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NEWSLETTER

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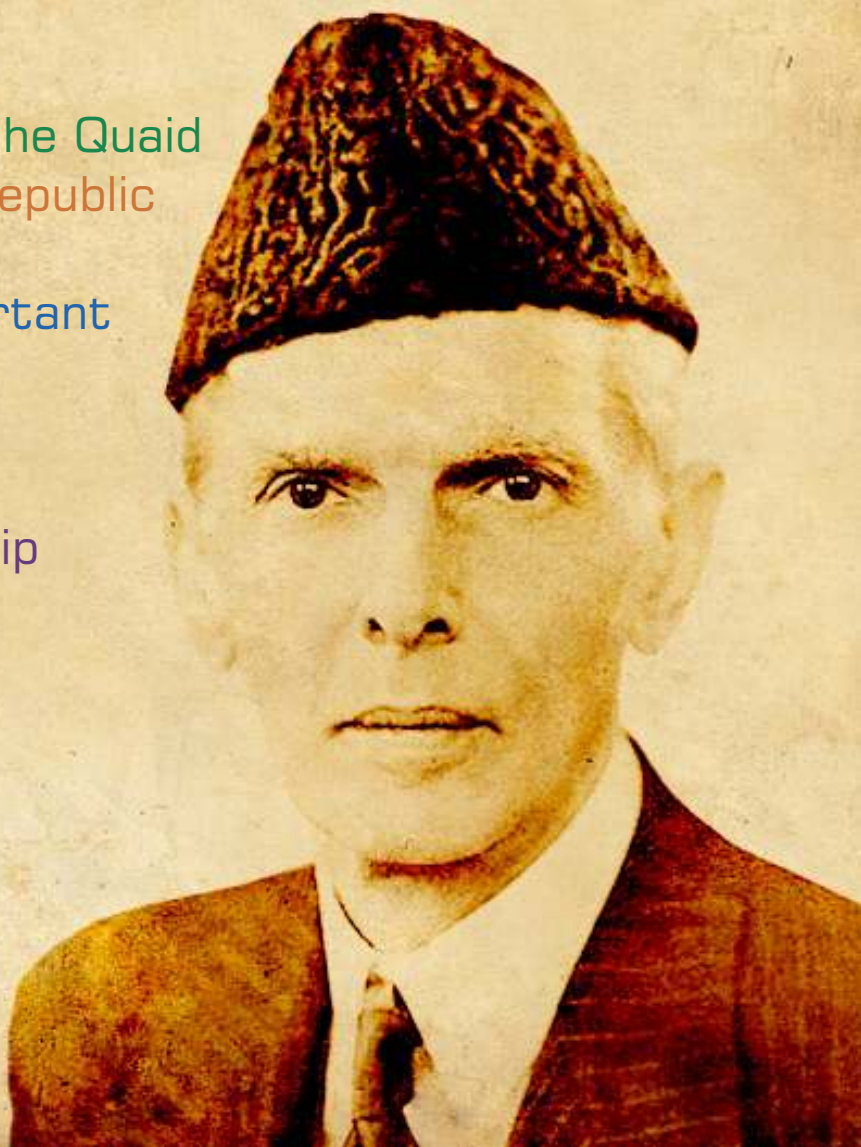
Rabi-al-Thani 1440

Quaid-e-Azam Day

25th December 1876

CONTENT



Kohistan Road, F-8 Markaz, Islamabad.
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The Wit and Humour of the Quaid

The following are excerpts from an article under the same headline that was published in Dawn on December 25, 1976, as part of a supplement marking the Quaid-e-Azam's birth centenary.

ALL those who knew Quaid-e-Azam intimately, know very well that he did never crack a joke merely for the sake of raising a laugh. He was too self-controlling and disciplined a man to waste time on little things. One thing he valued most was, Time. Time, he knew, can never return.

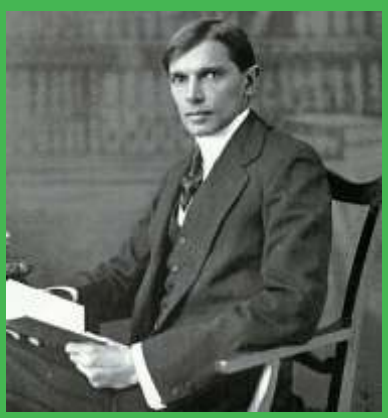
He was [once] arguing an appeal before the full bench of Bombay High Court. He argued the whole day. The working time was up to 5pm. The judges asked: "Mr. Jinnah, how much more time would you need to finish your side?" He replied: "My Lord, hardly 15 minutes."

Then the senior judge [on the bench] said: "Could you continue for a few minutes longer today and finish your address?" Normally, when a High Court judge says so, no lawyer would decline. But not so with Mohammad Ali Jinnah. "My Lord, I would love to do so, but I have a very important appointment which I can just make in time if I leave the court at once."

The junior-most judge sitting on the left side of the chief justice whispered to him to insist that the case be finished on the day. "That is all right, Mr. Jinnah. We also have an appointment, but we like to finish this today so that judgment can be delivered on Monday." Out came the reply from this great lawyer, shooting like a gun: "My Lords, the difference between your Lordships and myself is that (raising his voice) I keep my appointments."

The three judges, Englishmen, all went more red in their face than they already were. They all rose as if in a huff. Everybody got up and while the advocates bowed fully, the judges seemed only to nod. It was thought that the solicitor, who had instructed Jinnah, felt that this may affect the result of the case. The next morning the judges appeared in a very good mood.

Advocacy



Mr Jinnah was absolutely on the top of the profession. Therefore, naturally many lawyers tried their best to be allowed to work with Mohammad Ali Jinnah but very few could be taken. Mr. Frank Mores, then Editor of Indian Express, once wrote: "Watch him in the court room as he argues his case. Few lawyers can command a more attentive audience. No man is more adroit in presenting his case. If to achieve the maximum result with minimum effort is the hallmark of artistry, Mr. Jinnah is an artist in his craft. He likes to get down to the bare bones of his brief in stating the essentials of his case. His manner is masterly. The drab court rooms acquire an atmosphere as he speaks. Juniors crane their necks forward to follow every movement of his tall well-groomed figure. Senior counsel listen closely, the judge is all attention; such was the great status of this top lawyer."

People's enthusiasm

It was around 1936-37 that Quaid-e-Azam came to Karachi and appeared before the Chief Court of Sind, as it then was, and appeared in a very important case and three lawyers of Karachi appeared against him. He had made a name as a lawyer long ago and in politics also he figured as a giant personality.

Consequently the rush to the court room consisting of lawyers, students and politicians was so great that the court room was full to the brim. The entrance to the court room had to be closed to stop any noise, so that judicial work could be carried on with a decorum and dignity befitting the occasion. But at the end of every hour, the door was ordered to be opened so that those who wanted to go out or come in could do so. When the first opening of the door at 12 O'clock occurred there was such a noise of rush that it appeared that the judges would lose their temper.

"My Lords," said Jinnah in very sweet, melodious voice, "these are my admirers. Please do not mind. I hope you are not jealous."

There was a beam of smile on the faces of judges and they appeared to be magnetically charmed by the words of the great persuasive man. The door remained opened and Quaid-e-Azam looked back on the crowd, raising his left hand indicating that he desired them to keep quiet. The atmosphere became absolute pin-drop silence as if by magic. The case proceeded for two days.

Quaid and students

On one occasion at Aligarh after a hard day's work of meeting people, addressing the students as he was sitting in a relaxed mood, he was told that one student, Mohammad Noman, was a very fine artist of mimicry. He could impersonate and talk or make a speech with all the mannerism of his subject. Quaid-e-Azam was told that this student could impersonate him to such a degree that if heard with closed eyes, Quaid-e-Azam will think that it was he himself who was speaking and he will think as if he himself was talking to Quaid-e-Azam.

Quaid-e-Azam sent for the student at once. The student asked for 10 minutes' time to prepare himself. After 10 minutes the student turned up dressed in dark gray Sherwani, a Jinnah cap and a monocle, like Quaid-e-Azam. Of course, he could not look like Quaid-e-Azam, but the appearance on the whole was somewhat similar.

Then the student put on his monocle and addressed an imaginary audience. The voice, the words, the gestures, the look on his face and everything appeared like Quaid-e-Azam. In fact, if he had spoken behind a screen without being seen, the audience would have taken him to be Quaid-e-Azam speaking himself. Quaid-e-Azam was very much pleased with the performance. But when it was finished, the culmination came unexpectedly. Quaid-e-Azam took off his own cap and monocle and presented to the student, saying: "Now this will make it absolutely authentic."

Rose between thorns

On the 14th day of August, 1947, Lord Mountbatten with his wife came to Karachi for the investiture ceremony of the Governor-General of Pakistan. After Quaid-e-Azam was sworn in, the new State of Pakistan was handed over to him legally, constitutionally and with proper ceremony.

Lord Mountbatten proposed that Quiad-e-Azam be photographed with Lord and Lady Mountbatten. Quaid took it for granted, that, as usual etiquette requires, the lady will stand between the gentlemen. So he told Lady Mountbatten: "Now you will be photographed as the rose between the two thorns". But Mountbatten insisted that Jinnah should stand in the middle. He said that being a Governor-General etiquette requires that Quaid-e-Azam should be in the centre. Naturally, Quaid-e-Azam yielded.

And when Quaid-e-Azam stood between the two, Mountbatten said to him: "Now you are the rose between two thorns." He was right.

Trick countered

In 1946, political agitation both by Congress and Muslim League had reached its zenith. The British government, always master of the art of side-tracking the main issue, suggested to Jawaharlal Nehru that as very soon India will be handed over to them, so as a beginning some Hindus and some Muslims should be taken in the Interim Cabinet. Before that there was no such thing. The body which was functioning was the Viceroy's Executive Council. But Jawaharlal Nehru insisted that it should be called a Cabinet. Example was shown that the Viceroy himself calls it a Cabinet.

Quaid-e-Azam refused to do so. He said the Cabinet is a constitutional body the members of which are selected from the members of Parliament by the leader of majority. Here, there is no such thing. It is purely an Executive Council and it cannot become a Cabinet merely because you call it a Cabinet. A donkey does not become an elephant because you call it an elephant.

Call for honesty

Gandhi always used to speak about his inner voice. He seemed to create an impression that there is something spiritual within him, which, in time of necessity, gives him guidance and he obeys it and calls it his inner voice. As a matter of fact Gandhi often changed his opinion and suddenly took the opposite stand. Quaid-e-Azam called it a somersault.

Once having committed himself to a certain point of view, he took a dramatically opposite stance. On the next day, Gandhi maintained that his inner voice dictated him to take the opposite view. Quaid-e-Azam lost his temper and shouted: "To hell with this Inner Voice. Why can't he be honest and admit that he had made a mistake."

In June 1947, partition was announced by Lord Mountbatten. He insisted on an immediate acceptance of the plan. Quaid-e-Azam said he was not competent to convey acceptance of his own accord and that he had to consult his Working Committee. The Viceroy said that if such was his attitude, the Congress would refuse acceptance and Muslim League would lose its Pakistan. Quaid-e-Azam shrugged his shoulders and said: "What must be, must be."

In July 1948, Mr. M. A. H. Ispahani went to Ziarat where Quaid-e-Azam was seriously ill. He pleaded with Quaid-e-Azam that he should take complete rest as his life was most precious. Quaid-e-Azam smiled and said: "My boy there was a time when soon after partition and until 1948, I was worried whether Pakistan would survive. Many unexpected and terrible shocks were administered by India soon after we parted company with them. But we pulled through and nothing will ever worry us so much again.

"I have no worries now. Men may come and men may go. But Pakistan is truly and firmly established and will go on with Allah's grace forever".

Typhoid Fever – Islamic Republic of Pakistan

Disease outbreak news
27 December 2018

Pakistan Health Authorities have reported an ongoing outbreak of extensively drug resistant (XDR) typhoid fever that began in the Hyderabad district of Sindh province in November 2016. An increasing trend of typhoid fever cases caused by antimicrobial resistant (AMR) strains of Salmonella enterica serovar Typhi (or S.Typhi) poses a notable public health concern. In May 2018, the case definitions for non-resistant, multi-drug resistant (MDR) and XDR typhoid fever were formally agreed by the Regional Disease Surveillance and Response Unit (RDSRU) in Karachi, following a review by an expert group of epidemiologists, clinicians and microbiologists from Pakistan. All typhoid fever cases reported from 2016 to 2018 were reviewed and classified according to these case definitions (see Table 1).

Table 1. Classification of Typhoid Fever Cases by Drug Resistance Status, Pakistan, 2018

Classification	Case Definition
Non-resistant Typhoid Fever	Typhoid fever caused by *Salmonella* Typhi and/or Salmonella Paratyphi A, B or C strains which are sensitive to first-line drugs and third generation cephalosporins, with or without resistance to second-line drugs.
Multi-drug resistant (MDR) Typhoid fever	Typhoid fever caused by *Salmonella* Typhi and/or Salmonella Paratyphi A, B or C strains which are resistant to the first-line recommended drugs for treatment, with or without resistance to second-line drugs.
Extensive Drug Resistant (XDR) Typhoid fever	Typhoid fever caused by *Salmonella* Typhi strain which are resistant to all the recommended antibiotics for typhoid fever.

From 1 November 2016 through 9 December 2018, 5 274 cases of XDR typhoid out of 8 188 typhoid fever cases were reported by the Provincial Disease Surveillance and Response Unit (PDSRU) in Sindh province, Pakistan. Sixty-nine percent of cases were reported in Karachi (the capital city), 27% in Hyderabad district, and 4% in other districts in the province (Table 2). The circulating XDR strain of S. Typhi haplotype 58 was resistant to first and second-line antibiotics as well as third generation cephalosporins. Informal reports of XDR typhoid cases occurring in other parts of Pakistan were made and required further verification.

In addition, from January to October 2018, there were reports indicating international transmission of the XDR typhoid strain through persons who had travelled to Pakistan. Six travel-associated cases of XDR typhoid were reported; one in the United Kingdom of Great Britain and Northern Ireland, and five in the United States of America. Four of the travel-associated cases had visited or resided in Karachi (Sindh province), Lahore (Punjab province) and/or Islamabad in Pakistan. Details regarding these four cases are as follows:

Table 2. Distribution of reported XDR typhoid fever cases in Sindh Province, Pakistan
[1 November 2016 through 9 December 2018]

Year	Districts in Sindh Province			Total
	Karachi	Hyderabad	Other Districts	
2016	0	11	0	11
2017	175	488	67	730
2018	3483	906	144	4533
Total	3658	1405	211	5274

- Two of the cases travelled to Karachi, Lahore, and Islamabad.
- One case travelled only to Karachi.
- One case pending confirmation, is a resident from Lahore with travel history to the US where he/she was diagnosed and treated. The case has since returned to Pakistan.

Limited information is available about their mechanism of exposure or the exact date of onset of illness for these cases but, there are evidence that all the travel-associated cases were successfully treated.

WHO risk assessment

The risk of XDR S. Typhi at the national level is considered high in Pakistan due to insufficient water, poor sanitation and hygiene (WASH) practices, low vaccination coverage and limited surveillance for typhoid fever. The fact that AMR S. Typhi confirmatory testing and antimicrobial susceptibility testing is only conducted by major laboratories and tertiary care hospitals are other priority considerations in terms of risk. These factors, coupled with sub-optimal antibiotic prescribing practices, have limited the ability to track the occurrence, spread, and containment of XDR S. Typhi.

Outbreaks of MDR typhoid and sporadic cases of infection with ceftriaxone-resistantS. Typhi have been reported in several countries. However, this is the first time a large outbreak caused by XDR S. Typhi has been observed in Pakistan.

The risk at regional level is considered moderate due to the similar environments and approaches to treatment of typhoid fever, as well as the widespread over-use of anti-microbials which is compounded by considerable levels of migration within the region.

Globally, the risk is considered low due to the availability of antimicrobials and rational prescribing practices. However, S. Typhi has a global distribution and the potential for travelers to spread this resistant clone, especially in countries with poor WASH infrastructure, cannot be eliminated. The high level of resistance to traditional first-line antibiotics in the H58 clonal strain identified to be circulating in parts of Pakistan increases the potential risk at all three levels.

WHO recommendations

This outbreak highlights the importance of public health measures to prevent the spread of resistant and non-resistant pathogens. While the emerging resistance in S.Typhi complicates treatment, typhoid fever remains common in places with poor sanitation and a lack of safe drinking water. Access to safe water and adequate sanitation, hygiene among food handlers, and typhoid vaccination are the main and most important recommendations.

WHO recommends typhoid vaccination in response to confirmed outbreaks of typhoid fever, and travelers to typhoid-endemic areas should consider vaccination. Further, where the TCV is licensed, WHO recommends TCV as the preferred typhoid vaccine. Typhoid vaccination should be implemented in combination with other efforts to control the disease.

In view of the observed capacity for S. Typhi to quickly acquire new resistance mechanisms, WHO recommends strengthening surveillance of typhoid fever, including surveillance of AMR to monitor known resistance, detect new and emerging resistance, and mitigate its spread. WHO also recommends that surveillance data is shared locally and internationally in a timely manner.

Currently, azithromycin is the only remaining reliable and affordable first-line oral therapeutic option to manage patients with XDR typhoid in low-resource settings. Patients with suspected typhoid fever should be tested microbiologically to detect S.Typhi and define antimicrobial susceptibility wherever possible to inform patient management and contribute to the surveillance efforts. Verification and advanced testing (including molecular methods) of S. Typhi strains with unusual resistance should be performed by designated expert laboratories that provide confirmatory testing, where such capacity exists within countries. In countries where no laboratory capacity currently exists, regional collaboration may be an option, whereby a neighbouring country's reference laboratory or a WHO Collaborating Center can fulfill this role.

Appendix may have Important Function

Appendix may have important function, new research suggests

The human appendix, a narrow pouch that projects off the cecum in the digestive system, has a notorious reputation for its tendency to become inflamed (appendicitis), often resulting in surgical removal. Although it is widely viewed as a vestigial organ with little known function, recent research suggests that the appendix may serve an important purpose. In particular, it may serve as a reservoir for beneficial gut bacteria. Several other mammal species also have an appendix, and studying how it evolved and functions in these species may shed light on this mysterious organ in humans.

Heather F. Smith, Ph.D., Associate Professor, Midwestern University Arizona College of Osteopathic Medicine, is currently studying the evolution of the appendix across mammals. Dr. Smith's international research team gathered data on the presence or absence of the appendix and other gastrointestinal and environmental traits for 533 mammal species. They mapped the data onto a phylogeny (genetic tree) to track how the appendix has evolved through mammalian evolution, and to try to determine why some species have an appendix while others don't.

They discovered that the appendix has evolved independently in several mammal lineages, over 30 separate times, and almost never disappears from a lineage once it has appeared. This suggests that the appendix likely serves an adaptive purpose. Looking at ecological factors, such as diet, climate, how social a species is, and where it lives, they were able to reject several previously proposed hypotheses that have attempted to link the appendix to dietary or environmental factors. Instead, they found that species with an appendix have higher average concentrations of lymphoid (immune) tissue in the cecum. This finding suggests that the appendix may play an important role as a secondary immune organ. Lymphatic tissue can also stimulate growth of some types of beneficial gut bacteria, providing further evidence that the appendix may serve as a "safe house" for helpful gut bacteria.

Researchers collaborating with Dr. Smith on this study are William Parker, Ph.D., Department of Surgery, Duke Medical Center, Durham, North Carolina; Sanet H. Kotzé, Ph.D., Department of Biomedical Sciences, Faculty of Medicine and Health Sciences, University of Stellenbosch, Tygerberg, South Africa; and Michel Laurin, Ph.D., from the Muséum National d'Histoire Naturelle in France. Midwestern University Senior Research Associate Brent Adrian also contributed illustrations for the study.

Speech Language and Swallowing Problems

Ms. Qurat-ul-Ain Baig
Speech Therapist

Speech, Language and Swallowing Problems Relative to Neurological Disorders:

Speech, language and Swallowing difficulties due to any of the following neurological problems:

- Aphasia (mostly in Stroke patients).
- Dysphagia (Swallowing Difficulty).
- Apraxia.
- Motor Speech Disorders (Dysarthria).
- Early cognitive decline that is affecting communication due to Primary Progressive Aphasia (Dementia) and Alzhimer's Disease.
- Language difficulties due to Right Hemisphere Damage.
- Meningitis, Transient Ischemic Attacks, Parkinson's, etc.
- Cranial Nerve damage due to any surgery or disorder.
- Patients dependent on Ventilator or Tracheostomy tubes who require Assessment or Help to communicate and Swallow.
- Patients requiring evaluation of their swallowing using Video Fluoroscopy (VFS) or Fiber-optic Endoscopy (FEES).

Treatment Strategies for Speech and Language Difficulties:

- Exercises to strengthen muscles and to improve coordination.
- Sensory stimulation.
- Volume and breathe control exercises.
- Compensatory strategies to make your speech clearer.
- Word finding exercises.
- Supporting to develop skills to make communicating with others easier.
- Providing Augmentative Alternative Communication (AAC) devices.

Treatment Strategies for Swallowing Difficulties:

- Helping to find a safe and acceptable way to manage swallowing difficulties.
- Exercises, Maneuvers and treatment strategies if appropriate to improve swallowing.
- Postural management.
- Also to train family members, caregivers, on how to support swallowing and to communicate effectively with the patient.

Antimicrobial Stewardship Program

Waqas Ahmad
Clinical Pharmacist

Today: I treated my patient, Tomorrow: will I have any antimicrobials left to give?

Background

Antimicrobials are one of the most important resources in modern medicine, making once lethal infections readily treatable and making other medical advances, like surgeries possible. Their prompt initiation to treat infections reduces morbidity and save lives. However, 20–50% of all antibiotics prescribed are thought to be either unnecessary or inappropriate which lead to Antimicrobial resistance,(loss of effectiveness against microbes) and become biggest challenge for Healthcare system.

According to a study of University of Carolina USA mortality rate of Antimicrobial resistance (AMR) is greater than that of HIV infections, according to a study of University of Birmingham UK by 2050 mortality rate of AMR will be greater than that of road traffic accidents and in Aga khan University Hospital Pakistan patients have been reported with infections that were not sensitive to any of the available antimicrobial.

We can preserve the effectiveness of remaining antimicrobials by implementing Antimicrobial Stewardship Program (ASP)," which is judicious or sensible use of antimicrobials to ensure appropriate antimicrobials are used for appropriate indications, leading to overall decrease in Unnecessary/inappropriate use, less resistance and improved patient outcomes and safety.

How we can Implement this program in our Hospital?

- By working as a team because ASP is a multidisciplinary & collaborative approach. (Doctors, Pharmacists, Nurses & Management)
- By educating our all clinical staff about the basics of ASP (CMEs, Updated Guidelines, Newsletters etc.)
- By seeking advice of key opinion leaders (ID Physician and Clinical Pharmacist)
- By documenting Indication, Dose,Duration and route of administration of antimicrobials on prescription order.
- By restricting the use of Last Resort Antimicrobials like Linezolid, Fosfomycin, Colistin etc. (Restricted Antimicrobials)
- By Controlling the use of Broad spectrum antimicrobials like meropenem, Vancomycin, Pipracillin etc. (Controlled Antimicrobial)
- By promoting the practice of sending cultures before starting antimicrobials.
- By reviewing initial antimicrobial orders with in 72 hours (Prospective audits)
- By stopping use of double Unnecessary Coverage (Co-amoxiclav & Cefoperazone-sulbactam together)
- By introducing IT supported interventions such as Automatic stop orders for Antimicrobials.
- By monitoring consumption of antimicrobials and developing/updating Antibiogram on regular basis.

Restricted Antimicrobials	Controlled Antimicrobials
Their use require prior-authorization by ASP team.	Their use beyond 72 hours require Approval by ASP team.
- Linezolid - Fosfomycin - Tygecycline - Colistin - Moxifloxacin	- Meropenem - Vancomycin - Tiecoplanin - Pipracillin-Tazobactam - Levofloxacin - Cefoperazone-Sulbactam
Orders in CPOE System are processed only after Prior-Authorization of ASP team or automatically stopped after 24 hours.	Orders in CPOE system are automatically stopped after 72 hours.

References:

1. https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements.html1
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3. https://www.coursera.org/lecture/infection-prevention/1-1defining-antibiotic-resistance-Q5382

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News Alert!!

Following medicines are short from manufacturer's end:

1. Forane (Isofurane)
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3. Rabies Vaccine
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