with CMA on Commonwealth-wide AMR activities.

31. Form a Standing Committee for Antimicrobial Resistance under each National Medical Association within 3 months, ensuring junior doctor representation.

32. Recognize AMR and Infection Prevention and Control (IPC) as primary focus areas and showcase the Commonwealth Alliance of Medical Professionals on Antimicrobial Resistance (CAMP AMR) and the AMR Standing Committee on the National Medical Association's website within 3 months.

33. Establish formal partnerships with the veterinary, environmental, and agricultural sectors of respective countries within 6 months to address AMR jointly.

34. Lobby for the inclusion of AMR as a dedicated topic in the undergraduate and postgraduate medical curriculum in each country.

35. Request each National Medical Association to advocate for earmarked funding for AMR-related activities from their respective Governments within 6 months.

36. Allocate at least one session on AMR in the upcoming National Annual Conference of each National Medical Association and continue this annually.

37. Organize a joint celebration of World Antimicrobial Awareness Week across Commonwealth countries from November 2025 onwards.

38. Encourage the National Medical Associations to promote the publication of at least one AMR-related article per issue in the respective National Medical Journals.

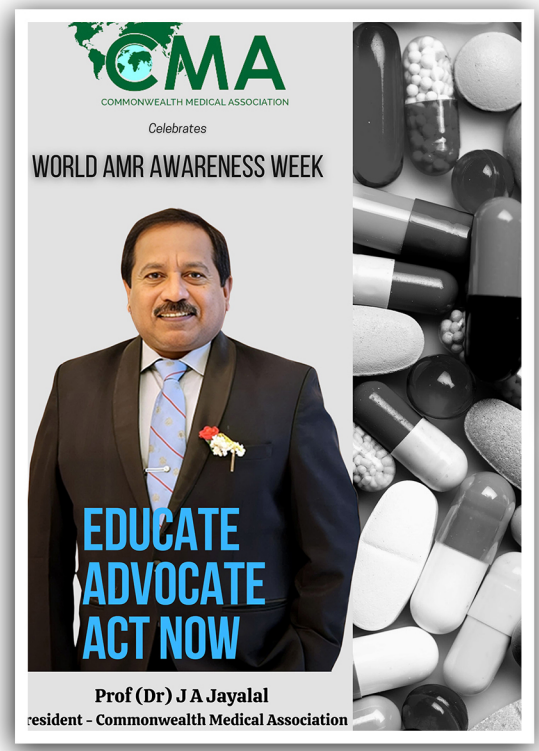
39. Virtually convene CAMP AMR members biannually to review AMR progress and strategize future actions.

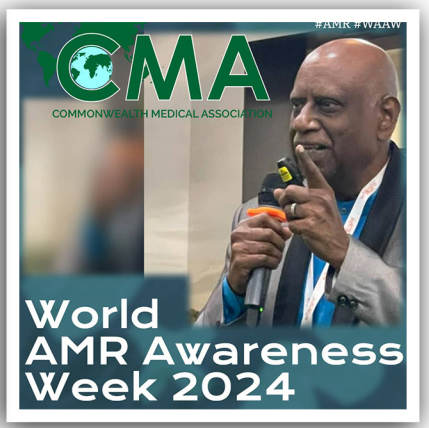
Conclusion

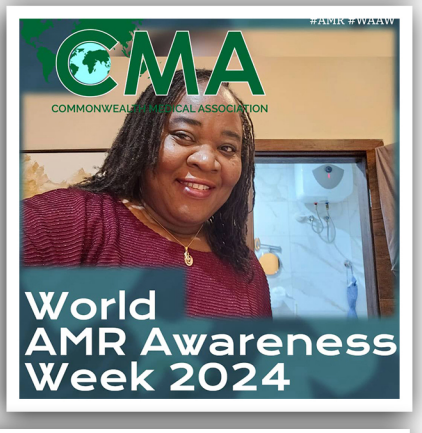
40. We, the representatives of the National Medical Associations of the Commonwealth countries, hereby reaffirm our commitment to this Commonwealth Declaration on Antimicrobial Resistance. Recognizing AMR as one of the most formidable global health threats, we pledge to work together, guided by the principles of One Health and in alignment with Sustainable Development Goals, to advance initiatives that will curb the spread of AMR and safeguard the health of all across the Commonwealth.

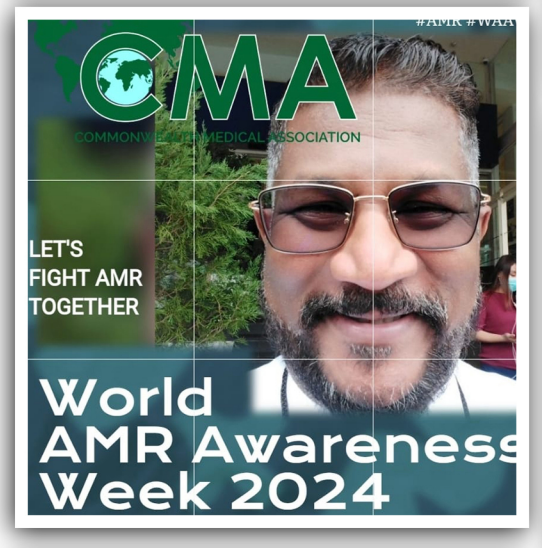
Drafted by:
Dr Narendra Saini, National Chairman – AMR, Indian Medical Association
Dr Venkatesh Karthikeyan, National Convenor – AMR, Indian Medical Association

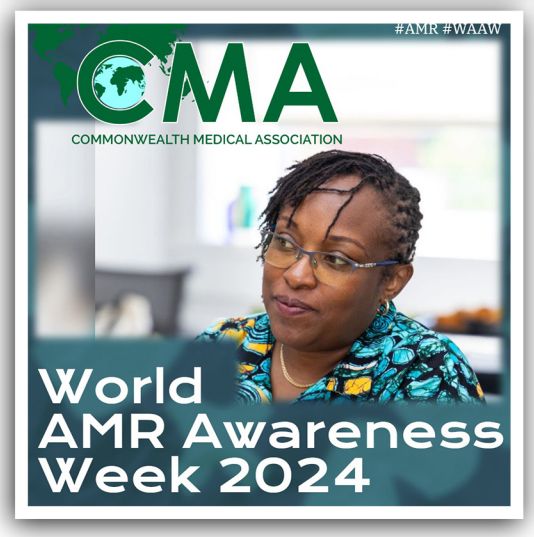
AMR REPORT & AMR PHOTOS



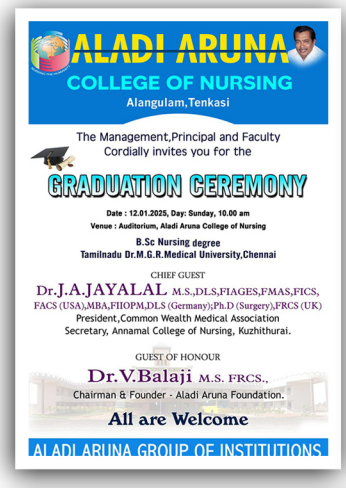








PRESIDENT IN ACTION



THE HINDU

Boost budgetary allocation towards healthcare, says Commonwealth Medical Association president

Updated - December 22, 2024 08:22 pm IST - COIMBATORE

THE HINDU BUREAU

India needs to increase its healthcare allocation to at least 5 % of the GDP (Gross Domestic Product) from the existing 2 % to bring about a sea change in the quality of delivery, J.A. Jayalal, president of the Commonwealth Medical Association and former National president of the Indian Medical Association (IMA), said on Sunday.

“The IMA has been advocating for a minimum of 10 % allocation from the Central government,” he added.

While access to healthcare has improved, there remains a lack of quality and standardisation, Dr. Jayalal noted. He pointed out that manpower and resource limitations hinder effective monitoring of pharmacies and enforcement of good manufacturing practices to curb the sale of spurious medicines that are mostly purchased based on lowest quotations in government hospitals.

PRESIDENT IN MEDIA

There have been several instances of confiscation of spurious medicines in government hospitals, Dr. Jayalal, who is also National Co-Ordinator, IMA UNESCO Bioethics Chair, said.

In an interaction with mediapersons, Dr. Jayalal attributed the increase in deaths related to diabetes and cardiac issues to the prevalence of low-quality medicines. The health schemes implemented by the Central and State governments have not achieved the desired impact, Dr. Jayalal said, and emphasized the need for the Central Budget to focus more on improving infrastructure, enhancing manpower, and advancing research. Additionally, he called for greater attention to preventive measures like nutrition, access to safe drinking water, and environmental protection.

Dr. Jayalal remarked that the health system in Tamil Nadu leaves a lot to be desired, and lamented the acute manpower shortage, with as many as 6,000 vacant posts that have not been filled for years at a stretch.

Emphasising the promotion of Primary Health Care, Dr. Jayalal said that unemployment was a reality among doctors, and that there are 12,000 applicants for the notification for filling 2,800 doctor vacancies.

He also called for governments to do a re-evaluation of their insurance schemes, highlighting the fact that less than a tenth of the over 400 procedures listed under these schemes were covered, and only in a limited number of empanelled private hospitals that account for 75% of healthcare provision.

As much as 30 % of the allocation of insurance schemes went towards administrative costs. This amount could, instead, be used for direct funding of government hospitals to upgrade infrastructure and manpower, he said.

Dr. Jayalal was also critical of the concept of NEET as the sole criterion for MBBS admission. Alongside cognitive ability, the aptitude and healthcare service rendered by the applicant must necessarily be factored in for the admission, he said.

Published - December 22, 2024 08:20 pm IST

Affordability is a big challenge, says Dr Jayalal

Rural India's health in focus: Dr Jayalal

SHRIMANSI KAUSHIK | DC
HYDERABAD, JAN. 3

India holds a 'blessed' position among Commonwealth nations in healthcare accessibility, opines Dr J. A. Jayalal, president of the Commonwealth Medical Association (CMA). However, he acknowledged that affordability continues to be a significant challenge, particularly in rural and tribal areas.

Highlighting the disparities, he pointed out, "Corporate hospitals remain inaccessible to a majority of the population, while public hospitals have been providing free care even before these schemes were contemplated. However, it does not cover the cost of healthcare, which is about 30 per cent of administrative expenses."

"India's insurance systems are underdeveloped. Despite noble intentions, government schemes like Ayushman Bharat have limitations," he told *Deccan Chronicle*.

On how Artificial Intelligence (AI) could help in braving these challenges, Dr Jayalal said, "Although it is a welcome technology, it is not going to help on the affordability and accessibility fronts. Moreover, they don't replace doctors, per se. The information that it is presently providing is from hyper-inflated data that lacks credibility. There is also no security to the patient's data that is being collected through AI." Dr Jayalal took a dig at the Ayushman scheme's concept of empanelled hospitals.

Q&A

Dr J.A. Jayalal

The cost of travel to corporate hospitals adds to the out-of-pocket expenses. People are not able to get treatment for common diseases and cardiac problems.

– DR J. A. JAYALAL
CMA president

"The cost of travel to corporate hospitals adds to the out-of-pocket expenses. People are not able to get treatment for common diseases and cardiac problems. Moreover, they are not able to get treatment at their doorstep. Why should the government bring free healthcare through the backdoor via the insurance sector? Let them come and say that 50 per cent of all private hospitals will provide free services for whatever treatment people get. The international body is looking at it quite critically. Of the nearly 75,000 hospitals in India, only 6,000 are accredited by the Quality Council of India," he observed.

Dr Jayalal expressed concern at India's Budget allocation for healthcare, which stands at less than two per cent of the GDP compared to five per cent in countries like Sri Lanka.

"Public hospitals shoulder 75 per cent of the healthcare burden, yet the funding is inadequate. Despite going through the pandemic and with the increased ambit of healthcare as highlighted by the government in its 'One Health' concept, it is important to make higher budget allocations to healthcare," he stated.

Addressing the increase in violent attacks against healthcare professionals, he said, "This is a global issue. While some countries enforce strict laws, India's fragmented approach undermines security."

He called for a Central Protection Act to safeguard medical professionals.

However, the Centre insists that health is a state subject. But there are many Central acts that have been implemented in states such as the Medical Termination of Pregnancy Act, Pocso Act, PN-MDP Act and the Clinical Establishment Act, among others.

'Lack of quality checks leading to misuse of drugs'

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Hyderabad: Dr JA Jayalal, president of the Commonwealth Medical Association (CMA), has expressed concern over quality of drugs circulating in India and said the spurious and low quality drugs pose a serious health risk to citizens.

Despite better accessibility to healthcare, Dr Jayalal said there is lack of a system to ensure quality of drugs. "This has contributed to rise in antimicrobial resistance due to misuse and overuse of drugs. More cases of drug-resistant TB and respiratory infections are being reported," he said in an interview with **TOI**.

Calling for stringent regulations and quality assurance mechanisms to combat this problem, Dr Jayalal, currently attending a conference in Hyderabad, stressed on the need for increased govt spending on healthcare. While India made progress in improving healthcare accessibility, the next step is enhancing the quality of services, he observed.

He said many developed countries allocate 5-15% of their GDP to healthcare, whereas India's healthcare budget is under 2%. "A larger investment in healthcare is essential to improve quality, especially in rural areas," he said.

Emphasising India's strong accessibility to healthcare services, especially when compared to other Commonwealth nations like the UK and Canada, he said: "In India, a person with any illness can easily meet a specialist, a level of accessibility not seen in manys Western countries where immediate care is often reserved only for critical emergencies."

Dr Jayalal said India's role as a medical tourism destination led to an influx of international patients, but the sector remains largely unorganised. "We need a centralised platform where international patients can easily access information about hospitals, treatment options, and costs," the CMA president said.

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Jayalal debunks doctor shortage myth in India, says efficient admin needed

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Guwahati: Prof (Dr) JA Jayalal, president of the Commonwealth Medical Association UK, challenged the prevailing belief about doctor shortages in India, saying that it's a narrative pushed by the govt and administrators. During his visit to Guwahati on Sunday for a doctors' convention, he spoke to TOI, emphasising India's position as a preferred medical tourism destination due to accessible and cost-effective surgical care. However, he acknowledged issues within the healthcare sector, including lack of standardisation, quality control, and pharmaceutical monitoring.

"It's a myth spread by the govt and the people who are in administration saying that there is no doctor in the country. Thirty years back, in India, there were 200 to 250 medical colleges. 35,000 to 40,000 doctors maximum were produced annually. Today, 1.27 lakh doctors are produced per year, and we have 727 medical colleges. Around 50,000 specialist doctors come out annually," Jayalal said.

"While about 50,000 are going for post-graduation, what are the rest of the people (doctors) going to do?" Jayalal said, questioning the notion of doctor shortage in the country. He referenced South India, particularly Tamil Nadu and Kerala, noting one doctor per 250 patients, surpassing WHO's recommendation of one doctor per 1,000 patients. Jayalal said, "It is not a lack of doctors, but we need efficient administration. Recruitment of doctors should be expedited."

He acknowledged some reluctance among doctors regarding PHC postings in rural areas, attributing it to insufficient regular positions and demoralizing temporary appointments in some states. "Appropriate counseling and posting have not been done in several states. For one post, 100 doctors are ready to apply in the country. Such is our strength."

Addressing criticism of modern medicine practitioners regarding rural postings, he questioned the role of Ayurvedic doctors (approximately seven to eight lakh in the country), while noting that India has 14 lakh modern medicine practitioners. "Show us a place where no doctor is going. We can give you 100 doctors," Jayalal said.

The Commonwealth Medical Association supports multiple medical systems based on nature and locality, according to Jayalal. "We need multiple systems of medicine, depending upon their nature and locality. Integration in the long term is developing a new system of medicine. But what we are opposing is a specialist of one system of medicine should not be allowed to practice the other system of medicine without adequate training. A doctor of the Ayush system of medicine, if allowed to practice allopathic medicine without adequate training, we call it 'mixopathy' which is not acceptable."

"Multiple systems of medicine should never be mixed together. An individual, unified system should be developed and doctors should be allowed to practice their respective medicines," he added.

The conference in the city addresses climate change mitigation in healthcare, noting hospitals as significant carbon producers. Emergency care improvement is another focus, highlighting India's 35% road accident mortality rate compared to 7% in the US and UK. Nevertheless, Jayalal praised India's healthcare accessibility, contrasting it with other Commonwealth nations' waiting times. However, he emphasized the need for increased health budget allocation, currently below 2% of GDP (in India) compared to the UK's 14%.

"Uniform, affordable healthcare can take India to the top," he concluded, advocating for accessible healthcare to reduce the burden on tertiary care facilities. He noted that govt hospitals often provide better critical care treatment, despite comfort differences.

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