



Lala Ram Sarup Institute of Tuberculosis and Respiratory Diseases

(Autonomous Institute under the Ministry of Health & Family Welfare, Govt. of India)

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News Letter

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NEWS ROUNDUP

Dear Readers,

Greetings for the New Year 2009 from LRS Institute! Here is a brief account of our activities for the first trimester of this year from January to March.

ART Sensitization Program: A training program on "Anti-retroviral Treatment in HIV" was organized from 25th February to 27th February under the supervision of Dr. Upasana



Nurses enacting a street play on the occasion of World TB Day

Agarwal. 121 trainees including medical professionals from within the Institute and outside attended this program. Eminent personalities working in this field shared their experiences and thoughts about the issue.

World TB Day was observed in the Institute on 24th March. WHO and Central TB Division organized a workshop on "Corporate response to TB & its challenges". The nurses enacted street plays and IEC materials like posters and banners were displayed for the visiting patients and their relatives.

A workshop on DOTS Plus training of trainers was held on 27th March. It was coordinated by Dr. Neeta Singla and Dr. Roopak Singla. Some of the key issues of concern discussed were:

1. Current status of nurses and their training on TB & MDR-TB
2. Current Role of Nurses at DOTS Plus site & existing modules used in ICT training

3. Paramedical workers in MDR-TB and DOTS Plus program

Over 45 participants attended this program

RNTCP Division of the Institute conducted a training program for STOs, DTOs and MOs from various states from 12th to 24th January.

The DNB Training program of the Institute got a boost as the numbers of seats per year were increased from six to ten. A fresh batch of ten post graduate students joined the Institute.

Dr. Sangeeta Sharma, Pediatrician was promoted from Specialist Gr.-II to Specialist Gr. - I. Dr. Alok Yadav joined the Institute as Medical Officer. Mr. Prasant Kumar as Junior Hindi Translator and Mr. Amit Kumar as X-ray Technician were the new entrants to LRS family. Ms. Sosamma Mathews, Nursing sister and Mr. Om Prakash, Ward Boy retired from the Institute on 28th February after long and dedicated service. Staff Nurses Ms. Koche Chhaya, Mr. Ajay Kumar Sepat, Mr. MS Meena, Mr. Deepak Sharma and Ms. Sunita resigned during this period. We lost Mr. Deen Mohammad, Ward Boy and Mr. Nanak Chand, Safai Karamchari to the cruel hands of death in February 2009.

Presentations:

1. Dr. D. Behera was invited as the Chief Speaker in State Task Force Meeting at Ludhiana, Punjab on 22nd January 2009.
2. Dr. D. Behera delivered a lecture on 'Programmatic management of MDR TB' and presided a session on RNTCP in '5th Orissa Conference on chest Diseases (5th CHESTCON)' at Cuttack on 14-15th February 2009.

3. Dr. D. Behera attended "International Symposium on Tribal Health" at Jabalpur between 27th February to 1st March 2009 and delivered a guest lecture on "Drug resistance issues in Tuberculosis- Specifically MDR/DXR TB" and also chaired a plenary session in the symposium. Dr. R. Sarin delivered a lecture on "Airborne Infection control-TB at this symposium
4. Dr. D. Behera attended meeting of Zonal Operational Research Committees of RNTCP at NTI Bangalore held on 13th - 14th March 2009.
5. Dr. D. Behera attended "Indo- South African joint workshop in the area of Health & Biotechnology" under the Indo-South African Inter-governmental cooperation in Pretoria, South Africa from 30th March to 1st April 2009.
6. Dr. R. Sarin participated in National DOTS Plus training for some States as facilitator from 17th-20th March.
7. Dr. S.B.Singh attended the World Conference on Tobacco Cessation held at Mumbai from 10-14th March

Clinical Activities:

A total of 7644 patients were seen in the OPD in these three months. 458 cases were enrolled for DOTS under RNTCP program. 116 major thoracic surgical operations were done which included 24 lung resections.

Protocol for management of Empyema at LRS Institute:

Chronic empyema is a very distressing condition, which results in a lot of suffering and

morbidity for the patient. The management is controversial because of lack of prospective trials and various modalities of treatment being available. Many patients are referred to LRS Institute with this condition with or without having undergone a tube thoracostomy. Generally, patients have an indwelling catheter without significant or complete expansion of lung. After admission, the following protocol is used:

1. A fresh intercostal chest tube is placed after removing the existing one. If the site of ICD placement needs a change, it is placed at a fresh and appropriate site. The tube is positioned and fixed well, so that the patient is comfortable and without much pain. If there is significant crowding of ribs, the new tube is placed after rib resection. At the time of rib resection, pleural biopsy is also taken.
2. All investigations including hemogram, blood chemistry, blood sugar, fresh X-ray chest etc. are carried out.
3. If the patient is toxic, is having fever or the counts show neutrophilia, broad spectrum antibiotics are given for at least seven days.
4. In tubercular cases, appropriate ATT is started as per their stage, category and previous treatment received.
5. Good chest physiotherapy, breathing exercises and shoulder exercises are ensured along with training by Yoga instructors. Patients are actively encouraged to do these exercises after properly explaining them about the technique and their significance.
6. For two weeks, the same treatment is continued and then the expansion of the lung is evaluated by a fresh X-ray chest
7. The chest tube is changed every week or whenever they are found to be blocked.
8. If there is no expansion of the lung by this time, bronchoscopy is done to rule out intra-bronchial obstruction, if any.
9. By this management. The objectives of full expansion, no pus discharge and no air leak are achieved in majority of the cases. Good chest tube management is the key to empyema management.
10. In those patients, in whom the lung does not expand, their suitability for decortication is assessed after good supervised tube management of 4-6 weeks. If the underlying lung is relatively healthy and multiple (or a single large one) broncho-pleural fistulae are NOT present, the case is suitable for surgical debridement of empyema cavity and decortication of the lung so that full expansion takes place. This assessment may require CT scan of the thorax. This is done under general anesthesia with double lumen endo-tracheal intubation and intensive monitoring. In suitable and selected cases, the results are very gratifying.
11. Patients, in whom the lung is highly diseased, or if large or multiple broncho-pleural fistulae are present, are judged to be unsuitable for decortication. We offer them open window thoracostomy (PC window). This is carried out under local anesthesia or occasionally under GA in



Infected open window thoracostomy in immediate postoperative period



Fully healed window in the same patient 8 months after the procedure

young children or un-cooperative patients. After 10 days, the patient is educated about the care of the window and then discharged.

12. The results of this simple procedure are surprisingly very good and in 70% of cases, the lung fully expands and wound is completely healed on this conservative management. (Fig. 1&2)
13. For those patients having persistent pleural space and problem of pus discharge, assessment is done for their fitness for space reducing thoracoplasty. In willing and fit patients, thoracoplasty is carried out as a major thoracic surgical procedure and after three weeks of postoperative care, they are discharged without any discharging sinus or pus.
14. Good chest physiotherapy, breathing exercises and shoulder exercises are ensured along with training by Yoga instructors for all surgical cases in postoperative period.
15. In our experience, we do not find many indications of treating these cases with

thoracoscopy (video-assisted), except for better drainage and removal of pleural debris.

16. Occasionally, other causes of empyema like dermoid cyst, hydatid cyst, malignancy, amoebic liver abscess, esophageal perforation or foreign body are detected in pre-operative assessment, for which appropriate medical and surgical treatment is given.

The above protocol is based on a large experience and suitable for Indian conditions.

-Dr. R.K. Dewan

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