AMDA NEWSLETTER

THE ASSOCIATION OF MEDICAL DOCTORS FOR ASIA

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AMDA IN RURAL COMMUNITY :

Dr.M.R.Bangera-AMDA India

Dr.M.R.Bangera, graduated in Integrated Medicine (G.C.I.M.) from Mysore, has been serving in the rural area as a general practitioner for the past 24 years with his wife, Dr.Sunanda. He is also a member of the Lion Club International and holding the office of District Cabinet Treasurer of the District 324-D4. He has 2 children, the daughter is an instrumental engineer and the son is studying in Dental Sciences.

Let me recollect my memory how I started my medical practice in a rural community on way back in 1964, after completing my degree in Integrated Medicine from the city of Mysore. I came back to my home town and started a clinic in a rural area called Padvu with a small population of about 7,000 people. This place was almost a semi-forest, undeveloped place with muddy roads and some times even wild animals could be seen on day time during those days. Most of the people who lived in this place were labourers, agriculturists and beedi rollers (country cigarettes).

We jointly started a clinic and contacted many of the local people for all assistance. Visited many places and houses on sick calls as well as casual visits to keep up better relationship with the people. Our working hours was from 6 a.m. to 12 noon and from 4 p.m. to 8 p.m. and our services were available round the clock whenever people needed us. Every Sunday I participated in medical camps organized by the Lions Club International as well as other service organizations. Later on, I joined the Lions Club's movement and held various offices and at present, I am serving as Cabinet Treasurer of the District 324-D4.

Problems were plenty and resources were few in the rural area. First of all, the people in rural area were not educated much nor they had the opportunities to know the preventive part of the diseases. Since the hygienic conditions were very poor, for example, latrine facilities were not available, people had

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AMDA NEWSLETTER

A MONTHLY PUBLICATION OF THE ASSOCIATION OF MEDICAL DOCTORS FOR ASIA

PURPOSES

1. To publish information about AMDA activities.
2. To provide a venue of communication among AMDA members.
3. To be a forum for AMDA members to express ideas and comments.
4. To publish articles about health care and community development

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EDITORIAL

Dr. Nipit Piravej

In most Asian countries, people in the rural areas constitute the major portion of the total population. However, it is hardly conceivable why the rural communities were more or less neglected by most governments for a long time in the past. Undoubtedly, this has brought about a viscious cycle of low socio-economic status, inadequate education and poor health among the rural people.

Fortunately, at present politicians and policy makers have become more and more aware of the problems. And in most countries, rural development has been accepted as one of the most urgent goals to be accomplished seriously.

In this issue of the newsletter, we publish an article by Dr.M.R.Bangera, the first article in the series of "AMDA in rural community", which are aimed to report and acknowledge the roles and activities of AMDA members in rural health development In fact, rural health development has been emphasized greatly by AMDA since its establishment. Actually, we have selected this as one of the major theme for this year AMDA meeting in Japan. Thus, we hope that these articles will warm you up for the discussion at the conference this August.

The Editor

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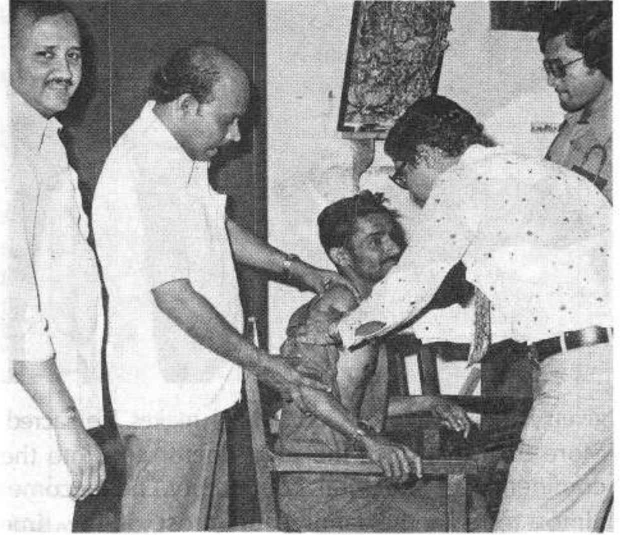
to go to open ground to attend the nature's calls. Parasitic infestation was a common problem seen in almost in every children in the families. Drinking water was not filtered or boiled and because of this, people got sick from gastroenteritis now and then. Skin conditions, such as scabies, were seen in every member of the same family and school children. Because they were not educated how the disease was spread, they had the impression that these etches were due to the impurity of the blood in the body. Of course that I found some times some major illnesses in these areas which needed special attention and dedication. Concentrating on the women folk, there were many problems such as not planning the family well which affected the economic conditions which in return made them more and more sick. Most of the family have more than five children. Pregnant women were found to be malnourished and anemic which needed more attention and treatment in time. After educating them recently, they began to come forward to get themselves immunized before as well as after child delivery.

Since in the rural area, most of the women delivered at home and labour calls were attended by the local experienced women called "dais" and since they did not know the antiseptic measures, complications such as neonatal tetanus, caused by the use of rusted blade or scissors to cut the umbilical cord, were commonly seen. Cases such as post-partum haemorrhage, purepural sepsis were also seen which needed special attention and treatment and even sometimes hospitalization. Rarely we came across cases of toxaemia of pregnancy such as pre-eclampsia and hydramnios.

I saw many cases of gastroenteritis and febrile convulsion in infants. Dehydration played an important part to worsen the illnesses and mostly it was combated by using 2.5 gm of soda bi carb, 3.5 gm of sodium chloride and 1.5 gm of potassium chloride and about 20 gm of sugar or jaggery in a glass of water. Since most of the items were available in every home, patients should be explained about the measures equivalent to spoon measures for easy understanding.

Facing the problems in the rural areas is a very big task. Problems are multifactorial as I handle paediatric, geriatric, gynaecological, accidental cases such as drowning and snake bites. Here the first aid part as well as immediate probable diagnoses are required to save life and later cases which are out of our reach to be hospitalized with proper care. As we find some of the patients come from



Dr.Bangera (dotted shirt) on a immunization compaign organized by the Lions Club.

a very poor family who cannot afford to spend even for the hospital cost and the transportation, it becomes a problem for the doctor and we have to take our own decisions how we can handle the cases. Sometimes a wise doctor can cut down the expenses on common problems by planning things such as whether a patient needs expensive allopathic medicines or just Ayurvedic medicine which, most of the time, is available along the surroundings. Choice should be properly made. Most of the medicinal herbs are available in the locality but the doctor has to select and give the right direction about how to use the medicine. Skin diseases, viral herpes, chronic conditions like arthritis and some of the liver disorders can be very well be cured by Ayurvedic drugs provided a little dietary restriction are needed to avoid allergic reactions to our body systems. Of course, acute conditions and serious accidents has to be treated with emergency medicine to save the life in time.

Serving in the rural area in a pleasent job provided we love to sacrifice and stay in such atmosphere. It is proud to know that the people of this area pay a very high respect to doctors and actually they have godly regards to doctors. In this moment, I recall a Sanskrit Shloka :

"Vaidya Narayana Hari
Akala mrutyu harnam
Sarva papa vinashinam
Vishnu padodakam, pavanam shubam."

It means doctor is just as a God Hari, to prevent accidental death and to forgive the sin, the medicine

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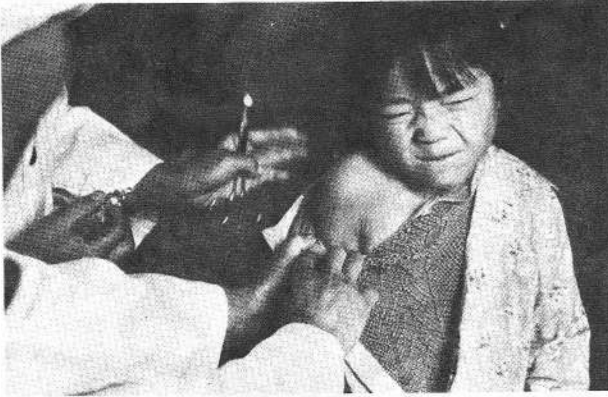
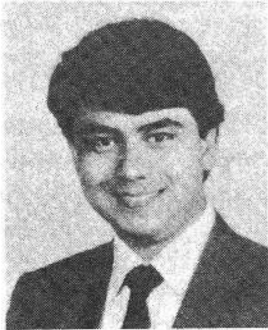


given is holy water of God, which makes life sacred. More than that once the rural doctor gets into the confidence of the rural community, he becomes almost one in the family and most of the time other than medical services they need the doctor in every domestic ceremonies like marriage, family problems and so on. Handling medical cases in the rural community will be much easy as we know all the family members and their previous records of illnesses which guide the doctor to the right diagnoses and treatments. On all emergencies, the rural doctor will be the first to attend the case in any branch of medicine. I feel that a doctor who has served in the rural community has better courage and experience in handling the cases with the minimum facilities available.

In conclusion, in recent days, the government of India with the colloboration of the World Health Organization have come out with many medical projects for the upliftment of the rural community. In this event. I feel proud that I, along with my wife, have served in the rural area for 24 years, which has enriched our knowledge. I must say I am fortunate to select the rural community in the right time.

AMDA IN FOCUS

Dr. Ewan Murugasu



Dr. Ewan Murugasu, *regional coordinator of AMDA Singapore, is completing his national service at HQ Medical Services, Singapore Armed Forces. He will enter the Postgrad Surgical Traineeship Program this May and sit for the F.R.C.S. Part 1 in June this year.*

Dr. Pancho Flores is now a first year resident in the Department of Internal Medicine at the Philippine General Hospital. He was also accepted to the Havard School of Public Health, U.S.A. in 1989-1990 and as a Jaime V. Ongpin Scholar for Business and Good Government.

Dr. Kenneth Hartigan-Go is now a third year resident in the Department of Internal Medicine, the Philippine General Hospital.

Dr. Virginia Martinez is presently a third year resident in the Department of Family Medicine, at the Philippine General Hospital.

Dr. Antonio "Tofi" Sison, the assistant editor of AMDA Newsletter, has completed his residency in Psychiatry and started his first year fellowship program in Social and Community Psychiatry in the Philippine General Hospital.

Dr. Emma Palazo is now in her two--year of rural service. She is tentatively scheduled to leave for a one-month seminar program in Bangkok. Dr. Jojo Balatbat has also just past his Medical Board Examination and start his rural service, congratulation!

Dr. Alvin Mojica will finish his fellowship program in Okayama by the middle of this year.

Dr. Carlson Lo is in his third year of training in Internal Medicine at the Makati Medical Center.

Dr. Lynn Panganiban has finished training in Family Medicine and now is working at the Department of Family Medicine, the Philipp General Hospital.

AMDA Philippines: From right, Dr. P. Flores, J. Balatbat, E. Palazo, V. Martinez, A. Sison & K. Hartigan-Go.

A PANACEA FOR FISTULA

Dr. M.S. Kamath

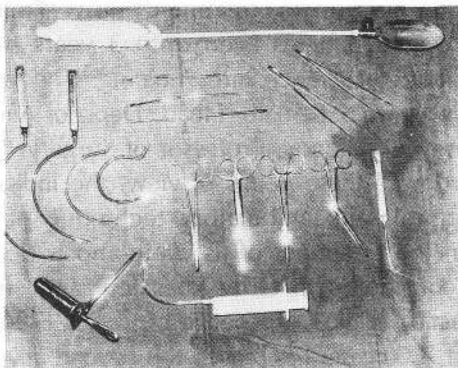
Dr. M.S. Kamath joined the first AMSA conference in 1980 and is still a very active senior AMDA member. Professionally, he has enormous experience in Indian traditional medicine and is now working at the Department of Ayurveda, Kasturba Hospital.

"The wise and experienced clinician never spurns an old wife's tale until he has good evidence for doing so. The lore of the countryman is built upon the experience of generations, often of centuries and the data upon which it is based have often been obtained at a price in human lives which no modern research worker would ever dream of considering".

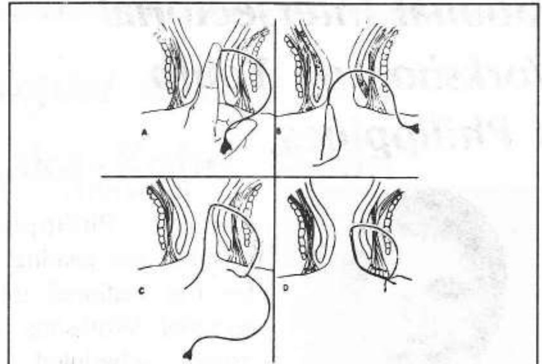
Fistula-in-ano constitutes an important condition among the anorectal disorders today. It has an age-old history. Susruta, an Indian surgeon who lived sometime between 600 and 1000 B.C. has described this disease in detail. Today the disease is common in all parts of the world having uniform global distribution.

Fistula-in-ano is a disease characterised by one of more tiny openings in the vicinity of anal orifice presenting a constant flow of pus and sometimes pain of mild to severe degree. Somethimes in the absence of pain, the continuous soiling of cloth is the main factor responsible to cause restlessness to the sufferer. The nature of the disease suggests that it is primarily a surgical condition. Therefore, the modern treatment of fustula-in-ano involves the excision of a wide area surrounding the fistulous tract, thus removing the entire fistula along with its origin.

In Ayurveda the disease is known as "Bhagandara" and the well-known doshic theory plays its role in this disease also to explain its pathogenesis.



Four kinds of treatment are offered, namely, Shastra (surgical), Kshar (causties), Agni (cauterization) and Oushada (medical).



Method of Application of Kshar Sootra

Kshar Sootra

Kshar Sootra is a cotton thread, size 20, (Sootra) smeared and coated with phytogenic causties (Kshar) processed inside a specially designed cabinet, following certain basic standards. The main ingredients being latex of "Snuhi" (Enphorbianerfolia), "Apamarga" (Achyranthus aspera) and Haridra (Curcuma longa). This is essentially an indigenous technique being practiced by ancient Indian surgeons, but modified and presented with necessary alterations to suit the need of the time, by Dr. P.J. Deshpande at Banaras Hindu University, Varanasi.

Application

Kshar Sootra treatment is a non-surgical method. The thread is passed into the fistulous tract with the help of a probe through the external opening, guided through the internal opening and is brought out through the anal opening and tied outside the anal aperture and left in situ. The whole procedure takes five to ten minutes and no anaesthesia is really necessary through it can be used to provide comfort to the patient or to a patient who is not co-operative. The thread thus ligatedis changed regularly once a week with a new one. At each seting the length of the thread diminishes and, ultimately, it falls out spontaneously. Thus, the whole fistulous tract is simultaneously cut and healed in this procedure. The resultant scar formation is very minimal and the method is safe and free from any complication. The whole procedures tolerated well by the patients.

"More reputations of surgeons are lost in operations of fistula-in-ano than in any other single operation". says Norburg, the surgeon. This shows that the surgical treatment of fistula-in-ano employed in modern medical science is disgusting the un-

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NEWS & NOTES

National Intersectorial Workshop on Youth in Philippines

Dr. Antonio C. Sison, AMDA Philippines

Presently, the AMDA Philippines member are gearing up for the National Intersectorial Workshop on Youth scheduled on February 21-23, 1989. This project is in co-operation with the World Health Organization (WHO) and the Presidential Youth Organization. An interesting feature of this workshop is the use of the "grid method" wherein various factors and levels of the problems are systematically tackled. This would be one of the highlights for AMDA Philippines in 1989.

Operation Binhi

Operation Binhi, a community based project for the Smokey Mountain residents is on going. Last Christmas, AMDA Philippines members distributed food supplies donated by various companies to the people in the community. Dr. Emma Palazo has noted a more active community participation of the residents together with the helping agencies. This shows a developing awareness of the community. AMDA is one of the pioneer Medical Missions which serves this community.

Ramathibodi Medical Student International Affair Committee Year End Meeting

After a long year of hard work, the members of Ramathibodi Medical Student International Affair Committee, led by Chairperson Miss Vibhakorn Permpoon, held a year end meeting on February 10, to report about their activities in 1988. The meeting was opened by professor Atthasit Vejchachiva, Dean of the medical school, followed by a talk on "Students and extracurricular activities" by Dr. Surakiat Achananuparp, one of the advisers to the committee. Dr. Nipit Piravej, the founding chairman of the committee, was also invited to give a talk on AMDA activities. The meeting was concluded by the beautiful multivision slides about the year round activities of the committee.

Dr. Nipit Piravej (with necktie), Miss Vibhakorn (on his right) and members of the 1988-1989 International Affair Committee

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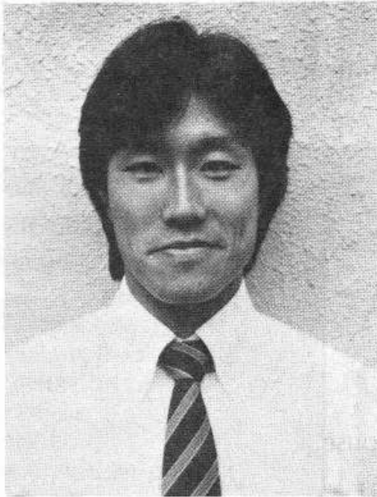
satisfactory. The famous Mayo Clinic reports as many as sixteen unsuccessful operations on a single fistula patient. The failure of surgery always carried with it four other problems: 1) extensive mutilation of the area 2) prolonged hospitalization 3) high rate of recurrence and 4) frequent occurence of complications, such as faecal incontinence, proctitis, fissures in-ano etc.

The Kasturba Hospital, Manipal has started using this technique in the treatment of fistula-in-ano, on a research base, under ICMR - New Delhi India. The work was started in 1986 March and so far 102 patients, are treated with this technique out of 102 patients 92 completed treatment successfully, remaining are under treatment now. Follow-up of completed patients even upto 3 years has not shown any recurrence after healing. The work is done by Dr. M.S. Kamath, Head, Dept. of Ayurveda and Dr. M.G. Shenoy, Professor of Surgery.

From all these points of view, the indigenous, non-surgical safe, ambulatory technique of Kshar Sutra in the treatment of fistula-in-ano is definitely to be considered in terms of safety and success. The practical clinical experience of Dr. P.J. Deshpande of about 2000 cases has proved this beyond any doubt.



1989 AMDA MEETING

August 4-6, 1989

Osaka-Kobe, Japan

Dr. Kohei Tohda, Chairman of the organizing committee

Tentative Program

PRE-CONFERENCE COURSES:

A. Field study on Primary Health Care in Japan.
Date: August 3, 4
Place: Kuchiki village clinic, Shiga prefecture, Japan.
Purpose: To appreciate the role of community medicine in Japan through the observation of a village clinic.

B. Hayashibara Forum on Asian Traditional Medicine for Specialists.
Date: July 30 - August 3
Place: Okayama.
Purpose: To promote the Chinese traditional medicine, Ayervedic medicine and Islamic traditional medicine for modern applications.

THE 1989 AMDA CONFERENCE:

August 4 All participants arrive at Fumonkan, Osaka.

18.00 hr. – Welcome Party

August 5

8.30 hr. – Openning Ceremony
Welcome address by President Dr. Shigeru Suganami
Welcome address by Chairman Dr. Pancho Flores
Welcome address and report by Chairman of the Organizing Committee: Dr. Kohei Tohda
Address by Honourable Advisor Dr. Debhanom Muangman
Greeting from Risshou-Kouseikai

9.00 hr. – Health Problems of the Refugees
Chairman: Dr. Yoneyuki Kobayashi

12.00 hr. – Lunch

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13.00 hr.	– Special Lecture: Dr. Krasae Chanawong
13.30 hr.	– Primary Health Care in Rural Health Development Chairman: Dr. Tounai
17.00 hr.	– Dinner
19.00 hr.	– Annual meeting of the executive commiteee

August 6

8.30 hr.	– Special Lecture: Dr. Debhanom Muangman
9.00 hr.	– Occupational Health Problems Chairman: Dr. Tsuyoshi Kawakami
12.00 hr.	– Lunch
13.00 hr.	– Transfer to Kobe International Conference House
14.00 hr.	– Joint Conference with AMSA Report from AMSA Report from AMDA Establishment of cooperative programs
17.00 hr.	– Closing Ceremony Farewell Party in Kobe
21.00 hr.	– Return to Osaka

POST-CONFERENCE STUDY TOUR IN OKAYAMA

Coordinator: Dr. Naomasa Hirota

Date: August 7-11 (5 days)

Place: Okayama University, Suganami Hospital, City Office, Mizushima Combined Factory, etc.

Purposes:
1. To study Japanese community health care system.
2. To study occupational health problems and managements of environmental pollution in Okayama.

FEES:

1. Pre-conference courses:

Course A (2 days)	10,000 yen
Course B (5 days)	40,000 yen

2. Conference:

Participation fee	5,000 yen
Reception fee	6,000 yen
Transportation fee	2,000 yen

3. Post-conference study tour:

5 days expenses	40,000 yen
Transportation fee	10,000 yen

APPLICATION: Please send the names of the participants of each of the 3 major activities, the date/time/flight number of arrival to:

Dr. Kohei Tohda, The 2nd Department of Pathology,
Akita University School of Medicine,
1-1-1, Hondo, Akita 010, Japan.