SANGYAHARAN SHODH

(**A Bi annual Peer Reviewed International Journal**)

August 2017 Volume 20, Number 2 ISSN 2278 -8166

Available online at www.aaim.co.in

संज्ञाहरण शोध

An Official Journal of

BHARATIYA SANGYAHARAK ASSOCIATION

(Association of Anesthesiologists of Indian Medicine)

Please encourage others to be new members

Bharatiya Sangyaharak Association (A.A.I.M.)

Postal Address: Operation Theatre Block, Indian Medicine, S.S. Hospital, Banaras Hindu University, Varanasi – 221 005.

Announcement

The membership of Association is available to persons who are activity engaged in the field of Sangyaharan (Anaesthesia), Pain or Palliation. Membership will entitle members to attend the annual conferences and to receive the official Journal 'Sangyaharan Shodh'. Please fill in enclosed form and send it with crossed cheque or D/D in favor of Bharatiya Sangyaharak Association, Varanasi.

Dr. R.K.Jaiswal
Hon. Secretary
A.A.I.M

SANGYAHARAN SHODH

Journal Subscription (For other than members)

Half yearly - Rs. 200.00 per copy

Annual - Rs. 380.00 for two copies

Please send cheque or D/D in favor of Sangyaharan Shodh, A.A.I.M., Varanasi.

Address: Dr. D.N. Pande, Chief Editor,GB-5, Lane-2, Ganeshpuri Colony, Susuwahi, Varanasi – 221 005.

Tariff for Advertisement in 'Sangyaharan Shodh'

Back Cover Rs. 100000.00-for 15years.

Full Page	-	Rs.	10000.00- annual
Half Page	-	Rs.	6000.00- annual
Qr. Page	-	Rs.	3500.00- annual
Front inside	-	Rs.	25000.00- annual
Back inside Cover	-	Rs.	20000.00- annual
Life member – Advertiser	-	Rs.	50000.00-One time full payment

D/D or Cheque in favor of Chief Editor, Sangyaharan Shodh, A.A.I.M., Varanasi.

Dr. Devendra Nath Pande

***Chief Editor* - Sangyaharan Shodh**

Sangyaharan Shodh is published bi-annually and is an Official Peer Reviewed International Journal of the Bharatiya Sangyaharak Association (Association of Anesthesiologists of Indian Medicine).

Subscription Rates for other than Life Members

Half-yearly	Rs.	200.00	
Annual	Rs.	380.00	
Life	Rs.	5000.00	(for 15 years)

Editorial Office

The Chief Editor, Sangyaharan Shodh, GB-5, Lane-2, Ganeshpuri Colony, Susuwahi, Varanasi – 221005.

SANGYAHARAN SHODH

(A Peer-Reviewed International Journal)

August - 2017 **Volume 20, Number 2**

CONTENTS

Office Bearers -Central Council

Patron
Dr. D.P. Puranik
Director
I.P.G.T.R.A, Tilak Ayurved College, Pune

President
Dr. Anil Dutt
Associate Professor, Deptt.of Shalya Tantra,R.G.G.P.G.I.A., Paprola.

Vice Presidents

Dr. S. Bhat Professor, Deptt.of Shalya Tantra, S.D.M.Ayurved College, Udupi.	Dr.SanjeevSharma Consultant Anesthesiologist VARANASI	Dr. N.V.Borse Professor & Head, Deptt.of Shalya Tantra, Tilak Ayurved College, Pune.

Secretary
Dr. R.K.Jaiswal
Asstt. Professor, Departt. Of Sangyaharan, I.M.S., B.H.U., Varanasi

Treasurer
Dr. P. K. Bharti
S.M.O., S.S.H., I.M.S., B.H.U., Varanasi.

Joint Secretaries

Dr. Vinod Seth, Pune	Dr. B.Maurya, Varanasi	Dr. Ajeet Kr.Rai, Gorakhpur.

Ex-Officio Member - Dr. K.K..Pandey, Past President, Professor, Deptt. of Sangyaharan, I.M.S.,B .H.U.

Executive Members:

Dr. S.K.Singh, Varanasi	Dr. P.Awasthi, Paprola	Dr. Deepak K.Poman,Pune
Dr. A.K.Rai, Pune.	Dr. Vimal Kumar, Haridwar	Dr. Shishir Prasad, Haridwar
Dr. J.K.Chaubey , Varanasi	Dr. A.K. Srivastav, Varanasi	Dr. Y.K.Mishra, Varanasi

EDITORIAL

Medical Commission Bill and fate of Indian Health Scenario

As I recalled my memories it was the year 2000 when I stated a movement to motivate the Government of India to frame a National policy on Indian System of Medicine. I wrote many letters to the authorities of Central Government and State Governments. I always emphasized the following points.

1- All the medical practitioners of India should be governed by only one Medical Council- "Integrated Medical Council of India"

Now the Government accepted to abolish all the existing councils to introduce Medical Commission under whom all the pathies will be governed.

2- To integrate the Allopathey with **AYUSH** to replace western model of Medical system.

Now it will be possible through Medical Commission.

3- Central Government should frame a uniform rule over the country which will permit all the systems of Medicine to use Allopathic Medicine whenever needed.

Now it will be true with creation of one Medical Commission in place of different councils.

4- A Future plan of Probable pattern of Integrated medical Education was submitted by me as President of A.T.I.M. & A.A.I.M.. (Included on Separate Page).

Now my dream would be true with commencement of Medical Commission.

I pray god and appeal to the members of Standing Committee to consider our long standing demand to integrate all the systems of Medicine for the benefit of global health care.

It will reduce the enmity and biases of the pathies and provide a best health system to the society in one campus/ Single window system.

To me all the different education systems of pathies should be integrated and all over the country all the Medical Systems should be under one umbrella.

All the medical Institutes should be merged and only one system should be incorporated. In first instance it will be very difficult to promote such type of system but after a time it will be appreciated by everyone who like their country with care of thier heart.

This National system of Integrative Medicine will open a new era and will change the Global health scenario.

Jai Hind

Devendra Nath Pande
Chief Editor, Professor & Founder Head, Deptt. of Sangyaharan,
I.M.S., B.H.U., Varanasi.

Memorandum to the Prime Minister / Health Minister (Union/State) / President C.C.I.M.

To,
The Honourable Prime Minister
Goverment of India,
N. Delhi.

Sub: Draft National Policy on Indian System of Medicine – 2001.

Hon'ble Sir,

On behalf of Association of Anaesthetists of Indian Medicine and Teachers Association of Indian Medicine, B.H.U., we want to draw your kind attention regarding following burning points –

- that we the Indian System of Medicine graduate and post-graduates are feeling unrest to some points of the National Health Policy which directly sabotage the Indian System of Medicine.
- that integrated system of medicine has been existing in this country for over 75 years. It was started with the blessing of our national leaders – Lokmanya Tilak, Mahatama Gandhi, Pt. Jawaharlal Nehru, Hakim Ajmal Khan, Pt. Madan Mohan Malviyaji etc. who believe that the practitioner equipped with the knowledge of Modern Medicine and Ayurveda/Unani would be better than the practitioners knowing a single Pathy.
- that for conducting this type of integrated medical education first of all Banaras Hindu University started Ayurvedic College in its campus and Hakim Ajman Khan started Tibbia College in Delhi.
- that afterward many institutes came in existence all over the country.

1

- that at present nearly 2.5 lakh integrated medical personals are taking care of the society with their full skill.
- that Chopara Committee – 1948. Pandit Committee – 1949, Dave Committee – 1954, Udupa Committee – 1959, Mudaliar Committee – 1964 recommended the model of integrated medical education for India.
- that International authority in health problem – UNICEF-WHO-1975 has also recommended integrated medical system for India.
- that with the establishment of C.C.I.M. a uniform course of I.S.M. came in existence and many steps were taken to give parity to these graduates. Courses framed by C.C.I.M. is integrated and the teaching institutions are providing integrated teaching uniformly all over the country.
- that the aim and object of the C.C.I.M. course is to integrate the Allopathic knowledge with our national heritage – Ayurveda and Unani and to replace the Western model of medical system with Indian system.
- that National Health Policy Act 2001 prohibit the I.S.M. graduates to use Allopathic Medicine and Blood Products which is totally injustice with I.S.M. graduates who are equally taught and trained in the Allopathic system of Medicine.
- that M.C.I. always try to sabotage the Indian Systems of Medicine by enforcing it's rules on I.S.M. practitioners.
- that Central Government should frame an uniform rule over the country which can protect the interest of I.S.M. graduates and permit to use Allopathic Medicine upto any extent. All the restrictions made by M.C.I. should be withdrawn.

- that furthermore it is necessary to frame a new model of Medical Education in the benefit of our country which should be provided at one place by one person.
- that all the different schools of different Pathies should be modified in only one **integrated system**.
- that all the medical practitioner of India should be governed by only one medical council that will be **'Integrated Medical Council of India.'**
- that I am submitting, the Future Plans of Probable Pattern of **Integrated Medical Education** in India which should be considered within a time framework.
- that we request that our suggestions should be incorporated by the Department of Health Ministry with a discussion with NIMA and other Associations of Integrated Practitioners e.g., Sushruta Association, Ayurvedic P.G. Association, Ayurvedic Surgeons Association.
- that the policy should be framed with great care so that it may cover the interest of integrated practitioners and the interest of our 100 crores of citizens.

With regards

Yours faithfully,

28/09/02

Dr. D.N. Pande
President
Teachers Association of Indian Medicine
B.H.U., Varanasi

Dr. P.K. Sharma
Secretary, A.A.I.M (C.C.)
Old Operation Theatre (I.M.)
S.S.H., I.M.S., B.H.U., Varanasi

Enclosure: Model of Integrated Course for Undergraduate and Postgraduate of Medical Education.

3

PROBABLE PATTERN

U.G. LEVEL

Hindi Version	:	**Bachelor of Bharatiya Samanyavit Chikitsa**
English Version	:	**Bachelor of Indian Integrated System of Medicine**
Duration	:	5½ years Ist Professional : 1 years IInd Professional : 1½ years IIIrd Professional : 1½ years Final Professional : 1½ years
Internship	:	6 months
House Job	:	6 months
Eligibility	:	10 + 2 with Physics, Chemistry, Biology and Sanskrit.
Subjects		
Ist Professional	:	Charak Samhita Sushrut Samhita Madhaw Nidan Homeopathic Principles and Materia Medica Unani, Sidha- Yoga Naturopathy Principles
IInd Professional	:	Anatomy Physiology with Biochemistry Pathology Pharmacology – Allopathy, Ayurveda, Hoemopathy , Rasshastra-Drabyaguna Ayurvedic view on Anatomy, Physiology and Pathology
IIIrd Professional	:	Forensic Medicine with Toxicology and Agad Tantra P.S.M. – Ayurvedic Swasthvrit Medicine
Final Professional	:	Eye, E.N.T. with Sushruta Concepts Surgery with Sushruta approach , Gyn, Obs, Paed.
Internship	:	Rotation in every clinic
House Job	:	In speciality clinic

P.G. LEVEL

Duration : 3 years

Speciality :

1. Ayurveda
2. Unani
3. Sidha
4. Yoga
5. Naturopathy
6. Homeopathy
7. Medicine
   - (a) Skin (b) Cardiology
   - (c) Neurology (d) General Medicine
   - (e) Chest and T.B.
8. Eye – Opthalmalogy
9. E.N.T.
10. Surgery
    - (a) General Surgery (b) Plastic Surgery
    - (c) Orthopaedic Surgery (d) Neurosurgery
    - (e) Urology (f) Cardiothoracic Surgery
    - (g) Anorectal Surgery (h) Obstetrics and Gynaecology
11. Anaesthesiology – Sangyaharan
12. Radiology
13. Radiotherapy
14. Oncology
15. Other specialities – as applicable

स्मारक-पत्र माननीय प्रधानमंत्रीजी/स्वास्थ्य मंत्री (केन्द्र सरकार/राज्य सरकार)/ अध्यक्ष भारतीय चिकित्सा केन्द्रीय परिषद

सेवा में,

माननीय प्रधानमंत्रीजी,
भारत सरकार,
नई दिल्ली।

विषयः भारतीय चिकित्सा प्रणालियों हेतु राष्ट्रीय नीति निर्धारण।

परमादरणीय महोदय,

भारतीय संज्ञाहारक एसोशिएशन एवं भारतीय चिकित्सा शिक्षक संघ काशी हिन्दू विश्वविद्यालय, वाराणसी की तरफ से हम आपका ध्यान निम्न ज्वलंत बिन्दुओं पर आकर्षित करना चाहते हैं -

- कि हम भारतीय चिकित्सा पद्यतियों के स्नातक एवं परास्नातक अत्यन्त क्षुब्ध हैं उन राष्ट्रीय चिकित्सा नीति के बिन्दुओं पर जो प्रत्यक्षतः भारतीय चिकित्सा प्रणालियों के प्रति षड़यंत्र हैं।
- कि भारतीय चिकित्सा प्रणाली एक समन्वित चिकित्सा पद्यति के रूप में लगभग ७५ वर्षों से अधिक समय प्रचलित है। यह समन्वित चिकित्सा पद्यति हमारे राष्ट्रीय नायकों - लोकमान्य तिलक, महात्मा गांधी, पं. जवाहरलाल नेहरु, हकीम अफजल खाँ एवं पं. मदन मोहन मालवीय जी के आशीर्वाद से प्रारम्भ हुई थी। उन महान नेताओं का यह अटूट विश्वास था कि वे चिकित्सक जो आर्युवेद व यूनानी के साथ एलोपैथिक का समन्वयात्मक ज्ञान प्राप्त कर रहें हैं, सिर्फ एलोपैथिक जानने वालों की अपेक्षा वे उम्दा चिकित्सक सिद्ध होंगें।
- कि इस तरह की समन्वित चिकित्सा पद्यति सर्वप्रथम पं. मदन मोहन मालवीय जी ने काशी हिन्दू विश्व विद्यालय में आर्युवेद कालेज की स्थापना करके शुरु की तथा हकीम अफजल खाँ ने दिल्ली में तिब्बिया कालेज की स्थापना द्वारा प्रारम्भ किया।

- कि इसके पश्चात् पूरे भारत में अनेक संस्थायें इस पद्यति की अनुयायी बनी।
- कि अब लगभग २.५ लाख समन्वित चिकित्सा पद्यति के चिकित्सक समाज की सेवा पूरी तत्परता से कर रहे हैं।
- कि भारत वर्ष के लिये समन्वित चिकित्सा पद्यति का अनुमोदन चोपरा कमेटी - १९४८, पं. कमेटी - १९४९, दवे कमेटी - १९५४, उडुपा कमेटी - १९५९ एवं मुदालियर कमेटी - १९६४ ने भी किया था।
- कि यूनिसेफ - अर्न्राष्ट्रीय प्राधिकरण ने भी १९७५ में भारत के लिये समन्वित चिकित्सा पद्यति अनुमोदित की थी।
- कि केन्द्रीय भारतीय चिकित्सा परिषद् की स्थापना के बाद एक समरूप पाठ्यक्रम इसके द्वारा पूरे भारत के लिये प्रारम्भ किया गया जो समन्वित प्रणाली पर आधारित है तथा इसी पद्यति का पाठ्यक्रम पूरे भारत में विभिन्न संस्थानों द्वारा दिया जा रहा है। इसका उद्देश्य धीरे-धीरे एलोपैथी के स्थान पर समन्वित चिकित्सा प्रणाली को स्थापित करना है।
- कि राष्ट्रीय चिकित्सा नीति २००१ इन समन्वित चिकित्सकों को एलोपैथिक औषधियों के उपयोग व रक्त के उपयोग से वंचित करती है। यह अत्यंत अमानवीय तथा अन्यायपूर्ण कदम है न सिर्फ समन्वित चिकित्सकों के प्रति बल्कि पूरे देश के नागरिको के प्रति भी।
- कि मेडिकल कॉन्सिल हमेशा से प्रयत्नशील है कि भारतीय चिकित्सा प्रणालियों का विकास न होने पाय तथा सिर्फ एलोपैथी का वर्चस्व रहे।
- कि केन्द्रीय सरकार को एक ऐसा कानून पूरे देश में लागू करना चाहिये हो हर प्रदेश सरकार को बाध्य करे कि वह समन्वित चिकित्सा प्रणाली के चिकित्सकों को एलोपैथी औषधियों का प्रयोग करने कि छूट प्रदान करे तथा मेडिकल कॉन्सिल अपने नियमों को उन पर न लाद सके।
- कि यह समय की माँग है कि भारत सरकार एक नया मॉडल चिकित्सा शिक्षा हेतु बनाये जो एक ही संस्था में सभी प्रणालियों की शिक्षा देने हेतु हो।

- कि सभी अलग-अलग प्रणालियों की संस्थायें एक ही समन्वित चिकित्सा पद्यति की संस्था के रूप में परिवर्तित कर दी जाय।
- कि सभी चिकित्सा पद्यतियों के चिकित्सक एक ही परिषद् केन्द्रीय समन्वित चिकित्सक परिषद् द्वारा संचालित हों।
- कि हम भविष्य हेतु भारतीय समन्वित चिकित्सा प्रणाली की एक भावी योजना प्रस्तुत कर रहे हैं जिस पर समयबद्ध कार्यवाही करके एकरुपता स्थापित की जा सकती है।
- कि हमारा यह आग्रह है कि आप हमारे इन सुझावों को चिकित्सा नीति निर्धारित करते समय अवश्य सम्मिलित करें। अन्य भारतीय चिकित्सा पद्यतियों की परिषदों जैसे N.I.M.A., सुश्रुत एसोशिएशन, आर्युवेदिक पी. जी. एसोशिएशन, आर्युवेदिक सर्जन एसोशिएशन, आदि से भी विचार विमर्श किया जाय तथा उनके सुझावों को सम्मिलित किया जाय।
- कि भारतीय चिकित्सा नीति अत्यन्त सावधानी से बनायी जाय जो भारत व भारतीयों के भविष्य की स्वास्थ्य हितों की रक्षा कर सके तथा साथ ही समन्वित चिकित्सकों को उनके सेवा कार्य से पथभ्रष्ट न कर सके।

आभार सहित,

28.09.02

डा. डी. एन. पाण्डे
अध्यक्ष
भारतीय चिकित्सा शिक्षक संघ
(ए.टी.आई.एम.)
का.हि.वि.वि., वाराणसी

डा. पी. के. शर्मा
सचिव
भारतीय संज्ञाहारक एसोशिएशन (केन्द्रीय समिति)
पुराना आपरेशन थियेटर(भा. चि.)
एस.एस.एच., का.हि.वि.वि., वाराणसी

संलग्नकः भारतीय समन्वित चिकित्सा प्रणाली का प्रारुप।

Palliative Care: Challenges and Prospectives in Ayurveda

***Dr. Satyendra Singh *Prof.K.K.Pandey**

Abstract: Over all well being and quality of life has always been of primary important in any medical system. Now a days is has been observed, while presenting a terminally ill patient many systemic disorders develop either because of progressive condition of disease and /or conventional treatment regime as per guide line of WHO a terminally ill patient suffering from specially cancer disease palliative care apart from routine treatment. Just to maintain the quality of life in spite of many modalities in modern treatment regime to provide relief from such systematic disorders many unwanted complication occurs during course of treatment. The textual references of *ayurveda* and its holistic approaches of treatment can better role in this regard how far *ayurveda* can take the challenges, to provide better health care and quality life of terminally ill patient will be discussed and presented during conference.

Key words: Palliative care, cancer disease, *Ayurveda*, quality of life.

INTRODUCTION: Palliative care is a multidisciplinary approach to specialized medical care for people with serious illnesses. It focuses on providing people with relief from the symptoms, pain, physical stress, and mental stress of a serious illness whatever the diagnosis. The goal of such therapy is to improve quality of life for both the person suffered from the cancer disease and their family.

WHO Definition of Palliative Care: Palliative care is "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual". Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;

Goals and Objectives: The goals and objectives for this project are that students training in nursing, medicine and ministry will:

- Improve their knowledge of palliative care and symptom management.

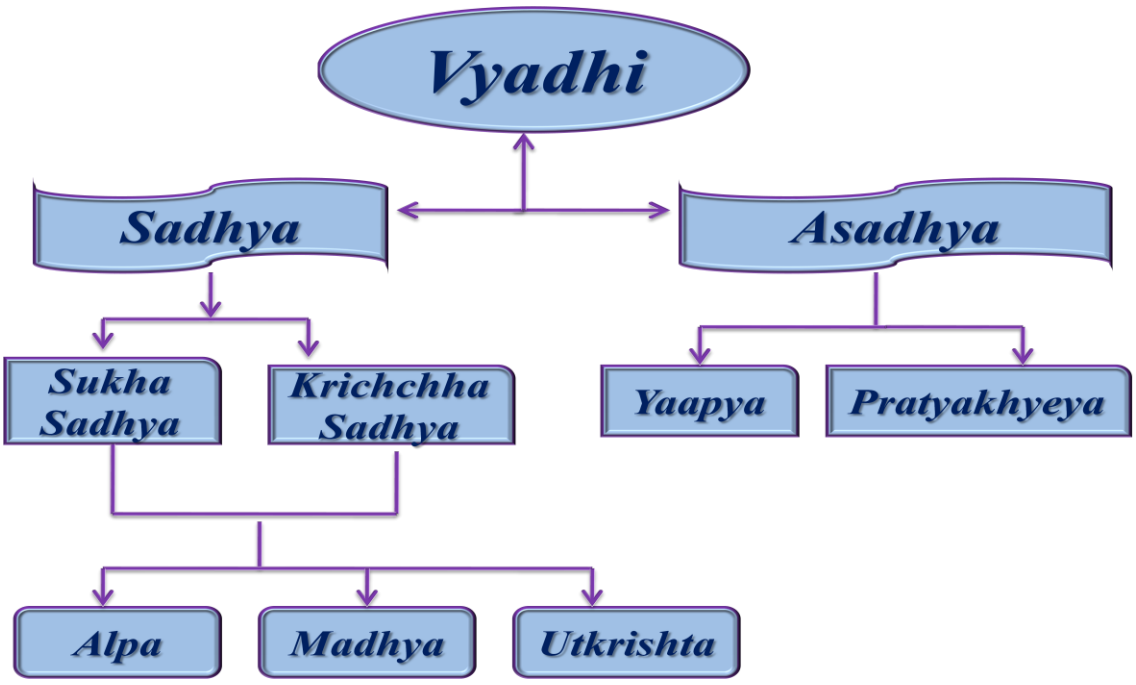
Improve their knowledge and appreciation for the spiritual needs of patients with terminal cancer.

*JR III **Professor, Deptt. of Sangyaharan, I.M.S, BHU, Varanasi

- Improve their cultural sensitivity and appreciate the role of culture in influencing a patient's experience of dying.
- Enhance their appreciation for a team approach to patient care, especially for the terminal patient.
- Appreciate the contribution of all health care professionals to the care of the terminal patient.

PALLIATIVE CARE IN AYURVEDA: The modern cancer therapy which is known to burdened by drug-induced toxic side effects hoping perfect cure of disease form the complementary and alternative medicine system. The main goal of Ayurvedic therapy is to find the ultimate cause of an illness while the therapeutic approach of Ayurveda is divided into four categories as Prakritisthapani chikitsa (health maintenance), Rasayana chikitsa, (restoration of normal function), Roganashani chikitsa (disease cure) and Naishthiki chikitsa (spiritual approach).

Commonly used herbal decoctions reported in Ayurveda are made of multiple herbs possessing great potential for a cancer cure; scientifically these formulations work on multiple biochemical pathways and influence different organ systems all together and nourish the body as a whole by supporting "body defense systems".



Ethics and Challenges in Modern Medicine:

The chief issue addresses the relief of pain and suffering. The availability, accessibility, and effectiveness of modern methods of pain control make it a moral mandate for every physician to be knowledgeable in the use of analgesics. It is estimated that less than 3% of India's cancer patients have access to adequate pain relief. Inadequate attention to pain relief is tantamount to moral and legal malpractice and is a violation of the principle of beneficence. Despite this, many physicians still lack an integrated comprehensive approach to pain management, which culminates to a fastidious use of analgesics.

Gastrointestinal symptoms:

- Dryness of mouth
- Nausea
- Vomiting
- Constipation and
- Anorexia

Psychological behaviour:

- Pain
- Anxiety
- Insomnia
- Depression
- Apprehension and
- Giddiness

Ill effect to Chemotherapy and Radiotherapy:

- Xerostemia
- Stomatitis
- Change in Voice
- Loss of Taste Sensation
- dryness of mouth and Weight loss.

Name	**Biological source**	**Chemical constituent**	**Uses**
Aconite	Dried root of aconitum napellus, Ranunculacece	Aconitine, hypaconitine, neopelline, napelline, neoline	Treatment of rheumatism, inflammation
Allium Sativum (Garlic)	Bulb of the plant know as allium sativum, lilaceae	Carbohydrate, protein (albumin), fat, mucilage	Carminative, aphrodisiac, expectorant, stimulant, disinfectant
Artemisia	Unexpanded flower Heads of Artemisia cina, Artemisia buvifolia wall, Artemisia maritime, compositae	Essential oil, santonin, artemisin	Anthelmintic
Camellia sinensis	Prepared leaves and leaf buds of Thea sinensis, Theaceae	Caffeine, theobromine, theophylline,gallatonic acid	CNS stimulant, diuretic
Catharanthus roseus	Dried whole plant of catharanthus roseus, apocunaceae	Vincristine, vinblastine, ajmalicine	Antineoplastic, acute leukemia, hodgkin's disease
Curcuma longa	Dried as well as fresh rhizome of the plant known as curcuma longa, zingiberaceae	Curcuminoids, curcumin, volatile oil, starch	Anti inflammatory, anti arthritic, cervical cancer
Glycyrrhiza glabra	Dried peeled or unpeeled root and stolon of glycyrrhiza glabra, leguminosae	Glycurrhizin, glycyrrhizinic acid which on hydrolysis yield glycyrrhetinic acid	Expectorant, demulcent, antigastric effect
Zingiber	Rhizomes of zingiber officinale roscoe, zingiberaceae	Volatile oil, starch, fat, fibre, inorganic material, residual moisture, acrid resinous matter.	Stomachic, aromatic, carminative, stimulant, flavouring agen
Podophyllum peltatum	Dries rhizomes and root of podophyllum peltatum, barberidaceae	Podophyllin, podophyllotoxin, alpha and beta peltatins	Cytotoxic action, treatment of veneral, purgative
Taxus brevifolia	Dried leaves, bark and root of various species of taxus, taxaceae	Taxane, cephalomannine, 10-deacetyl baccatin, taxol	Lung carcinoma, gastric and cervical cancers and also carcinomas of head, neck, prostate and colon
Viola odorata	Dried aerial parts obtained from viola odorata, violaceae	Essential oil, alkaloid, saponins, glycoside of methyl salicylate.	Expectorant, diaphoretic, antipyretic, antibacterial

CONCLUSION: The goal of palliative care should continue to focus on the relief suffering and the improvement of the quality of life for patients with advanced illnesses such as cancer. It is based on an interdisciplinary approach that is offered simultaneously with other appropriate medical therapies and involves close monitoring of the emotional, spiritual, and practical needs and goals of patients and of their family members. Although several cancer centers today now have a palliative care program, significant gaps and delays in the delivery of care still remain.

References:

1.Rajagopal MR, Joranson DE, Gilson AM. Medical use, misuse, and diversion of opioids in India. Lancet.2001;358:139–43.

2. Quill TE. Principle of double effect and end-of-life pain management: Additional myths and a limited role. J Palliat Med. 1998;1:333–6.

3.Kokate C.K., purohit A.P., Gokhale SB., nirali prakashan., 39th edition., 2007, 215, 221,349,385, 395, 360, 381, 415, 424, 450, 484, 511, 515, 534.

4.Bharadwaj P, Vidyasagar MS, Kakria A, Tanvir Alam UA. Survey of palliative care concepts among medical interns in India. J Palliat Med. 2007;10:654–7.

5.Page no.203, 10/9-10,Charak smhita,Sutra sthan,kashinath shashtri gorakhnath shshtri chaukhamaba bharti academy Varanasi ,2009.

हृच्छूल -ANGINA PECTORIS

***Dr.Alok kumar Srivastava **Prof.D.N.Pande**

Key words: beta blockers, calcium channel antagonists, glyceryltrinitrate, stable angina

कफपित्तावरुद्धस्तु मारुतो रसमूर्च्छितः ||१३१||
हृदिस्थः कुरुते शूलमुच्छवासारोधकं परम् |
स हृच्छूल इति ख्यातो रसमारुतसम्भवः ||१३२||(Su.Ut.42)

Angina is caused by myocardial ischaemia. Chronic stable angina has a consistent duration and severity, and is provoked by a predictable level of exertion. It can also be provoked by emotional stress. The pain is relieved by rest or short-acting nitrates.

तत्रापि कर्माभिहितं यदुक्तं हृद्विकारिणाम् |१३३|(Su.Ut.42)

The aim of medical therapy is to minimise symptoms and retard disease progression. This requires lifestyle modification as well as drug treatment.

Clinical evaluation: The history, examination, ECG and laboratory tests provide important prognostic information. Increasing age, chronic kidney disease, diabetes, hypertension, current smoking, previous myocardial infarction, hypercholesterolaemia and heart failure are predictive of adverse outcomes.

Echocardiography: Echocardiography provides information about left ventricular function, and regional wall motion abnormalities that may be related to infarction or ischaemia. In patients with stable coronary artery disease, left ventricular ejection fraction is the strongest predictor of long-term survival. The 12-year survival of medically treated patients with ejection fractions greater than 50% is 73%, and 54% if the ejection fraction is between 35% and 49%. Survival is only 21% if the ejection fraction is less than 35%.

Stress testing: Stress testing on a treadmill or bicycle is recommended for patients with normal resting ECGs who can exercise. Symptoms such as chest discomfort and dyspnoea, exercise workload, blood pressure response and ECG changes consistent with ischaemia are recorded as the patient exercises. Abnormalities present at rest such as atrial fibrillation, left ventricular hypertrophy, intraventricular conduction abnormalities and ECG changes related to electrolyte imbalance or digoxin will result in more frequent false-positive results. Stress testing is also used to evaluate the efficacy of revascularisation and medical treatment, and to direct the prescription of exercise.

***Ph.D. Scholar, Deptt. of Sangyaharan, Faculty of Ayurveda ** Professor & Head, Deptt. of Sangyaharan, Faculty of Ayurveda B.H.U.**

Imaging of coronary arteries: Computed tomography (CT) of the coronary arteries without contrast injection can show coronary calcification, although correlation with the degree of luminal narrowing is poor.

Lifestyle modification: The management of cardiovascular risk factors plays an important role in the overall care of patients with chronic stable angina. Modifiable cardiovascular risk factors include hypertension, hypercholesterolaemia, smoking, diabetes, obesity and sedentary lifestyle. Regular exercise, a healthy diet and maintenance of ideal weight reduce the risk of adverse cardiovascular events. Smoking is a strong and independent risk factor for coronary artery disease so efforts to quit should be encouraged and supported. Control of blood pressure and diabetes is paramount to reducing cardiovascular morbidity and mortality.

Management of chronic stable angina: Prevention of cardiovascular events-

Low-dose aspirin reduces major cardiac events by up to 30% and should be prescribed to patients with coronary artery disease.Clopidogrel is an alternative option for patients intolerant of aspirin. Patients with established coronary artery disease should be prescribed statin therapy irrespective of their lipid profile to slow the progression or even promote regression of coronary atherosclerosis.4

Angiotensin converting enzyme (ACE) inhibitors should be prescribed for patients with stable angina, particularly those who have hypertension, left ventricular dysfunction, diabetes6 or chronic kidney disease. Adverse effects include a persistent cough, hyperkalaemia and, rarely, angioedema. Angiotensin receptor antagonists may be used for those who do not tolerate ACE inhibitors.

Drug therapy: The aim of drug therapy is to minimise symptoms and prevent progression of coronary artery disease. Short-acting nitrates are prescribed to relieve acute symptoms or anticipated angina. Drug therapy aims to reduce myocardial oxygen demand or increase coronary blood supply. The choice of drugs is influenced by factors such as comorbidities, tolerance and adverse effects.

Drugs for angina: Beta blockers-

Beta blockers are first-line therapy to reduce angina and improve exercise tolerance by limiting the heart rate response to exercise. Although they reduce the risk of cardiovascular death and myocardial infarction by 30% in post-infarct patients, their benefits in those with stable coronary artery disease are less certain. The drugs most widely used for angina in the context of normal left ventricular function are the beta1-selective drugs such as metoprolol and atenolol.

Adverse effects include fatigue, altered glucose, bronchospasm, bradycardia, impotence and postural hypotension. Switching to a less lipophilic beta blocker such as atenolol may alleviate symptoms such as insomnia or nightmares. They are usually well tolerated in patients with emphysema who have predominantly fixed airways disease. Beta blockers should not be stopped abruptly due to the risk of rebound hypertension or ischaemia.

Calcium channel antagonists:

Calcium channel antagonists improve symptoms of angina via coronary and peripheral vasodilation. They are indicated for those who cannot tolerate or have insufficient control of ischaemic symptoms on beta blockers alone. Non-dihydropyridine drugs such as verapamil and diltiazem also reduce heart rate and contractility. Verapamil has comparable antianginal activity to metoprolol and can be useful for treatment of supraventricular arrhythmias and hypertension. However, verapamil should be avoided in patients taking beta blockers owing to the risk of heart block, and in those with heart failure because of its negative inotropic effect. Diltiazem has a low adverse effect profile with a modest negative inotropic effect. Care should be taken when prescribing in combination with a beta blocker and in patients with left ventricular dysfunction.

The dihydropyridines such as amlodipine, felodipine and lercanidipine have greater vascular selectivity and minimal negative inotropic properties. They are therefore safer in patients with left ventricular dysfunction. Amlodipine is an effective once-daily antianginal drug that can be used in combination with a beta blocker. Long-acting nifedipine is a proven antianginal drug and is most effective when used in conjunction with a beta blocker. Contraindications to nifedipine use include severe aortic stenosis, obstructive cardiomyopathy and heart failure. Short-acting nifedipine is rarely used as monotherapy due to reflex tachycardia, which can worsen ischaemia and has been associated with a dose-related increase in mortality. It should therefore be avoided.

Nitrates: Sublingual glyceryltrinitrate tablets or nitroglycerin spray remain the treatment of choice for rapid relief of acute symptoms and anticipated angina. Sublingual glyceryltrinitrate tablets are absorbed in the sublingual mucosa and take effect within a couple of minutes. The tablet can be discarded with resolution of chest pain to minimise adverse effects such as headache. Glyceryltrinitrate spray is equally effective and, due to its longer shelf-life, is more convenient for those with infrequent symptoms of angina.

Isosorbidedinitrate undergoes hepatic conversion to mononitrate, resulting in an onset of action of 3–4 minutes. It can provide an antianginal effect for up to one hour. Less commonly it is used as a chronic antianginal drug but requires multiple dosing, and tolerance limits its usefulness. It is often used up to three times per day with a nitrate-free period of up to 14 hours to minimise tolerance.

Long-acting nitrates such as oral isosorbidemononitrate or transdermal patches are effective in relieving angina and can improve exercise tolerance. Chronic nitrate therapy is limited by the development of nitrate tolerance. A nitrate-free period of at least eight hours may reduce this problem. The mechanism of nitrate tolerance is not well established but involves attenuation of the vascular effect of the drug rather than altered pharmacokinetics. A nitrate-free period restores the vascular reactivity of the vessel. Transdermal patches are generally used for 12 consecutive hours with a 12-hour nitrate-free period. There is no evidence that nitrates improve survival. Common adverse effects include headache, hypotension and light-headedness. Nitrates should not be prescribed for patients taking phosphodiesterase-5 inhibitors such as sildenafil due to the risk of profound hypotension. Other contraindications include severe aortic stenosis and hypertrophic cardiomyopathy.

Nicorandil: Nicorandil is a potassium channel activator that improves coronary flow as a result of both arterial and venous dilation. It may be used in addition to beta blockers and calcium channel antagonists to control angina or in patients who are intolerant of nitrates. Nicorandil has been shown to reduce cardiovascular events by 14% in patients with chronic stable angina. Its use has been associated with headaches, hypotension, painful ulcers and genital and gastrointestinal fistulae.

Ivabradine: Ivabradine can be considered for patients intolerant of, or insufficiently responsive to, other drugs. It acts on If channels in the sinus node to lower the heart rate of patients in sinus rhythm without affecting blood pressure, conduction or myocardial contractility. Ivabradine has been shown to reduce a composite primary end point of cardiovascular death and hospitalisation with myocardial infarction or heart failure.

Perhexiline: Perhexiline promotes anaerobic metabolism of glucose in active myocytes. Its use is limited by a narrow therapeutic window and high pharmacokinetic variability. Given its potential for toxic effects such as peripheral neuropathy and hepatic damage, it is usually reserved for patients whose angina is refractory to other therapies. It may be used safely with conscientious monitoring of clinical effects and regular measurement of plasma drug concentrations.

Conclusion: Stable angina is typically provoked by exertion and relieved by rest or nitrate therapy. Risk stratification should be done to define prognosis, guide management and select appropriate patients for revascularisation. The aims of medical therapy are to control symptoms, improve quality of life and prevent cardiovascular events.Beta blockers and calcium channel antagonists remain first-line options for treatment. Short-acting nitrates can be used for symptoms.

References:

1. Australian Institute of Health and Welfare. Cardiovascular disease: Australian facts 2011. Cardiovascular disease series no 35. Cat. No. CVD 53. Canberra: AIHW; 2011. www.aihw.gov.au/publication-detail/?id=10737418510 [cited 2015 Jul 1]
2. Abrams J. Clinical practice.Chronic stable angina. N Engl J Med 2005;352:2524-33. [PubMed]
3. Montalescot G, Sechtem U, Achenbach S, Andreotti F, Arden C, Budaj A, et al. Task Force Members. ESC Committee for Practice Guidelines. Document Reviewers . 2013 ESC guidelines on the management of stable coronary artery disease: the Task Force on the management of stable coronary artery disease of the European Society of Cardiology. Eur Heart J 2013;34:2949-3003. [PubMed]
4. Catapano AL, Reiner Z, De Backer G, Graham I, Taskinen MR, Wiklund O, et al. European Society of Cardiology (ESC) European Atherosclerosis Society (EAS) . ESC/EAS Guidelines for the management of dyslipidaemias: The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS). Atherosclerosis 2011;217:3-46. [PubMed]
5. Fihn SD, Gardin JM, Abrams J, Berra K, Blankenship JC, Dallas AP, et al. American College of Cardiology Foundation. American Heart Association Task Force on Practice Guidelines.American College of Physicians.American Association for Thoracic Surgery.Preventive Cardiovascular Nurses Association.Society for Cardiovascular Angiography and Interventions. Society of Thoracic Surgeons. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the diagnosis and management of patients with stable ischemic heart disease: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons. J Am CollCardiol 2012;60:e44-164. [PubMed]
6. Heart Outcomes Prevention Evaluation Study Investigators. Effects of ramipril on cardiovascular and microvascular outcomes in people with diabetes mellitus: results of the HOPE study and MICRO-HOPE substudy [Erratum in: Lancet 2000;356:860]. Lancet 2000:355:253-9. [PubMed]
7. Norhammar A, Lagerqvist B, Saleh N. Long-term mortality after PCI in patients with diabetes mellitus: results from the Swedish Coronary Angiography and Angioplasty Registry. EuroIntervention 2010;5:891-7. [PubMed]
8. Emond M, Mock MB, Davis KB, Fisher LD, Holmes DR, Jr, Chaitman BR, et al. Long-term survival of medically treated patients in the Coronary Artery Surgery Study (CASS) Registry. Circulation 1994;90:2645-57. [PubMed]
9. Hjemdahl P, Eriksson SV, Held C, Forslund L, Näsman P, Rehnqvist N. Favourable long term prognosis in stable angina pectoris: an extended follow up of the angina prognosis study in Stockholm (APSIS). Heart 2006;92:177-82. [PMC free article] [PubMed]
10. Ashley EA, Myers J, Froelicher V. Exercise testing in clinical medicine. Lancet 2000;356:1592-7. [PubMed]
randomised, double-blind, placebo-controlled trial. Lancet 2008;372:807-16. [PubMed]
11.SushrutSamhita

BHARATIYA SANGYAHARAK ASSOCIATION

(ASSOCIATION OF ANAESTHESIOLOGIST OF INDIAN MEDICINE)

MEMBERSHIP FORM

I wish to join **BHARATIYA SANGYAHARAK ASSOCIATION** as Life/Annual/Associate (Life/Annual)/Honorary member and enclose Cheque/Bank Draft/Money Order/Cash for Rs……..... towards subscription for the association, for the year……..

Full Name (in Block Letter) :……...

Date of Birth & Sex ……...

Qualifications :

Designation/Profession :

Permanent Residential Address with Tel. No. :……...

E-mail ID :……...

Present Address to which correspondence :……

to be sent ……...

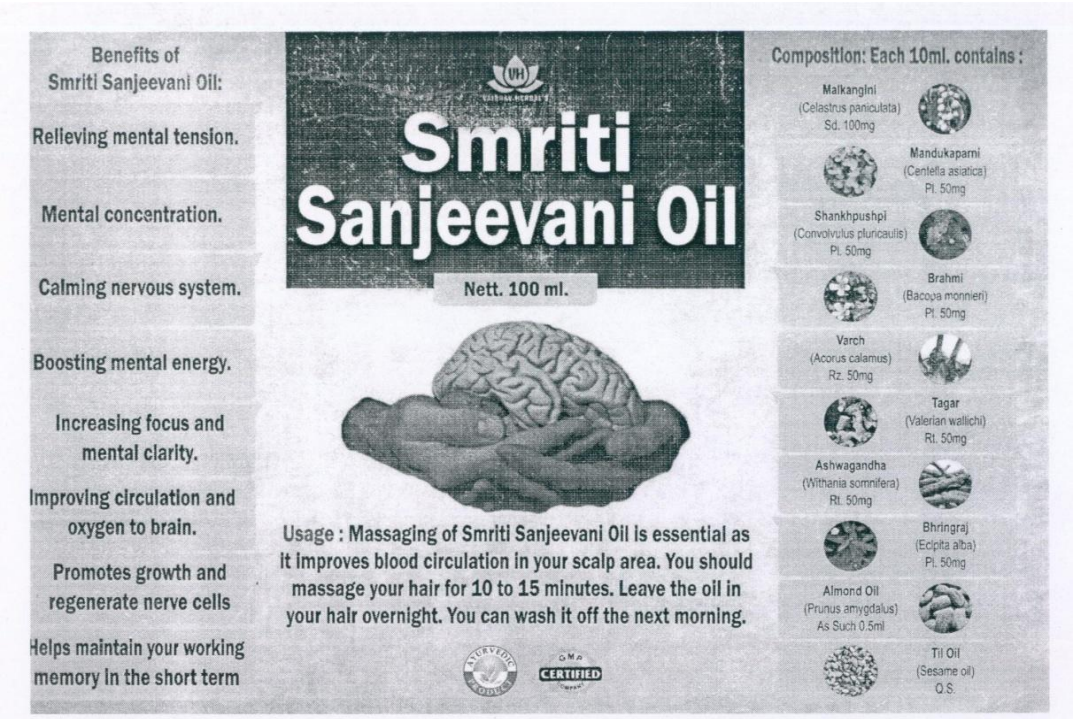
Specialty	:	Sangyaharan/Pain/Palliation	
Membership Fee	:	**Life Member**	**Annual Member**
Membership Fee Bonafide	:	Rs. 5000/-	Rs. 500/-
Associate Membership	:	Rs. 5000/-	Rs. 500/-

I agree to abide by the rules and regulation of the Bharatiya Sangyaharak Association.

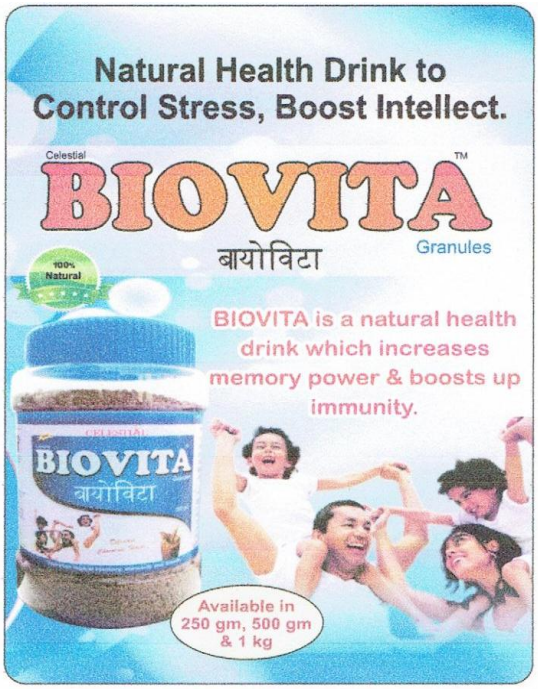
Date: …… Signature _____

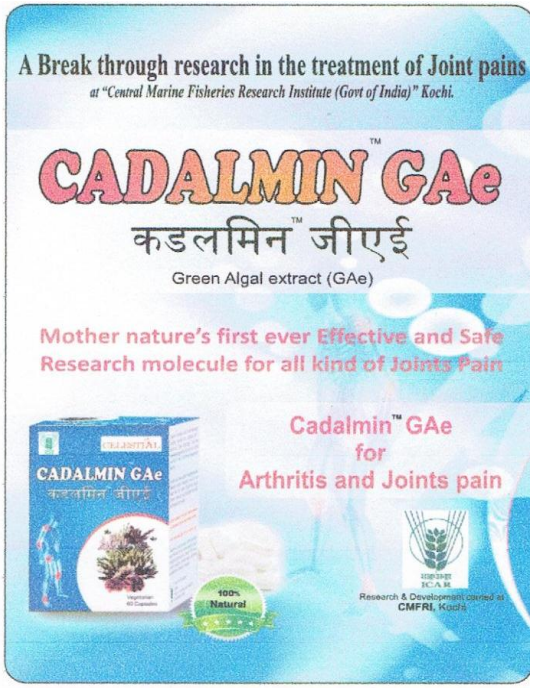
Correspondence Address: Bharatiya Sangyaharak Association, Section of Sangyaharan, Deptt. Of Shalya Tantra, I.M.S., B.H.U., Varanasi – 221005

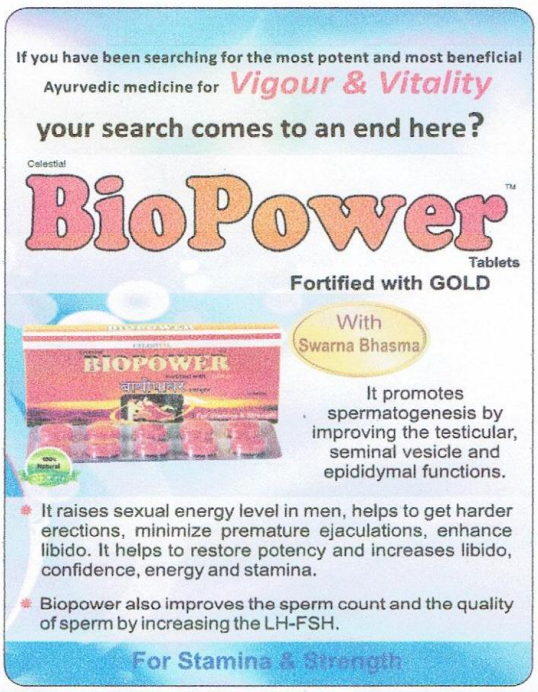
☞ Out station cheques should be accompanied by Rs. 50/- as Bank charges. Cheque/Draft should be send in favor of Bharatiya Sangyaharak Association, Varanasi.


Benefits of Smriti Sanjeevani Oil:
Relieving mental tension.
Mental concentration.
Calming nervous system.
Boosting mental energy.
Increasing focus and mental clarity.
Improving circulation and oxygen to brain.
Promotes growth and regenerate nerve cells
Helps maintain your working memory in the short term
Smriti Sanjeevani Oil
Nett. 100 ml.
Usage : Massaging of Smriti Sanjeevani Oil is essential as it improves blood circulation in your scalp area. You should massage your hair for 10 to 15 minutes. Leave the oil in your hair overnight. You can wash it off the next morning.
AYURVEDIC PRODUCT
GMP CERTIFIED COMPANY
Composition: Each 10ml. contains :
Malkangini (Celastrus paniculata) Sd. 100mg
Mandukaparni (Centella asiatica) Pl. 50mg
Shankhpushpi (Convolvulus pluricaulis) Pl. 50mg
Brahmi (Bacopa monnieri) Pl. 50mg
Varch (Acorus calamus) Rz. 50mg
Tagar (Valerian wallichi) Rt. 50mg
Ashwagandha (Withania somnifera) Rt. 50mg
Bhringraj (Eclpita alba) Pl. 50mg
Almond Oil (Prunus amygdalus) As Such 0.5ml
Til Oil (Sesame oil) Q.S.


VAIBHAV HERBAL
JIVANYA SANJEEVANI (GOLD)
AYURVEDIC PRODUCT
GMP CERTIFIED COMPANY
जीवन्य संजीवनी (गोल्ड)
Nett Contents : 15 Capsules
Composition:
Each capsule contains:
Ext. Ashwagandha (Withania sominfera) (Rt.) 80 mg
Ext. Shatavari (Asparagus racemosus) (Rt.) 80 mg
Ext. Vidari Kanda (Pueraria tuberosa) (Rz.) 80 mg
Ext. Mulathi (Glycyrrhiza glabra) (Rt.) 80 mg
Ext. Gokshura (Tribulus terrestris) (Fr.) 80 mg
Shuddh Kaunch (Mucuna pruriens) (Sd.) 80 mg
Shilajit Purified (Asphaltum) (Exd.) 80 mg
Ext. Triphala (As such) 40 mg
Ext. Trikatu (As such) 40 mg
Abhrak Bhasam Biotite Calx (As such) 30 mg
Mandoor Bhasam Ferric Oxide Calx (As such) 30 mg
Yashad Bhasam Rumex crispus (As such) 30 mg
Praval Pishti Paederia foetida (As such) 30 mg
Rajat Bhasam Argentum (As such) 20 mg
Makardhwaj Sulphide of Mercury (As such) 20 mg
Swaran Bhasam Auric Oxide (As such) 2 mg
General Debility
Weakness due to Diabetes
Diabetic Neuropathy
Loss of Libibo







Manufactured & Marketed by
CELESTIAL BIOLABS LIMITED
(An ISO 9001:2008 certified company)
Plot No. 58, Road No. 12, TSIIC Tech Park, IDA Nacharam, Hyderabad - 500076, Telangana, INDIA
Customer Care : 040- 65358555, 65498555 . E-mail : customercare@celestialbiolabs.com, Web : www.celestialbiolabs.com