Telemedicine makes its appearance felt in India

Telemedicine, the use of telecommunications to provide medical information and services, was the focus of a National Conference (the first of its kind in India) organized by the Sanjay Gandhi Postgraduate Institute of Medical Sciences at Lucknow (23–27 April 2001). The conference was sponsored by many agencies including the Ministry of Information Technology. Peter Yellowlees, a psychiatrist from Australia described how the Queensland Telemedicine Network provides extensive facilities for online teleconsultation, especially for practitioners from isolated areas. Albert Benhamou, a French surgeon, detailed the setting up of a virtual medical university on the web where medical students can access information. Interestingly, this interactive access will be free and many French professors have agreed to provide course material without any fees. Presentations from various parts of India described how telemedicine has been utilized for either providing health care or medical education. These included experiences from the Gujarat earthquake, the Kumbh Mela, the Kailash–Mansarovar trek as well as those augmenting health care facilities in rural areas. In India, where specialists are reluctant to go to rural areas, the potential of this technology to link primary health centres and rural practitioners with large city hospitals was emphasized. A symposium on the legal and ethical issues in telemedicine was also held as part of the conference. Benedict Stanberry, a lawyer from Cardiff who specializes in Telemedicine Law, described some of the peculiar legal issues arising from telemedicine practice in Europe and the efforts to monitor them. Some speakers from India including a sitting judge of the consumer court in Lucknow cautioned against excessive enthusiasm about such technology when many basic problems of health care were as yet unresolved. The potential of the medium to provide inaccurate information as well as its use for soliciting and advertising was also discussed. The conference coincided with the formation of an Indian Society of Telemedicine.

SANJAY NAGRAL, Mumbai

Vascular surgery specialization found unnecessary in Tamil Nadu

The Madras Medical College is the only institution in India running a recognized MCh course in vascular surgery. The MGR Medical University, which is the apex body in Tamil Nadu on matters concerning medical education, did not notify the course for the entrance examination for the year 2001. On enquiry, it was found that the MCI had decided to amalgamate some courses, and the MCh in vascular surgery had been combined with that of cardiac surgery. The college has appealed to the MCI to reconsider the amalgamation and a decision is expected soon. It would be interesting to know how many cardiac surgeons perform vascular surgery. This information would make it clear if a dedicated vascular surgery course is superfluous. On the other hand, the MCI has permitted courses in fields which can be considered equally narrow, e.g. gynaecological oncology. The larger question, therefore, is the basis on which courses are started or closed.

THOMAS GEORGE, Chennai

Global Tuberculosis Control Report

The World Health Organization (WHO) recently released the fifth annual report on global tuberculosis control. The data were obtained from the national control programmes of the 23 high-incidence countries, which account for 80% of all new cases. The main aim of the report was to assess progress towards the goal of a case detection rate of 70% and a treatment rate of 85% by the year 2005 by implementing DOTS (directly observed treatment, short-course), the internationally recommended tuberculosis control strategy, based on five pillars:

1. Government commitment;
2. Case detection by sputum smear microscopy among symptomatic patients self-reporting to health services;
3. Standardized treatment regimen of six to eight months for at least all sputum smear-positive cases, with directly observed therapy (DOT) for at least the initial two months;
4. A regular, uninterrupted supply of all essential anti-tuberculosis drugs; and
5. A standardized recording and reporting system.

The number of countries implementing the DOTS strategy (at least in part) increased by 8 during 1999, bringing the total to 127 (out of 211). About one-quarter (23%) of estimated new smear-positive cases were reported to DOTS programmes in 1999, as compared with 22% in 1998; this is consistent with the average increment of about 120 000 cases in each year since 1994. If this trend is maintained, the target of 70% case detection under DOTS will not be reached until 2013; to get to the target by 2005, DOTS programmes must collectively recruit at least 300 000 additional smear-positive cases each year. Of note, almost all (92%) of the progress in DOTS expansion, as judged by smear-positive case
In February 2001, residents in north Bengal in and around the sub-Himalayan town of Siliguri were in the grip of panic as a mystery ‘killer disease’ spread across the region. Although the situation was the gravest in Siliguri, a number of deaths were reported from Daikhata village in Jalpaiguri and the Chopra area of North Dinajpur. In early February, 9 patients reached various hospitals in a semi-conscious state following a short febrile illness. This suggested the possibility of encephalitis and 7 succumbed, mostly due to respiratory failure. No epidemiological pattern could be established. In the next phase, 59 cases were reported with 36 deaths. Most patients were treated at the North Bengal Medical College (NBMC). In the second phase, epidemiological evidence of person-to-person transmission became obvious. In the first phase, one patient admitted to Paramount Nursing Home died within 72 hours but his brother and some of the nursing staff developed similar symptoms. Dr Aruna Chakraborty, a resident doctor treating a patient at the Medinova Nursing Home, developed the illness and died a few days after the patient. Subsequently, 11 nursing staff, a night watchman, an ambulance driver and Dr A. K. Maity, a cardiologist from Siliguri who treated the resident doctor contracted the disease. Eight of the nursing staff and Dr Maity, who was evacuated to Kolkata, succumbed. Medinova Nursing Home was closed. However, since none of the close relatives of the doctors or paramedical staff developed the disease, the mode of transmission continued to remain conjectural.

In the meantime, local residents, including students from the NBMC and University, left Siliguri in large numbers. Many medical stores in Siliguri downed their shutters. People in Siliguri wore masks. As doctors and health officials began fleeing town, non-government organizations kept vigil at the airport, railway station and the bus terminus in an effort to send them back. The exact nature of this killer disease eluded experts from the WHO, the National Institute of Virology, Pune and the National Institute of Communicable Diseases (NICD), Delhi. Describing the disease as a ‘localized viral epidemic’, the 15-member delegation led by Dr J. C. Gandhi said, ‘the situation, though critical, is not out of control’ and recommended that high-risk persons, particularly doctors, nurses and relatives of the patients take precautions. ‘Protective gowns, gloves, clothes and masks must be provided to both medical staff and relatives.’ Experts recommended quarantine, fearing that patients travelling to Kolkata could start an outbreak of the disease there. Samples from the patients had been sent to laboratories in Pune and New Delhi. Meanwhile, the West Bengal Health Minister Partha De dismissed fears of an epidemic. He told the press at Kolkata, ‘What is the big hurry in knowing the exact cause of the deaths? Everything will be known when the time comes.’

The Times of India (Kolkata, 6 March 2001) stated that the mystery of Siliguri fever had been solved, quoting Mr De, that the mysterious disease has been identified as being due to a ‘mutating measles virus’ by the Indian Council of Medical Research in its preliminary report. However, on 28 March 2001, the same newspaper reported that the Siliguri fever had been identified as Hantavirus Pulmonary Syndrome (HPS) on the basis of a report from Dr Devadasan from WHO and Dr Harit from NICD, who indicated that the pathogen may have been shortlisted as the ‘Hantavirus or Sin Nombre Virus (SNV)’. While HPS affects the pulmonary system, at Siliguri it appears to have struck the nervous system before affecting the pulmonary tissues. Dr Harit states ‘the prodromal period of these viruses exists for 3–5 days from the time of infection. Cough and shortness of breath generally develop by day 7. Once the cardiopulmonary phase begins, the disease progresses rapidly and hospitalization is generally required within 24 hours. But it is not very contagious and virulence is not as high as it was seen in Siliguri.’

There are unconfirmed reports that the airconditioning recently installed in Medinova Nursing Home was submerged in floodwaters in Malda last year. Could that be containing the virus in rodent excreta? In which case, were there two different diseases, which occurred at the same time? One, a mutating measles virus, which could explain why no children were affected and the other, an outbreak of Hantavirus in Medinova which explains why none of the close contacts of the medical staff were affected. The mystery of the fever has not been solved. It has died a natural death and history suggests that the investigation too will soon die.