Correspondence

Some thoughts on a recent issue of the Journal

Dengue and chikungunya have become endemic in India. A systematic study on the breeding and feeding habits of the *Aedes* mosquito is required to prevent the spread of the disease. The entomological work done by a group from Madurai fills the void to some extent. The study highlights that mud pots, discarded tyres and containers and grinding stones are the major breeding spots. These are found mostly in urban slums with heavy population density and most sufferers of these illnesses live in these areas. It is also known that one infected person can be bitten by many mosquitoes and can spread the disease to many persons—the so-called super-spread.

Adequate information should be widely disseminated particularly among the poorer sections and effective steps should be taken by public health workers. A little time spent by all of us to explain to the sufferer and the relatives about the cause and spread of the disease will also help.

The same issue of the *Journal* carries an editorial on public health and epidemiology. The present-day health scenario focuses on curative medicine at the cost of preventive medicine. This is one reason for many preventable illnesses to proliferate. Though the editorial envisages at least one epidemiologist at the district level in the next 10 years, I doubt whether we will succeed in attracting quality doctors to become epidemiologists.

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B.C. Rao
847, 2nd Cross, 7th Main, H.A.L. 2nd Stage Bengaluru Karnataka badakere.rao@gmail.com

Was it wrong to discard NEET?

This is with reference to Professor Ananthakrishnan’s letter in the *Journal*. I could not agree more with the first seven points mentioned by him, being the parent of a child who recently went through the pain of appearing in multiple examinations, having paid multiple fees and having travelled to various cities for this purpose. There is no doubt that a single examination would spare students and parents all this trouble, besides curbing a number of unfair practices commonly associated with entrance examinations. There were convincing signs that NEET, which made its debut in 2013 and was aborted subsequently, would improve the situation of the students as well as society. It seemed to be reassuring for students and their parents.

However, for someone concerned with education, it did not appear reassuring because the predictive utility of such an exercise did not seem to have been researched well during the discussions mentioned by Professor Ananthakrishnan. In the same issue of the *Journal* which carried this letter, there was a research paper by Gupta *et al.*, which, in a limited way, showed that marks and rankings of students in selection tests have a poor predictive value as far as their performance during the MBBS course is concerned. The educational literature is replete with research findings which show that the only useful predictor of future performance is past performance. I would now like to go back and ask the question posed in Professor Ananthakrishnan’s letter—did we present our case well to the courts when the system of entrance examinations came into being about three decades ago? Has anyone in India ever examined the predictive utility of these examinations in the future performance of the student? More importantly, has anyone ever shown that a student who is not admitted because he has scored one mark less than the selected student would have made a poor specialist compared to the latter? I have not come across any references relevant to these questions and would be interested in finding some answers. In the absence of such information, the learning curves presented in the letter become in infructuous. And, I am not even talking about the educational side-effects of baring careers on a single examination.

The social media was flooded with arguments in favour of NEET during the post-judgment days. Comparisons were often made with single-examination selections for the civil services, etc. Most of these comments missed the single most important point that graduates aspiring for the civil services do not need any specific (and mandatory) skills, unlike medical graduates. The primary objective of the medical curriculum is to produce a graduate who can work as a primary care physician, which implies that he/she has acquired the basic skills, and not to produce a person who is fit to crack the postgraduate entrance examination. I do not need to write about the hit that the internship programme took when the entrance examination was introduced. I am sure someone is going to remind me about the United States Medical Licensing Examination (USMLE) model. If it works there, why not in India? Again, the missing links in this argument are glaring. The total testing time for the USMLE is more than 41 hours (compared to 3 hours in the case of our entrance examinations), and there is no ambiguity regarding the fact that the reliability of a test is proportional to the testing time (reliability is to be viewed not in terms of consistency of marking, but consistency of performance). Further, the scores in the USMLE do not override other measures of selection, such as past performance during medical studies, reference letters and an interview. The USMLE and NEET simply cannot be compared.

Many have argued that such an examination would have helped in maintaining the quality of education. In this context, the learning curves presented by Professor Ananthakrishnan attract one’s attention. Let us not forget that as a part of the welfare measures in India, a number of students are admitted under special categories and many of them, in addition to many of those who secure admission on payment, will have a trajectory of line C. Let us also not forget the differences between students who are from metropolitan cities and have attended coaching classes throughout their internship and those who come from smaller towns (as mentioned in point 8 of the letter). In that sense, a system such as the NEET promotes a ‘survival of the fittest’ culture. If we admit a student to a medical school (which has been established after obtaining due permissions of the Medical Council of India and the Ministry of Health and Family Welfare and going through the requisite inspections, and which has also been inspected regularly for 5 years before being granted recognition), we cannot simply discard a student at the end of 5 years. It is our responsibility to ensure that entrants to a medical school reach a
common minimal level before being put in a race. We need equity, not equality. If we are so concerned about the admission of those with money power (but without competence), why are we hysterically promoting boards of for-profit medical schools?

We need to be careful about establishing ‘substandard’ medical colleges. We must have an assessment system to help students acquire the requisite competencies. We need to lower the stakes on individual assessments so that they become a learning tool. Finally, we should introduce an exit examination to be held when all the students have a level playing field. To borrow an analogy from Martin Luther King, introducing an exit examination simply to weed out ‘incompetent’ students is like ‘asking them to lift themselves up by pulling their shoe strings, while forgetting that most of them are barefoot anyway’.

The honourable courts had different reasons to discard NEET but did we present an educationist’s perspective before the courts? There is no doubt that merit needs to be considered and recognized. However, let us ask ourselves this question—what is merit: the ability to crack a multiple-choice question examination or the ability to work as a competent physician?

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Tejinder Singh
Department of Paediatrics
Christian Medical College
Ludhiana
drtejinder22@gmail.com

Primary Sjögren syndrome

Sjögren syndrome is a chronic autoimmune disorder affecting many organs but predominantly the exocrine glands. It is usually associated with other connective tissue disorders; when it occurs in isolation it is called primary Sjögren syndrome (PSS). We report the case of a woman presenting with hypokalaemic periodic paralysis as the initial presentation of PSS.

A 36-year-old woman from Punjab, India presented with weakness of the lower limbs followed by the upper limb for 2 days. She also developed dysphagia, inability to open the mouth and difficulty in breathing. She had had four such episodes of weakness in the past.

Clinical examination revealed quadriparesis with grade 1/5 power on all four limbs, weakness of neck flexors and bilateral foot drop. Reflexes were absent except for sluggish knee and ankle jerk on the left side. The abnormalities detected on investigations were leukocytosis (28 600/mm3), hypokalaemia (2.1 mEq/L) and hypophosphataemia (1.2 mEq/L). Analysis of blood gas revealed metabolic acidosis (pH 7.19, HCO3 9 mg/dl). Urine analysis revealed tubular proteinuria (0.46 g/24 hours) and decreased excretion of potassium and chloride (K 15 mEq/L, normal 25–120 mEq/L; Cl– 105 mEq/L, normal 110–150 mEq/L).

Ventricular bigeminy was present on electrocardiogram. Ultrasonogram of the abdomen revealed nephrolithiasis on the left side and bilateral mildly echogenic kidneys. A diagnosis of hypokalaemic periodic paralysis with predominant features of type 1 renal tubular acidosis (RTA; symptomatic hypokalaemia, acidosis and nephrolithiasis) was made.

On reviewing the history she had symptoms suggestive of xerophthalmia and xerostomia. Severe dryness of both eyes was noted on Schirmer test. On further evaluation, anti-Ro antibodies were 96.3 (normal <3) and anti-La antibodies were 5.96 (normal <3). Antinuclear antibodies (ANA) and anti-ds DNA levels were within normal limits. She thus fulfilled four criteria according to the current American European Consensus Group Diagnostic criteria for Sjögren’s syndrome.

Hypokalaemic periodic paralysis as an initial presentation of PSS is rare. RTA is the main cause of hypokalaemia with normal anion gap metabolic acidosis. The hypokalaemia may be due to proximal tubular HCO3 wasting (type 2 RTA) or impaired H+ secretion due to a defect in the H+ ATPase/H+K+ ATPase (type 1 RTA). Hypokalaemia is more severe and symptomatic in type 1 RTA.

The pathogenesis of distal RTA in Sjögren syndrome is not clear. Takemoto et al. found that patients with Sjögren syndrome with distal RTA had high levels of anti-carbonic anhydrase antibodies which affect the function of carbonic anhydrase in cortical collecting ducts.

In a large case series, the renal defects in PSS included reduction in urinary concentrating capacity (20%), reduction in creatinine clearance (13%), distal RTA (5%), hypokalaemia (7%), subnephrotic proteinuria (17%) and nephrotic syndrome (3%). Treatment of distal RTA involves oral intake of sodium bicarbonate along with potassium supplementation as citrate to keep serum K+ levels normal and serum HCO3 >18 mEq/L.

Hypokalaemia periodic paralysis could be an initial presentation of PSS. Hence, we would like to stress upon the need to evaluate the cause hypokalaemic periodic paralysis.

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Jency Maria Koshy
jencymkoshy@gmail.com

Mary John
Department of Medicine
Pratish George
Department of Nephrology
Christian Medical College
Ludhiana
Punjab