

Quest for Doctors in a Dodoland

Almost every day, we hear about violence on doctors and health establishments from different parts of India. The violence against doctors in India is often vicious, violent and mob directed, and not infrequently claiming the life or limb of the doctor concerned [1,2]. This violence not only physically harms the doctor but also mentally and often socially jeopardize the career of the doctor. Moreover, costly hospital instruments and furniture are often damaged, vandalized or looted by the irate mob. Surprisingly many of these violent instances are politically motivated; small time goons or politicians take the advantage of patients and their relatives' distress and incite violence for financial or other ulterior motives.

Doctor, if they escape the violence of the patients' relative or the murderous mob, they may have to face consumer – and criminal courts. In West Bengal, they have to face another organization that can take action considering every practice as a malpractice on the basis of West Bengal Clinical Establishment bill of 2017.

In spite of all the laws against violence, both state and central governments have been inefficient in bringing the perpetrators of violence to justice. Normally justice in India is a slow long and tedious process and that itself has been thought of one of the reason for increasing violence against doctors [3]. Doctors often expect that medical and professional organizations at least will stand up against outrageously illegal and unlawful instances of

violence. However these organizations appear to be helpless and toothless.

No doctor in this world wants to harm his/her patients, and whatever they do, most of them do it with best of the intentions in their mind. Many times doctors in this country are working under impossible circumstances. Whether we consider the violence as a class war [4], or a consequence of rise of pseudointellectuals in the society [5] or reflection of tremendous medical advances coupled with our failure to ensure immortality of human being or reflection of protest against abject corruption in the society; we have to act to stop it. If we do not act now, the day may not be far away when we will have severe death of doctors in this country to treat our ailments – like the Dodos which vanished from Dodoland because of human violence and greed.

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Human Milk Banking in India: Still in Infancy

Human milk banking is an absolute necessity to provide full benefits of breast milk to all babies. All mothers must be counseled and encouraged to breastfeed their babies as it is the greatest gift a mother can offer to her baby. A large number of preterm infants are not fortunate enough to get sufficient amounts of their mothers' own milk due to many reasons. Human milk banks can play very important role in such conditions. Donated human milk by other eligible lactating mothers can fill this gap.

Greatest beneficiaries to such an arrangement will be preterm babies who are at risk of necrotizing enterocolitis and neonatal sepsis – diseases well known to be

associated with high mortality and morbidity. It also helps them to reach full enteral feeds earlier than without human milk by strong trophic effects on gut. A meta-analysis of trials comparing formula feeds *versus* donor milk has shown significant protective effect of donor milk compared to formula in preventing necrotizing enterocolitis (RR: 2.46, 95% CI 1.19, 5.08) [1].

With better availability and improved quality of care of neonatal intensive care units (NICUs) in India, more and more extremely preterm babies are surviving. A recent survey of NICUs in India concluded median (IQR) survival of 44% (18%, 60%) in those <28 weeks of gestation [2].

First human milk bank of Asia '*Sneha*' was founded in 1989 in Mumbai, but there is still insufficient number of milk banks in India (around 22; most in private hospitals)

[3]. Brazil which registers 10,000 births a day (almost one-fifth of India) has 219 human milk banks. The India Newborn Action Plan is committed to reducing preventable newborn deaths to single digits (<10 per 1,000 live births) by 2030. This is possible by successfully integrating human milk banking services with newborn care across India.

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An Uncommon Cause of Stridor in a Young Infant

Inspiratory stridor is an important clinical finding that requires immediate and adequate evaluation of the underlying etiology in children. Some of the commonly encountered causes are acute laryngotracheobronchitis, laryngomalacia, and foreign body aspiration. Other rare causes should be considered if basic work-up does not reveal any of these common etiologies.

A 3-month-old girl was brought to our pediatric emergency services with history of cough and cold, noisy breathing and chest indrawing for last five days. She had inspiratory stridor with subcostal and suprasternal retractions on examination, with bilateral equal air entry on auscultation. Chest X-ray and X-ray neck were apparently normal. At admission, child was treated with steroids and adrenaline nebulization considering a diagnosis of acute laryngotracheobronchitis. As there was no symptomatic improvement, direct laryngoscopy was performed that did not show evidence of any abnormality. Contrast enhanced computed tomography (CECT) neck showed a lateral pharyngeal mass (**Fig. 1A**). Transoral surgical procedure was performed under general anesthesia, and a 1.5 x 1.5 cm cyst in the left lateral pharyngeal wall closely abutting the left arytenoid was seen (**Fig. 1B**). Thick whitish fluid was aspirated and cyst was marsupialized. No pus cells were seen on microscopic examination. Fluid culture grew normal respiratory flora. Biopsy of the cyst wall showed stratified squamous epithelium and a final diagnosis of left pharyngeal wall submucosal retention cyst was made. Child was discharged four days after surgery. On follow up, child had no stridor or respiratory distress.

Stridor may be the first sign of a life-threatening disorder. Acute onset stridor can result from obstruction

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FIG. 1 (A) CECT showing lateral pharyngeal wall cyst; and (B) Intraoperative left pharyngeal wall cyst.

to the airway anywhere from nose to thoracic trachea and major bronchi [1]. Common causes of obstruction at the level of pharynx include retropharyngeal and parapharyngeal abscesses. Some of the rare causes include dermoid cyst, thornwald cyst, duplication cyst, pharyngeal teratoma and pharyngeal choristoma [2,3]. Pharyngeal wall sub mucosal retention cyst is an uncommon cause of stridor in children. A timely imaging procedure like CECT helps in correct diagnosis and appropriate management.

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