The jhoola bed

The jhoola (swing) is a convenience enjoyed by most traditional Indian households. A wooden plank 6 x 2.5 feet, the size of a bed suspended from the ceiling, serves multiple roles and is used by all members of the family and visitors.

Besides its many functions, it provides the soothing motion of a rocking chair and keeps the occupant cool without the need for a fan. Not connected to the floor, it is free of insects and facilitates sweeping and washing of the floor.

The modern hospital bed has been imported as a component of the western style hospital regardless of our requirements with an entirely different climate, culture, lifestyle and economy. The Fowler bed is an expensive modification to meet the varying medical, surgical and nursing requirements of a patient. The jhoola bed offers many advantages over the existing hospital bed and has far greater versatility.

1. The height of the jhoola bed can be adjusted to any level merely by shortening or lengthening the chains with a simple S-shaped link. The Trendelenburg and anti-Trendelenburg positions and even lateral tilt can be achieved to the desired degree.

2. The chains also provide a means for suspending an intravenous drip or other equipment at any height and in any position without the need for special floor-based stands.

3. The chains can be utilized for supporting or elevating the arm or leg at any angle, using cross-chains as and when required.

4. It lends itself to the draping of a mosquito net or an oxygen tent.

5. Since the vast majority of patients in most ‘need-based’ countries normally sleep on the floor, there is no need to have a mattress on the jhoola bed. This also helps to reduce cost and eliminate a potent source of hospital infection. A simple durry (a thick cotton carpet) which can be readily washed and dried in the sun or a washable sheet of plastic foam suffices. The wooden surface of the bed can be easily cleaned and swabbed with a disinfectant.

6. The jhoola bed can be adapted for paediatric patients by using a smaller plank and attaching additional chains or wooden panels to the sides to serve as safety guards. The height of the bed can also be adjusted to a convenient level for nursing.

Jhoola beds have been in use in the ward of the Tata Department of Plastic Surgery at the J.J. Hospital for over 20 years (Figs. 1 and 2). The versatility of the jhoola bed for hospital use is limited only by the ingenuity of the nurse, doctor and patient, e.g. hanging of heaters or fans, a cradle for warming the patient, making a tent for inhalation, for intragastric feeding as well as for displaying the patient’s charts and notes. The patient can lull him/herself to sleep with the help of a rope tied to any adjacent post. It can also be used for hanging pictures or toys for children or a television set at the foot of the bed with the infrared remote control hung at the head end.

I have experienced considerable resistance to the use of this remarkably cheap and versatile piece of hospital equipment even though it is often used by the staff in their own homes. Is this the result of western influence that continues to dominate the medical and nursing professions even half a century after gaining independence?

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Candidiasis in HIV-infected patients: A clinical and microbiological study

Oropharyngeal candidiasis is the most common opportunistic infection in patients with HIV infection in India. Various studies
have shown an increasing incidence of candidiasis in HIV-infected patients even at an early stage of infection. In the recent past, there have been increasing reports implicating the non-albicans species of Candida in oropharyngeal candidiasis. We studied the prevalence and clinical and microbiological variations of candidiasis in HIV-infected patients.

We did a descriptive study of all HIV-seropositive patients (by double ELISA method) who attended the Dermatology and Sexually Transmitted Diseases Outpatient department or were admitted to the Infectious Disease ward (September 1998 to June 2000 at the Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry). They were screened for mucocutaneous fungal infections and those with candidal infections were recruited for this study. A total of 185 HIV-infected patients with mucocutaneous lesions of candidiasis were subjected to clinical and microbiological evaluation.

Candidal infections of the skin, nail and mucosae were found in 74 HIV-infected patients (40%). The mean age of the affected individuals was 31 years with a men to women ratio of 2.4:1. Oral candidiasis was observed in 63 cases (85%), genital candidiasis in 22 (29.7%), candidal onychomycosis in 12 (16.2%) and cutaneous candidal infections in 6 (8.1%). Among the 63 patients with oral candidiasis, pseudomembranous candidiasis was observed in 55 patients (87.3%) followed by angular cheilitis in 13 (20.6%), atrophic candidiasis in 10 (15.9%) and hyperplastic candidiasis in 1 (1.6%). Eight cases had both pseudomembranous candidiasis and angular cheilitis. Forty-eight patients with candidiasis had oral candidiasis with dysphagia and were accordingly considered to be in HIV Group IV. Candida albicans was grown in 72 samples (60.5%) and non-C. albicans species in 24 (20.2%), C. tropicalis and C. parapsilosis in 8.4% each and C. kefyr in 3.4%. No growth was observed in 23 samples (19.3%).

Oropharyngeal candidiasis, the most common opportunistic infection in patients with HIV infection, occurs in as many as 90% of HIV-infected patients at some point during the course of the disease. Oral candidiasis probably precedes other opportunistic infections and may be a sign of transition to AIDS. In India, it is the commonest manifestation in HIV-infected patients.

Though C. albicans is the most common cause of oral candidiasis, certain non-C. albicans species such as C. glabrata, C. parapsilosis, C. tropicalis, C. pseudotropicalis (C. kefyr) and C. krusei are also encountered, especially in HIV-infected individuals. Barchiesi et al. observed that non-C. albicans strains accounted for 3.4% of cases during the late 1980s compared to 16.8% during the 1990s; a four-fold increase in non-C. albicans infection in HIV patients. In the present study, C. albicans was cultured from 60.5% cases of candidal infections of the skin, nails and mucosae. Non-C. albicans species were cultured from 20.2% of cases, C. tropicalis and C. parapsilosis from 8.4% of cases each and C. kefyr from 3.4% cases. This study confirms the substantial increase in candidiasis due to non-C. albicans species in HIV-infected patients.

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