IPF-TIMES The Official Newsletter of IPF

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(for free circulation to IPF members only)

Dear Friends,

It gives us immense pleasure to bring forth the 2nd edition of quarterly E-newsletter of our Forum – the **"IPF- TIMES"**

This quarter we had two well attended CMEs that covered Diabetes and Renal failure along with other topics. IPF members were also blessed with the presence of Esteemed Endocrinologist from USA, Dr Paresh Dandona who shared his words of wisdom and experience with the attendees.

This edition includes the academic program of our 1st Annual Conference **IPF MEDICON 2018** that is being held on **December 2nd, at Hotel The Lalit, New Delhi**. It also includes *Journal watch* section and state-of-the-art articles by two of our esteemed members. It's a matter of pride to congratulate few learned members of our IPF fraternity who have been awarded honorary fellowships from prestigious international bodies in the previous year.

We sincerely hope that this edition of **IPF-TIMES** will serve its purpose of providing you an enjoyable academic reading. As always, we look forward to your valuable support, manuscripts and suggestions in making this effort fruitful.

Looking forward to see you in **IPF MEDICON 2018**

Warm regards

E-newsletter team

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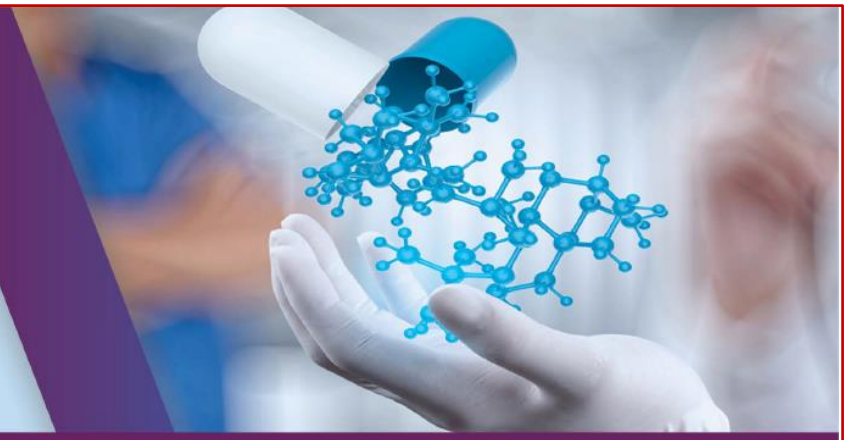
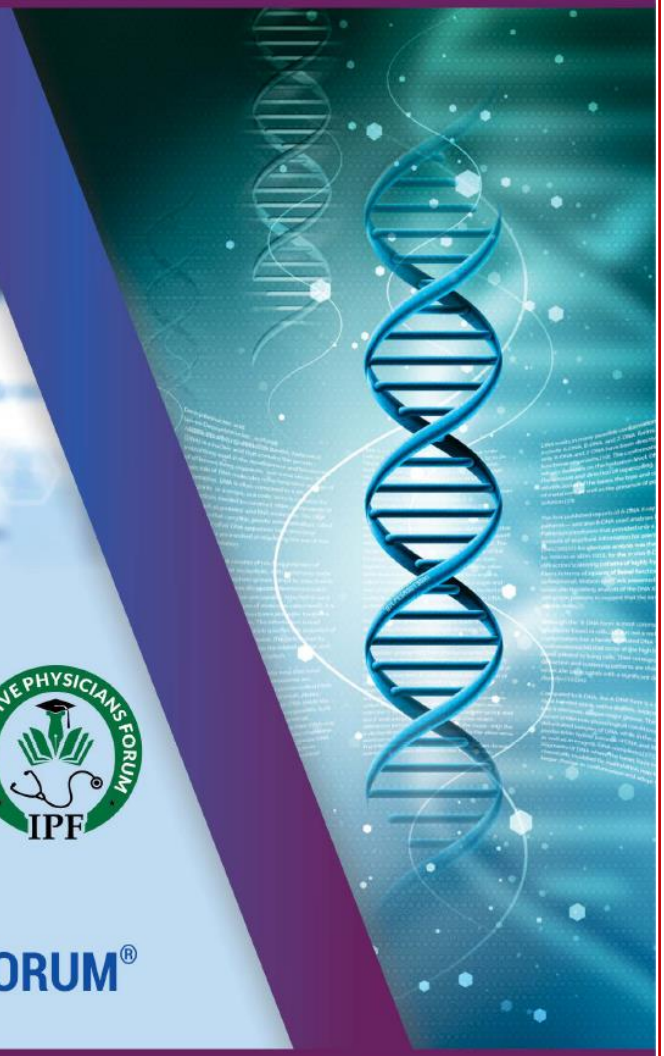


"PURSUIT OF EXCELLENCE IN EVIDENCE BASED MEDICINE"



IPF MEDICON 2018 | Internal Medicine Meeting

Organised by

INNOVATIVE PHYSICIANS FORUM®

2nd December 2018 | Hotel The Lalit, Delhi

For more information Visit: www.iphysiciansforum.com

Scientific Programme

Time	Topic	Speaker
8 am – 8.30 am	**Registration & Fellowship**	
8.30 am – 9.30 am	**Free Papers and Oral Presentations**	
9.30 am – 9.50 am	*Tackling Antibiotic Resistance in Community. Can Biomarkers help?*	***Dr BK Rao***
9.50 am - 10.10 am	*Management of Heart Failure: Role of ARNI*	***Dr JC Mohan***
10.10 am -10.30 am	*Osteoporosis: Management and role of Newer Agents*	***Dr SK Wangnoo***
10.30 am - 10.50 am	*Stool Microbiota Transplantation: Present Scenario and Future Directions*	***Dr Randhir Sud***
10.50 am – 11.10 am	*Stroke Management and its Prevention*	***Dr Vineet Suri***
11.10 am – 11.30 am	*Rational and Utility of Combination Therapy in Hypertension management*	***Dr JPS Sawhney***
11.30 am – 11.50 am	*Non-Diabetic Nephropathies*	***Dr DS Rana***
11.50 am -12.20 pm	***IPF Chairman's Oration: Rationalising Anti Diabetic Therapy--Indian Scenario***	***Dr Meena Chhabra***
12.20 pm – 12.50 pm	***1st Dr O P Sharma Oration***	***Dr Ashok Seth***
12.50 pm – 1.20 pm	**INAUGURATION**	
1.20 pm – 2.00 pm	**INSULIN WORKSHOP**	***Dr Meena Chhabra / Dr Minal Mohit***
2.00 pm – 2.20 pm	*Legal Tangles & Ethical Issues in Medicine*	***Dr Girish Tyagi***
2.20 pm – 2.40 pm	*Strategies to reduce Systemic Inflammation in Metabolic Diseases*	***Dr Anuj Maheshwari***
2.40 pm – 3.00 pm	*Newer developments in OHA in Diabetes Management*	***Dr BM Makkar***
3.00 pm – 3.20 pm	*Injectable Therapy in Diabetes Management*	***Dr Rajeev Chawla***
3.20 pm – 3.40 pm	*Chronomedicine: Understanding Biological Rhythm*	***Dr Narsingh Verma***
3.40 pm – 4.00 pm	*Adult Immunization: Current Recommendations*	***Dr OP Sharma***
4.00 pm – 4.20 pm	*CBC-What is new?*	***Dr Pradeep Suri***
4.20 pm – 4.40 pm	*Asthma-COPD Overlap: A distinct Phenotype*	***Dr Puneet Khanna***
4.40 pm – 5.00 pm	**VALEDICTORY**	

Conference Secretariat

IPF MEDICON 2018

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RESTLESS LEG SYNDROME: an overview

Dr Anil Manchanda

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Introduction

Restless legs syndrome (RLS), or Willis-Ekbom disease, is a common sensorimotor-neurologic disorder characterized by a constant urge to move the legs that often is associated with discomfort or dysesthesia. Given the timing of onset and the association with immobility, patients commonly report sleep disturbance in addition to sensory symptoms. RLS varies in severity, with some experiencing mild, infrequent symptoms while others having severe, daily symptoms that cause substantial sleep disturbance and reduced quality of life. About 3–15% of the general population suffers from RLS.[1] It typically presents in the first to third decades of life, but diagnosis is usually delayed until the fifth to sixth decade. Women are at higher risk [2]

Clinical features

Patients with RLS have uncomfortable sensations in their legs (and sometimes arms or other parts of the body) with an irresistible urge to move their legs to relieve the sensations, often described as an "itchy," "pins and needles," or "creepy crawly" feeling in the legs. These are usually worse at rest, especially when sitting or lying in bed. [3] All patients presenting with insomnia should be evaluated about the presence of RLS as more than 88% of patients with RLS report at least 1 sleep symptom *(inability to fall asleep, inability to stay asleep, or poor-quality sleep)* in addition to an uncontrollable urge to move the legs. Other patient-reported symptoms commonly attributed to RLS include leg pain, fatigue, leg jerks, and daytime sleepiness [2,4]

Diagnosis

The diagnosis of RLS is based on the presence of clinical diagnostic criteria. (Box 1). Polysomnography (PSG) or other diagnostic studies are generally not indicated, unless there is a concern for a co-morbid sleep disorder, neurologic condition, or complex medical condition. Approximately 85% of patients who

Diagnostic Criteria for Restless Legs Syndrome from the International Restless Legs Syndrome Study Group[1]

All criteria must be met.

1. An urge to move the legs usually but not always accompanied by, or felt to be caused by, an uncomfortable and unpleasant sensations in the legs.
2. The urge to move the legs and any accompanying unpleasant sensations begin or worsen during periods of rest or inactivity, such as lying down or sitting.
3. The urge to move the legs and any accompanying unpleasant sensations are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues.
4. The urge to move the legs and any accompanying unpleasant sensations during rest or inactivity only occur or are worse in the evening or
night than during the day.
5. The occurrence of the above features are not solely accounted for as symptoms primary to another medical or a behavioral condition (e.g., myalgia, venous stasis, leg edema, arthritis, leg cramps, positional discomfort, habitual foot tapping).

(Allen RP et al. *Sleep Med. 2014 Aug;15(8):860-73.)*

have RLS also have periodic limb movements on PSG which do not usually affect sleep.

Key elements of assessment include the *timing* and *severity* of RLS symptoms, effect on daytime mood and function, medical history, symptoms of other sleep disorders, family history, and medications.

Treatment

Aim of treatment is to reduce symptoms as well as the distress and anxiety of sleep disturbance and to improve daytime function. ***First-line medications*** are dopamine agonists (i.e., pramipexole and ropinirole). A well-known side effect of both medications is an increase in compulsive behaviors. Patients also may complain of "augmentation", which is an occurrence of RLS symptoms earlier than usual in the daytime, increased intensity, or spread of symptoms to the arms. ***Second-line medications*** include gabapentin, opioids, and carbidopa / levodopa.

Role of Iron and supportive measures

Iron therapy **above** daily dose of 150–200 mg/day should be attempted if serum ferritin levels are in the low-normal range (<45–75 µg/L). Other ***supportive measures*** include counselling, mental-alerting strategies such as knitting and video games, as well as activities that require standing, locomotion, or exercises.

Monitoring

Initially, doses should be titrated to the lowest effective dose, as tolerated, with close monitoring for side effects and dopaminergic induced augmentation.[4] There is no standard approach for treating augmentation, but one can split the dose of the drug, with additional dosing earlier in the day, or changing to a longer-acting agent in the same medication class. Medication rebound should be watched for with shorter-acting RLS medications (e.g., ropinirole). In some cases, dual treatment with different classes can be used. For individuals with progressive augmentation and increasingly early symptom onset, discontinuation of the dopaminergic agent and substitution with either an alpha-2 delta ligand or a high-potency opioid should be considered.

Prognosis

Although RLS is generally an incurable chronic condition, current therapies can control the disorder, minimize symptoms, and increase periods of restful sleep. Prompt recognition of the condition and appropriate treatment has demonstrated a large impact on morbidity and quality of life

TAKE HOME MESSAGE

1. Restless legs syndrome is a common but under-recognized disorder.
2. Exacerbators like poor sleep hygiene, caffeine, alcohol, smoking, and drugs like anti-depressants, neuroleptics, make it worse
3. Use the minimum dose of dopaminergics to avoid augmentation and impulse control disorders
4. Prompt recognition prevents over treatment

REFERENCES

1. Allen RP, Picchietti DL, Garcia-Borreguero D, et al. Restless legs syndrome/Willis-Ekbom disease diagnostic criteria: updated International Restless Legs Syndrome Study Group (IRLSSG) consensus criteria--history, rationale, description, and significance. *Sleep Med. 2014 Aug;15(8):860-73.*
2. Ohayon MM, O'Hara R, *Epidemiology of restless legs syndrome: A synthesis of the literature. Sleep Med Rev 2011*
3. Winkelman JW, Redline S, Baldwin CM,et al. Polysomnographic and health-related quality of life correlates of restless legs syndrome in the Sleep Heart Health Study. *Sleep 2009; 32:772-8.*
4. Ekbom KA. Restless legs: a clinical study. *Acta Med Scand 1945;158(suppl):1-122.*
5. Michaud M, Chabli A, Lavigne G, et al. Arm restlessness in patients with restless legs syndrome. *Mov Disord 2000;15: 289-93.*

Rationalizing Treatment in Diabetes: Premixed Insulin Analogues

Dr Dheeraj Kapoor MBBS, MD, DM (Endocrinology), FRCP (Edin.), FACP(USA), FICP

FRSSDI, FIACM, FDiab, FGSI

Introduction

In India, according to the latest reports,[1] only 19.7% of type 2 diabetes patients have HbA1c of < 7% compared to type 1 diabetes where it is 16.3%. In a country like India where the carbohydrate intake is on the higher side, people with diabetes usually have poor glycemic control with high post prandial glucose. Basal insulin alone is not enough to cover mealtime glucose excursions[2]. Adding mealtime insulin after basal insufficiency is a challenge for patients and doctors. Patients' perceived treatment burden increases with number of injections. Timely initiation and appropriate intensification of insulin therapy may therefore help improve glycemic control[3].

Insulin degludec/aspart (IDegAsp) is the first soluble co-formulation combining a long-acting insulin degludec (IDeg) and rapid-acting insulin aspart (IAsp) [4] In patients with uncontrolled glucose with OAD inadequacy, insulin initiation with IDegAsp once daily provides superior long-term glycemic control compared to insulin glargine with similar FPG and insulin doses, and numerically lower rates of overall and nocturnal hypoglycemia.[5]

Furthermore, in patients with uncontrolled type 2 diabetes (T2DM) previously treated with insulins, IDegAsp twice daily effectively improves glycated hemoglobin (HbA1c) and fasting plasma glucose (FPG) levels with fewer hypoglycemic episodes versus premix insulins and basal bolus therapy.[6] In patients with type 1 diabetes mellitus (T_1DM), IDegAsp once daily and IAsp at remaining meals provides more convenient three injection regimen per day over conventional 4-5 injections based basal-bolus therapy.[6] IDegAsp is an appropriate and reasonable option for initiation as well as intensification in both type 1 and type 2 diabetic patients with the glycemic control being comparable to multiple daily injections and lesser number of pricks.

TAKE HOME MESSAGE

Insulin degludec/aspart (IDegAsp) is a safe and appropriate option for both initiation as well as intensification in type 1 and type 2 diabetic patients

References:

1. Mohan V *et al. Diabetes* 2012;61: A645-A677
2. Garber et al. *Diabetes Obese Metab* 2009;11 (Suppl. 5):14-8)
3. IDF Global Guideline for Type 2 Diabetes. *Diabetes Res Clin Pract.* 2014;104:1-52.
4. Havelund et al. *Pharm Res* 2015 Jan 8.
5. Onishi et al. *Diabetes ObesMetab* 2013;15:826–32
6. Rodbard et al. *Diabetes ObesMetab*. 2016 Mar;18(3):274-80)

Glimpses of CME on 12 May 2018

Glimpses of CME on 26th July 2018

Journal Watch

1. **Epinephrine Versus Norepinephrine for Cardiogenic Shock After Acute Myocardial Infarction. Levy B[1], Clere-Jehl R[2], Legras A[3], et al. J Am Coll Cardiol. 2018 Jul 10;72(2):173-182.** *The goal of this paper was to compare in a prospective, double-blind, multicenter, randomized study, the efficacy and safety of epinephrine and norepinephrine in patients with CS after acute myocardial infarction. In patients with CS secondary to acute myocardial infarction, the use of epinephrine compared with norepinephrine was associated with similar effects on arterial pressure and cardiac index and a higher incidence of refractory shock*
2. **Effects of aspirin on risks of vascular events and cancer according to bodyweight and dose: analysis of individual patient data from randomised trials. Rothwell PM[1], Cook NR[2], Gaziano JM[3], et al Lancet. 2018 Jul 12. pii: S0140-6736(18)31133-4.** *Low doses of aspirin (75-100 mg) were only effective in preventing vascular events in patients weighing less than 70 kg, and had no benefit in the 80% of men and nearly 50% of all women weighing 70 kg or more. By contrast, higher doses of aspirin were only effective in patients weighing 70 kg or more. Given that aspirin's effects on other outcomes, including cancer, also showed interactions with body size, a one-dose-fits-all approach to aspirin is unlikely to be optimal, and a more tailored strategy is required*
3. **A Two-Center Validation of "Patient Does Not Follow Commands" and Three Other Simplified Measures to Replace the Glasgow Coma Scale for Field Trauma Triage. Hopkins E, Green SM, Kiemeney M, Haukoos JS. Ann Emerg Med. 2018 May 2. pii: S0196-0644(18)30312-3.** *Out-of-hospital personnel worldwide calculate the 13-point Glasgow Coma Scale (GCS) score as a routine part of field trauma triage. Authors independently validated a simpler binary assessment to replace the GCS for this task. In this 2-center external validation, they confirmed that a simple binary assessment-"patient does not follow commands"-could effectively replace the more complicated GCS for field trauma triage*.
4. **Long-term albumin administration in decompensated cirrhosis (ANSWER): an open-label randomised trial. Caraceni P[1], Riggio O[2], Angeli P[3], et al; ANSWER Study Investigators. Lancet. 2018 Jun 16;391(10138):2417-2429.** *Evidence is scarce on the efficacy of long-term human albumin (HA) administration in patients with decompensated cirrhosis. The human Albumin for the treatmeNt of aScites in patients With hEpatic ciRrhosis (ANSWER) study was designed to clarify this issue. In this trial, long-term HA administration prolongs overall survival and might act as a disease modifying treatment in patients with decompensated cirrhosis.*
5. **Sulfonylureas as second line drugs in type 2 diabetes and the risk of cardiovascular and hypoglycaemic events: population based cohort study. Douros A[1,2,3], Dell'Aniello S[1], Yu OHY[1,4], et al BMJ. 2018 Jul 18;362: k2693.** *The objective of the study was to assess whether adding or switching to sulfonylureas is associated with an increased risk of myocardial infarction, ischaemic stroke, cardiovascular death, all cause mortality, and severe hypoglycaemia, compared with remaining on metformin monotherapy in patients with type 2 diabetes.It was found that Sulfonylureas as second line drugs are associated with an increased risk of myocardial infarction, all cause mortality, and severe hypoglycaemia, compared with remaining on metformin monotherapy. Continuing metformin when introducing sulfonylureas appears to be safer than switching*

Compiled by: Dr Amitesh Agarwal

Heartiest Congratulations!!

IPF members who received

FELLOWSHIPS

(Awarded from 1st April 2017 to 31stAugust 2018)

Fellow of American College of Endocrinology (FACE)

DR JUGAL KISHOR SHARMA

Fellow of Royal College of Physicians of London- FRCP (Lond)

DR NARSINGH VERMA

Fellow of Royal College of Physicians of Edinburgh - FRCP(Edin.)

DR JUGAL KISHOR SHARMA

DR SUDHIR MEHTA

DR AMITESH AGGARWAL

DR PUNEET KHANNA

DR SAURABH SRIVASTAVA

DR M V JALI

DR SANDEEP RAI

DR SUDHIR BHANDARI

DR DHEERAJ KAPOOR

DR NEERAJ JAIN

DR J P S SAWHNEY

DR MINAL MOHIT

Fellow of Royal College of Physicians & Surgeons of Glasgow- FRCPSG

DR JUGAL KISHOR SHARMA

DR M V JALI

DR AMIT GUPTA

DR AMITESH AGGARWAL

DR SAURABH SRIVASTAVA

DR MINAL MOHIT

Fellowship of European Society of Cardiology (FESC)

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INVITATION LETTER

Dear Esteemed Member & Colleague,

Greetings from IPF!

As you all know, we are having a series of very successful scientific meetings regularly since the time of inception of our forum. This time, the bi-monthly CME has been planned on second Thursday of this month i.e. **13th September 2018, 8.30 PM** onwards **followed by dinner**. The details are as below:

Chairpersons:

1. **Dr Pardeep Bageja,** DNB(Ortho),MNAMS,PLAB(UK), Sr.Consultant, Orthopedics, Joint Replacement & Arthroscopic Surgery, Sir Ganga Ram Hospital, New Delhi-110060

2. **Dr Ashok Jain,** MD, Medical Director, Shivaji Medical Centre, Shivaji Enclave, New Delhi-110027

Topics & Speakers:

1. **Current outcomes & myths after TKR - Dr Vivek Mittal-** Associate Director, BLK Centre for Orthopaedics, Joint Reconstruction & Spine surgery

2. **Laparoscopic metabolic surgery- Current perspective- Dr Deep Goel-** Director in Minimal Access, Bariatric & Surgical Gastroenterology Department at BLK Super Speciality Hospital

Date & Time- 13th September, Thursday, 8.30 pm onwards

Venue- Hotel Royal Plaza, Ashoka Road, New Delhi

You are requested to come, attend and involve yourself to have an active interaction and discussion in the scientific proceedings as both talks will be very informative and relevant to the present-day scenario. Hope to see you on 13th September 2018. Thanks.

Dr. Meena Chhabra	Dr. J K Sharma	Dr. Vinod Mittal
Chairperson	Secretary General	Chairman, Scientific Committee