Reply

The article Heart Failure : Current Concepts, is primarily meant for physicians and MO's outlining the accepted modalities of management of heart failure. Para wise reply to the comments:

- (a) Serial No 1, 2 and 4 are accepted as mentioned.
- (b) Serial No.3 Eplerenone is a selective Aldosterone receptor antagonist, which has been accepted in a select population of

heart failure patients with recent myocardial infarction and LV systolic dysfunction as studied in the EPHEsus trial.

- (c) Serial No. 5-these modalities are investigational and not yet approved for the treatment of heart failure.

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Increase in Incidence of Pterygium in High Altitude Areas

Dear Editor,

Incidence of pterygium is high in the sunny, hot, dusty, dry region of the world near the equator, where there is direct exposure to sunlight. High incidence of pterygium has also been found in the arctic region. Routine medical examination reveals increase in incidence of pterygium in our unit serving in a high altitude location. Ultraviolet (UV) light is the main aetiological factor in causation of pterygium. It is proposed that UV rays alter the deoxyribonucleic acid in fibroblasts, which then multiply and invade the cornea. In high altitude region people are exposed to ultra violet light reflected from the snow clad mountains. Here, pterygium is usually seen among those who are posted for more than one and half years

duration. Prevalence of pterygium is also high among the civilian population of this region. Cases seen are mostly over 35 years of age and with no ocular diseases in the past. The affected people did not use UV protective goggles regularly. Pterygium cases seen are usually found to be thick, vascular and bilateral. Usual complaint is of a foreign body sensation with occasional irritation in the affected eye. Visual impairment was not found in any of the cases seen so far. Eye drop dexamethasone sodium phosphate 0.1% and hydroxypropyl methyl cellulose 2% are found to give symptomatic relief. Advanced stage of pterygium requires surgical intervention.

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Bed Occupancy Rate

Dear Editor,

The latest encounter that I had with the mysterious term 'bed occupancy rate' was when I had to interact with a high power committee dealing with rationalisation of medical establishments. For them, that term was as relieving as measuring 'weight by kilogram or measuring length by meter'. I sulked in surprise. "If you think that hospital utilisation rate is more intricate than bed occupancy rate, you produce another formula", they suggested. Quickly another formula was prepared and given to keep the issue simmering.

Bed occupancy rate has remained as the most important parameter to evaluate the utilisation of hospitals. Accordingly, many studies have recommended redistribution of hospital beds and closure of under-utilised hospitals. But a curious finding is that many of the so called underutilised hospitals are still remaining busy and many busy hospitals are coping up with the load on loaned manpower. How is that? Is there any other unidentified process that keeps the staff busy? Is the unadulterated bed occupancy rate, the sole decider? It is also observed that the utilisation of male beds and female beds has been different in the same hospital.

It is amazing that the bed occupancy has remained more or less steady for the last decade with only marginal variation. Remember, it is happening when the clientele is increasing by about 50,000 per year. Where are the clientele gone? Many have no access. A few of them will be dying out from the pool, others are thronging to the OPDs (out patient dept) and getting well without availing admission. The average increase in OPD has been about one lakh per year for the last ten years. It is very very significant. Its effect on hospitals is never calculated seriously. It has to be considered as a major form of workload. OPD cases are to be attended within a time frame unlike many of the stabilised admitted cases. Yet, they are many

times more than the admitted cases.

The present OPD with multiple specialists, newer generation investigational facilities and quick response have attracted a wide clientele. Effective OPD services have systematically contained the patients' load. But it is at a cost. The clients have multiple contact points in the OPD in the form of general duty medical officers, specialists, super specialists, technicians for modern investigations, physiotherapists, pharmacists etc.; and take away contact time which is not counted as a major parameter of hospital utilization. In the past, the contact points were limited to a few specialists and basic investigational facilities. The increase in contact points is to be seen in the back drop of systematic pruning of AMC manpower. It is to be remembered that the tremendous advancements in medical care, though revolutionised health care, have sought for more qualified work force. The requirement of radiographers / X-ray assistants can be taken as an example. The radiographers / X-ray assistants are authorised as per the bed slab. When we modernize the hospitals with more X-ray machines, ultrasound machines, CT scanners and MRI equipment, the authorisation does not change though common sense will dictate requirement of additional workers to receive the patients, to document them, to operate the machines, to distribute results, to maintain the equipment, to maintain the area and so on. Then how do we manage? We either don't manage well or manage it with 'whimsical flexi-posting' of all staff. So called 'low bed occupancy' of the hospitals gives scope for internal adjustment. Under-deployed and suspended field ambulances also function as donors.

The objectives for consideration are use of out-patient load and investigational load as important parameters for evaluating hospital utilization. These can either be taken independently or be given a weightage and added to the bed occupancy. Is it an easy job? Not at all! There is a hospital with 78 beds and seven specialists. There is another hospital of 148 beds with just three specialists. There are