

Shree Vithalrao Joshi Charities Trust's
B.K.L. WALAWALKAR HOSPITAL,
DIAGNOSTIC & RESEARCH CENTRE, DERVAN
ISO 9001-2000 CERTIFIED HOSPITAL

SVJCT's Walawalkar Hospital



Transforming lives...
one at a time !

SOUVENIR



“भक्तश्रेष्ठ कमलाकरपंत लक्ष्मण वालावलकर रूग्णालयाचे ग्रामीण भागात चाललेले रूग्णसेवेचे कार्य अद्वितीय आहे, अतुलनीय आहे . खूप वरे वाटले . It is a great institution. मी वरेच ऐकले होते, पण प्रत्यक्ष बघितल्यानंतर अनुभवले . Seeing is believing . अशा प्रकारच्या युनिक सेवा उपलब्ध असलेले, इतक्या प्रकारच्या सोई असलेले हॉस्पिटल या विभागात एकही नाही . अत्याधुनिक रूग्णसेवा ग्रामीण भागातील गरीब जनतेला उपलब्ध करून देऊन या रूग्णालयाने देशात एक आदर्श निर्माण केला आहे . हे कार्य पाहून मी अत्यंत प्रभावित झालो आहे आणि याचा गरीब जनतेला फायदा होत असल्याने त्याची उत्तरोत्तर प्रगती निश्चितच होईल अशी खात्री आहे” .

Padma Vibhushan Dr. Anil Kakodkar.

Chairman, Atomic Energy Commission of India (AECI).
Secretary, Department of Atomic Energy, Government of India.

DERVAN DIGNITARIES SUMMIT 6TH JANUARY 2008, PUNE



Walawalkar Hospital has a very distinguished visiting faculty. These are medical professionals who have excelled in their fields. Hospital has attracted them due to various reasons. For some it is spiritual, but others have been attracted by the vision with which the hospital was started in this near forest area & also because of transparency of work.

It was realized that care of critically ill patients is incomplete without super specialty services. These services are now in the reach of rural kokan people & they are benefiting greatly. The people here, who could not reach the super specialty services in cities, get it now at their doorsteps.

Visiting faculties include Cardiologists, Nephrologists, Neurologist, Dermatologist, Psychiatrist, Gastroenterologist, Plastic Surgeons, Medical Oncologists, Radiation Oncologists, Urosurgeons, Oncosurgeons, Endoscopic spine surgeons, Orthodontist, Interventional radiologists etc. Since so many different specialists visit the hospital on different days of the week or month, they hardly get to meet each other. Thus it was envisaged that they should all meet at the same time so that they get to know each other and also get to know the variety of work that is being carried out at B.K.L.Walawalkar Hospital, Dervan.

We hope to have one such meeting every year with the ultimate aim of exchange of thoughts and plans to have collaborative work between various specialists so as to expand the nature of work at B.K.L.Walawalkar Hospital, Dervan.

Editorial...

Suvarna N. Patil, M.D. (Medicine)
Director, B.K.L. Walawalkar Hospital, Dervan
Mobile: 9921251695,
Email: suvarnapatil@walawalkarhospital.com

I consider it a great privilege today, to interact with you as the Director of BKLW Hospital. I have to admit that, starting as a working member of the hospital and moving ahead through 12 years of varied work, I have learnt several things which surpass my clinical knowledge and experience. Primarily, it has made me realize the importance of moral values in medicine. I have also realized that, medicine is an effective tool to serve humanity.

The Hospital has the objective of making basic and essential health care accessible to every individual in our Konkan region. It was with this vision the hospital was conceptualized by Sadguru Shree Digambaradas Maharaj. This vision started turning into reality since 1996 through the dedicated and continuous efforts of Shree Sadguru Kaka Maharaj.



Hospital in 1996



Hospital in 2008

The idea of a Souvenir made my mind go back 12 years down the memory lane, and one by one all milestones flashed in front of my eyes. In the following few lines I will like to share a few important ones with you.

After completing M.D. in Medicine, I started working in one of the hospitals in Mumbai, India's biggest commercial city. A renowned hospital, a specialized degree and academics, everything perfectly falling in place, but still I consistently felt I was missing something and made me dissatisfied with my work. I could soon figure out that, it was due to the budding desire to do something new and challenging. My inner strength and enthusiasm to make a difference provided all the motivation.

This made me find Dervan and I reached Sawarda. The people around told me that hospital was nearby and I started walking. Believe me I walked 4 kilometers and saw a small but well built clean building standing out in the surrounding barren land with no population around. My mind questioned the purpose of existence of the hospital in this region. I decided to stay for a month as an experiment.



Scorpion

One morning a child was brought gasping to the hospital. He was sweating and pink froth drooled from his mouth. It was scorpion sting. Working in urban areas only, I had never treated such patients. Still I accepted the child and managed his treatment. In coming few days he recovered and went home. This was the first time I experienced the spiritual support of this land.



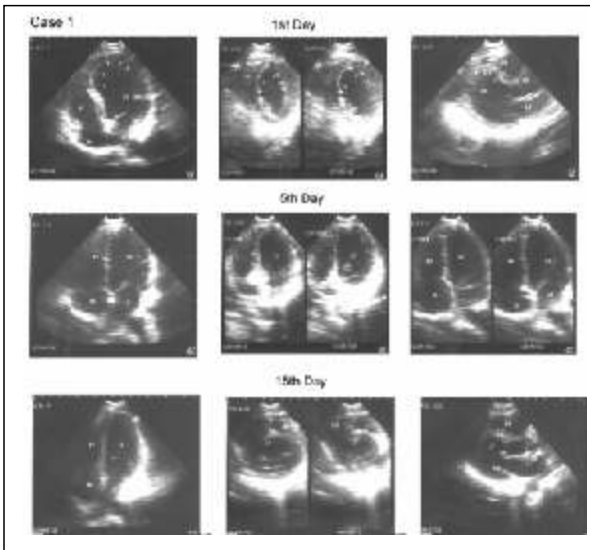
Tall T Waves in scorpion sting



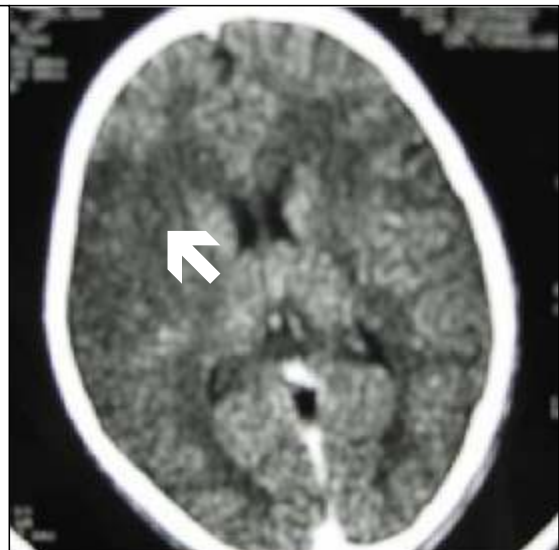
Pulmonary oedema in scorpion sting



15 Yrs old boy with pulmonary oedema



Serial 2D-Echo showing gradual improvement in LV function after Dobutamine



Post scorpion sting cerebral infarct in 20 years old boy with EF 20%

Next day a 60 year old man entered the hospital and collapsed at the doorsteps. A team of doctors took him to the ward and resuscitated him. He had complete heart block. We could not put a pacemaker in time and he went home walking. This made me realize the importance of modern infrastructure in this hospital and its existence in Dervan. Such incidents multiplied and made me believe that "Fortune favors the brave", and also that there is some power which has its blessings for this venture. Then I had an opportunity to meet Shree Kaka Maharaj. His divinity, power and fatherly affection influenced me and I decided to work in this hospital only. His guidance has been persistent and continuous.

Over time we treated several complicated and critical patients and understood that this area needed a critical care centre and it should be developed in the hospital (as people around us needed it the most). Soon a four bedded ICU was started equipped with ventilators, defibrillators, a pathology lab and most of all, a CT scan. Soon the work increased and keeping in mind the needs of local people, various wards, Neonatal ICU, Operation theatres and Obstetric wards were opened.

Medicine is not mathematics and 1+1 may not always be 2. But in this hospital the power of spirituality, dedication and devotion coupled with the knowledge and skill base of doctors has achieved success in unfavorable circumstances also. To quote a few examples... Once an 18 year old girl was admitted with neuromuscular type snake bite and respiratory paralysis. Of course she was put on ventilator and received 90 vials of anti-snake venom. This was much more than the usual dose, but still she was showing no improvement. We had lost hope and were about to give up. Then we had a discussion with our spiritual guide Shree Kaka Maharaj, who advised us to give her another 3 vials. We followed his advice and the young girl became conscious. She was weaned off the ventilator and discharged healthy.

Another incident that comes to my mind is that of three cervical spine trauma cases who were admitted with quadriplegia on the same day! One of them was pregnant. Fortunately, eminent spine surgeon Dr. Sunil Nadkarni happened to be at Dervan the same day. All of them were operated immediately and recovered completely. We believe that presentation of three rare trauma cases on the same day and presence of a spine surgeon at the same time in a place like Dervan, was not just a mere coincidence and certainly points to the existence of a spiritual power.



Viper Snake



Snake bite : Bleeding tendency



Snake bite : Neuroparalysis

To serve a patient is to serve God. The resources are limited and need to be used for the benefit of people with prudence. There is an emphasis on clinical judgment than on diagnostic services. Preventive medicine is given priority. Needless to say that this view has never interfered with the welfare of the patients. Substantial concessions are given on OPD and IPD treatment. Amount spent till today for IPD concession is Rs. 4 crores, 10 lakhs and for OPD concession is Rs. 55 lakhs. The incentives and concessions given are substantial, for example, first normal delivery is still done free of cost and further deliveries costs only Rs.500, simply to motivate pregnant ladies for hospital delivery. Anti-tuberculosis drugs are given free of charge.

In the early days of the hospital, health-care in the local communities was shadowed by poverty, superstitions and false religious beliefs. Health awareness did not exist at all. Seeking treatment for smaller ailments was luxury and was also never thought of. At the same time they could not afford the treatment of serious diseases. Therefore, hospital decided to provide all emergency services at affordable costs at the doorsteps of the patients. We also organized general check up

camps in all the villages of Ratnagiri district. In an attempt highlight the GPs of the work in the hospital and to provide them information about rare cases accomplished, we publish a periodic magazine called "Uplift".



Nursing College classroom



Lamp Lighting Ceremony



Demonstration room

Development is not complete without social upliftment and education. This was the belief of Shree Digambardas Maharaj. To bring it into reality and thus to provide education/employment opportunities to the local youth, the trust has started different educational programs related to the health-care initiative e.g. nursing courses (ANM -18 months & GNM 3 ½ years), lab technician diploma and post basic B.Sc. nursing, dialysis technician course, X-Ray technician course, dietetic course and O.T assistant course. As a hospital with 300 beds is available for practical experience, the nursing/pathology students gain much more than a textbook training. Earlier, any nursing aspirant in Konkan had to go to Mumbai for education. Now the same is available at Dervan and that too at reasonable costs. Further, at the end of the educational programme, the student is assured of an employment opportunity at the hospital. Today, more than 200 girls trained at the Nursing School and College are employed with the health-centers in the nearby villages which have helped to improve the quality of the health-care in the area. Similarly, pathology related programme ensured that a B.Sc. holder going through the programme would be able to run a small lab on his or her own in the village and help local population.



English medium school practical class room.



English medium school computer lab.



English medium school library.

A part of Shree Digambardas Maharaj's vision consisted of a school aimed at an overall development of the students, one where the medium of instruction is English, but the values are deeply rooted in the Indian culture. Such a school was

established in the hospital complex. It not only aims at imparting the standard class-room education but also at training the students in horse-riding, rifle shooting, dance, drama, musical instruments, computers etc. It provides separate hostel accommodation for boys and girls. The school which started with 16 students in nursery class in 1997 today has more than 800 students studying up to tenth class. Efforts are made for these students to develop a multi-faceted personality and they would no doubt add to the glory of the society and the country. It is a miracle to see these students who come with a background of poor conversational skills even in Marathi, today speaking excellent English with great confidence.



Moving Mullakhamb



Ring Dance



Horse Riding

FREE CATARACT OPERATION CAMPS

Total 1,100 Patients of Cataract were operated in 1997



A congenitally blind girl and a boy were successfully operated in 1997. It was the happiest moment in her life as she could see the rains for the first time.



Dr. Dugald Bell (UK) performing Phaco Surgery



Cataract Operated Patients



“Shrimati Malatitai Kamalakar Walawalkar Netra Rugnalaya”

Achievements of the hospital

Achievements of the hospital are combined efforts of in-house doctors and the visiting doctors from Mumbai & Pune. Our skills and knowledge thus gets updated regularly. For organised working and maintaining work quality the hospital went for ISO certification.



ISO Certification Ceremony



ISO Certification Ceremony

The Quality Policy

To become a quality driven hospital aiming for the patient care and treatment and to make continuous improvement by involving all the staff members and society at large'.



Hospital's New Auditorium With 100 Chair Capacity

Malnutrition Eradication Project

'Health for all' means removal of obstacles leading to good health. Eradication of malnutrition was one of them. Villagers were malnourished and hence prone to develop various infections including tuberculosis. Antenatal mothers were not gaining enough weight and children



Malnutrition Project Opening Ceremony in 2001 Chief guest Shri. Vijaysingh Mohite Patil (Minister, Maharashtra Government)

born to such mothers had a low birth weight. To overcome this problem we started malnutrition eradication project where nutritious diet was supplemented to antenatal mothers, children below 6 years of age & lactating mothers. The Trust is

currently spending more than Rs. 3, 00,000/- per month on this project. At present more than 5000 children are benefited. More than 1600 ladies have consumed nutritious ladoos and gave birth to healthy babies.



Village level Camps

As malnutrition also leads to tuberculosis, TB medicines are dispensed free of cost to all TB patients for 6 to 9 months.



Physical Examination by Medical Officer



Blood Sample Collection



Distribution of nutritious Ladoos



Distribution of free medicines



Workshop for anganwadi sevikas



Health awareness by nursing Students



Mother's checkup in ANC clinic at Anganwadi



Malnourished children

Malnutrition Data :

Total Registered Cases	5151
Grade I	1246
Grade II	1932
Grade III	843
Grade IV	424
Congenital abnormalities	19
Normal	687

A. N. C. Mother Data :

Total Registered Cases	1569
Delivery Cases	1301
Old Anganwadi A.N.C.Cases	1501
New Anganwadi A.N.C. Cases	68
OPD Cases	102

Cleft Lip & Cleft Palate Project

The transparent and selfless work of the trust attracted many super-specialists from Mumbai, Pune and even abroad. One of them was the world famous plastic surgeon Dr. Ravin Thatte. On his way to Goa, he saw the board of Walawalkar hospital and visited it. He was amazed to see the infrastructure and staff working at such a remote place. He was touched by the place and expressed the desire to perform cleft-lip and palate corrective surgeries at this hospital itself. This was a major breakthrough in the history of this hospital. Along with Dr. Thatte came his dedicated team members who visit hospital regularly with no expectation of remuneration.



This effort was later partially supported by a Canadian agency "Transforming Faces Worldwide" and later also by "Smile Train" from USA. With the help of these agencies Walawalkar hospital is successfully running this project free of cost along with orthodontic and speech therapy treatment. Till date 396 children have benefited.



Bringing Smiles on faces...

From Right : Dr. Chintamani Kale (Orthodontist),
Mr. Lasso (TFW, Canada) & Dr. Bharati Khandekar (Plastic Surgeon)



Cleft Palate Surgery



Speech Therapy



Orthodontal Treatment

PRE OPERATIVE



POST OPERATIVE



SUMMARY:

1. Year 2000 - 2002 :
Patients Enrolled = 57

2. April 2002- March 2007 :
Partially Sponsored By -
Transforming Faces Worldwide (Canada)
Patients Enrolled = 245

3. March 2007 Till Date :
Partially Sponsored By
Smile Train Express (America)
Patients Enrolled = 94

Intervention Summary:	
Lip Surgeries	160
Palate Surgeries	224
Rhinoplasty	9
V.Y. Plasty	6
Bone Grafting	2
Orthodontist Consultations	86
Speech Therapy	75
Total No. of Cleft Lip & Cleft Palate Camps	47

TMCROP : CANCER CONTROL PROGRAMME SINCE 2003

Tata Memorial Centre appreciated the massive work the trust was doing and BKLW hospital was recognized (in the year 2003) as a centre for Rural Outreach Programme in two districts for oral, cervical and breast cancers. In this screening programme, the population is screened for precancerous and cancerous lesions and any positive case is referred to Dervan. Treatment is done free of cost. Till date 324 patients have been operated, 297 patients have received radiotherapy and 217 patients have received chemotherapy.



Inauguration Ceremony of TMCROP 17 Aug. 2003



To impart comprehensive cancer care under one roof, Radiotherapy unit was installed under the guidance of AERB and BARC. Dr Anil Kakodkar (Chairman, AECL) personally visited the hospital and appreciated the unique cancer screening work going on at Dervan.

A visit to Community
Dr. Dinshaw, Director, TMH



Dr. Surendra Shastri,
Project Incharge TMCROP,
HOD, Preventive Oncology Dept. TMH



Dr. Sharmila Patil,
Associate Professor,
Preventive Oncology Dept. TMH.

TMCROP Activities



Household Survey
Eligible M/F Tobacco users for oral Exam.
Female 35-60 Yrs age group for Br/Cx Exam.



Cervical Screening at camp site
(VI, VIA, VILI Tests & Colposcopy)



Health Awareness Rally
by school children



BHABHATRON-2 :
Radiotherapy unit installed at Dervan

Major Events In TMCROP



National Training Programme in
Preventive Oncology 6-7 Feb 2005



Visit of Doctors from
Regional Cancer Centres 20-21 Feb 2005



Nigerian Sisters Training Programme:
May 2005



WHO's Director, Cecilia Visit
on 29th April 2007

Summary : Sept.2003 December 2008	
Household Survey Completed Villages	1,345
Total No. of Household Covered	3,62,396
Screening Camp Completed	1143 Villages + 4 Towns
Total Screened Population	
Male (Tobacco Users)	43,627
Female (35-60 yrs. Breast & Cervical Examination)	62,737
Female (<35>60 yrs. Tobacco Users)	23,869
TOTAL	1,30,233

Investigations at Screening Camp Site	
Oral Biopsy	93
FNAC	600 + 76 NDC
Cervical Biopsy	2,023
ECC	114
Referred Patients to hospital for further treatment	
Oral	1166
Breast	87
Cervical	125

Registered Cancer Cases:

Category	Oral	Breast	Cervix	Total
Total Cases Registered	736	206	226	1168
Malignant	426	99	82	607
Pre Cancerous Lesions	167	0	66	233
Benign / No malignancy	84	97	72	253
Unknown	59	10	6	75

Patient Treatment Profile :

No. of Patients Operated	:	324
Chemotherapy	:	217
Radiotherapy	:	297

REACH: Rural Empowerment And Community Health

Apart from health and education the trust is also interested in the social and economic progress of the people in the region. Healthcare was now touching the poorest in the region but socially they were still lagging behind, because of which delivery of health-care was not complete. Community participation was poor. This thought gave birth to "REACH", the Rural Empowerment and Community Health programme. It was inaugurated by Dr. (Ms) Kshama Mhetre, the National Director of Chinmay Organization for Rural Development.

Working of REACH is unique. It establishes several groups in community to target different sections, creating a medium to discuss the problems of similar people thereby giving rise to indigenous solutions. The various groups are Mahila Mandals, Self help groups and Yuva groups. In coming few years, we intend to have Balvihar groups and Kisan groups. The project is implemented in Ratnagiri and Sindhudurg districts. In a nutshell the objective is to improve Woman's social and



Inauguration on April 2007 by Padmashree Dr Kshama Mhetre



Cotton garland workshop



Handicraft workshop



Handicraft material

economic status. Mahila Mandals help them to acquire new skills which make them independent.

REACH project has helped us generate health awareness in the community and has made people concerned about their own health. The aim is to implement community based projects through community participation.

In due course of time the news about the nature of work in the region reached abroad and trust was pleasantly surprised when a team of doctors and nurses from England expressed their desire to serve the hospital. Globalization of health had now taken place at Dervan. The hospital team at Dervan and the doctors from England together made it a huge success and now this is done once every year.



Charcoal Training Programme

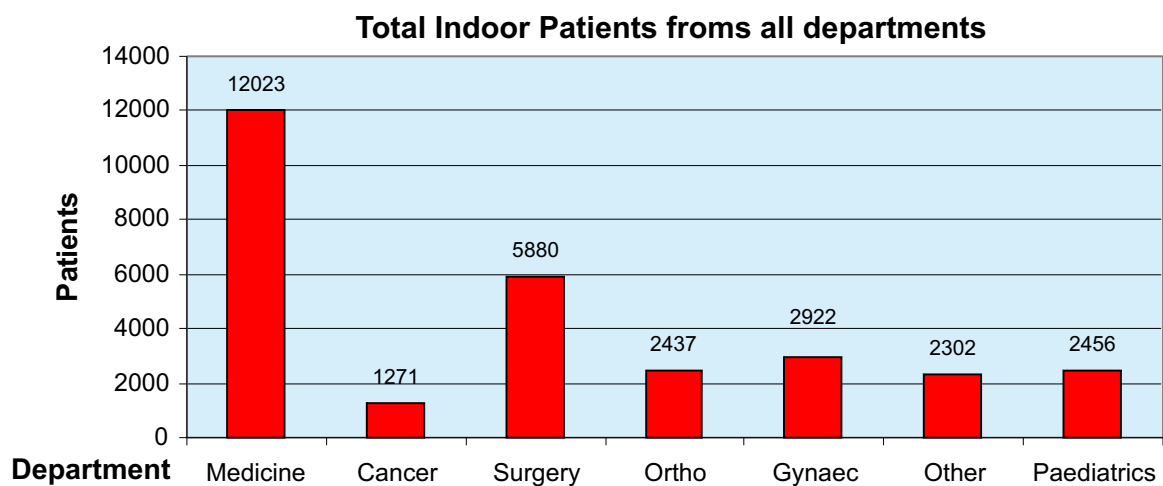
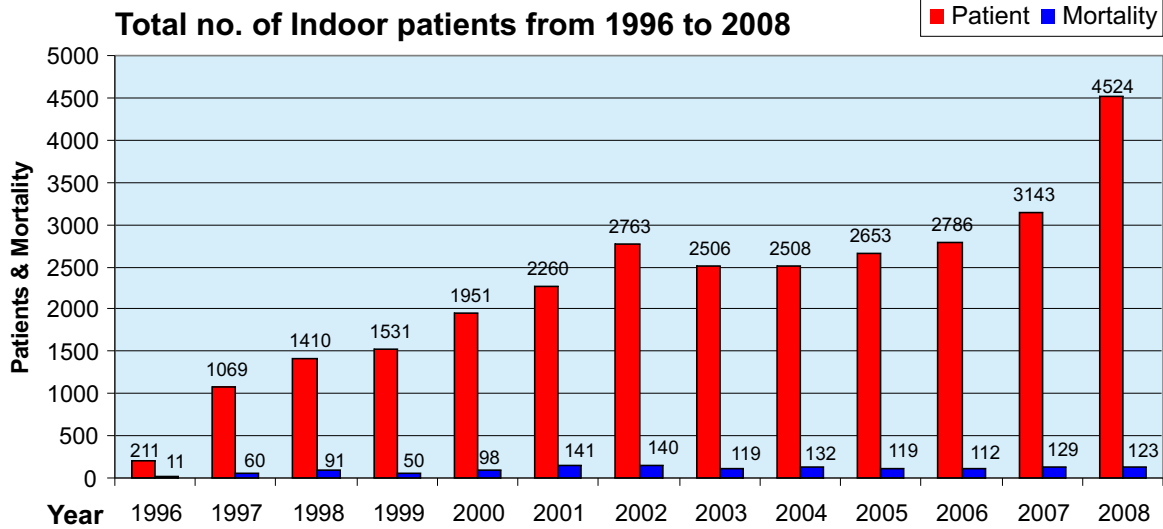
All this has made my determination to achieve more and accept more challenging projects in the region. Sky is the limit now, for those with zeal to work. Somewhere, we are now on the path of developing a modern medical care system tailored to the need of local population and at the same time considering the geographical, social and economic issues of the population.

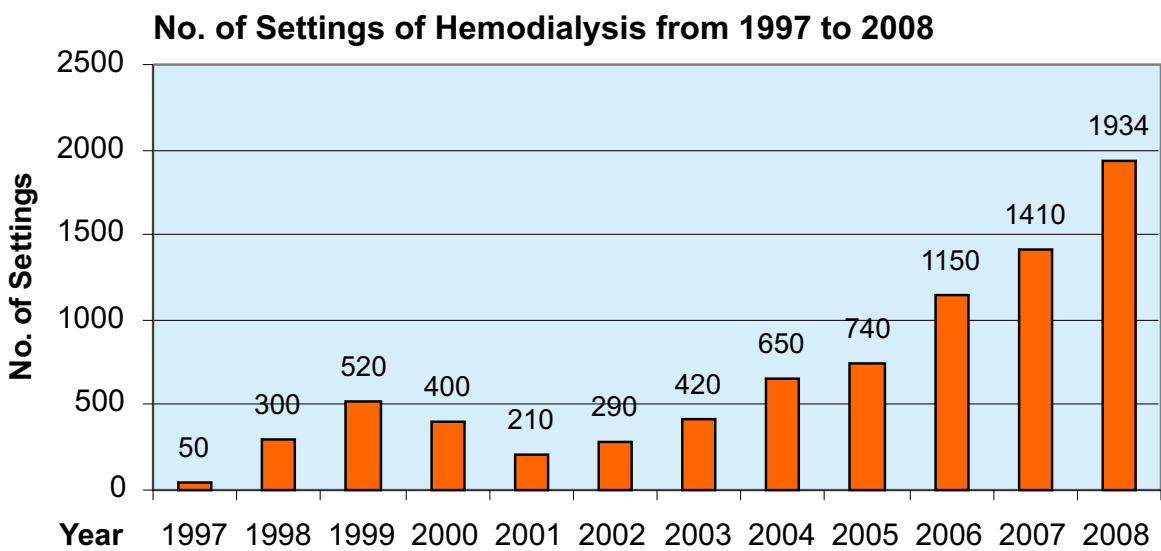
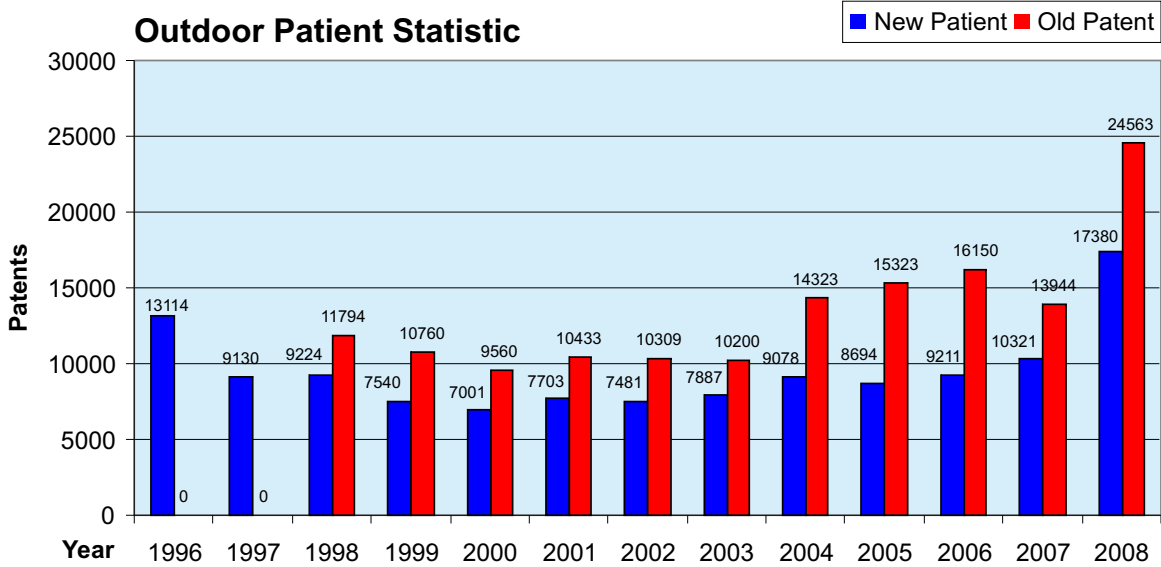


Mahila Bachatgat Melava

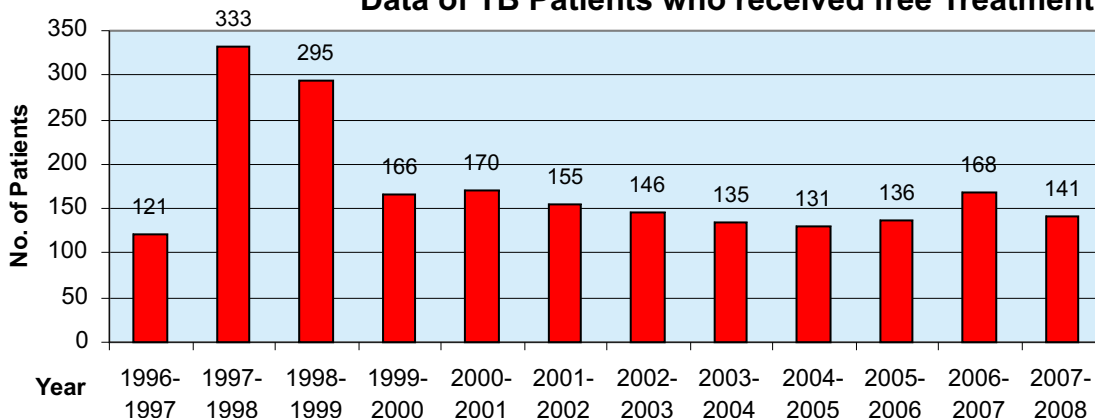
The best of medical care for the poorest of the villagers around Dervan and in the region of Ratnagiri is the mission of hospital. Today I feel that all this happening at Dervan is blessed and supported by power of Shree Digambaradas Maharaj and Shree Kaka Maharaj.

Graphical Interpretation of Patient Data

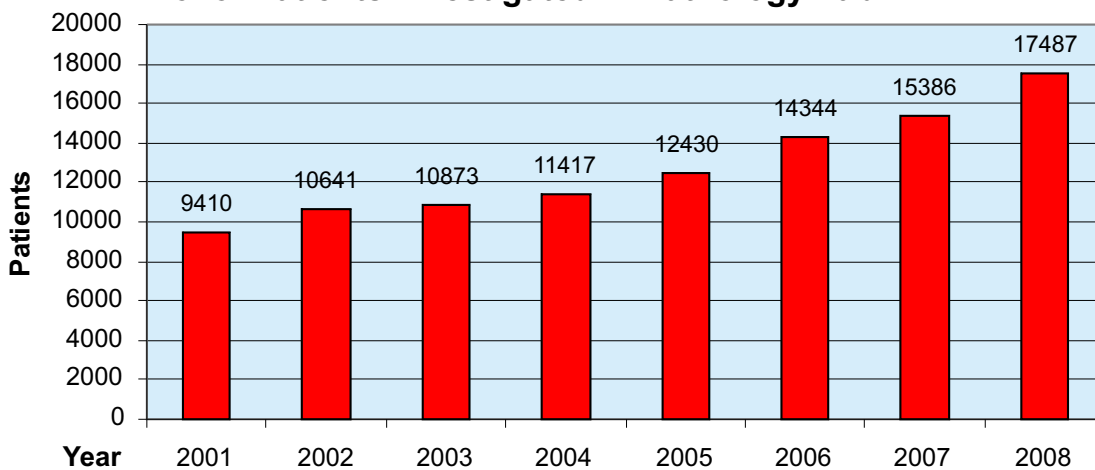




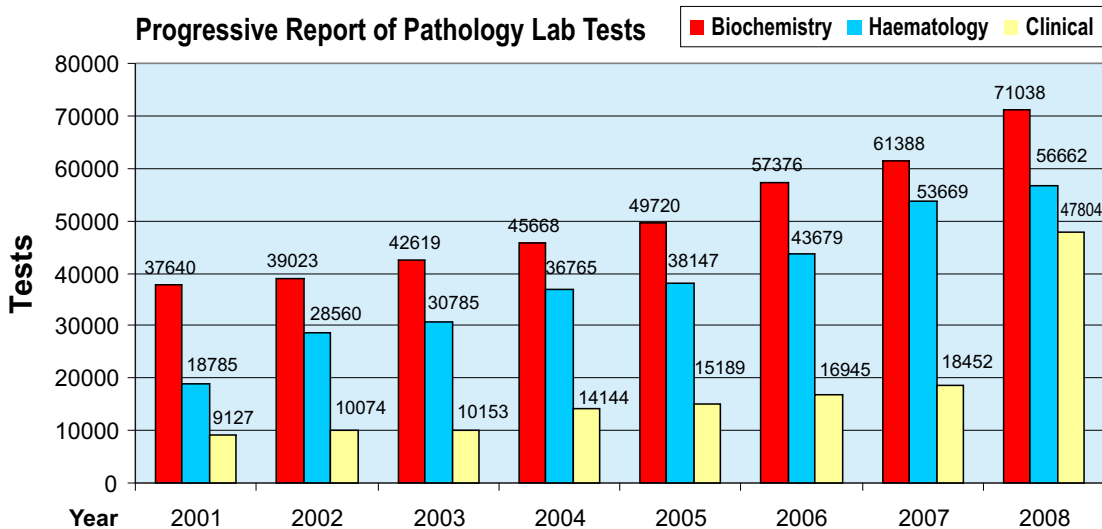
Data of TB Patients who received free Treatment



No. of Patients investigated in Pathology Lab



Progressive Report of Pathology Lab Tests



Special Views by Dervan Dignitaries

AN IDEA CALLED "DERVAN "

Ravin Thatte

M.S., M.C.H.

(Plastic Surgery), FRCS

- 1981 to 1990 : the plastic surgeon who had maximum research papers published in British Journal of Plastic Surgery.
- Awarded by Royal College of Edinberg.
- Fulbright Scholarship, Alabama University.
- Only Asian awarded by Royal College of Surgeons Edinberg for social work and Scientific research.



Time has flown as it does and always will, but the memory of my first, almost aborted trip to the Walawalkar Hospital, is still fresh. We were about half a dozen consultants. Bags all packed to take a train to Dervan, when news arrived that a major accident had disrupted the Konkan railway and the route was to remain closed for an indefinite period. I had to perforce phone Walawalkar's office to tell them that the trip was cancelled, when I was instructed to wait for another half an hour and was told that attempts were being made for alternative arrangements to travel. And sure enough, they were made. Two vehicles were to arrive at my doorstep in an hour and thus we set off on that 6 hour journey on a murky, wet and foreboding monsoon afternoon to Dervan. It actually took much longer and it was well past 10pm when we turned off the highway to complete the last 2 kilometers to approach the hospital. That road was much different then with very little habitation, hardly one street light, rain was lashing with some fury and the faces of my companions bordered on the grave. Then we were within the porch of the hospital, which was well lit, got down to see neat and clean corridors, entered the children's ward, to be met by local consultants who had worked up 10 cases for surgery the next day. We were told that blood transfusion services were on standby and post surgery recovery room had been organized next to the operation theatre. My companion consultants could not believe their eyes and ears. They got down to their work with the kind of enthusiasm which I had rarely seen in my long career. Dervan had touched them as it had touched me on my previous exploratory visit. It was mid-night when we went to our beds. The first incision was made at 7 am the next day. We finished all the cases that were posted by late evening and our efforts were as if blessed because not even the slightest hitch marred our day's

proceedings. We have not looked back ever since.

According to the tradition, the land around the Walawalkar Hospital is blessed because two saints lived in this area in the last century. Also according to tradition, the mentor of one of them, Shree Digambardas Maharaj had visions of a centre in this area, which will serve the poor and thus transform the neighborhood. One has to see the campus of the Walawalkar Hospital and its surroundings to be able to understand how truly that faith has come true. I have known hospitals follow commercial or industrial development, but to see a medical facility, a nursing college and a proper regular school induce a civilizational impact in a backward area is something extremely unusual, may be even unique, except perhaps in the case of the efforts of Mayo brothers in Rochester, Minnesota. If it was the brothers Mayo in Rochester, here in Dervan, it is the father (senior Kamalakarpant Walawalkar) and his son (Vikas Walawalkar) who have realized the vision and the dream of their guru, Shree Digambardas Maharaj. The Walawalkar hospital in Dervan is an extraordinary combination of the spiritual and the karmic world. The mentor of the young Vikas Walawalkar, Shree Kaka (Maharaj) Joshi, an engineer by training and a past government employee, has the kind of resourceful managerial techniques which will put in shade, many a CEO of multinational companies. This not only because of his skill but even more so because he does what he does as a mission to serve with compassion and also to serve with his feet firmly on the ground. Vikas (Walawalkar) has in the process risen to the challenge with great assurance and aplomb and has supported efforts of his guru with open hands. A more self effacing philanthropist I have yet to see.

It is this background which has attracted a huge number of talented consultants to this hospital to give their services free of charge. One common thread that runs through them is their ethicality. Medical profession, I am afraid, has now turned itself to in a mercenary pursuit and resembles the outlet of malls, where technological products are sold with one eye firmly fixed on the profit margin. The Walawalkar hospital shines in this world as an island of moral and ethical medicine. Consultants, who come here, arrive to nurture their inherent goodness and to relieve themselves of the guilt which is unavoidable in the rest of the medical world. It is an oasis to which we come to drink and are thankful that this water allows us to cross the desert which seems to inexorably encroach on our lives. On this occasion when the hospital adds a weighty feather to its cap, I wish I have enough strength in the years to come to do more for the institution.

WORK IS WORSHIP

Sunil Nadkarni.

M.S., F.R.C.S., M.C.H. (Ortho)

12 years experience in U.K.(including 4 years as consultant) and 2 years specialist training in spine surgery in Sydney Australia. Now practicing as Spine Surgeon. Pune.

Email: sunil.nadkarni@gmail.com



Professional fulfillment requires constant challenges. At Dervan there is a penchant for unique and challenging problems asking to be treated. There are several examples that come flooding into the mind.

Three years ago during Dahi Handi a person on the ground watching the proceedings had the collapsing human pyramid fall on his head. His neck was severely injured resulting in a fracture of the pedicles of the axis bone or the 2nd cervical vertebra (commonly known as the hangman's fracture). The spinal cord was at risk of further injury. This was duly treated surgically by bringing the fracture to its original position and held in place by passing two 4 mm diameter screws through the pedicles of 2nd cervical



Pre-Operative CT image

vertebra without damage to the spinal cord. He recovered well and went home walking within a week.



Post-Operative X-Ray

Then there was this lady who was developing a slow type of paralysis because of a bad deformity of her neck, the kind that is commonly called a swan neck deformity. She had several underlying medical problems such as diabetes and hypertension. She was unable to walk. She had been to several hospitals in Mumbai and told that she required surgery that was both expensive and too risky. Because of the faith of her family in Dervan and financial constraints they arrived for the surgery at Walawalkar hospital. Following a five hour surgery the deformity was corrected and the spinal cord decompressed. The neck was held in the corrected position with a special rod and screw system.

With the constant vigilance of the physicians and doctors and nurses in the ICU major complications were averted. With the help of the physiotherapist she was walking at the end of the week and went home in three weeks.

With the passing of years in one's chosen profession there is a special pleasure derived from teaching and training others. I can remember two unique experiences in this regard at Dervan.

There was a lady who had fallen into a ditch with dislocation between the 5th and 6th vertebrae of the neck and injury to the spinal cord. I explained to the young orthopedic surgeons how it was safe to apply traction to this patient before surgery because the CT scan had confirmed that there was no herniated disc fragment at that level. We took her for surgery and while this was in progress another patient was brought in with exactly the same kind of injury. Only on this occasion there was a disc fragment so it was simple to drive the point home about how it would be dangerous to apply traction in this other patient. I do not remember another instance where a point of training was driven straight home fortuitously in one day.

Again some time back a contingent of doctors from Malaysia and Korea came to Dervan with Dr. Satishchandra Gore for observing endoscopic spine surgeries done by the master himself. This was arranged extempore. We were concerned whether there would be enough endoscopic spine surgeries in day to make their trip worthwhile. To our utter surprise not only were there four endoscopic spine surgeries on that day, but they all



Malaysian & Korean Doctors at Hospital

highlighted a different pathology and therefore a different surgical approach. Even with long planning one would have found it difficult to arrange such a varied session. Four poor patients from rural India derived the benefit of ultra modern high technology treatment in the presence of internationally recognized spine surgeons.

Finally in all of us, no matter what our profession, there is a need to help the poor and less fortunate people. Giving money and alms does not necessarily reach the needy. Our abilities nurtured through education and experience gives us the opportunity to set up a business and lead a comfortable life. But beyond that what remains is the vexing question. The plenty that our knowledge and experience accrues leads to a bigger and better lifestyle but there is something lacking. Walawalkar Hospital run by Shree Vithalrao Joshi Charities Trust has filled this need in a unique fashion and substituted the emptiness with empathy.

The following example is one of the many such representative instances. A 30 years old rural lady who worked in a small café for a pittance and leading a hand to mouth existence with her husband, unfortunately developed spondylolisthesis of her lumbar spine wherein the vertebrae got misaligned. Unfortunately for her the misalignment was of a kind that caught the nerves to her legs when she stood or walked. She was trapped between the real needs of hunger, thirst and survival and the crying pain in her legs from the trapped nerves. I had a surgical solution to her problem. To deliver such solutions requires state-of-the-art infrastructure with all modern facilities such as a CT scanner, C arm, clean state-of-the-art operation theatres, blood bank, ICU, pathological facilities, supporting trained devoted staff, team work between different doctors. Walawalkar Hospital was able to provide all this and more and not at some distant metropolis but right in the heart of the deprived, geographically difficult but beautiful forest land of Dervan.

It reminds one of the utopian cities in Ayn Rand's 'Atlas Shrugged'. Having a spiritual basis and hence complete in itself, it shuns publicity and recognition. There are devoted volunteers for whom Kaka Maharaj's (the spiritual leader) words are all the food, water and sleep required. Kaka Maharaj himself although endowed with unlimited spiritual powers that need to be experienced to believe in, leads an exemplary 'normal' life and stresses the need to be simple and demands that he should be treated no different than any average person. He, through example extols simple religious truths, virtues and devout living in a manner that is immediately understandable to lesser mortals like me. He shows that being religious is no different from being practical in a visionary manner for the greater good. He insists that being religious does not require one to close one's eyes but instead to keep the eyes open and being alert 24 hours. He proves the point that being religious is not being weak but striving for strength in a positive and accommodative way. He encourages one to be constantly working and directs with gentle suggestions leading towards upgrading our skills in all aspects of life in a practical manner. The rules of religion then instead of coming across as being cut and dry become the only way towards love and continual happiness. Through example it becomes clear that just as sorting out which side of the road we should drive on and agreeing on a set of traffic rules we are able to drive at good speeds in comfort and enjoy the drive, similarly the age old values and religion lead us to enjoy life at full speed and attain our goals. It reminds me how the inner warmth and beauty that necessarily accrues from our religion when it is taught in a practical open minded manner by a leader who in intense continuous activity is completely detached, and all the activity is completely for the betterment of our society. Otherwise why would anyone setup such a huge facility in a jungle; why would one engage 24 hours x 7 days a week for the rest of one's life in proper setting up of such facilities and conveniences and their continuous betterment in a constant but impersonal way reminding that all this is his Master's doing and he is but an ordinary employee. To

prove the point he leads a disciplined life engaged in continuous activity. A tiny glimpse of his impeccable decision making quality that borders on surreal be it a structural engineering problem, financial problem, personal problem of any devotee, conflict resolution amongst the workers, small or big belonging to locals or foreigners, the ability is incredible.

And at the end of the day where does all this crystallize; when this lady successfully undergoes the 6 hour operation paying only a pittance that is only a miniscule of what the actual cost of delivery of this level of care. And this 'care' is truly caring not only to the patient but to the doctors and staff too !

It is only because of some quirk of fate that I had the opportunity to witness all this. I consider it the highlight of my life. My life has been enriched to an indescribable extent. I have now become a busy spine surgeon with some special skills. I and my family have benefited tremendously in both cash and kind. The list of visitors to Dervan reads like 'who's who'. I could not have dreamt in my entire lifetime of meeting these kinds of people and talking to them over a cup of tea and having a free discussion.

With the help of the Trust and its activities I am slowly beginning to realize what is meant by 'work is worship'.

Tumors of posterior elements of vertebral column are rare. Examples of two such cases treated successfully at Walawalkar Hospital recently.

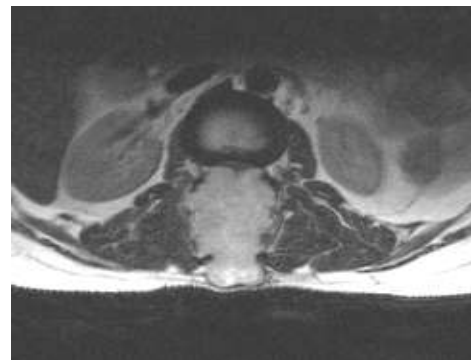
Case : 1 →



Post - Operative Specimen

CT Scan Image

Case : 2 ↓



Post - Operative Specimen

MRI Images

सतारीचे बोल

Anil Purohit.

M.D. (Neurology),

A well known neurologist from Kolhapur having his own neuro-centre and EEG Laboratory.

Email: neuroanil@sancharnet.in



“काळोखाची रजनी होती
हृदयी भरल्या होत्या खंती
अंधारातची गढले सारे
लक्ष न लक्षी वरचे तारे”

अंदाजे १० वर्षांपूर्वी केशवसुतांच्या या काव्यपंक्तींची मला तीव्रतेने आठवण होत होती .

साधारण ३० वर्षांपूर्वी मी माझ्या न्यूरॉलॉजी प्रकल्पाच्या पहिल्या टप्प्यात मुंबईतच सुरु असलेली न्यूरॉलॉजी कोल्हापूरला आणली . त्यावेळी मुंबईपासून ते थेट बंगलोरपर्यंत आणि गोव्यापासून नागपूरपर्यंत मी मान्यताप्राप्त पदवी संपादन केलेला पहिलाच न्यूरॉलॉजिस्ट होतो .

माझ्या प्रकल्पाच्या पुढच्या टप्प्यात ही न्यूरॉलॉजी मी मिरज-सांगली -सातारा -वेळगाव या आजूबाजूच्या शहरात नेली .

त्या पुढच्या टप्प्यात - साधारण १९८० पासून २००६ पर्यंत ही न्यूरॉलॉजी मिरज वैद्यकीय महाविद्यालय, डी . वाय . पाटील वैद्यकीय महाविद्यालय, कृष्णा वैद्यकीय महाविद्यालय येथील पदवी व पदव्युत्तर वैद्यकीय विद्यार्थ्यांपर्यंत अध्यापनाच्या माध्यमातून पोहोचविली .

अशाप्रकारे न्यूरॉलॉजी प्रचारावरोवरच या भागात न्युरोरेडिऑलॉजी (ईईजी,ईएमजी,इव्होकड पोटॅशियल)सेवा प्रथमच सुरु करण्याचा मानही मिळवला . तसेच न्युरोरेडिऑलॉजी (कॅरॉटिड अँजिओग्राम, मायलोग्राम ,सीटी स्कॅन,एमआरआय)या सुविधांचाही प्रथमच पाया रचला .

एक हाती कोणत्याही मदतीशिवाय, विशेषतः सरकारी-अथवा एखाद्या संस्थेची मदत न घेता हे सर्व प्रकल्प पूर्णत्वाला नेले .

हळू हळू महाराष्ट्राचा नकाशा न्यूरॉलॉजिस्टनी भरला . कोल्हापूर नंतर पुणे, नाशिक, औरंगाबाद,जळगाव, सांगली, मिरज येथेही न्यूरॉलॉजिस्ट आले .

तरीसुद्धा एक खंत होतीच! अद्याप शहरापासून लांब खेड्यापाड्यात,वाडीत न्यूरॉलॉजी सुविधा पोचल्या नव्हत्या . माझ्या प्रकल्पाच्या पुढच्या टप्प्याच्या दृष्टीने पाहणी चालू असतांना डेरवण येथील वालावलकर हॉस्पिटलची माहिती मिळाली . कोकणातील २-३ रुग्णांनी या हॉस्पिटलमधील मेंदूचे सी . टी . स्कॅन वरोवर आणले होते . माझी उत्कंठा वाढली आणि पुढच्या टप्प्याची जागा जवळ जवळ निश्चित झाली . सी . टी . स्कॅनची ज्या अर्थी व्यवस्था होती त्याअर्थी इतर व्यवस्थाही चांगली असणार याची खात्री होती . कोल्हापुरात आम्हा डॉक्टरांनी भारतातील पहिले सी . टी . स्कॅन उभारण्याचा अनुभव गाठीशी होताच .

प्रकल्पाचा पुढचा भाग म्हणून एपिलेप्सी (फीट्स) शिवीरांसाठी हे हॉस्पिटल योग्य वाटले . शिवीरामध्ये तपासणी, रक्त तपासणी,ई .ई .जी .,सी .टी .स्कॅन आणि मार्गदर्शन या सर्व गोष्टी झाल्या तर रूग्णांचा पूर्ण अभ्यास होऊन कोकणातल्या खेड्यापाड्यात -पाड्यात -वाडीत राहणा-या जनतेला याचा उत्तम फायदा मिळेल याची खात्री होती .या रूग्णांना मुंबई सारख्या ठिकाणी जाण्याची, तेथल्या गैरसोयी -महागाई, घराची गैरसोय या सगळ्या गोष्टी टाळता येतील याचा कोल्हापुरातील दीर्घ अनुभव गाठीशी होताच .एपिलेप्सी सारख्या आजारात गैरसमज फार आणि गैरमार्गदर्शन फार .त्यात तपासण्या-उपचार यांची वानवा ! म्हणूनच ही शिवीरे निश्चीत केली . मुंबईसारख्या ठिकाणी २-४ दिवस राहता येत नाही, 'डॉक्टर, संध्याकाळी घरी पोहोचलेच पाहिजे-गुरांच्या धारा काढायच्या आहेत', किंवा 'शेताला पाणी पाजायचे आहे' किंवा घरी वृद्ध आई वडील आहेत संध्याकाळपर्यंत घरी पोहोचलेच पाहिजे, अथवा लहान मुलांना शेजा-यांच्याकडे ठेवून आलो आहोत -ती जेवणार नाहीत, रडतील आम्ही पोहोचलो नाही तरया प्रश्नांची -अडचणींची समज पुण्या-मुंबईकडील 'व्हाई ट -कॉलर्ड 'डॉक्टराना येणारच नाही !! म्हणूनच या सर्वांवर मात करण्यासाठी हे हॉस्पिटल निवडले .

“वरती मग मी नजर फिरविली

नक्षत्रे तो अगणित दिसली

अस्तित्वाची त्यांच्या नव्हती

हा वेळवरी दादच मज ती”

अगदी हीच अवस्था माझीही झाली ! प्रथम फेरीतच या हॉस्पिटलने जिंकले . स्वच्छ ,प्रशस्त निसर्ग परीसर , प्रदुषणविरहीत स्वच्छ हवा ,निसर्गाचा तोल संभाळतच आणि एकाही वृक्षाला धक्का न लावता उरलेल्या जागेत कल्पकतेने उभारलेल्या इमारती, त्यांची नद्यांची नावे यामुळे 'निसर्गात जा ' या गुरूदेव टागोरांच्या संदेशाची प्रचीती आली .

पहिल्याच भेटीत हा संपूर्ण प्रकल्प अभ्यासला . श्री क्षेत्र डेरवण, भक्तश्रेष्ठ कमलाकर लक्ष्मण वालावलकर रोगनिदान व संशोधन केंद्र ,श्री विठ्ठलराव जोशी चॅरीटेबल ट्रस्ट, श्री .सदगुरू दिगंबरदास महाराज या सर्वांबद्दल माहिती मिळाली . शेजारील शिवसृष्टी प्रकल्प ,मंदिरे, निसर्गरम्यता आणि इतर अध्यात्मक व्यक्ती -शक्ती कार्याला प्रेरणा देत होते , आदर्श निर्माण करत होते .

हॉस्पिटल मधील स्टाफसाठी निवासस्थाने, त्यांच्या आणि आजूबाजूच्या लहान मुलासाठी तसेच इंग्रजी माध्यमाची शाळा इथपासून ते नर्सिंगस्कूल पर्यंतच्या सर्वांची यथोचित वांधणी या गोष्टी दूरदृष्टी आणि उज्वल भविष्याची ग्वाही देत होत्या .

हॉस्पिटलमध्ये सर्वच विभाग होते . वाह्यरूग्णविभाग प्रशस्त जागेत होता . सगळ्यात महत्वाचे -वाह्यरूग्ण विभाग तळमजल्यावर होता -म्हणजे अति आजारी ,अत्यवस्थ -वेशुध्द रूग्ण ,वृद्ध रूग्ण ,गरोदर स्त्रिया , लहान अर्भके घेऊन येणा-या माता ,अस्थीभंग असणारे रूग्ण,या सर्वांनाच लांब चालत न लावण्याचा ,जिने न चढण्याचा विचार होता- नाहीतर मुंबई-पुण्याकडील मोठ्या मोठ्या रूग्णालयात जिने चढून किंवा लांब लांब चालून साधे रूग्णसुध्दा अत्यावस्थ होऊन सरळ अतिदक्षता विभागातच (किंवा दुस-या जगात) जातात . पूर्ण विचार करूनच याच विभागाजवळ क्ष-किरण ,रक्त तपासणी व इतर रक्ततपासणी विभाग ,अतिदक्षता विभाग ,डायलेसिस विभाग , हृदयविकाराच्या सर्व तपासण्याचे विभाग याची योजना म्हणजे तिथे येणा-या रूग्णाच्या सानिध्यातच कायम डॉक्टर वावरणार - म्हणजेच रूग्णांना मोठाच दिलासा मिळणार तसेच संबधित डॉक्टराना कमीत कमी त्रासात रूग्णांपर्यंत पोहोचण्याचा विचार करून केलेल्या या योजना होत्या .आंतररूग्ण विभागात सर्व विभाग तर होतेच पण अतिदक्षता विभागातील शिशु अतिदक्षता विभाग हा भारताची भावी पिढी निरोगी कशी राहील यासाठी जाणीवपूर्वक केलेले प्रयत्न होता . या सर्वांबरोबरच कोकणातील खास प्रश्न -म्हणजे विंचू दंश आणि सर्पदंश यांचा विचार करून त्यावरील सर्व उपचारांची सोय होती .

पहिल्याच शिवीरात डॉ.सौ. सुवर्णा पाटील व त्यांचे यजमान डॉ.नेताजी पाटील यांच्याबरोबरच श्री. गोडवोलेंचीही चांगली ओळख झाली. श्री. वामणे, जाधव सिस्टर, विंचू सिस्टर, सागवेकर यांचीही ओळख झाली. त्यापुढील शिवीरातही वेळोवेळी त्यांच्याबरोबर चर्चा करत भावी वैद्यकीय प्रकल्पांची ओळख आणि विचारांची देवाणघेवाण होई. सर्वच जण अथक आणि कौशल्यपूर्ण काम करणारे. 'रूग्णसेवा हाच धर्म' हे आचरणात आणणारे ! वैद्यकीय, सामाजिक आणि स्थानिक प्रश्नावर त्यांच्याशी चर्चा करणे उत्साहवर्धक असे.

प्रत्येक वेळी नव्या प्रकल्पांची माहिती घेणे आणि त्यांच्याबरोबर परीसरात हिंडून सर्व पाहणे हा वेगळाच आनंद असे. शाळेतल्या चिमुरड्यांच्याबरोबरही त्यांची इंग्रजीची प्रगती पाहणे तसेच त्यांची कवायत पाहणे हा आनंददायी अनुभव होता. या रूग्णालयात नुसते रूग्णावर उपचार होत नव्हते तर भावी पिढीवर संस्कार करणारे हे संस्कार मंदिर होते.

एपिलेप्सी शिवीराच्या यशाची व्याप्ती वाढवण्यासाठी माझ्याबरोबर माझी पत्नी डॉ.सौ. छाया (वालरोगतज्ञ) सोबत येऊ लागली आणि बालवयातील आणि कुमारवयातील एपिलेप्सी रूग्णांना सेवा पुरवू लागली. आमची मुले पण या शिवीरात उत्साहाने भाग घेऊ लागली. त्यांनी शिवीराचे वेळी लहान मुलांच्या चित्रस्पर्धा, एपिलेप्सी प्रश्नपत्रिका सोडवणे हा कार्यक्रम आणि उत्तेजनार्थ वक्षिसे देणे हा कार्यक्रम सुरू केला. या कार्यक्रमाचा रूग्णबालकांनाच नव्हे तर पालकांनाही फायदा झाला. आपली मुले सर्व क्षेत्रात सहभागी होऊ शकतात हा आस्विश्वास त्यांनाही आला. प्रत्येक शिवीराच्यावेळी एपिलेप्सी आजाराची माहिती, मार्गदर्शन, प्रदर्शन, सूचना यांची पत्रके आणि टीव्ही कॅसेट यांची व्यवस्था हे अमोल्ये काम. श्री. रमेश -उमेश -भालचंद्र ही मंडळी शिवीराच्या वेळी सकाळी ७ वाजल्यापासूनच ई.ई.जी. काढण्याचे काम इतके तल्लीन होऊन करत की त्यांना जेवायलासुध्दा ओढूनच न्यावे लागे. दरवेळी रात्री जवळजवळ १-२ वाजेपर्यंत सर्व काम संपवून आणि सर्व स्वच्छता करूनच थांबत. त्यांनाही या संस्कारक्षम रूग्णालयात अखंड काम करत राहण्याची प्रेरणा मिळे.

आमचा एपिलेप्सी शिवीराचा सर्व संघ डेरवण रूग्णालयाच्या प्रगल्भ भरभराटीचा साक्षीदार आहे. आमचे एपिलेप्सी कार्य या कार्याच्या एक टक्का सुध्दा नाही. नव्या इमारतीचे नियोजनपूर्वक बांधकाम, कॅन्सर प्रकल्प, गावोगावी कॅन्सरनिदानासाठी फिरणा-या रूग्णवाहिका, टाटा रूग्णालयाशी संलग्नता, कोबाल्ट थेरपी या सर्व प्रकल्पांचे आम्ही साक्षीदार आहोत. रूग्णालय आता बाल्यावस्थेतून आता परिपूर्ण प्रौढत्वाकडे आले आहे. त्याच्या उत्तुंग यशात आमचा खारीचा वाटा !

मला जर कोणी या रूग्णालयाचे वर्णन करायला सांगितले तर मी म्हणेन "कोकणवासीयांसाठी अखंड २४ तास, वैद्यकीय क्षेत्रातील उच्चतंत्रसोयींनी परीपूर्ण असलेले प्रशस्त, स्वच्छ, हवेशीर, निसर्गसानिध्यातले, रूग्णसेवेसाठी प्रसन्न हसतमुख स्टाफसह असलेले सेवा-संशोधन -मार्गदर्शन - सुसंस्कार करणारे स्वस्त आपले रूग्णालय"

या रूग्णालयाच्या उत्तुंग यशाबद्दल रूग्णालयाशी संबंधित सर्वांचे मनःपूर्वक अभिनंदन आणि उज्ज्वल भविष्यासाठी इश्वरचरणी प्रार्थना.

आणि केशवसुतांच्याच शब्दात आठवतात त्या "सतारीचे बोल" च्या पंक्ती ---

“शांत धरीत्री शांत निशा ती
शांतच वारे शांतच सारे
शांतच हृदयी झाले सारे
असा सुखें मी सदना आलो
शांतीत अहा ! झोपी गेलो
बोल बोललो परी कितिकदा
स्वर्णी दिड दा, दिड दा, दिड दा“ !

A GLANCE AT DERVAN A PSYCHIATRIST'S PERSPECTIVE

K. S. Kulkarni.

M.B.B.S., D.P.M., M.D.

A renowned Psychiatrist from Pune.

Email: kulkarniks@hotmail.com



INTRODUCTION:-

"Mind & Body, Heart and Soul. Is Mein Shakti Hai Anmol"; is a very frequently heard slogan on TVs these days. This slogan is used on TV channels to inspire our heroes cricketers. The slogan has a message to convey the message that there is a strong co-relation between mind, body, heart and soul.

I am blessed to be associated with Dervan Hospital for the past about 10 years. This association has given me immense opportunity to gain greater insight into the community we are serving and in understanding of psychiatric illnesses with the psycho socio cultural background of the people.

PILGRIMAGE:-

In this article, I am not trying to give you any figures, but only trying to give some insights related to working in a place like Dervan .It is astonishing to share what I get in working with patients in Dervan, often makes me humble with the realization that there is some mysterious grace more than Dr. K.S. Kulkarni, guiding the lives and suffering of patients who are seeking help from this hospital. In fact, my visits to Dervan every month make me feel that I am going on a pilgrimage there than to attend to the medical camps.

COMMON PSYCHIATRIC DISORDERS:-

1) Perhaps the commonest psychiatric disorders seen are depression, anxiety, psychotic disorders, addictions and neuropsychiatric disorders in that order.

2) The striking observation has been the amount of psychiatric help required for patients in ICU, neurological disorders, diabetes mellitus (endocrinological and metabolic disorders), gastrointestinal disorders, cardiovascular disorders, dermatological cases and pediatric cases.

DEPRESSION & ANXIETY DISORDERS:-

My common experience in working at Dervan Hospital is the frequency and prevalence of anxiety and depressive Disorders. Hence I am making these disorders as the main theme of this article .There is plausible biological basis for the association between psychiatric morbidity and cardiovascular disorders. Anxiety, panic disorder and depression are common in patients with coronary heart disease and hypertension. One or two questions regarding sadness and loss of interest serve as simple and effective screening tools for post myocardial infarction depression.

Substantial prospective, epidemiological evidence now suggests that among patients admitted to hospital for an acute coronary syndrome; those suffering from co-morbid depression are at significantly increased risk for future cardiovascular mortality. This appears to be true even for patients with mild depressive symptoms that do not meet full criteria for major depression. Given the remarkable prevalence of depressive symptoms among patients with coronary disease (20-30%), the issue is far from trivial.

Although treating depression in acute coronary syndrome makes sense, only minority of patients appear to receive treatment.

WALAWALKAR HOSPITAL - MY EXPERIENCE

Pankaj Kulkarni.

M.B.B.S., D.G.O.

Renowned Gynecologist from
Pune.

Cell No. 9822533515



We started "SAKHI CLINIC" in 1996 and it was like a very major milestone in our life to start a small nursing home on Fergusson road without any Godfather in Pune (As one requires it in medical practice) and mainly everything on loan with interest rate of 18.75%, at that time. Naturally I was focused on earning money and that was all.

That time I happened to meet Dr. Achyut Joshi incidentally to request him to help us set our practice. I do not know how and why, but in our first visit he mentioned to me that I must come to Mandir, which was very close to my clinic and

now very close to my heart. I happened to go there on Thursday with him and that was immediately followed by a trip DERVAN. I say 'trip' because that time there was not a single operation for me at Dervan and I did not know that there existed a beautiful hospital. It was monsoon time and I went there for a trip. The moment I entered the premises, I fell in love with the hospital and since then my association began and I pray GOD that it remains like this in future too... Initially we used to advertise our camps in newspapers and started getting tremendous response. Since I come from Konkan, I have an idea regarding the difficulties in treating the patients and how hard it is for the patient to get medical aid. In fact I got an opportunity to see many interesting patients and also to operate complicated operations, which in turn gave boost to my confidence in my routine practice too. Our pride was endoscopic surgery as we started doing it there when it was getting introduced in India. It suited the patients from Konkan also as laparoscopic surgery definitely reduced the time for the recovery so that they could work in the field in lesser time following surgery as compared to conventional surgery. Today at Dervan we have the best equipment for laparoscopic surgery in India- at par with the other hospitals, probably even a better one. I am proud to say that we have one of the best ART centre at Dervan offering various artificial reproductive treatments like IUI to people from Konkan. Our goal is to have a training centre in laparoscopic surgery, and I am sure we will have it in near future with participation from other doctor colleagues. I am proud and happy that I am associated with the organization which is doing so much for the people from Konkan not only with respect to medical service but also by starting various programmes through which local people are generating funds for themselves. We have started medical insurance schemes for people so that they should not feel the pinch for the expenses for medical illness. Those of you who know the terrain of Konkan will have an idea as how difficult it is for a person residing in that area to have medical aid and in that this hospital is really doing thankless job. Help given with the hands is superior to the prayer said by lips, which is so true in case of Walawalkar Hospital.

Regarding my personal experience, I have no words to put on paper. My attitude towards life is totally changed and I am being more positive now. Because of my association I had an opportunity to interact with various types of people who have really attained heights in their respective fields. In my practice too my experiences are beyond imagination. I wish this hospital the very best in all the future projects and consider myself fortunate to be associated with the hospital.

A UNIQUE AND ENRICHING EXPERIENCE

Achyut Joshi

M.D. (Med).

A well known Nephrologist practicing in Pune

Cell No. 982203024



My association with "Samadhi Mandir", Dervan and Parampujya Shree Digambardas Maharaj gets back to my Childhood, early sixties. I was a small child visiting Samadhi Mandir along with my father. While offering my Namaskar to Shree Maharaj, I could sense something 'different', sense serenity while being with Maharaj for few minutes. It was in 1984 when I passed my post-graduate examination in M.D. Medicine, our association became stronger, adherent and permanent. Shree Maharaj was not keeping well and I had the privilege to be with him and offer my help and service, if not treatment. It was enriching, eye-opener experience which I will cherish for ever. I realized and understand that 'Theory' and 'Practical' are different in life. There is something else in life beyond books and theory that one has to experience & practice himself.

It helped me in my personal life and my profession. It helped me to tide over difficult times. It helped me to be nicer to people who are nice and to maintain your 'self' and to guard your interest while dealing with bad people.

With advent of Walawalkar Hospital our association continued. It's my privilege to be one of smallest participants in working of the Hospital. Those who are acquainted with Konkan area would not believe that such big hospital could ever exist in Konkan area. Such hospital could easily be prestigious even in big cities like Pune and Mumbai.

I have been looking after 'Medicine' department of the hospital. With the blessings of Shree Kaka Maharaj we started 'Artificial Kidney Unit' which is offering Hemodialysis facilities to whole Konkan area from Panjim to Panvel.

It was my amazing experience that many complicated cases could be successfully treated with positive and favorable outcome. Could there be other reason than blessing of Shree Digambardas Maharaj & Shree Kaka Maharaj? This is not to belittle the hard work of doctors working at Walawalkar Hospital. A lot many problems crop up while running the hospital, but one experiences that they are sorted out surprisingly as if somebody is helping us. I'm sure all my colleagues will endorse my opinion.

Common man dies and is forgotten, but legendary men like Walawalkarsaheb and Digambardas Maharaj, though pass away bodily they stay alive forever by their souls and their deeds.

REAL FACTS ON THE LIFE GIVING HOSPITAL

Nitin V. Shah

M.D., D.V.D.

A well known Skin V.D. Specialist
(Dermatologist) from Pune.

Phone No. 020-4334885



'Service to man is service to God', living up to this idea is very difficult. 'Doctors are life givers' is a real fact. Mahatma Gandhi once wrote in the 'Harijan Sewak' (15 July 1947) that the doctors in India are inclined to save the people's lives.

I have a personal experience of visiting an absolutely dedicated hospital, "Walawalkar Hospital". Doctors here whole-heartedly attend to the patients in OPD. This hospital is flanked by greenery from all sides that helps the patients recover sooner amidst the nature. The facilities and provisions like surgeries, operating sector and also the theatres are well equipped with necessary tools and implements. It is due to the hard work and skill and also intelligence of doctors that they attain perfection in their life long training. 'Work is Worship' is rightly stated, for it needs a person like Florence Nightingale who was a nurse by profession.

The poor and the needy people are given proper attention and correct treatment without any discrimination on any ground. They are charged merely a very small amount. Different doctors from all over the world hold free camps for sick and ill people. This helps in curing the lay man as early and quickly as possible.

Ambulances, cars and even mini-buses work for hospital and reach out to the accident scenes within few minutes as they are on their toes for service from heart.

Here in Konkan, a vast area is covered by the hospital. There is absolutely no help from any politician. It is necessary to mention that if a project like this is established in every village, city or town in India people will live a healthy life.

And in concluding I, a doctor myself, would like to state that if we cannot communicate with people, be selfless and sacrificing we are only an animal which does not have feelings at all and we are not recognizing the main aim of life which is to contribute our might to the society and live our life to its fullest, otherwise we are adding to the scrap i.e. the burden of the earth, which will make human race extinct one day or the other.

ENDOSCOPY SUIT AT B.K.L. WALAWALKAR HOSPITAL

Anand Joshi.

D.M. Gastroenterology.

A well known Gastroenterologist from Hinduja Hospital, Mumbai.

Email: joshianand3@rediffmail.com



We have acquired state of art Olympus videoscope and recently moved to the new endoscopy suite which has better patient waiting area, post procedure recovery areas, toilets and bigger endoscopy room to enable us perform more therapeutic/ C arm procedures.

We have trained our staff at P.D. Hinduja National Hospital and Medical Research Centre.

After patients register in OPD, they are clinically examined by physician/surgeon/gastroenterologist. If their symptoms merit, they are advised endoscopy/ colonoscopy.

Patient is explained in detail about the procedure. Consent is obtained. After changing in hospital clothes, patients undergo procedure. We prepare patients for upper GI endoscopy in fasting state and for colonoscopy; we give laxatives for bowel cleansing.

In brief, review of our initial 50 patients included 38 males and 12 females. We performed 37 upper GI and 13 lower GI colonoscopies. In upper GI endoscopies, we had 9 patients with esophageal varices (7 adult male, 1 female, 1 child) who had bleeding which was controlled with sclerotherapy. Barrett's esophagus in 2 females; duodenal ulcer in 1; hiatus hernia in 12 patients (9 males and 3 females); gastritis in 3; G.E.R.D. in 15 (12 male and 3 females). In lower GI colonoscopies, Ca colon was diagnosed in 2 male patients; diverticulosis in 3 (1 male, 2 female), rectal polyp in 1 and hemorrhoids in 3 male patients.

A patient's perspective:

In 2006, 67-year-old Mrs. Patil, a mother of three and house wife of a wholesale book seller, began experiencing an unexplainable and startling condition that caused her to vomit the food and beverages she consumed. At first it only happened

weekly, but soon it progressed to the point where the Chiplun native wasn't digesting any food, and she knew she had to act quickly.

"My first reaction was to wonder if I was sick or if certain foods were triggering my reaction," says Mrs. Patil. "But it was strange, because I didn't have nausea or any of the symptoms typically associated with acid reflux."

Mrs. Patil's doctor ran a series of tests, but was unable to determine exactly what was wrong with her. That doctor recommended Cholecystectomy (removal of Gall Bladder) which contained stones revealed on sonography.

"I said 'no way, I'm not going to do that!'" says Mrs. Patil. "I knew I needed to get another opinion, and I'd always heard such good things about the top medical facilities, but Walawalkar Hospital always stuck out in my mind as being the best. Earlier on in my life, I decided that if there was ever something really wrong with me, that's where I would like to go."

Initially, when seeking an appointment at Walawalkar Hospital, Mrs. Patil met with some resistance from a local physician, but she persisted and eventually a different doctor agreed to refer her. She got the news of free medical camp from referring doctor as well as advertisement appeared in local newspaper.

Diagnosis

After initial clinical examination at the Walawalkar Hospital with Dr. Suvarna Patil, she met me and I performed endoscopy. Mrs. Patil was diagnosed to be suffering from duodenal ulcer (breach in mucosa of duodenum) and Gastric outlet obstruction. This causes the solids or liquids in the stomach to flow backwards into the esophagus, thus causing vomiting.

After the difficult seven months of testing Mrs. Patil had just experienced in Chiplun — without a clear diagnosis — she was amazed at the swiftness and efficiency at Walawalkar Hospital.

"At Walawalkar Hospital, I started testing on a Sunday, got the diagnosis on the same day and could avoid scheduled surgery on Thursday," says Mrs. Patil. "I couldn't believe it."

Compassion and care helped calm Mrs. Patil

"I think that this hospital has got an amazing infrastructure — my guess is that it is one of the best in its field. In addition to taking care of my medical condition doctors were extremely compassionate and concerned about how I was doing emotionally and my comfort level with the procedure."

Mrs. Patil also felt calmed by the caring during endoscopic procedure Walawalkar Hospital follows after admitting patients for Endoscopy.

"When I went in for my endoscopy, there were probably 50 people there all waiting to have their own consultation," she explains. "Yet each person had a Walawalkar Hospital staff person assigned to who would stay with them the whole day and get them from point A to point B. That person literally walks you into the endoscopy room. It made me feel at ease that they were with me the whole way through the process."

Endoscopic diagnosis successful

Mrs. Patil's endoscopic procedure meant that it would take less time and the recovery would be much faster. The endoscope, which is essentially a small tubular video camera, was inserted through mouth.

"Endoscopy literally means 'to visualize inside,'" explains Dr. Anand Joshi. "In Mrs. Patil's case, the endoscopy revealed normal stomach and esophagus. This technique revealed duodenal ulcer that had formed from stomach acids and gastric outlet obstruction which ended in vomiting".

Follow-up care makes a difference; future looks bright

Throughout her experience at Walawalkar Hospital and after her return home, Mrs. Patil's thoughts continue to focus on the helpfulness and care she received.

"When I rang my bell, not just one nurse came, but sometimes three," she explains. "They'd ask, 'Would you like a washcloth for your face? Something to drink? Are you uncomfortable?' I've been in hospitals where 30 minutes after you ring for assistance, you are still waiting. But at Walawalkar Hospital, they come right away."

Today, Mrs. Patil is feeling much better as a result of her treatment and appreciates the continued care she receives.

"At first, I was on a bland, almost liquid diet, and then I added bhakri, and similar foods," she explains. "Now I eat anything I want. The facilities at the Walawalkar Hospital are the best of the best. I am sure of it."

Walawalkar Hospital : A Key Hole Surgeon's Perspective

Ajit Gurjar

M.S. (Surgery)

Laposcopic Surgeon from Pune.

Email: agurjar@vsnl.com



I have been privileged to be associated with the Walawalkar Hospital at Dervan ever since its conception. The name and the address get a stereotyped image to our minds. We visualize the palms, the sea, the red soil, mango trees and imagine a modest structure with rural infrastructure doling out primary health care.

A visit to Dervan however dispels this myth. Yes the ambience of the Konkan is very much there. However the campus is a great surprise. It is like an oasis in the otherwise dry rustic setting. Modern buildings, good roads, uninterrupted electricity, piped water, excellent staff hostels, schools and canteens spring out of nowhere. The services impress you much more than this hardware. The discipline and cleanliness coupled with the humility of the office bearers and the staff is to be seen to be believed. The cynic would still say that don't judge a hospital by the ambience but put it to the test on professional matters. And that is the greatest achievement which I would like to dwell on as a member of the Dervan medical community.

Surgery is a very specialized field in the medical profession. It needs a lot of gadgetry installed in aseptic theatres and a highly trained staff. It is a challenge to operate this branch even in urban areas, as the risk profile is very high. One of the first patients I saw at Dervan was a middle aged farmer with gall bladder stones. In the late nineties asking for laparoscopic equipment even in urban institutes was unknown. But here was a very impressive "working" laparoscopy set in the OT. The patient had a laparoscopic cholecystectomy and went home the next day. I was asked by some colleagues about the relevance of high tech laparoscopy in underdeveloped areas. The economically deprived rural patient cannot "afford" to stay bedridden for long periods. A technique like laparoscopy sends a family bread earner back to work much faster than traditional surgery.

Today we feel proud to have a CT scan, a full fledged ICU/CCU, a dialysis centre, high class cancer care and a medical team with unique expertise of dealing with local problems like snakebites. Dervan is now becoming "Global". We have many doctors from Europe visiting our hospital on a regular basis. They don't come only to teach but also to learn from the Dervan model.

It is said that coming together is a beginning, staying together is progress and working together is success. I believe that the first two phases have been already achieved at Dervan. We now have to work towards success.

My Experiences At Walawalkar Hospital, Dervan

Dilip Wani

M.D. (Patho)

Consultant of Chain of Voluntary Blood Banks.

Cell No. 9823230466

Email: medicarelabs@gmail.com



It was a pleasant surprise for me when my friend and colleague from my medical college days, Dr. Achyut Joshi invited me in 2005 to visit Walawalkar Hospital located at a small village called Dervan near Chiplun in Konkan area. As a nature lover I immediately accepted the invitation, since I did not want to miss the opportunity of closely watching “The Shivshrusti” at Dervan & the scenic beauty of various ghats in Konkan. Once I reached there, another big surprise was waiting for me. A huge campus just like a Medical College was awaiting me at Dervan. After taking the DARSHAN of MAHARAJ, I was taken around to the impressive Shivshrushti & then to the hospital by Mr. Godbole. It was a feast to my eyes & mind to observe all the modern medical facilities established at Dervan. Being a pathologist & a blood banker, I was very keen to observe the pathology laboratory & the blood bank. The spacious premises, all modern equipments & a well qualified staff greeted me in the department of pathology. I was spell bound to see the infrastructure like a medical college. I was then taken to the teaching facilities at Dervan. Various colleges for medical students, nursing, laboratory technicians etc. greeted me. Being a born teacher I immediately accepted to teach my subject to the students at Dervan. Since 2005, I have been teaching at Dervan. Each visit to Dervan is an electrifying experience for me, which keeps me charged for months. Not only it enhances my activities in Pune, but it gives me a long lasting eternal pleasure.

Extending medical services to the down trodden population in the remote areas of our country is a big challenge. Walawalkar hospital has fulfilled this need at least in Konkan area. The new National Blood Policy has envisaged the extension of Blood Component Laboratory Services, mostly located in the district places to reach to the periphery of the country in the form of “STORAGE CENTRES”. Walawalkar Hospital can become a prototype example for this service. Such blood component storage centre can be slowly upgraded to Blood Component Laboratory and then to the Department of Transfusion Medicine in near future. There is a dearth of manpower in the field of Transfusion Medicine all over the world. Starting a teaching & training facility at Dervan can bridge this gap.

Rajiv Shah

M.S. (Surgery)

General Surgeon, B.K.L.Walawalkar Hospital

Mobile: 9923361533.

॥ गुरुर्व्रह्मा गुरुर्विष्णु गुरुर्वेदो महेश्वरः ॥

॥ गुरुर्साक्षात्परब्रह्म तस्मै श्रीगुरुवे नमः ॥

भौतिकदृष्ट्या तसे पाहू गेल्यास मी एक शल्यचिकित्सक . परंतु पिंडाने शल्यचिकीत्सक असलो तरी अध्यात्मिकता वंशपरंपरेने माझ्या रोमारोमात भिनलेली असल्याने कस्तुरीमृगासारखी माझी वणवण गेल्या कित्येकवर्षांपासून चालू आहे . वरीचशी शहरं, गावं मी पालथी घातली व इथे नाही तर तिथे मन :शांती, स्थैर्य, कार्यकारणत्वातून समाधान मिळेल म्हणून प्रयत्न करीत होतो . वेळी अवेळी मंदिर, मठांचा व संतसज्जनांचा सहवास मिळण्याची संधी साधून मन :शांती मिळवण्याचा प्रयत्न करीत होतो . असाच अेकदा अहमदनगर येथील श्री क्षिरसागर महाराजांचे मठांत मी त्यांच्या प्रतिमेसमोर उभा असताना मानसिक संकल्प केला की, मी येथे राहून गोरगरीवांची सेवा करीन,त्यांच्या वेदना शमविण्याचा यथामति,यथाशक्ती प्रयत्न करीन तेव्हा मला शक्ती द्यावी, प्रेरणा द्यावी . मला माझ्या आल्याच्या आवाजाने साद दिली व सांगितले जरा धीर धर! तू तुझ्या ध्येयाच्या वाटेने योग्य दिशेने वाटचाल करीत आहेस . लवकरच तुला तुझे गंतव्य प्राप्त होईल आणि असेच अचानक माझे भक्तश्रेष्ठ कमलाकरपंत लक्ष्मण वालावलकर रुग्णालयांत आगमन झाले . जसजशी माझी पावले वळत होती तसतसे मला जाणवू लागले की हेंच ते स्थान असावे ज्याच्या शोधात मी होतो . येथे आल्यानंतर येथील नैसर्गिक वातावरण, अध्यात्मिक पार्श्वभूमी असलेले रुग्णालय, “Work is worship”चे ध्येय असलेली कार्यप्रणाली आणि “भिऊ नकोस मी तुझ्या सोबत आहे” अशी अदृश्य प्रेरणा मला जाणवते .

सर्जन म्हणून मला पुष्कळवेळा मनांत धाकधूक होती की, हे मला जमेल का? ऑपरेशन वरोवर झाले तर वरें पण मी ऑपरेशन थिएटरमध्ये गेल्यावर माझ्या मनातील किंतु परंतु नष्ट होतात आणि माझे हात अव्याहत चालू होतात . कांही वेळा मला असे जाणवू लागते की कुणीतरी माझ्यावरोवर वरोवर काम करीत आहे आणि दुःखीकष्टी होऊन आलेली माणसं हंसतखेळत घरी जातांना पाहून समाधान वाटते, ते सर्व मी येथे अनुभवतो . त्यामुळे मला हे ठिकाण भावले शिवाय येथे असलेली अद्यावत साधन सामुगी बुद्धीला चालना देते व विविध प्रकारच्या निष्णातांच्या संपर्काने बुद्धी व्यापक होऊन कल्पनाशक्तीला प्रात्यक्षिकाची अनुभूती होते . हेच येथील उद्दिष्ट माझ्या मर्मबंधात घर करून गेले .

मनाला विशेष आकर्षित करणारी गोष्ट म्हणजे कांहीवेळा आपणच आपले मत बांधण्याचा प्रयत्न करतो . परदेशी डॉक्टर्स या रुग्णालयात गेल्या तीन वर्षांपासून येत आहेत अर्थात माझी ही पहिलीच वेळ त्यांचेवरोवर काम करण्याची . मला वाटले ते आपल्याशी वोलतील की नाही, ऑपरेशनचे वावतीत त्याचेसोबत काम होईल की नाही? ते काय म्हणतील वगैरे विचार फक्त आपल्याच मनात येतात बाकी प्रत्यक्ष त्यांच्या परिचयात , सान्निध्यात आल्यावर त्यांचे वागणे, मार्गदर्शन करणे, ऑपरेशनचेवेळी समजावणे इतके सहज होते की ते वाहेरून आले आणि आपण त्यांना अपरिचित आहोत ही शंका मनातून निघून गेली व काम करण्यात खूपच आनंद आला . वच्याच नवनवीन गोष्टी व टेक्निकल स्किल शिकायला मिळाले .

सर्वश्री डॉ .नाडकर्णी, डॉ .गोरे, डॉ .पळणीटकर, डॉ .श्रीरंग जोशी व डॉ .सौ .सुवर्णा पाटील, श्री .गोडबोले हे सिनियर्स अगदीच आपुलकीने वागत असल्याने व त्यांच्या साध्या राहाणी व उच्च विचारसरणीने तर मी खूपच भारावून गेलो आणि ह्याशिवाय त्यांचे खरेखुरे शिरोमणी म्हणजे श्री .विकासराव वालावलकर ! म्हणतातनां “शुचीनामश्रीमतां गेहे योगभ्रष्टोऽपि जायते” खरोखरच योगी पुरुषच म्हणावे लागेल . एवढी सालसता, निरागसता आणि कार्यकुशलता मला प्रथमच अनुभवायला मिळाली या सर्वांच्या सहवासाचे कारण म्हणजे माझी तपश्चर्या फळाला येत असल्याची अनुभूती मला वाटते . हे सर्व मला येथेच मिळाले म्हणून मी स्वतः रुग्णालयाच्या व्यवस्थापन मंडळाला धन्यवाद दिल्यावाचून राहू शकत नाही .हे सर्व जरी खरे असले तरी प .पू .श्री .काकामहाराजांचे आशिर्वादाशिवाय हे पूर्णत्वास जाउच शकत नाही ही माझी धारणा आहे .

शैक्षणिक प्रगतीतून स्वावलंबनाकडे - श्री क्षेत्र डेरवण

सौ .सुधा जयंत नार्वेकर

प्रिन्सिपॉल

श्री समर्थ इनस्टिट्यूट ऑफ नर्सिंग एज्युकेशन,
श्री क्षेत्र डेरवण, रत्नागिरी



कोणत्याही गोष्टीची खात्री पटण्यापूर्वी ती स्व:तच्या कानाने ऐकावी व डोळ्याने पहावी म्हणतात . श्री क्षेत्र डेरवणच्या बाबतीत माझेही तसेच झाले . काही वर्षापूर्वी डेरवण या गावाचं नांव ऐकलं होतं पण पाहिलं नव्हतं . पहायचा योग आला तो २००७ सालच्या जून महिन्यात .

जून महिन्याची पहिली तारीख ,मला अचानक एका तरुणाचा फोन आला आणि भेटण्याची इच्छा व्यक्त केली . पुढे प्रत्यक्षात बोलणी झाली . समर्थ नर्सिंग कॉलेजच्या प्राचार्यांचे पद स्विकारायचे मी कवूल केले . आणि तसेच मी कामावर रूजूही झाले . तो तरुण म्हणजे माझ्या मुलाच्या वयाचा, प्रचंड आत्मविश्वास असलेली व्यक्ती, श्री प्रफुल्ल गोडवोले आपले अॅडमिनीस्ट्रेटिव्ह ऑफिसर (A.O.)

मुंबई -गोवा महामार्गावर 'श्री भक्तश्रेष्ठ कमलाकर पंत वालावलकर रुग्णालय' असा भला मोठा फलक दिसतो . तो डेरवण फाटा , तिथून साधारण अडीच ते तीन किलोमीटर अंतरावर हे हॉस्पिटल आहे . निसर्ग रम्य शांत वातावरण, स्वच्छ परिसर, 'हायटेक हॉस्पिटल' हे विशेषण लावायला कुठेही कमी पडणार नाही असे सुसज्ज जनरल हॉस्पिटल, I.S.O. प्रमाणित आणि तेही ग्रामीण भागात किंबहुना हे इथल्या जनतेचे सौभाग्य आहे असे म्हणावे लागेल .

आपले हॉस्पिटल परिचारिका शिक्षणक्रम (नर्सिंग) राबविण्यास योग्य आहे . हे जाणून संचालकांनी हा कार्यक्रम हाती घेतला . कुटुंबातील एखादी स्त्री सक्षम असेल तर ती संपूर्ण कुटुंबाची प्रगती करू शकते . अशा स्त्रिया प्रगतीशील राष्ट्राच्या मुलभूत पाया असतात . तसेच इच्छुक आणि होतकरू मुली ज्यांना आर्थिक पाठबळ नसल्याने पुढे शिकणे जमत नाही, अशा मुलींकरीता विविध नर्सिंग कोर्सेस संस्थेने उपलब्ध करून दिले . नियमानुसार वार्षिक फी आणि जेवणाचा खर्च या व्यतिरिक्त विद्यार्थिनींवर कुठलाही वोजा नसतो . एका गोष्टीची मला आवर्जून नोंद करावीशी वाटते की हे अभ्यासक्रम मुरु करताना मुलभूत सुविधा व प्रतिवर्षी अभ्यासक्रम चालविण्यासाठी, संस्थेला वराच आर्थिक घाटा सहन करावा लागतो . हे कार्य सामाजिक वांधिलकी आणि परोपकारी वृत्ती असल्याखेरीज शक्य नाही .

२००१ साली श्री समर्थ नर्सिंग स्कूलचा श्री गणेशा झाला आणि Auxiliary Nurse Midwife (A.N.M.) हा दीड वर्षे अवधीचा कोर्स सुरु केला . दहावी पास झालेल्या वीस विद्यार्थिनींना प्रवेश देण्यास मान्यता मिळाली होती . त्यांना आरोग्य विज्ञान, पौष्टिक आहार, प्रसुती शास्त्राची प्रॅक्टिकल सहित माहिती देण्यात येते . उत्तीर्ण विद्यार्थिनींना सरकारी आणि खाजगी क्षेत्रात नोकरी मिळते . खेड्यातून घरोघरी जाऊन या स्त्रिया सेवा वजावत असतात . स्त्री शिक्षणाच्या योजनेचा हा पहिला टप्पा होता .

२००२ साल हे संस्थेच्या इतिहासातले नर्सिंग एज्युकेशनच्या दृष्टीने अतिशय महत्वाचे पर्व आहे . कारण या वर्षी खऱ्या अर्थाने समर्थ नर्सिंग स्कूल सामर्थ्यवान झाले . इंडियन नर्सिंग कौन्सिल व महाराष्ट्र नर्सिंग कौन्सिलच्या अटींची पूर्तता ,

डेरवणसारख्या ग्रामीण भागात ही अभ्यासक्रमाला मान्यता मिळविण्याच्या दृष्टीने संस्थेची फार मोठी जवाबदारी होती . परंतु संस्थेने ही जवाबदारी व्यवस्थित पार पाडली आणि सन २००२ मध्ये G.N.M.(General Nursing and Midwifery) या तीन वर्षे अवधीच्या नर्सिंग कोर्सची सुरुवात झाली . सध्या हा कोर्स साडेतीन वर्षांचा आहे . कोणत्याही शाखेतील बारावी उत्तीर्ण विद्यार्थिनीला ही उत्तम संधी आहे . जागतिक मान्यता प्राप्त हा शिक्षणक्रम पूर्ण केलेल्या विद्यार्थिनींना नोकरीची विवंचना नाही . सध्या बऱ्याच मुलांचाही कल या क्षेत्राकडे झुकत आहे . हा दुसरा टप्पा यशस्विरित्या पार पडल्यानंतर संस्थेला नर्सिंग कॉलेज स्थापनेचे वेध लागले .

G.N.M. नंतर पुढील शिक्षणाची ही व्यवस्था आहे . G.N.M. उत्तीर्ण झालेल्या ग्रामीण भागातील नर्सना ना B.Sc. नर्सिंगची पदवी घेउन उच्च शिक्षित व्हावे, त्यांची प्रगती व्हावी व तेही माफक खर्चात या उदात्त हेतूने श्री समर्थ नर्सिंग कॉलेज उदयाला आले . हे कॉलेज महाराष्ट्र हेल्थ युनिव्हर्सिटीच्या अखत्यारीत येते . कॉलेज स्थापनेची तळमळ, सुरवातीच्या काळातील अडचणी व त्यावर मात करण्याची धडपड, याची मी साक्षीदार आहे . संस्थेने मजल मारली आणि शेवट गोड झाला . श्री समर्थ नर्सिंग कॉलेजची स्थापना झाली . २००७ सालच्या ऑक्टोबर महिन्यात पहिल्या B.Sc. नर्सिंगच्या बॅचला प्रवेश दिला . सध्या नर्सिंग स्कूल आणि कॉलेज 'श्री समर्थ इन्स्टिट्यूट ऑफ नर्सिंग एज्युकेशन' (SINE) या नावाने ओळखले जाते . डेरवणच्या इतिहासात नर्सिंग शिक्षणाचा हा तिसरा टप्पा अतिशय उल्लेखनीय आहे .

शिक्षण, आरोग्य आणि आर्थिकदृष्ट्या कमकुवत असलेल्या तळागाळातील ग्रामीण जनतेला विशेषतः महिला वर्गाला सक्षम व स्वावलंबी करणे हा संस्थेचा उदात्त हेतू आहे . या अंतर्गत सदगुरू श्री . काका महाराजांच्या कल्पनेतून REACH (Rural Empowerment And Community Health) ही संकल्पना २००७ साली कार्यान्वीत झाली . स्त्रियांना साक्षर करणे, त्यांची आरोग्य चाचणी व उपचार, संघटीत करून आर्थिक प्राप्ती होईल असे गृहउद्योग शिकविणे वगैरे कार्यक्रम REACH तर्फे राबविले जातात .

नर्सिंग शिक्षणाच्या भावी योजनेतर्गत कॅन्सर नर्सिंग, डिझास्टर नर्सिंग, क्रिटिकल केअर नर्सिंग हे अल्पावधीचे कोर्सेस सुरू होतील . प्रयोगशाळा, उत्तम शिक्षक वृंद, वसतीगृह आणि सर्वात महत्वाचे म्हणजे सोबत आधुनिक व सुसज्ज श्री . वी . के . एल . वालावलकर हॉस्पिटल जिथे नर्सिंगची प्रात्यक्षिके (Practicals) शिकविली जातात . एका खेडेगावात सर्व सोई उपलब्ध असलेली नर्सिंग इन्स्टिट्यूट म्हणजे एक फार मोठे आश्चर्यच आहे . एक आदर्श नर्सिंग इन्स्टिट्यूट अशी याची ख्याती आहे .

ग्रामीण भागातील सर्व सामान्य स्त्रियांना, पोरीवाळींना अशा प्रकारच्या शिक्षण माध्यमातून योग्य दिशा दाखवून स्वावलंबी करणे व सन्मानाने जगण्याची संधी उपलब्ध करून देणे हे कार्य लाख मोलाचे आहे .

अध्यात्मिक तत्वांची बैठक असलेले वातावरण, सदगुरू श्री काका महाराजांचे खंबीर नेतृत्व व सर्वांगीण मार्गदर्शन , शिस्त आणि नियमांचे पालन , पौष्टिक आहार , अभ्यासक्रमाव्यतिरिक्त योगासनांची सवय सुसंस्कारांची शिकवण यामुळे या संस्थेतून शिकलेल्या विद्यार्थी व विद्यार्थिनी निष्णात नर्सना व आदर्श नागरिक म्हणून गणले जातात .

आता हॉस्पिटलमध्ये रेडिओथेरेपी युनिटची स्थापना होत आहे . ही गरजू रुग्णांच्या दृष्टीने समाधानाची वाव आहे . हा उपचार मोठ्या शहरात जाऊन घेणे काही रुग्णांना साध्य होत नाही त्यांना हा एक मोठा दिलासा आहे .

संस्थेच्या सर्व परोपकारी आणि उदात्त कार्यावहल धन्यवाद, तसेच भावी कार्यासाठी शुभेच्छा, आणि संस्थेची ही वाटचाल अशीच चालू राहून जागतिक कीर्ती प्राप्त व्हावी अशी श्री स्वामी समर्थांचे चरणी नम्र प्रार्थना .

Shri. Sukthankar

(Ex. Chief Secretary Maharashtra State)

सुमारे ७०० किलोमिटर लांबच लांब
कोकणपट्टीत फक्त एकच ठिकाणी डेस्कॉप
येथे अत्याधुनिक सेवा-सुविधा पुरविल्यास
समर्थ असलेले वैद्यकीय केंद्र निर्माण
करणान्या आपल्या किमयाकार संस्थेला
व तिच्या शिल्पकार महाराजांना माझा
सादर प्रणाम. हे आपले कार्य बरोबर
कोणासाठी थक करणारे असून आहे.

आपल्या या भागिरथ प्रयत्नांना
उत्तरेतर अधिकाधिक यश मिळो हीच
सुभेच्छा व परमेश्वर-चरणी प्रार्थना.

दि. म. सुकथानकर
27-07-2000

Director's Message

Professor Dr. Rajan A. Badwe

Director, Tata Memorial Center,
Parel, Mumbai 400012. INDIA.



Tata Memorial Center Rural Outreach Programme (TMCROP) at Walawalkar Hospital, Dervan started as an ideal service program for cancer with components of screening, treatment and telemedicine. The primary goal being state of art cancer care at doorsteps of those who need it. This goal has been successfully implemented with local training and visiting faculty from Tata Memorial hospital and other medical doctors visiting this rural outpost at regular intervals. The final component of radiotherapy will be now put in to complete the avowed goal of cancer care at doorsteps. The Bhabhatron II, the refined version of the very Indian cobalt machine adequately tested and confirmed to be better than other state of art machines of its class will be inaugurated by Padmavibhushan Dr Anil Kakodkar, Chairman Department of Atomic Energy on 7th February 2009. This would fill the gap in radiotherapy facility within 200-250 kilometers all around Dervan and would serve a population of over 10 million between the seafront from Mumbai and Goa on one hand to Miraj/ Kollhapur / Belgaum on the other.

We now embark upon research and education component of cancer care depending upon local needs to evolve a model for ideal rural outpost that offers optimum cancer care that is cost effective. To this end we inaugurate a cancer registry to gauge the magnitude, type of cancer problem and document trends in incidence and mortality the two important yardsticks in national cancer care program. We are already implementing service for oral, uterine cervix and breast cancer but we have also identified esophagus as another important site that needs attention. There are no worldwide data on efficacy of screening and awareness for this cancer and we intend to run such a study for the benefit of local population. The early experience of this program can be well utilized at other sites in India like Shillong (Meghalaya), Mizoram and Guawahati (Assam) where this cancer is rampant and carries very poor prognosis. This would be the first exercise of its kind globally. Research in affordable and implementable interventions with comparable outcomes to standard of care (e.g. metronomic chemotherapy) is on the anvil at Dervan in conjunction with TMC.

Finally students of all oncology specialty who train at TMC will be rotated thro' this center to understand and learn optimum utilization of basic infrastructure offering the best outcome in absence of expensive, hi-tech intervention. This will not only allow them to be prepared for the most equipped to optimally equipped environment to offer the same cancer care but also allow local students to interact with students from different educational background. This kind of interaction will instill the importance of novelty and creativity in devising and implementing cancer care.

Reaching the Difficult to Reach

Dr. Gauravi Mishra

- Former, Consultant, Community Health Department, B. K. L. Walawalkar Hospital
 - Presently, Consultant, Preventive Oncology Department, Tata Memorial Hospital
- Mobile : 9819107589
Email : gauravi_2005@yahoo.com
-



India got its political independence in the year 1947. There after rapid development took place in various fields like engineering, science, commerce, literature, medicine etc. Life expectancy at birth increased from 35 years in 1947 to 64 years in 2005. Newer and broad spectrum antibiotics were developed. Diagnostic modalities changed from mere x-ray films to ultra-sonography, CT scans and MRI. Treatment methods revolutionized rapidly, with laparoscopic surgery now largely replacing general surgery. Thus all seems to be doing well. But is this picture uniformly distributed amongst the population? Looking at the intricacies, we find large differences in the urban and rural India, between different states within the country and also between different districts and towns within the state. We have latest, state of the art medical facility in few of our cities. At the same time, there are many regions where people still succumb to malnutrition, diarrhea and common infections for lack of most primary health care facility. International concern of achieving the Millennium Development Goals to provide a basic standard of Health for All by 2015, will remain a distant dream if we fail to achieve uniform and sustainable distribution of these services and are unable to reach even the most difficult to access group with primary health care.

Konkan region in Maharashtra has villages located at far off distances in between hills and valleys and health care remains largely inaccessible. This region has inadequate government facilities, illiteracy, poverty, poor health awareness, misconceptions due to blind faith and inaccessibility with scarce transportation services. Till recently, patients traveled to Mumbai (which is 250 kms away), for medical treatment. The population in this region belongs to socio-economically disadvantaged group; and availing medical care in cities includes travel and accommodation cost which remains largely unaffordable. Hence to reach the most difficult to reach with good medical care, the Shree Vithalrao Joshi's Charities Trust established the BKL Walawalkar Hospital in Ratnagiri district in 1996.

Till about a decade ago, inhabitants of this district died of road accidents, cardiac arrest, snake and scorpion bites, kidney failure etc. as there was lack of a comprehensive secondary health care facility to handle such cases. Over the last 12

years, the BKLW hospital has been providing good quality secondary care services. It is backed up with tertiary level medical care and has expanded its scope very rapidly since its inception. The immediate but short lasting reduction in morbidity amongst the population was soon evident because of excellent hospital facilities. However, there was need to change the health risk behaviour and provide primary care for the effect to be long lasting. Though the mission of the hospital was to provide good quality medical care in the hospital premises, it was soon realized that reaching people in the community, providing health services at their door steps and encouraging them to avail the facilities was the need of the hour. The major obstacles towards utilization of the hospital services were ignorance, superstitious beliefs and most importantly fear of visiting a large set up. Hence in addition to speciality services like General Medicine, Surgery, Gynaecology, Paediatrics, ENT, Ophthalmology, Orthopaedics, Anaesthesia, ICU, NICU, Dialysis, Radiology, Dentistry etc. a Community Health Department was set up in the year 2000. This department soon became the back bone of the hospital services and an important link between the hospital and the patients, their families and the community at large. Health care evolved from patient care to family care. The department has reached the most difficult to reach and has proved beyond doubts that good outcome can be achieved by doing ordinary things extraordinarily well.

India accounts for nearly half of the global preventable disease burden. The Community Health Department established its roots at the BKLW Hospital and spread its tentacles in the community to spread health awareness and to work with people assisting them to help themselves to change their behaviour, to promote health and prevent diseases. The different programmes undertaken by the department are as follows :

1. Health Awareness Programmes : Health awareness programmes on different topics like basic hygiene, prevention of water borne diseases, treatment of diarrheal diseases, healthy diet, care during pregnancy, child birth, care of the infant, importance of investigating and taking treatment completely for endemic diseases like tuberculosis, when to get patient to hospital etc. are regularly conducted in different villages using audio-visual aids to educate the community and reduce the disease morbidity. Since many of the health issues of adults like heart diseases, diabetes, cancers are lifestyle related, these topics are also covered with health education to promote positive life style and prevent illnesses.

2. Maternal and Child Health Programme : Women in childbearing age, adolescent girls and children constitute nearly 40% of the Indian population, 70% of which live in rural India. On one hand this is the most vulnerable group to develop preventable health problems and on the other hand, if this group is taken care of, it would decrease the immediate mortality and morbidity to a great extent and more importantly will help us to build healthier India. The important child health priorities in this region are worm infestations, diarrhea, acute respiratory infections, vaccine preventable diseases, nutritional deficiency disorders like vitamin A, D, iron, PEM etc.

Children with such conditions receive treatment at the temporarily set up clinic in villages. The high maternal mortality and morbidity is due to widespread prevalence of home deliveries preceded by absence of antenatal care. This necessitated providing obstetric and antenatal services that are effective, accessible and acceptable to the women and their families. The community health department provides basic antenatal care and health check up at the village level and the women are motivated for institutional deliveries. Women reaching the hospital are offered free deliveries.

3. Nutritional Surveillance Programme : Survey for growth monitoring is conducted in every village and all children under six, pregnant women and lactating mothers are registered. Malnourished children are identified and their growth curves plotted. All malnourished children, pregnant women and lactating mothers residing in all villages of Ratnagiri district, receive supplemental nutrition in the form of highly nutritious and palatable balls (ladus) along with iron and vitamin supplements. Referral services are provided as and when required.

4. School Health Programme : Every village in Ratnagiri district has a small kindergarten like school called anganwadi. In addition some villages have a primary or secondary level school. Different health programmes that are regularly conducted in these schools include health check up, growth monitoring and education on health and disease. Malnourished students are identified, registered under the Nutritional surveillance programme, provided with supplemental nutrition and followed up regularly. Children requiring referral services are brought to BKLW hospital for specialized services and treatment.

5. Vaccination Programme : In addition to a Immunization OPD at the hospital, vaccination camps are held in different villages. Children are immunized against tuberculosis, polio, diphtheria, pertussis, tetanus and measles. Pregnant women are immunized with tetanus vaccine. In addition Hepatitis B and typhoid vaccine is made available at minimal charges.

6. General OPD Services : To take care of felt need of the community, general check up clinics are held in different villages as an out reach activity. Primary care is provided, basic medicines are supplied, pregnant women are examined and assistance is provided for referred cases.

7. AIDS Awareness Programme : HIV is universal, hence to curtail spread of the disease and to inculcate preventive measures in lifestyle of young adolescent boys and girls, education on different aspects of the disease such as risk factors, preventive measures etc. is imparted at the village level.

8. Family Planning Education : Population of India is increasing at a rapid speed leading to exhaustion of resources. Education about different measures of family planning, spacing, ideal age for marriage and child birth is imparted to women and adolescent girls. Eligible people are offered facility for permanent sterilization including laparoscopic tubal ligation, free of cost.

9. Cleft lip and palate project : Till about a few years back, the local community identified children with cleft lip and palate as abnormal, associated it with evil spirits and assumed that it was an incurable condition. The hospital from the year 2000, started conducting awareness programmes giving information about this condition in different villages in co-ordination with health care workers and general practitioners. Similarly, the community leaders in various villages are approached to identify the children with cleft lip and palate in their respective villages. Personal visits are made to the patient's house by our team members and the need of surgery explained. They are brought to the hospital for corrective plastic surgery. This entire treatment along with speech therapy, dental treatment and paediatric care is offered free to the patients. Media of newspapers is used to spread the message. This project received funding support from the Transforming Faces Worldwide for the initial five years and is presently supported by the Smile Train project.

10. Cancer screening and referral services : Surgery and chemotherapy for cancer cases was carried out at the hospital as a supplemental service as and when the honorary doctors were available. Patients were referred to the Tata Memorial Hospital whenever radiotherapy was required. This service which initially started at a slow pace, picked up rapidly. The number of cancer cases treated at the hospital increased every year. A programme for early detection of common cancers namely breast, cervix and oral cancers was initiated by the Tata Memorial Hospital, Mumbai, in the year 2003, in collaboration with the BKL Walawalkar Hospital, it being the nodal hospital for programme implementation. The aim is to cover the entire eligible population of the two districts of Ratnagiri and Sindhudurg with cancer awareness education and screening of breast, cervix and oral cancers. This programme which was initiated under the Xth plan project of the Department of Atomic Energy will be continued under the XIth plan project. It will serve as a Model District Cancer Control Programme and form the basis of National cancer control programme.

Thus determined efforts of the VJC Trust contributed to improving lives through provision of ultra-modern medical health care facilities in Konkan region. It has succeeded in providing health care beyond its four walls, reaching the most difficult to reach population living on the hills and in deep valleys and has set an example of an ideal Community Health Centre. Encouraged by the impact it has had on the society and the stakeholders- the hospital has initiated the REACH (Rural Empowerment and Community Health) project in April 2007, with the main objective of bringing about a total socio-economic transformation by the people and for the people. It aims at making the people self sufficient so they are capable of addressing their own issues and needs. Thus the hospital has acted as a catalyst for the socio-economic upliftment of the underprivileged society of konkan area and has been successful in reducing the inequalities of access to healthcare.

Cancer Treatment with Radiotherapy

Dr. S. K. Shrivastava

Professor & Head
Department of Radiation Oncology
Tata Memorial Hospital, Parel, Mumbai 400012
radonco@tmc.gov.in



What is radiotherapy?

Radiotherapy (also called radiation therapy) is a very important tool in the fight against cancer and is used in the treatment of as many as 50% of all cancer patients. In excess of half a million cancer patients receive radiotherapy each year, either alone or in conjunction with surgery, chemotherapy or other forms of cancer therapy. Radiotherapy is useful in cases where surgical removal of the cancer is impossible or might debilitate the patient, for example, tumors that are located close to the spinal cord. Together with image guided treatment planning, radiotherapy is becoming more powerful in the elimination of cancer, particularly when the cancer is detected at an early stage.

Radiotherapy, also called radiation therapy, is the treatment of cancer and other diseases with ionizing radiation. Ionizing radiation deposits energy that injures or destroys cells in the area being treated (the "target tissue") by damaging their genetic material, making it impossible for these cells to continue to grow. Although radiation damages both cancer cells and normal cells, the latter are able to repair themselves and function properly. Radiotherapy may be used to treat localized solid tumors, such as cancers of the skin, tongue, larynx, brain, breast, or uterine cervix. It can also be used to treat leukemia and lymphoma.

One type of radiation therapy commonly used involves photons, "packets" of energy. X-rays were the first form of photon radiation to be used to treat cancer. Depending on the amount of energy they possess, the rays can be used to destroy cancer cells on the surface of or deeper in the body. The higher the energy of the x-ray beam, the deeper the x-rays can go into the target tissue. Linear accelerators are machines that produce x-rays of increasingly greater energy. The use of machines to focus radiation (such as x-rays) on a cancer site is called external beam radiotherapy.

Gamma rays are another form of photons used in radiotherapy. Gamma rays are produced spontaneously as certain elements (such as radium, uranium, and cobalt 60) release radiation as they decompose, or decay. Each element decays at a specific rate and gives off energy in the form of gamma rays and other particles. X-rays and gamma rays have the same effect on cancer cells. External radiotherapy

does not make you radioactive, and it is perfectly safe for you to be with other people, including children, throughout your treatment.

Another technique for delivering radiation to cancer cells is to place radioactive implants directly in a tumor or body cavity. This is called internal radiotherapy. (Brachytherapy, interstitial irradiation, and intracavitary irradiation are types of internal radiotherapy.) In this treatment, the radiation dose is concentrated in a small area, and the patient stays in the hospital for a few days. Internal radiotherapy is frequently used for cancers of the tongue, uterus, and cervix. Internal radiotherapy is given in one of two ways: either by placing solid, radioactive material close to or inside the tumour, or by giving a radioactive liquid, either by mouth or as an injection into a vein. If you have internal radiotherapy, you will have to stay in hospital and some special precautions will have to be taken while the radioactive source is in place. Once the treatment is over there will be no danger to your family or friends.

Several new approaches to radiation therapy are being evaluated to determine their effectiveness in treating cancer. One such technique is intra-operative irradiation, in which a large dose of external radiation is directed at the tumor and surrounding tissue during surgery.

Another investigational approach is particle beam radiation therapy. This type of therapy differs from photon radiotherapy in that it involves the use of fast-moving subatomic particles to treat localized cancers. A very sophisticated machine is needed to produce and accelerate the particles required for this procedure. Some particles (neutrons, pions, and heavy ions) deposit more energy along the path they take through tissue than do x-rays or gamma rays, thus causing more damage to the cells they hit. This type of radiation is often referred to as high linear energy transfer (high LET) radiation.

Scientists also are looking for ways to increase the effectiveness of radiation therapy. Two types of investigational drugs are being studied for their effect on cells undergoing radiation. Radio-sensitizers make the tumor cells more likely to be damaged, and radio-protectors protect normal tissues from the effects of radiation. Hyperthermia, the use of heat, is also being studied for its effectiveness in sensitizing tissue to radiation.

Other recent radiotherapy research has focused on the use of radio-labeled antibodies to deliver doses of radiation directly to the cancer site (radio-immunotherapy). Antibodies are highly specific proteins that are made by the body in response to the presence of antigens (substances recognized as foreign by the immune system). Some tumor cells contain specific antigens that trigger the production of tumor-specific antibodies. Large quantities of these antibodies can be made in the laboratory and attached to radioactive substances (a process known as radio-labeling). Once injected into the body, the antibodies actively seek out the cancer cells, which are destroyed by the cell-killing (cytotoxic) action of the radiation. This approach can minimize the risk of radiation damage to healthy cells.

The success of this technique will depend upon both the identification of appropriate radioactive substances and determination of the safe and effective dose of radiation that can be delivered in this way.

Radiation therapy may be used alone or in combination with chemotherapy or surgery. Like all forms of cancer treatment, radiation therapy can have side effects. Possible side effects of treatment with radiation include temporary or permanent loss of hair in the area being treated, skin irritation, temporary change in skin color in the treated area, and tiredness. Other side effects are largely dependent on the area of the body that is treated.

Since the discovery of X-rays over one hundred years ago, radiation has been used increasingly in medicine both to help with diagnosis (by taking pictures with X-rays), and as a treatment (radiotherapy). While there is increasing concern about the dangers of radiation, doctors now have great experience in its use in medicine, and, when used properly, the risks are small and are greatly outweighed by the benefits.

Radiotherapy works by destroying the cancer cells in the treated area. Although normal cells are also affected, they can repair themselves more effectively. The treatment is therefore normally divided into several sessions (called fractions), usually one session a day for five days with a rest at the weekend. Fractionation ensures that less damage is done to normal cells than to cancer cells. The damage to normal cells is usually temporary, but is the reason that radiotherapy has some unwanted effects (side effects).

The number of treatments you have depends on several factors, including your general health, the site and type of cancer being treated and whether or not you have received, or are going to receive, surgery or chemotherapy as part of your treatment. For this reason, treatment is planned for each patient individually, and even those with the same type of cancer may receive different treatments.

Who's who in the radiotherapy department?

Radiotherapy requires a team effort. A radiation oncologist heads the cancer patient/radiation therapy care team. Other team members include radiation therapy technologists and radiation therapy physicists. Each of these professionals has an important set of responsibilities, described below. The radiotherapy team (oncologist, physicist and technologist) work together on the patient's radiation treatment session. The computer monitor for the system control console is in the foreground.

The Radiation Oncologist is a specialist having his or her medical doctorate (MD). This training includes special instruction in the use of radiotherapy systems and other radiation therapy devices. Clinical oncologist - also called a radiotherapist. He or she is a doctor who is a specialist in both radiotherapy and chemotherapy, and will be responsible for prescribing and supervising your course of treatment. Radiation Oncologists see the patient during your course of treatment, so that the

progress can be monitored. If you are having chemotherapy as well, it may be given under the care of a different doctor, called a medical oncologist.

Medical Physicist: Working with the radiotherapist is a physicist who helps to plan your treatment. He or she is a specialist in the subject of radiation. The physicist assists the radiotherapist in deciding on the best way of delivering the amount of radiation prescribed by the doctor and the type of machine to use for your treatment. The physicist is also responsible for maintaining the accuracy of the equipment used. he or she usually works 'behind the scenes'. Radiation Therapy Physicists have advanced degrees in physics and assist the team by assuring the quality and calibration of the therapy systems used for patient care, developing new applications for radiation therapy, and assisting with the development of new applications.

Radiographers and Technicians: The Radiation Therapy Technologist is specifically trained to operate the sophisticated systems and computers used for radiation treatment. Typically, technologists have had two or more years of training in radiation therapy and have certified course done. The radiation therapy technologist performs the patient therapy session under the supervision of the oncologist and physicist in planning the treatment. Patients can discuss any of their concerns or anxieties with them. When a mould of a part of body is needed to keep it still during treatment this will usually be done by technical staff in the mould room.

Nursing staff : Like hospital wards, the radiotherapy clinic has nursing staff - usually a sister or a team of nurses. They ensure the clinic is running smoothly and look after the general needs, such as dressings and medications, and provide advice and practical support.

Social worker : Social workers can offer advice about any problems patient may have. This includes practical and financial help as well as counseling and emotional support for patient and their family. When necessary they will refer to local agencies that can help at home. Some people can claim travelling expenses and others may be able to apply for a grant from a charity.

Symptom control team (palliative care team). There may be other staff such as dieticians or physiotherapists who will be able to help with specific questions that patients have.

Counsellors : Counsellors are available in some centres. If patients feel speaking to a counsellor would be helpful, ask the staff looking after you to arrange an appointment.

External radiotherapy

The treatment is planned by looking at a number of factors and each person has an individual treatment plan. In order to reduce the side effects of radiotherapy, the full dose of radiation is usually divided into several smaller doses or 'fractions' which add up to a full course of treatment. Some people will have different treatment plans. They may have more than one treatment a day or treatment only on three

days a week. Sometimes treatment may also be given at the weekend. A course of treatment may last for up to eight weeks.

There are several different machines used for giving radiotherapy. The various machines work in slightly different ways. Some are better for treating cancers near the surface of the skin, while others work best on cancers deeper in the body. The type used is carefully chosen by your radiotherapist and physicist to give you the most appropriate treatment. Some machines are quicker than others and may give treatment in a short time, but treatment should seldom last more than 10 to 15 minutes on any machine.

People react to radiotherapy in different ways: some find they can carry on working, taking time off for their treatment, while others find it too tiring and prefer to stay at home. If you have a family to look after you may find you need extra help. Don't be afraid to ask for help, whether it's from your employer, family or friends, social services, or the staff in the radiotherapy department. As your treatment progresses you will have a better idea of how it makes you feel so you can make any necessary changes to your daily life.

Getting to the appointment : If patient live a long way from the hospital, you may need to be admitted to the ward, or a hostel ward in the hospital or nearby, or it may be possible to organize local accommodation for you while you are having radiotherapy.

Planning the treatment : Your first appointment at the radiotherapy department will be a planning session. This is a very important part of your treatment as the results of this session will be used to finalise your treatment plan. It is important for you to feel you are involved in your treatment so ask as many questions as you like. People often feel that staff is too busy to answer questions. Yes, they are busy, but the more you understand about your treatment, the easier it is for you and the staff. It may help to write down a list of questions to take with you.

Your specialist may plan your treatment by placing ink markings directly onto your skin. Alternatively, you may need to be X-rayed or measured on a machine called a simulator, so called because it moves in exactly the same way as the treatment machines but it takes X-rays so the radiographer can get the correct position for your treatment. It takes about 15-45 minutes and during this time you will be lying on a fairly hard couch that can be slightly uncomfortable. The radiographer may be able to make you more comfortable by placing foam pads under you. You have to lie very still so that accurate measurements can be taken and your exact position recorded. The radiographer can then check that you are lying in the correct position each time you have treatment.

Some special precautions may be necessary to make sure the radiographers get a clear picture. The radiographers will explain these to you. For example, to plan treatment to the pelvic area, a liquid which shows up on X-ray may be passed into your back passage, or a vaginal tampon may be used to show the exact position of the vagina. These may be slightly uncomfortable but are not painful and will only be

for a few minutes. These procedures are used only for planning, and not during the treatment.

A CT scan is taken of the area to be treated and this may be done before your planning session appointment. A CT scan is a type of X-ray which gives a detailed picture of the inside of the treatment area. The scan will be done in the hospital's scanning department. The staff in the department will go through the details of the scan with you beforehand; again, no pain is involved.

Sometimes more than one planning session is necessary; it depends on the size and position of the tumour. You may have your first treatment on the same day as your planning session, but often it is necessary for you to wait a few days while the physicist and your consultant decide on the final details of your treatment.

Skin markings : Once the treatment area has been finalised, ink markings are usually made on your skin to pinpoint the exact place where the radiation is to be directed. The staff will explain how to look after these markings; if the marks begin to rub off, tell your radiographer. Do not attempt to redraw them yourself. Since they can rub off onto your clothes, some people choose to wear older clothes next to the skin during your treatment.

Sometimes two, three or more permanent pin-point tattoo marks are also made on your skin. This will be done only with your permission. It is a little uncomfortable while being done.

Mould room : Because radiotherapy is planned very precisely, to treat exactly the right area, it is important to keep that part of the body as still as possible during treatment. For radiotherapy to some parts of the body, a see-through perspex device called a mould or shell may be made, to prevent movement during treatment. This is often the case with treatments to the head and neck. Any marks needed can be made on the mould instead of your skin. Your mould will be made before your treatment is planned.

In the mould room a plaster cast mould is made of the body part. Some people may find this claustrophobic or a little frightening, particularly if the mould is of the face and neck, but it does only take a short time. After you leave the department, perspex is moulded onto the cast to form a mask. This mask fits snugly to your face and neck, with holes cut for your eyes, nose and mouth. The mould is ready to wear at your first planning or treatment session. Again, this can be claustrophobic for some people, but try to remember that you will only have it on for a few minutes at a time. You should find you soon get used to it. Sometimes a mould of your leg or arm is used to keep the area still while your treatment is in progress.

The treatment : It is quite normal to feel anxious about having your treatment but as you get to know the staff and the procedure it should become easier. The sight of large machines can be frightening, especially for children. Don't be afraid to express any fears or worries to the staff; they are there to help you, and the more relaxed you are, the easier it is to give you your treatment.

Radiotherapy itself is painless and may take anything from a few seconds to several minutes. Because your positioning is so important, however, the radiographers may take a little while to get you ready - they may call this 'setting up'.

Once you are in the correct position the staff will leave you alone in the room; this is to prevent them from being exposed to any unnecessary radiation. You will only be alone for a few minutes and there may be an intercom so that you can talk to the radiographers. They will be watching you carefully, either through a window or on a closed-circuit television screen. To protect your privacy, no one else will be able to see you. If you have any problems you can raise your hand to attract their attention and they will come in to help you.

Most radiotherapy machines will be able to rotate around your body to give the treatment from several different directions. At first this, together with the sound of the machine, can be unsettling. Before your first treatment your radiographers will explain to you what you will see and hear. Some treatment rooms have tape players so that you can listen to music during your treatment, to help you relax.

The radiographers may have to come into the treatment room and change your position slightly in the middle of your treatment. Also, small changes sometimes have to be made to your treatment plan. There may be a number of reasons for this and your radiotherapist will explain these changes to you and keep you up to date with your progress.

Internal radiotherapy

There are two ways of giving internal radiotherapy: either by placing solid, radioactive material (the 'source') close to or inside the tumour (called brachytherapy), or by giving a radioactive liquid, either by mouth or as an injection into a vein (called radioisotope treatment). When patient have internal radiotherapy they will need to stay in hospital for a few days until the radioactive material has been removed, or until most of the radioisotope material has disappeared from your body.

Because of the possibility of unnecessary radiation exposure to the hospital staff and friends and relatives of patient, certain safety measures are taken while patients are being treated with the radioactive source, or after given a liquid radioisotope. Depending on the type of treatment, this means the restrictions may be needed for a few days. But sometimes they are only needed for a few minutes. The staff looking after you will explain these restrictions in detail before start of the treatment. Each hospital has different routines, and it is worth visiting beforehand to discuss what will happen with the nursing and medical staff.

Patient may be admitted to the ward the day before your treatment so the staff can go over the procedure with you. This is a good time to ask questions and it may help to make a list beforehand so you don't forget something important.

While the radioactive source is in place, or after treatment with a liquid radioisotope: You will probably be nursed in a side room, away from the main ward.

You may be nursed alone or with someone else having similar treatment. Lead screens may be placed on either side of your bed to absorb any radiation that is given out. The doctors and staff on the ward will only stay in your room for short periods at a time. Staff and visitors will be asked to stand away from your bed to reduce their exposure to the rays. An instrument called a Geiger counter can be used to monitor the level of radiation in the room. The nurses may wear a small counter. Visitors will be restricted, and only allowed to stay in the room or sit at the end of the bed for a short time, if at all. Visitors will be able to talk to you from outside the room through an intercom. Children and women who are pregnant will not be allowed to visit.

These precautions can make you feel very isolated, in addition to the fears you may already have about your treatment. People are different in the way they handle their fears; some find it easier to know everything about their treatment, while others prefer to know as little as possible. If you want any explanations the staff on the ward will be happy to help you. It often helps to bring any fears or worries you have into the open by talking to the staff or to family and friends. You will probably only be in the single room for a short time, sometimes only one or two days. You can bring books and magazines into your room, watch TV or listen to the radio.

If you are being treated with a radioactive source, the safety measures are only necessary while it is in place. Before and after your treatment, your visitors can come at normal visiting times.

Some people worry that they will remain radioactive once the treatment is over, and are dangerous to their family and friends. If you have been treated with a radioactive source, this is not so. As soon as the radioactive source has been removed, all traces of radiation disappear.

If you have been given a liquid treatment, however, the radioactivity will disappear gradually. Before you leave hospital the staff will check that most of the radioactivity in your body has gone, and that your belongings are free of any signs of radioactivity. After you leave hospital you should be able to carry on your life almost as normal, but there may be a few restrictions about meeting people - especially children and pregnant women - for a few more days.

Caesium insertion: This type of internal radiotherapy treatment is used for treating cancer of the cervix, uterus or vagina. The radioactive source most commonly used is called caesium-137. The advantage of caesium insertion treatment is that it gives a high dose of radiotherapy directly to the tumour, but gives a low dose to normal tissues.

The caesium source has to be put inside an applicator (there may be more than one) to keep it in place. The applicator is inserted into the vagina, while you are under a general anaesthetic or sedation in the operating room. At the same time, a flexible tube called a urinary catheter may be put into your bladder to drain off urine. This means you don't have to get on and off bedpans and risk moving the applicators. Once the applicators are in place an X-ray will be taken to check they are

in the correct position. Sometimes the radioactive source is put into the applicator while you are in the operating room, but more commonly it will be put in place once you are back on the ward. You may hear this referred to as 'afterloading'.

The applicators are kept in place by a pack (cotton/gauze padding) inside your vagina. This can be uncomfortable and you may need to ask your nurse for regular painkillers.

Once the source is put into the applicators you have to stay in bed. This helps to keep them in the correct position. If you need anything, you can call a member of staff by using the call bell by your bed. If the source does get dislodged, you should call the staff on the ward immediately.

Brachytherapy machine: In some hospitals a machine, which may be called a Selectron or similar name, is used to put the radioactive material into the applicators. The machine is attached by tubes to the applicators. When the machine is switched on it passes small radioactive sources into the applicators. If the machine is switched off, the source is pulled back inside the machine. The machine is kept switched on throughout your treatment, except when someone needs to go into your room. It can then be turned off, so reducing their exposure to the rays. However, safety measures and visiting restrictions are still necessary. The time you spend on the machine varies but it is usually between 12 and 48 hours. Sometimes a machine called a Microselectron or similar name can be used to give internal radiotherapy. This gives the radiotherapy more quickly, so the treatments last for only a few minutes and you can go home the same day.

After the treatment : Once you have received your dose of radiation the sources and the applicators will be removed. This is usually done on the ward. As it can be a little uncomfortable, you will be offered some painkillers beforehand. The staff on the ward checks that all the applicators and sources have been removed. Your catheter may be removed at the same time. Your doctor may suggest you use vaginal douches for a few days after the insertion has been removed to keep the vagina clean. Your nurse will show you how to use these. You will probably be able to go home the same, or the following, day. Once the radioactive sources are removed, all traces of radioactivity will immediately disappear.

Side effects : Many women will be treated with both internal and external radiotherapy to ensure the area is treated in the most effective way. There is a slight risk of infection following caesium insertion but this is very rare. If you do develop a high temperature or heavy bleeding after your treatment you should contact your doctor as soon as possible. You will be prescribed antibiotics to deal with the infection.

Caesium or iridium implants these can be used to treat a number of tumours including those in the mouth, lip and breast. Very fine needles, wires or tubes carry the radioactive source, and are inserted while you are in the operating room under a general anaesthetic.

An X-ray may be taken to ensure that they are in the correct position. You will be nursed in a separate room, and safety measures will be applied until the wires are removed, usually between three and eight days. Sometime this is done under general anaesthetic.

Implants in the mouth can be uncomfortable, and can make eating and talking difficult. A soft or liquid diet may be necessary while the needles are in place. Your nurse will show you how to keep your mouth clean, using regular mouthwashes. If eating is a problem you may be fed through a thin tube (nasogastric tube) which is passed via your nose and into your stomach.

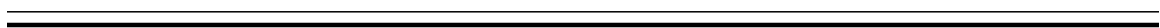
The implant is removed once the correct dose of radiation has been received. This may be after two days, if the treatment is given as a booster after external treatment, or up to one week if given as the only form of treatment.

Once the implant has been removed the area will feel sore for up to two or three weeks afterwards. Your specialist will prescribe pain killers that you can take regularly until this improves.

Radioactive isotopes: These are given as liquids, either through the mouth (in capsules or as a drink) or by injection into a vein (called an intravenous injection). The commonest form of radioisotope treatment is radio-iodine. It is used to treat tumours of the thyroid gland, and is given in the form of an odourless and colourless drink.

The same safety precautions will be taken with this type of treatment as with implants. Any radio-iodine which is not absorbed by your thyroid will be passed from the body in sweat and urine. You should drink plenty of fluids during your treatment as this helps to flush the iodine out of the body. The amount of radiation in your body will be checked regularly and as soon as it falls to a safe level, after about four to seven days, you will be able to go home. You may need to take some special precautions for a short time after going home - particularly with young children and pregnant women. The hospital staff will explain these to you.

Radioisotope treatment can also be given when certain types of cancer have spread to the bones (secondary cancer in the bone). A radioisotope is injected into a vein and this is normally given as an out-patient. Before you go home you will be given some simple advice to follow as your urine and blood are slightly radioactive for a few days.



The Role of Rural Comprehensive Cancer Centers in the War against Cancer.

Dr. Shripad D. Banavali

Professor & Consultant
Department of Medical Oncology,
Tata Memorial Centre, Mumbai.



Approximately 25 million (1 million = 10 lakhs) people worldwide are living with cancer. Of the 10 million new cancer cases seen each year worldwide, 4.7 million are in the more developed countries and nearly 5.3 million are in the developing countries. It is the second leading cause of death worldwide, accounting for about 13% of all deaths. WHO has forecast that by 2030, the annual global cancer death toll will rise to above 11.5 million. Although survival rates for cancer are improving in the more affluent countries, both incident and death rates are worsening in the developing world, and the gap is expected to widen. Worldwide, cancer accounted for 7.9 millions deaths in 2007, but 72% of these deaths occurred in low and middle income countries, where resources available for cancer control are limited or non-existent. In the recently conducted UICC congress, WHO Director-General Dr. Margaret Chan told that, "The rise of cancer in less affluent countries is an impending disaster. The time is right to make cancer control a development policy". Cancer control which includes both, cancer prevention and treatment, is a question of human rights, and above all, it is a question of human dignity.

About one-third of cancer cases can be prevented and onethird can be cured if detected early and treated properly. Target for cancer control includes drop in tobacco consumption, proper nutrition, prevention of obesity, decrease in alcohol intake, universal vaccination programmes for Hepatitis B and Human Papilloma Virus to prevent hepatic cancer and cervical cancer; universal availability of effective pain medications and dispelling of myths and misconceptions of the disease.

In India, there are about 2.5 million cancer cases at any given time. An estimated 1 million new cancer cases are diagnosed each year. Nearly 70% of these die each year. The common cancers in males are cancers of oral cavity, lungs, and esophagus and stomach; and in females are of cervix, breast and oral cavity. Tobacco related

cancers (oral cavity, pharynx, larynx, and lungs) account for 200,000 new cases and 140,000 deaths annually, Cervical cancer accounts for 132,000 cases and 74,000 deaths annually. Breast cancer accounts for 83,000 new cases and 45,000 deaths annually. Many of all these can be totally prevented or diagnosed early. The heavy cancer toll in our country is due to the fact that over 70% cases are detected late. Patients report for treatment is very advanced stages. This has serious impact on the patients as well as their families in the form of mortality as well as morbidity in the form of pain and misery as well as disability. Cancer is also economically catastrophic. It costs approximately Rs.3,50,000 to treat one tobacco related cancer. The cost of both cancer diagnosis and treatment is on the rise.

One of the main reason for late presentations, is that there are hardly, if any comprehensive cancer centers in rural India as well as in smaller cities. Thus, all these patients have to go to major cities for cancer therapies. Because of financial constraints and cultural barriers, these patients present late to the tertiary cancer centers. Also because of our male dominated society, very few girls or women are brought to the tertiary centers for treatment and this is reflected in the very high male: female ratios in most hospital based registries! There are significant challenges of providing cancer care in a tertiary cancer center. Most tertiary centers are over crowded with patients and because of decreased manpower and limited infrastructure, there are further delays in treatment. Also, these rural patients face cultural shock when they come to the cities. There is no place to stay; difficulty in transport. In addition, it is very expensive to stay in cities and at the same time they have loss of job and daily wages. Because of this there is refusal or abandonment or non-compliance of treatment. Many go back once their limited finances are exhausted. Some are lost because of infections and malnutrition related toxicities associated with such lifestyle. Above all, most of the treatments developed at the tertiary cancer centers are based on the western literature and not modified according to the local needs, leading to very expensive treatments or in some cases even inappropriate treatment. All this leads to the poor outcomes noted in patients with cancer not only in India, but all developing countries. The parody of cancer care in developing countries is that the early / curable cancers are inappropriately treated locally by non-oncologists, without using principles of oncology and are made incurable. At the same time, patients with advanced / metastatic, incurable cancers patients who need only palliative care are referred to tertiary centers. This leads to inappropriate use of our limited, precious resources. All this will hopefully change if more rural comprehensive cancer centers are developed. Barshi has already set an example in this regards.

Since the time President Nixon declared war on cancer in 1971, we have made really little progress in curing the real (metastatic) cancer patients. The west has always explored the strategy of using more and more aggressive therapies including Autologous and Allogenic Stem Cell Transplant (SCT) however, this has not worked in most of the adult cancers. Time has come to think out of the box- to think very differently. There is more chance that this will come from the developing countries, where we have to think differently out of necessity. The prime example is that of Acute Promyelocytic Leukemia (APML), where the west went up and up on chemotherapy including Allogenic SCT to improve the survival. However, this did little to improve survival which was around 40%. At the same time, investigators in the then rural China tried a simple oral derivative of vitamin A called All Trans Retinoic Acid (ATRA), which caused revolution not only in the treatment of APML with improved survival rates of > 75%, but also opened a wide new world of differentiating therapies and targeted therapies in cancer!

This is what we plan to do at the Rural Comprehensive Cancer Center at B.K.L. Walawalkar Hospital, Dervan. We have started the silent revolution of "Metronomic" Therapies at this hospital, which has now spread to Tata Memorial Center. Metronomic Therapy is the concept wherein we give very low doses of chemotherapeutic agents and / or biologic response modifiers on a continuous daily basis, rather than three weekly standard chemotherapy. The advantage of metronomic therapies is that they are based on sound translational research. Most of these are oral and thus provide good quality of life. They have excellent toxicity profile with nil grade III and IV toxicities and do not require intensive monitoring (blood test, mostly CBC, is done once in 3 weeks to 3 months!) However, most important is that they are very cost effective with monthly cost of Rs. 200/- to Rs. 4000/- as compared to thousands and lakhs for "standard" therapies. In addition, they may be more scientific, since they take into account both the cancer cells as well as its environment: along with cytotoxic principles, they also work through anti-angiogenic principle and may also preserve immunity. The initial results are very encouraging and we are eagerly waiting for the long term outcome. Most of the agents used in metronomic therapies are age old, simple, cheap chemotherapeutic drugs like methotrexate, cyclophosphamide, etc. The parody is that we still do not know how best to use the existing, old cheap chemotherapeutic agents and we go after the non-time tested newer drugs which are very expensive and at the same time have marginal, if any, benefit! We should not view all differences in clinical practice between affluent countries and the developing world as negative. From such differences in care approach, we physicians can obtain new insights in patient care. Patients from affluent countries and the developing countries have much to teach each other.

Most of the published literature consists of therapies developed in affluent countries. These are then used in developing countries since they are considered “standard of care” However, these protocols do not take into consideration the locally existing infrastructure, available supportive care, as well as local socioeconomic realities. We have to be aware of the real needs of the majority of patients in the developing countries. If we have to improve cancer care in developing countries, one has to take the help not only of the brain, but also of the heart! There is an acute need to develop affordable, effective treatment for patients with cancer. Time has come to put our priorities right.

A major study published in August 2003 in the British Medical Journal looked at the results of trials of 12 new anticancer drugs that had been approved for European market from 1995 to 2001, and compared this with standard treatments for their respective diseases. The researchers found no substantial advantages - no improved survival, no better Quality of Life, and no added safety - with any of the new agents. All of these, though, were several times more expensive than the old drugs. In one case, the price was 350 times higher! High cost therapies can present a financial challenge for patients and health care systems in any country. Health care provides do no service to patients by only offering unaffordable therapies. Risk-benefit advice given to patients must factor in patient economies. More than teaching evidence based medicine to the next generation of doctors, we have to teach them moral reasoning. We do not need lawyers treating our patients, we need doctors! Doctors, who think not only by their brains, but also through the heart!

We are yet far away from winning the war on cancer. Optimism is essential, but the percentage of even Americans dying from cancer is still what it was in 1970...and in 1950! They say targeted therapies will shift the paradigm and cure cancers, but given what is known about the diversity and evolution of tumor cell population, genomic instability, drug resistance and so on, one feels that these phenomenally expensive drugs are missing the mark. We have moved away from the cancer cell and its environment to intracellular pathways! This takes us away from the goal of cancer cure. The funding for such studies only helps to gain another publication! Presently we are trying to treat symptoms rather than the disease. Just like instead of treating fever with paracetamol alone we treat what caused the fever, similarly instead of concentrating on the cancer cell alone, we should treat what caused the cancer cell to grow. Along with the cancer cell, we should concentrate on its microenvironment and on tumor immunology. It seems clear that neither current dogma nor traditional thinking is likely to get us to the next step. Truly creative ideas will be required. Embracing new thinking, as difficult as it may be, is

crucial for the advancement of science and medicine. Instead of looking at incremental improvement in treatment of cancer, we should be looking for genuine breakthrough!

We do not start extinguishing fire after flames start coming out of the barn, we attack the fire when it just starts. Similarly, we need to identify pre-malignant conditions, molecules to diagnose pre-malignant condition before it becomes cancer. We need to concentrate on pre-malignant conditions and ways of preventing them from becoming cancerous! It is much easier to deal with them, than metastatic disease. We have prevented many heart attacks, strokes, using this same strategy! Heart disease does not start with heart attacks, but long earlier with elevated blood cholesterol and lipids that cause arterial plaque. So we treat them. Stroke does not start with blood clot in the brain. It starts with hypertension, so we treat it with both life style changes and drugs. Similarly we should not go after curing cancers, but prevention and / or early diagnosis of cancer. Through the Tata Memorial Center Rural Outreach Programme (TMCROP) at the BKL Walawalkar hospital, this is what we are trying to do. This is also a much easier proposition for any rural cancer center, since most of the prevention / early diagnosis activities can be done even by trained paramedical staff whereas to treat advanced cancers we require skilled surgeons and aggressive chemotherapies which require extensive infrastructure and are very expensive to deliver. And in spite of all this, the outcome still remains poor.

Considering the type of patients initially seen in the rural centers, it is very important that each of these rural cancer centers are equipped with Radiotherapy facilities, since many patients present with advanced disease and many others need palliative care. Thus, though a little late, we are inaugurating the radiotherapy facility today at the BKL. Walawalkar Hospital, making it now a Rural Comprehensive Cancer Center in the true sense. Also it is more important that doctors working in the rural comprehensive cancer centers are fully trained. Because only a scientifically trained mind can think of innovating. We need medical personnel who not only “see” but also “observe”.

We all want to win the war over cancer. However, wars cannot be won with generals (Tertiary Cancer Centers) alone! We also need the foot soldiers (Rural Cancer Centers)! If ACTREC is the face of cutting edge research of Tata Memorial Center, Walawalkar Hospital can become the face of community initiatives of Tata Memorial Center! The mission of the Rural Comprehensive Cancer Center at Walawalkar hospital is to be a shining example of fusion of science and humanity and to serve as a catalyst for the National Cancer Control Programme.

CASE : 1

BROWN TUMOR CAUSING PARAPARESIS

Pankaj Joshi.

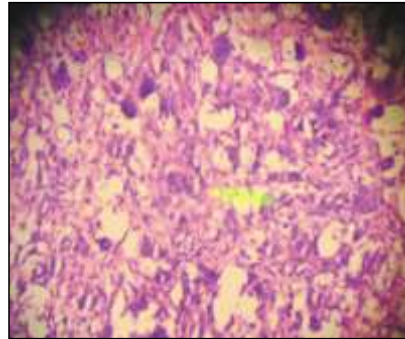
D. Ortho.
Orthopedic Surgeon,
B.K.L.Walawalkar Hospital, Dervan
Mobile: 9860686232, Email:
joshidrpankaj@gmail.com

Sunil Mankame.

M.B.B.S., D.O.R.L.
ENT Surgeon, B.K.L.Walawalkar
Hospital, Dervan
Mobile: 9423236587, Email:
mankamesunil@yahoo.com



Parathyroid Adenoma



osteoclastic giant cells



Osteolytic lesions

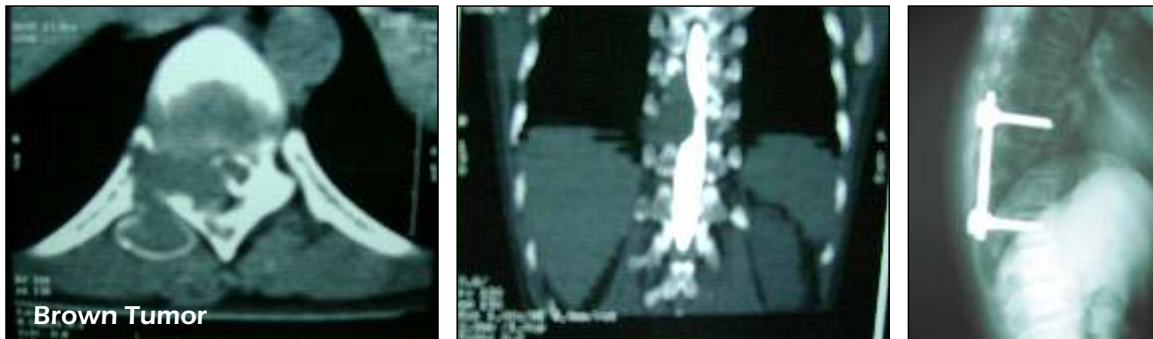
A 30 years old female presented with painless swelling over right mandible & right heel, with difficulty in walking since 2 months. There was history of gradual onset weakness in both lower limbs. There was no history of fever or weight loss. There was no h/o trauma or no h/o similar complaints in past. There was no past h/o tuberculosis or malignancy. There was h/o renal calculus in past for which she was operated.

On examination patient was afebrile; pulse rate was 84/min, blood pressure was 130/80 mm Hg. On local examination there was swelling over right lower jaw which was non tender, non pulsatile & hard. Other swelling was over right calcaneum which was also hard & non tender. There was no e/o lymphadenopathy. Neurological examination revealed motor power of grade IV in both lower limbs with hyper reflexia and normal sensory system. There was no bowel bladder involvement. There was no deformity of the spine. Rest of the systemic examination was within normal limits.

Lab investigations revealed: Hemoglobin: 9.9 g/dl; Total WBC Count: 10,100/ μ L; differential count: N: 90 %, L: 7 %, E: 01 %, M: 02 %; Platelets 200 x 10³/ μ L; Serum Ca⁺⁺ - 10.09 mg/dl; Serum electrolytes Na⁺: 139 mEq/L, K⁺: 3.5 mEq/L, Cl: 104 mEq/L, Phosphorus 13.9 mg/dl

X-rays showed osteolytic lesions in 7th rib on right & 8th rib on left side. Multiple osteolytic lesions were noted in left scapula, clavicle, T10 vertebra and skull. CT of thoraco-lumbar spine showed well defined, expansile lesion involving the body of D10 vertebra and encroaching the spinal cord, thus giving rise to cord compression.

There were two differential diagnoses, one was multiple myeloma and other one was osteitis fibrosa cystica (OFC) associated with primary hyperparathyroidism (PHPT). To confirm the diagnosis she was investigated for Hyperparathyroidism. Serum parathyroid hormone level was 1197 pg/ml. (Normal: 12 to 65 pg/ml); USG neck was done to confirm primary hyperparathyroidism which showed 33 mm x 14 mm x 11 mm, well defined oval, homogenous, hypoechoic lesion postero-lateral to left thyroid gland s/o left parathyroid adenoma.



Decompression and right D10 laminectomy was done to prevent complete paraplegia as she was already having paraparesis. Tumor measuring 3.5 x 1.5 mm. was removed from D10 vertebra. Biopsy from the right mandibular swelling was taken. Both biopsy reports showed osteoclastic giant cells surrounded by fibrous stroma and foci of hemorrhages consistent with brown tumor. She was operated for parathyroid adenectomy. HPR confirmed it as parathyroid adenoma.

Primary hyperparathyroidism (PHPT) is relatively common endocrine disease. Estimated incidence is 1 case per 1000 men and 2 to 3 cases per 1000 women. Clinically, symptomatic PHPT presents with nephrolithiasis in >50% of patients and with OFC in 25% of patients. OFC is characterized by the presence of subperiosteal resorption of digits, skull and long bones, diffuse osteopenia and brown tumors. Brown tumors often develop at multiple sites including clavicle, ribs, tibia, femur and pelvic bones. They rarely involve mandible and very rarely maxilla. The tumors occasionally can be mistaken for malignant lesions. Although there is general consensus that the gold standard for treatment of PHPT is parathyroidectomy, opinions are divided on the course of management of bony lesions once parathyroidectomy has been performed. Brown tumor regression after successful parathyroid tumor resection has been frequently reported. However, if the patient derives a quick resolution and if bony lesion is symptomatic or if the lesion failed to regress, surgical resection of the brown tumor should be considered.

To conclude our patient had primary hyperparathyroidism with multiple osteolytic lesions in bones and vertebral brown tumor leading to compressive myelopathy. Parathyroid adenectomy with decompression and laminectomy of D10 to prevent paraplegia has corrected the condition. She is under regular follow up.

PSEUDO ACUTE RENAL FAILURE

Suvarna Patil (Physician)

Vikram Dalvi (Intensivist)

Abhay Desai (General Surgeon)

Netaji Patil (Radiologist)

B.K.L. Walawalkar Hospital.

Introduction :

Urinary bladder ruptures are commonly encountered in blunt or penetrating lower abdominal injuries. Spontaneous rupture of bladder is rare. Such ruptures are known to occur in a carcinoma of bladder, neurogenic bladder or in post irradiation bladder. Bladder rupture is of two types: intra peritoneal & extra peritoneal. We present a case of spontaneous intra peritoneal rupture of bladder which mimicked acute renal failure without any of the causes stated above. But probably was due to focal detrusor weakness following instrumentation performed for urethral stricture.

Case Presentation :

A 28 years old male patient, painter by occupation presented with burning micturation, dribbling & distention of abdomen since 4 days. He had undergone urethral instrumentation 3 years ago for urethral stricture with obstructive uropathy. He was found to have duplex ureter during IVP that time. As he was asymptomatic, he did not follow up in the previous 3 years.

His vitals were stable. He had pallor, no oedema / icterus / cyanosis / clubbing / lymphadenopathy. He had ascites. Liver & spleen were not palpable. Other systems were normal. Lab investigations were S. Creatinine 5 mg/100ml, urine had 50 to 60 pus cells /HPF but no casts; liver function tests were normal. USG abdomen and Doppler study showed gross ascites, altered echo texture of liver & normal portal vein and spleen.

Abdominal paracentesis was performed & 3 liters of straw colored fluid was removed. Cyto chemical analysis of ascitic fluid showed transudate with lot of mesothelial cells. Ascitis was fast refilling & needed daily tapping of about 2-3 liters. During these 4 days, patient was afebrile & vitals were stable. His creatinine gradually increased to 6.8 mg/100ml, potassium to 5.2 mEq/L.

Until day 5 of admission patient was not catheterized since he was passing about 800-1000 cc urine/day and USG did not suggest obstruction any where in urinary tract . He was treated with ciprofloxacin. Finally patient was posted for diagnostic laparoscopy & peritoneal biopsy.

Repeated ascitic fluid examination was suggestive of transudate which was not fitting in any differential diagnosis. So we thought of urine leaking into peritoneal cavity to substantiate, foley's catheter was put in. Ascitic fluid was sent for serum creatinine & urea. Ascitic fluid creatinine was 14 mg/100ml & urea was 234 mg/100ml which was supporting our clinical suspicion. Hence instead of

laparoscopy, cystoscopy was performed, that showed a rent of 6x1 cm in the bladder dome. Margins of rent were devitalized. Then laprotomy was done and rent was repaired following a biopsy. Biopsy did not reveal any abnormality. He made an uneventful post operative recovery with disappearance of ascitis, and creatinine, BUN level reverting to normal.

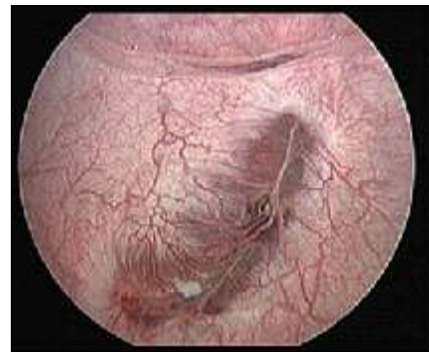
Discussion :

Spontaneous rupture of bladder is uncommon and only 26 cases have been reported in the literature. Substance abuse with alcohol, cocaine & amphetamine all has been associated with spontaneous rupture of bladder. In other cases pelvic irradiation, inflammation of bladder from interstitial cystitis, or eosinophilic cystitis or tuberculosis, entero cystoplasty, erosion by an indwelling catheter or a large vesical calculus have been implicated.

The pathogenesis involves bladder over distention and thinning of the dome from diuresis. The patient ignores natural urge to void due to alcoholic stupor. There after even trivial increase in intra abdominal pressure like coughing can rupture the bladder. Patient develops vague abdominal pain and progressive abdominal distention, developing from urinary ascites. Urinary ascites causes reverse auto dialysis wherein urea and creatinine molecules are absorbed into the blood and produce a picture of pseudo renal failure. While most ruptures are intra-peritoneal with resultant urinary ascites, extra-peritoneal has also been described.

In this case, patient was not under influence of alcohol. He gives history of some instrumentation for urethra 3 years back. History of early morning painful voiding, and sudden stoppage of flow, vague abdominal pain with gradually increasing abdominal pain over 4 days.

The key to management is a high index of suspicion. A history of alcoholic binge, urethral stricture, incomplete emptying of bladder all leads to over distention of bladder. A CT cystogram is diagnostic, but it is costly and not available at all places. A simple lab investigation ascitic fluid creatinine and urea which is less expensive and available every where, is the diagnostic test. Standard methods of bladder closure are recommended. A bladder biopsy is necessary to exclude any pathology. The condition is often diagnosed late and is associated with high morbidity and mortality of 50%.



Picture 1 :
Cystoscopic view :
Rent in dome of bladder
with devitalized margins.



Picture 2 :
Rent in Urinary bladder

CASE : 3

Pregnancy or Tumor? : Lack of standard medical care can raise this question!

Maneesha Shrivastava.

M.D. (Gynec.)

Gynecologist. B.K.L. Walawalkar Hospital.

Mobile: 9922931040,

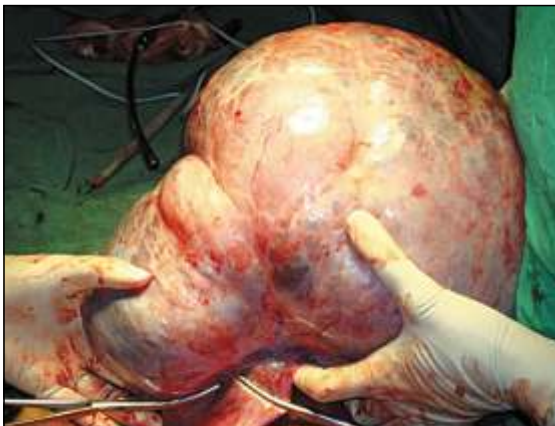
Email: maneesha_74@yahoo.co.in

This is the story of a woman from our own Konkan village. She was 30 years old and mother of two children. The younger one was a year old. Three to four months after her delivery she noticed a lump in her abdomen gradually increasing in size. She thought it to be pregnancy as she was amenorrhoeic. It is not uncommon in our country to conceive in lactational amenorrhea.(a condition when woman does not get monthly periods as she is breast feeding but still can conceive). As time passed her abdomen kept on distending. She finally reached Walawalkar hospital at Dervan with a huge abdomen. On sonography it was found to be an ovarian tumor and not pregnancy.

A laparotomy was done and a 9 kilogram solid right ovarian tumor was removed at Walawalkar hospital. She has now recovered well and discharged on 6th postoperative day.

The Department of Obstetrics and Gynecology wants people of Konkan to read this and think not because a massive tumor was removed in Walawalkar hospital but why she reached this critical situation when the tumor had already compressed kidney, ureter and other organs endangering life.

This is due to sheer lack of standard medical care in the region and women not reaching for a proper medical care in time. BKL Walawalkar hospital is committed to the dream and mission of providing a standard, advanced, cost-effective and modern health services to people of Konkan thereby preventing such mishaps and distress.



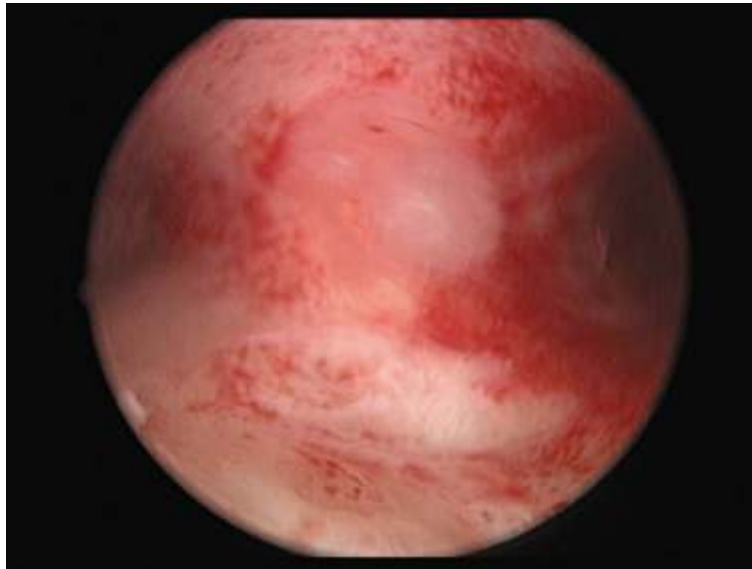
9 kilogram solid right ovarian tumor

CASE : 4

Surgery without pain, scar, blood loss and no hospital stay ! The treatment of this era.

Maneesha Shrivastava.

M.D. (Gynec.)
Gynecologist. B.K.L. Walawalkar Hospital.
Mobile: 9922931040,
Email: maneesha_74@yahoo.co.in



Inability to conceive is a problem which causes significant social and marital disharmony. One of the treatable causes of infertility is presence of a uterine septum. In a layman's term it can be understood as presence of dividing bridge in the uterine cavity which distorts the uterine cavity and prevents implantation of the embryo leading to repeated abortions.

Couple of years back this problem required a major surgery and a huge abdominal incision. Still in rural areas women undergo surgery with huge incisions increasing morbidity and delay recovery because of lack of proper hospitals and equipments.

In BKL Walawalkar hospital recently women underwent hysteroscopic resection of the septum. Which means the bridge in the uterine cavity was removed telescopically using specialized instruments. Patients were discharged on the same day with no scars, no pain, no blood loss and immediate recovery.

The Unit of Minimally Invasive Surgery is functioning regularly in Walawalkar hospital so that even the poorest patients of Konkan region receive the most advanced treatment existing in today's world with minimal expenses.

CASE : 5

Superior Mesenteric Artery Syndrome

Netaji R. Patil.

D.M.R.E.

Radiologist, B.K.L.Walawalkar Hospital.

Mobile: 9763551583

Email : drnetajipatil@yahoo.com

History:

A 19 years young male patient came to B.K.L. Walawalkar Hospital, Dervan, with chief complaints of vomiting 1 to 2 hours after taking food. Vomiting was bilious in nature. There was history of abdominal pain in epigastric region; history of severe recent weight loss. All these symptoms were since last 1½ months, after completion of fasting "Roja". There was no past history of vomiting, tuberculosis or jaundice, or any other major illness. The general examination was unremarkable.

Investigations:

1) Barium meal examination-



Barium findings

- Marked dilatation of stomach.
- Stomach showed hyper peristalsis & delayed emptying indicating gastric outlet obstruction.
- 1st and 2nd part of duodenum was dilated & showed to & fro peristaltic movements.
- Vertical cut off line was seen at 3rd part of duodenum
- No ulcer.

2) CT Scan Examination:



Plain Study



Contrast Study

CT Finding:

Marked narrowing of the third portion of the duodenum which appears to be compressed in aortico-mesenteric triangle.

Impression:

CT & barium study show third part of duodenal obstruction due to compression of third part of duodenum in aortico-mesenteric triangle highly suggestive of superior mesenteric artery syndrome.

Discussion-

Superior Mesenteric Artery Syndrome-

Third part of duodenum lies in fixed position and is bounded anteriorly by the root of mesentery carrying the superior mesenteric artery and posteriorly by aorta and lumbar spine. When this compartment becomes narrowed, the third part of duodenum may be obstructed, this is known as SMA syndrome. SMA is also known as vascular compression of duodenum or Wilkie Syndrome or Chronic duodenal ileus or body cast syndrome. Vascular compression of 3rd portion of duodenum within aorto-mesenteric compartment; probably representing a functional reflux dilatation etiology. Narrowing of angle between SMA & aorta to 10- 22 degree occurs (normal angle is 45-65 degree). Most patients are asthenic and symptoms often develop following weight loss, particularly when the patient is bed ridden with a chronic wasting disease. Patient presents with history of repetitive vomiting, abdominal cramps.

Narrowing of the compartment may be caused by -

- 1) An aneurysm of aorta or a retroperitoneal tumor.
- 2) The association is also been reported with
 - peptic ulceration,
 - prolonged bed rest (often in a body plaster cast),
 - severe weight loss,
 - diminished peristalsis as may be seen with scleroderma.

The duodenum dilates proximal to a broad, vertical band like narrowing which crosses the third part of duodenum, as it passes over the spine. In most cases exception of those with scleroderma, fluoroscopy shows vigorous to & fro peristalsis proximal to site of obstruction. In some, obstruction is related to posture and by turning patient prone or on to left side the obstruction is released. The attacks of abdominal pain and vomiting encountered in this condition then tend to be intermittent and radiological features are best detected during an attack.

Initial treatment is aimed at weight gain and duodeno-jejunostomy is reserved for patients who fail to respond to dietary treatment.

CASE : 6

Benign Metastasizing Leiomyoma

Netaji R. Patil. D.M.R.E.

Radiologist, B.K.L.Walawalkar Hospital.

Mobile: 9763551583

Email : drnetajipatil@yahoo.com

History-

A 30 years old female patient- normotensive, nondiabetic- came with chief complaints of dyspnea and cough from 4 to 5 months

- Past history- Myomectomy done 3 years back (Intramural Leiomyoma)
- O/E: conscious, oriented, dyspneic. Cyanosis present.
- RR-45/min, PO₂-60%, P- 90/ min, BP 110/70 mm/Hg,
- Respiratory system : Bilateral crepts and rhonchi noted.
- CVS system: S1 and S2 normal; P/A- Soft, non-tender.

Investigations-

CBC- normal, BSL- normal, BUN and Creatinine - normal.

Radiological Investigations-

1) Chest X-Ray-



X-Ray in 2005



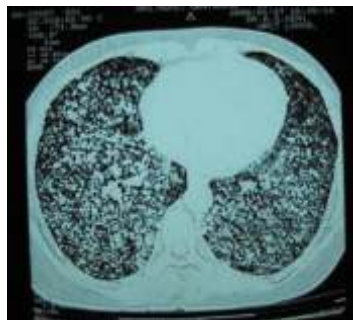
X-Ray in 2006



X-Ray in 2007

Multiple tiny reticulo-nodular opacities are seen throughout both the lungs.

1) CT Scan-



Innumerable tiny nodules in both the lungs with random distribution.

Differential Diagnosis-

- 1) Millitary Koch's,
- 2) Alveolar cell carcinoma,
- 3) Lymphangitis carcinomatosa,
- 4) Microlithiasis,
- 5) Silicosis

Right lung biopsy : Metastasizing Leiomyoma -Lung.

Discussion:

Benign metastasizing leiomyoma is a rare lesion characterized by benign-appearing smooth muscle tumor most frequently involving the lung and usually associated with a benign leiomyoma or intravenous leiomyomatosis of the uterus. The pathogenic mechanism of the tumor has not been clarified, but the possibilities including hormone-sensitive in situ proliferations of smooth muscle bundles, mechanical displacement or intravascular spread of preexisting benign uterine tumor tissue, and metastasized very low-grade uterine leiomyosarcoma have been proposed.

Pulmonary nodules are usually fairly well demarcated grossly. Histologically they consist of interlacing fascicles of spindle shaped cells with variable admixture of collagen. Nuclei are typically uniform in size and shape with little hypochromasia and a low mitotic index.

Radiographically, the tumors are usually multiple and bilateral and range from 0.5 to 5.0 cm in diameter. Rarely the pattern is micronodular or millitary. The nodules can increase in size and in number or can remain fairly stable over long periods of time. New nodules may appear, while others shrink and actually disappear. Such regression seen to follow termination of pregnancy or progestin withdrawal, implying the hormonal effect on tumor growth.

These tumors exclusively occur in females. The nodules may present at the same time the uterine neoplasm is recognized, more often they appear after hysterectomy, sometimes after an interval as long as 20 to 30 yrs. Metastasis usually do not produce symptoms and are discovered incidentally on a screening chest x ray. Occasionally patient has dyspnea, cough or chest pain. Rarely tumors are large in size and number to cause severe pulmonary function impairment or respiratory failure.

Benign metastasizing leiomyomas (BML) may comprise a heterogeneous group of tumors in terms of their malignant potential and pathogenic mechanism. Most patients are asymptomatic. Symptomatic cases may report to the clinic treatment of oophorectomy. However, in others symptoms may appear after oophorectomy and these cases may respond to anti-estrogen therapy (tamoxifen, raloxifene, goserelin). Because of the limited number of therapeutic options and the mismatched results of several reports concerning previously known hormonal therapy, some of the new drugs like imatinib (anti c-kit) have been suggested to have some therapeutic effect on this tumor.

DERVAN DIGNITARIES A JOURNEY TOWARDS ACCOMPLISHMENT...



Dr. Amol Talavlikar
(Urosurgeon)



Dr. Ashish Parulekar
(Gynecologist)



Dr. Patki (Cardiologist) delivering a lecture on
"Cardiology at Dervan" in Summit 2008



Dr. Jayashri Todkar
(Laparoscopic surgeon)



Dr. Sudhir Joshi (Trustee), offering flowers to
Digambar Das Maharaj at Summit 2008



Dr. J. M. Phadtare (Chest Physician)
with Lam Louis, Elizabeth - 2007

DERVAN DIGNITARIES A JOURNEY TOWARDS ACCOMPLISHMENT...



Dr. Hemant Dabake
(ENT Surgeon)



Dr. Shirang Joshi & Dr. Kadam
(Orthopedic Surgeon)



Dr. Satischandra Gore
(Endoscopic spine Surgeon)



Dr. Shirole
(Paediatrician)



Dr. Sunil Nadkarni
(Spine Surgeon)



Dr. Anil Damle
(Cardiologist)

DERVAN DIGNITARIES A JOURNEY TOWARDS ACCOMPLISHMENT...



Dr. Bharti Khandekar
(Plastic Surgeon)



Dr. Shripad Banavali
(Oncohematologist)



Dr. Anil Kakodkar
with TMCROP team



Dr. Palnitkar
(Anaesthetist)



Dr. Shyam Srivastava (center) (Radiation Oncologist, TMH)

VISITING DOCTORS / STUDENTS FROM ABROAD



Team of doctors from UK- 2006



Team of doctors from UK- 2007



U.K. Surgical team - 2008



Dentist, Dr. Kathy Wilson, UK- 2008



Dr. Sanjay Deshpande (UK) Conducting ALERT Course for Dervan Medicos



Dr. Kamil Wyne, Dr. Sanjay Deshpande, Shri. Arun Gujrathi & Shri. Vikas Walawalkar (Trustee)

VISITING DOCTORS / STUDENTS FROM ABROAD



Dr. Benedicto, Spain (Barcelona)
Plastic Surgeon - 2006



Dr. Paco Parri, Spain (Barcelona)
Plastic Surgeon - 2006



Dr. Satish Gore & Dr. Shirole
with Spanish Medicos



Spanish Plastic Surgeons - 2008



Medical Students
from University of Barcelona- 2008



Superspeciality Medical students
from Barcelona - 2007

VISITING DOCTORS / STUDENTS FROM ABROAD



Dr. Wong & Dr. Lim, observers from Korea with Dr. Nadkarni



Dr. Carlos Algora, Spanish Orthopedic Surgeon



Students from Rosalind Franklin University USA & Hamburg University Germany
June 2008



Laser Machine used in Urology and Spine cases in Feb 2008 camp.



Dr. Benedicto & Dr. Paco Pari with Shree Kaka Maharaj



Dr. Sunil Nadkarni with Barcelona Students - 2007

Visit of Honorable Guests



Hon. Minister Mr. Ashok Chavan as a chief guest for inaugural function of Nursing School.



Hon. Minister Mr. Narayan Rane inaugurating Free Cataract Eye Camp.



Hon. Ministers Mr. Chandrakant Khaire, Dr. Doulatrao Aher, Mr. Sudhir Joshi & Mr. Shashikant Sutar at the inaugural function of hospital



Hon. Minister Mr. Krupashankar Sing at the inaugural function of Pre-Primary School at Dervan.



Visit of Hon. Minister Mr. Vjaysinh Mohite Patil to hospital.



Visit of Hon. Minister Mr. Babanrao Pachpute to hospital.

Visit of Honorable Guests



Visit of Hon. Minister
Mr. Eknath Gaikwad to hospital.



M.L.A. Mr. Husain Dalwai as a Chief guest
at Inaugural function of P.G.D.M.L.T College



Visit of Mr. N.D. Patil to hospital



M. L. A. Mr. Ramesh Kadam



Smt. Reshma Desai, Mrs. Anchan and Mrs. Momin
as guests for Maharashtra Nursing Council
Workshop at Dervan.



Hon. Minister Mr. Prabhakar More,
Mr. Shashikant Sutar, Mr. Bhaskar Jadhav
and Editor (Daily Sagar) Mr. Nishikant Joshi with
Mr. Kamlakar pant Walawalkar
at Bhoomipujan Ceremony.

Goodwill Visit to Hospital



Shri Lalkrushna Advani



Shri Anna Hajare



Smt. Asha Bhosale



Dr. Vijay Bhatkar



Mr. Kumar Ketkar



Dr. Nitu Mandke

German Students



German Student Ute Ohlenschlager & Petra Frohloff
from University of Mainz - 2002



German Student Victoria & Astrid from
University of Tubingen, Germany - 2003

Other Activities



Managing Trustee Mr. Vikas Walawalkar
inaugurating Primary & Secondary Scholarship
Guidance Workshop at Dervan - 2006



S.S.C. Student Guidance Workshop
at Dervan - 2006



Students participated in
Scholarship Examination Guidance Workshop
from all over Ratnagiri District.



Dr. Mr. & Mrs. Limaye, USA with
Mr. Godbole (Administrative Officer)



Hon'ble Dr. K. A. Dinshaw
Former Director, Tata Memorial Centre, Mumbai



Hon'ble Dr. Rajan Badwe
Director, Tata Memorial Centre, Mumbai



Shree Vitthalrao Joshi Charities Trust's
B.K.L. Walawalkar Hospital,
Diagnostic & Research Centre

Shreekshetra Derwan, Taluka: Chiplun, District; Ratnagiri 415606

Trustee : Vikas K. Walawalkar
 Tel: + 91-2355-264137/264149/264691, 92, 93
 Fax: + 91-2355-264181
 E-mail : info@walawalkarhospital.com
 Website: www.walawalkarhospital.com
